



HIT Perspectives

Perspectives and Updates on Health Information Technology

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Electronic Health Records

Moving the Ball Up the Field: Minnesota Mandates Electronic Prior Authorization

by Tony Schueth, Editor-in-Chief

The Minnesota legislature has given a shot in the arm to the use of electronic prior authorization (ePA) by requiring its use by January 1, 2011. In the next 6 months or so, the commissioner of health, in consultation with the state's eHealth advisory committee and administrative uniformity committee, will thrash out the specifics. We know that faxes will not count.

The move is indicative of ePA's gaining traction in the business and standards worlds. A recent survey by the National Council for Prescription Drug Programs (NCPDP) places use of ePA high on many people's wish list—which we have heard anecdotally for several years from payers, providers and other stakeholders.

Since the 2006 Centers for Medicare and Medicaid Services (CMS) pilots, in which the ePA standard was judged not ready for prime time, NCPDP and the industry have come together to address shortcomings identified in the pilots and to add enhancements. The next step is a pilot, which again was identified as a high-priority "need to have" in the NCPDP survey. But the devil is in the details. A clear sponsor and funder is essential so this standard can be tested and adopted sooner rather than later. Federal support of such a pilot is critical, as the weight of the Medicare program is the main impetus to drive standards adoption by payers and vendors. Furthermore, analysis done in 2005 showed that Medicare Part D doubled the number of drugs that required PA.

ePA is important because it is a key piece of simplifying health care transactions and ensuring their interoperability. Use of an ePA standard, along with ePrescribing, could eliminate a barrier to adoption for many emerging therapies, which frankly may not be prescribed because of the "hassle factor" involved in the current process. Moreover, widespread adoption of the ePA standard could remove a barrier to adoption of certain brands, decrease off-label prescribing and justify the prescribing of more complex therapies, such as specialty medications. This certainly would get the support of many physicians and patients with chronic diseases, as well as decrease administrative burdens on the payer side.

We believe Minnesota will not be the only entity to require ePA. There has been a trend among other states to follow Minnesota's example on such related issues as ePrescribing. In addition, it wouldn't be difficult to take ePA to regional and national levels because most of the development costs will have already been incurred by payers, pharmacies and vendors doing business in Minnesota—a large number of which are national in scope.

Health Information Exchanges

In the meantime, we should test the ePA standard to make sure it is the best that it can be and something on which policymakers can rely with confidence at both the state and national levels.

HITECH Funding Means Big Changes—*And What it Means to You*

by Ed Daniels, Contributing Editor

On August 20, the White House rolled out the first two grant programs funded under the Health Information Technology for Economic and Clinical Health Act (HITECH), which was included in the recent stimulus legislation. The grants provide \$564 million to support state-level planning and implementation projects to advance health information exchange (HIE) and \$598 million for the newly created Health Information Technology Extension Program. Just 20 days before this announcement, the Center for Best Practices, part of the National Governors Association (NGA), released its report, "Preparing to Implement HITECH – A State Guide for Electronic Health Information Exchange." The NGA report, followed by the federal funding announcement, provides us with a much clearer picture of how the HIE landscape will develop over the next few years. Questions still remain regarding the long-term viability of these initiatives once the federal bonanza is tapped out, but the short term, 3- to 5-year landscape is becoming much clearer.

How will these grant programs work? The Health Information Technology Extension Program will provide 70 nonprofit organizations with between \$1 million and \$30 million each. These organizations will become "health information technology regional extension centers," which will offer hospitals and clinicians hands-on technical assistance to support HIE and meaningful use of certified electronic health record (EHR) systems. Dr. David Blumenthal, National Coordinator for Health Information Technology, likened these new centers to the agricultural extension centers Congress set up early in the 20th century. Their goal is to help advance the adoption of meaningful HIT, which will be defined by the federal government in the near future. They will be supported by a new national health information technology research center (HITRC), which will help the regional centers and serve as a national clearinghouse to identify and share best practices. These grants will be a terrific plus for the lucky 70 nonprofits selected and a great resource for many hospitals and clinicians across the US and its territories. For the majority of hospitals, physicians, health care corporations and government agencies, we believe this program will be a good resource, but not a game changer.

