HIT Perspectives
Perspectives and Updates on Health Information Technology

eMedication Management

Why Is ePrescribing of Controlled Substances Off to Such a Slow Start?
By Mihir Patel and Sherry Neuman, Contributing Correspondents

Not quite half a year has passed since the Drug Enforcement Agency (DEA) technically allowed the ePrescribing of controlled substances. So, how's it going? Unfortunately, the going is mighty slow. Our work in the field and in updating our quarterly pharmacy law compendium revealed three reasons why things have barely gotten off the ground.

The first is the industry's inability to quickly meet the extremely stringent DEA requirements. ePrescribing is legal at the federal level as long as vendors and prescribers conform to the DEA's numerous inflexible requirements that were not standard in the industry when the final implementing regulations became effective in June 2010. Consequently, the industry is expected to require much time developing systems that will be compliant. So far, the vast majority of vendors are still struggling to adapt or are deciding whether or not they want to play.

Second, a significant, unexpected roadblock has come in the form of impediments to implementing the DEA requirements on the pharmacy side…

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CMS Distributes 2009 ePrescribing Payments and Feedback Reports
By Tony Schueth, Editor-in-Chief

Good news, ePrescribers! A bonus check could be in the mail. The Centers for Medicare and Medicaid Services (CMS) just announced distribution of 2009 Electronic Prescribing (eRx) Incentive Program payments to eligible professionals who have met the criteria for successful reporting of ePrescribing use in 2009.

No, these are not the incentives forthcoming for those meeting the new "meaningful use" requirements associated with electronic health record adoption. Rather, these are incentive payments solely for ePrescribing…

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Pharma & HIT

Time Is Right for Pharma Brand Managers to Look at HIT
By David Green, Senior Correspondent

The rapid rise of health information technology (HIT) adoption has created a new vibrancy in the marketplace and a wealth of opportunities for all stakeholders, including pharmaceutical manufacturers. Although pharma has been minimally engaged until now, the advancement of HIT has developed an environment that poses some risks, but also far greater opportunities…

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Patients & HIT

HIT to Benefit From a CLASS Act
By Michael Solomon, Contributing Editor

Tucked away in the middle of the recent health reform legislation are provisions that could represent a significant boon to health information technology (HIT) industry. These provisions are in the CLASS (Community Living Assistance Services and Support) Act…

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To summarize information that has been provided to Point of Care Partners (POCP) from state boards of pharmacy sources, a pharmacy will not be able to process electronic prescriptions for controlled substances until its pharmacy application (software) provider has obtained a third-party audit or certification review to determine that the application complies with the DEA requirements. An audit/certification report must be supplied to the pharmacy by the application provider to allow the pharmacy to determine if the application is compliant.

A pharmacy cannot process electronic prescriptions for controlled substances until its pharmacy application provider has obtained the third-party audit or certification review, and no certification bodies have stepped up to the plate. Until the third-party audit or certification review is completed, the pharmacy may continue to use its current system to store and process paper, fax or oral controlled substance prescriptions it receives but, in some instances, hard-copy records must be maintained. In addition, according to some state boards of pharmacy regulations, once the pharmacy has received notice that its system is DEA compliant and begins to receive controlled substance prescriptions electronically, it still must still print a hard-copy prescription document and file it in numerical and chronological order as in past practice. All these onerous requirements have had a chilling effect on pharmacies' ability to process ePrescriptions for controlled substances.

Finally, a lack of action by the states is another overlooked factor that is seriously retarding implementation. According to POCP's latest nationwide survey of pharmacy laws, most state legislatures need to enact conforming legislation to make ePrescribing of controlled substances legal in their jurisdictions. An exception is Michigan, which did not have to make any changes because its statutes basically allow ePrescribing of controlled substances as long as federal requirements are met. The remaining states will most likely delay legislative action until receiving guidance from their boards of pharmacy, which are figuring out what needs to be changed in terms of statutes and administrative rules to be in sync with the DEA. In addition, states may need to consult with their Department of Health, Bureau of Narcotics, or some other separate entity before they could even start the ball rolling within the assembly. This means that most states are unlikely to address ePrescribing of controlled substances anytime soon, much less make it legal. As a result, there will not be an immediate nationwide ability to seamlessly ePrescribe controlled substances; rather, we are apt to see a confusing patchwork quilt of laws, regulations and gaps that can seriously hinder implementation.