On the other hand, the 50 HIE grants to states and state-designated entities (SDEs) will range between \$4 million and \$40 million (essentially one per state) and will likely change the way HIEs develop. To date, state government involvement in HIT and HIE has been limited. The national spotlight has been on private regional health information organizations (RHIOs) to facilitate development of critical HIE infrastructure. But RHIOs have struggled to find financially sustainable models and, except in rare instances, can hardly be considered game changers.

The NGA and federal government have gone public with their conviction that EHRs and HIE are critical infrastructure necessary to facilitate health system reform. State government interest in helping HIE succeed has accelerated over the past few years, but a chronic lack of funds has inhibited action. Now the HITECH Act is providing funds to greatly expand the role of states in promoting and even mandating HIE and the adoption of EHRs. HITECH firmly

places the states at the forefront of planning and implementation of HIE.

The \$564 million from the "State Health Information Exchange Cooperative Agreement Program" will go to state governments or one specific not-for-profit entity designated by each state government. The funds will be used to promote information exchange through new policies and procedures and by providing technical, legal and financial support. They may also be used to create the state's own network infrastructure.

The NGA is clearly aligned with the goals of HITECH: get states to use these new resources to immediately accelerate adoption of EHRs and HIE as well as more quickly generate the anticipated benefits of cost savings, better quality, improved population health and system reform.

What does all of this mean for POCP clients?

Will \$1.2 billion in grants and a report from the NGA really make a difference to the multibillion-dollar HIT industry? We think it will. According to recent data from the eHealth Initiative, fewer than 20 for-profit, not-for-profit and quasigovernmental entities have struggled to form RHIOs or HIEs to date. Some have fared better than others. However, none has had a transformative effect beyond its region and all are facing a questionable financial future. Now the states are being encouraged to step up to the plate and engage in advocacy of HIE and EMR meaningful use.

How is this different than before?

These good intentions are now being backed up with significant federal funding and policy support. In these difficult economic times, nothing makes state government heads turn faster than funding opportunities. The HITECH Act is using billions of stimulus dollars to encourage states to follow its agenda and to step up and take charge. And that is just what they will do. Because of the states' regulatory authority, this relatively small amount of funding will make a much bigger impact than if the same dollars were spent to grow nongovernmental organizations. As we have seen with ePrescribing, financial incentives plus regulatory requirements can make hospitals, providers, corporations and coalitions change much faster than a good idea and a long-term promise of efficiency.

POCP anticipates that the HIE grants will be a game changer. All 50 states will finally step up to the plate and establish offices responsible for the promotion of HIE and meaningful use of EMRs. They may stumble a bit in deciding which model to follow and struggle over whether to create a new organization or designate an existing private entity as their SDE. But by the deadline of 5:00 p.m., Eastern Time, October 16, 2009, we expect that all 50 states will make their application and the change will be under way. Once in place sometime in 2010, the new, more effective HIE entities will bend the ear of their respective legislatures and begin enforcing change from a regulatory platform. While arguments may continue for years over the specifics of health reform and coverage options, the decision has already been made as far as HIE policy is concerned: it boils down to enforcement and facilitation at the state government level. To learn more about the HITECH priority grants program and application requirements, visit <http://healthit.hhs.gov/HITECHgrants>.

Health Reform & HIT

POCP is monitoring these developments closely and can leverage its management and HIT expertise to help states and other groups apply for HITECH grants and manage the resulting organizations. The application deadlines are fairly tight, and POCP is a significant resource.

One-Stop-Shopping: HIPAA Privacy and Security Enforcement Now in One Place

The Department of Health and Human Services has announced that it is consolidating oversight and enforcement of Health Insurance Portability and Accountability Act (HIPAA) privacy and security into the Office for Civil Rights (OCR). The move transfers HIPAA security oversight and enforcement from the Centers for Medicare and Medicaid Services (CMS), where it has been housed since the HIPAA Security Rule was issued in 2003.

This makes a lot of sense. The splitting of functions between the two agencies has made enforcement more cumbersome and lengthy than it needs to be. When a privacy and/or security complaint came in, CMS and OCR often had to coordinate to determine jurisdiction. In many cases, it was a joint endeavor because it is difficult to have a privacy breach without a security breach. This added to the costs and complexity of the process. Having everything in one place should make it easier for the government to budget and administer security complaints and regulatory guidance.

Speaking of regulatory guidance, on August 24 OCR issued an interim final rule requiring that individuals be notified of breaches involving their electronic health records. It also issued further guidance specifying "encryption" and "destruction" as technologies that would best protect health information. The Federal Trade Commission issued a companion rule to cover vendors and others that are not HIPAA-covered entities.

The regulations require health care providers and other HIPAA-covered entities to promptly notify affected individuals of a breach, as well as the HHS Secretary and the media in cases when a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate.

All of this activity raises questions: Why this? Why now?

We can only speculate, but our guess is that it is a potential signal of heightened complaint volume and enforcement that may come because of new and expanded privacy and security provisions in the American Recovery and Reconstruction Act of 2008 (ARRA). The new OCR regulations concerning breach notifications implement those provisions in ARRA. Other ARRA requirements include the following, and we expect more regulations will be forthcoming to implement them:

- Applying privacy and security requirements to business associates
- Imposing restrictions on certain disclosures, sales and marketing of protected health information
- Requiring an accounting of disclosures to a patient upon request

- Authorizing increased civil monetary penalties for HIPAA violations
- Granting authority to state attorneys general to enforce HIPAA

In addition, we wonder if the “encryption” language is a harbinger of the long-awaited regulation from the Drug Enforcement Administration concerning ePrescribing of controlled substances.

POCP will be watching to see if there are any changes in complaints or enforcement. Stay tuned.

Medication Management

CMS May Make It Easier for Physicians to Qualify for ePrescribing Incentives

It's a safe bet that the new Medicare Physician Fee Schedule Proposed Rule did not top anyone's vacation reading list. But those few who slogged through the 1,600-page document, published in mid-July, learned that the Centers for Medicare and Medicaid Services (CMS) aims to simplify reporting requirements for 2010 for the ePrescribing incentives available as a discrete part of the Physician Quality Improvement Reporting Initiative (PQRI). In addition, the proposed rule expands eligible services to include home and nursing home visits and contains a new, but limited reporting option for group practices. Comments are due August 31. Adopted changes will become effective November 1.

The major proposed change is the streamlined process for the 2010 reporting year. For 2009, physicians had to report using one of three G codes on 50% of their office visit claims to prove they are ePrescribing and collect their 2% incentive payment. A lesson learned from a PQRI evaluation is that administrative complexity and burden limit the number of providers participating and, thus, those that can participate successfully.

CMS seems to have taken that lesson to heart in trying to boost ePrescribing adoption among Medicare providers. Eligible providers will only need to report electronically prescribing using one G code (instead of three) 25 times in 2010 to earn a bonus equal to 2% of total Medicare allowed charges for the year. According to the proposed rule, ePrescribing can be indicated by using code **G8443** along with the following expanded list of CPT and G codes: **90801-90809, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99241-99245, 99304-99310, 99315-99316, 99341-99345, 99347-99350, 90862, G0101, G0108 and G0109**. The use of two other G codes from 2009 in the numerator—indicating that ePrescribing was not done during a particular visit or could not be done for various reasons—was eliminated. However, the same minimum would apply in 2010—10% of allowed charges must come from professional services eligible for ePrescribing.

Acknowledging the technological changes that are occurring, CMS is suggesting more choices for reporting ePrescribing under PQRI. In 2010, providers can use claims-based reporting or report the measure through qualified registries or qualified EHRs. Obviously, only those registries or EHRs with the capability of submitting the data in the ePrescribing measure will count. Vendors must indicate their desire to have one or more of their products qualified when they submit their self-nomination letter for the 2010

PQRI. Details will be posted on the CMS Web site at <http://www.cms.hhs.gov/ERXIncentive>. CMS also hopes to post a list of qualified vendors.

In addition to broadening eligibility for incentive payments by including professional services in nursing homes and skilled nursing facilities, CMS is proposing that ePrescribing incentive payments be based on the group level as well as individual provider level. However, for purposes of ePrescribing, a group practice must have 200 or more eligible providers. This would effectively eliminate most group practices from qualifying, but CMS apparently wants to keep the number down in 2010 to see how it goes. In addition, group practices would be required to participate in both PQRI and the ePrescribing incentive program.

POCP has been carefully tracking the ePrescribing incentive program since it began last fall, along with other legislation and regulatory changes that create incentives for ePrescribing adoption. Write or give us a call if you have questions about how this impacts your business or practice.

Note: For those who want to review the ePrescribing language in the proposed rule, go to <http://www.federalregister.gov/inspection.aspx#special>, page 343.

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