The status of ePrescribing in the states is among the pharmacy-related issues addressed in POCP's compendium of state pharmacy laws, which is updated quarterly in March, June, September and December. The compendium is a useful resource for policy makers, vendors, intermediaries, retail and specialty pharmacies, and other stakeholders who need the latest state-specific information on the changing regulatory landscape affecting ePrescribing and the exchange of prescription information across state lines. It contains the most currently available information as of September 30, 2010, which is gleaned from

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from board of pharmacy Web sites and other published materials, such as pharmacy association and board of pharmacy newsletters, state health and safety codes, as well as other statutes and Medicaid rules and regulations (where applicable).

The compendium is compiled by Sherry Neuman, PharmD, an affiliated consultant with POCP who created the compendium and has updated it every quarter since 2006. She and our on-staff experts are available to interpret the DEA's new rule and analyze state laws and regulations on a customized basis for the range of ePrescribing stakeholders. Let us conduct a custom analysis for you.

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which were made available through CMS' Physician Quality Reporting Initiative (PQRI) as part of the Medicare Improvements for Patientsand Providers Act of 2008 (MIPPA). (See the May 2009 issue of *HIT Perspectives* for more information). These incentives could be hefty for physicians who correctly followed CMS' process: the MIPPA bonuses are equal to 2% of certain kinds of Medicare-allowed charges (Part B) for the year.

As promised, CMS has made reporting and collecting the MIPPA incentives faster, easier and on a broader basis. The 2009 MIPPA incentives have been processed and distributed by carriers and Medicare administrative contractors (MACs). CMS expects this process to have been completed by the end of October.

To help eliminate confusion as to which PQRI incentives are being posted in what check, CMS instructed Medicare contractors to use a new indicator, "LE," which will appear on the electronic remittance advice. Additionally the paper remittance advice will read, "This is an eRx incentive payment." In an effort to clarify the type of incentive payment issued, the LE indicator will be accompanied by the 4-digit code of RX09. If you have questions about the status of your incentive payment, contact CMS' Provider Contact Center. The Contact Center Directory is available on the CMS Web site at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip.

Of particular interest to group practices, the ePrescribing incentives earned by individual participating physicians and other eligible professionals (EPs) are paid as a lump sum to the taxpayer identification number (TIN) under which an EP's claims were submitted. It is then up to the practice to decide how to distribute the incentive.

In addition to the incentive payments, ePrescribing feedback reports from 2009 will be available beginning the second week of November on the Physician and Other Health Care Professionals Quality Reporting Portal located at http://www.qualitynet.org/pqri.

We think this is good news for ePrescribing, physicians and patients. Having CMS put money on the table for physicians who use ePrescribing technology will move the needle on adoption, as intended. For physicians who already are using ePrescribing technology, getting an incentive bonus is a welcome payback for being early adopters. For physicians who have not yet adopted ePrescribing, money talks. The MIPPA incentives show that

ePrescribing is here to stay and the government is serious about improving adoption. Even though it's past 2009, it's still not too late for eligible providers to take advantage of the MIPPA incentive program. Let's not forget that ePrescribers currently receiving an MIPPA incentive payment are also eligible to receive incentive payments under the Medicare and Medicaid EHR Incentive Program down the road. For patients, moving the ePrescribing adoption curve means that they are getting safer, more therapeutically appropriate and cost-effective health care. We know that payment hasn't been as expedient as we'd all like but "the check is in the mail" (finally). The glass being half-full, what's not to like?

Pharma & HIT

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Pharma's interest in HIT has been sporadic. In the mid- and late 1990s, some companies invested in immature technology that lacked such fundamentals as standards and infrastructure. In the subsequent years, pharma had forward-looking strategy or innovation groups that followed HIT, in general, and ePrescribing, in particular. With the recent onslaught of legislation designed to encourage adoption of ePrescribing and HIT, government affairs teams have been seeking information to help them make educated comments and influence the process. With the growth of electronic health record (EHR) adoption, clinical trial groups have sought to leverage the robust technology. More recently, managed markets have taken an interest in the accuracy of formulary information presented in the ePrescribing process.

But brands have been slow to the table, partly because of low adoption rates. That is changing, however. According to Surescripts, 200,000 physicians are prescribing electronically and it expects to facilitate the transmission of 300 million ePrescriptions by the end of 2010, a 181% increase over 2009. Furthermore, both the Congressional Budget Office (CBO) and Pharmaceutical Care Management Association (PCMA) predict that half of all prescribers will be ePrescribing by 2012, and we're ahead of schedule.

So, for brand managers, the time is right to study the effects of HIT and ePrescribing on their brands. To be sure, HIT can be leveraged to increase competitive advantage, boost sales and maximize return on marketing investments, but by how much and in what manner? The reality is that if a brand invests in a direct-to-consumer advertising campaign, it has a pretty good sense for the return.

But what is the return on a HIT campaign? To answer that, you'll have to start with the definition of a "HIT campaign." Here is a sample of how innovative HIT tools can engage highly targeted consumers and increase positive interactions with physicians:

- *eCoupons* – eCoupons represent a new and exciting opportunity for pharmaceutical brand managers to increase prescription rates while providing benefits to physicians and patients alike. Integrated with ePrescribing systems and printed directly from a doctor's office, eCoupons allow patients to try new drug therapies or continue existing ones at a lower cost and assist with medication compliance—all the while increasing brand loyalty. For many physicians, these

coupons reduce the need for drug samples and decrease the hassle of maintaining a samples inventory while providing patients reduced costs.

- *iRX* – iRX programs are designed to provide patients with clinically relevant information about prescribed drug therapies. Integrated into ePrescribing systems and provided at the point of care in conjunction with ePrescriptions, this information educates patients on product details, available resources and the benefits of therapy adherence. Possible results include increased fill rates, better patient outcomes, increased product Web site traffic and greater patient satisfaction.

- *mHealth* – Mobile-powered health applications, known as mHealth, are a fresh and exciting development in the health care industry. From providing mobile applications that assist patients with specific medical conditions to creating innovative physician- directed mobile marketing campaigns, the opportunities are endless.

We are doing more and more hands-on studies of the results of these and similar interventions. While the findings are proprietary, we build on our contacts, experience and lessons learned to shape a program that gives our clients findings unique to their brand and situation.

Patients & HIT

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which was a separate piece of legislation that was folded into the reform law.

CLASS is a voluntary insurance program to provide home care and other nonclinical services to the disabled as an alternative to institutional care. The program covers anyone who becomes disabled and is vested in the program. It will pay an average of at least $50 per day, $18,250 a year, with no lifetime limit. Premiums are expected to be low cost. The notion behind the plan was simple: it is in everyone's best interests to avoid expensive institutional care and keep the chronically ill and disabled in the community, which is a preference for most patients and their families.

So, what has this got to do with HIT? The answer is plenty, down the line. Because of CLASS, significantly more chronically ill and sicker patients will be living in their homes

and other places in the community. Not only will they will have to be monitored for a wide range of vital signs and clinical data, but patients – with the help of their families – must assume most of the responsibility for "self-managing" their health and health care. This is where HIT comes in.

HIT infrastructure is key to the success of the patient-centered care model being fostered by CLASS and central to several care management programs, including medical homes and self-management, listed in the health reform legislation. (See the February 2009 issue of *HIT Perspectives* for an explanation of the patient-centered medical home concept). Numerous HIT tools can be leveraged into these programs, including telemetry, mobile health applications, and Web-based self-management tools, interoperating with electronic health records.

However, it isn't simple to use HIT effectively to engage patients and develop their self-management capabilities, and to aid clinicians in proactively collaborating with patients in their care decisions; applications must be designed to attract and retain patients. For example, hardware and software will need to be adapted to be readable for people with low vision or usable for everyday people who are not clinicians and do not understand medical terminology and clinical "mumbo jumbo." Recent POCP-conducted research shows that Web-based patient portals, which deliver health education materials tailored to a patient's particular medical condition and increase the level of "activation" in their health decisions, improved patients' self-management capabilities.

Until CLASS came along, simply offering health care consumers the opportunity to electronically manage their health information did not translate into a compelling value proposition for the HIT industry. However, under CLASS, the money follows the patient and we believe that some of it, logically, will be available for HIT to support the sick and disabled in non-institutional settings. We also believe there will be training opportunities as well.

To be sure, there are many details to be ironed out, not the least of which is uptake. We do not know how many employers will join the program, what the premiums will be, or how many workers will elect to pay into the program.

However, we do know that Congress and the federal government are banking on the success of this program, which will depend in large part on the availability of a new generation of HIT applications. POCP is monitoring implementation of the CLASS provisions, which is among our many efforts to monitor issues, trends and drivers relative to particular HIT topics. Let us know how we can help you develop and execute a winning strategy for HIT in the context of chronic care management, which is one of our principal lines of business.