Connecting for Heath,• a public-private collaboration operated by the Markle Foundation, responds to CMS on the proposed Final Rule of the E-Prescribing Incentive Program.

The following is a collective comment on behalf of the signatories, who are members of the **Connecting for Health** Steering Group,[1] in response to the Final Rule of the E-Prescribing Incentive Program issued November 19, 2008, in the Federal Register.[2]

We encourage the Centers for Medicare & Medicaid Services (CMS) to incentivize not only use of electronic prescribing tools but also use of information that those tools make available for better medication management.

The **Connecting for Health** approach is framed by three foundational attributes that must be achieved in all health information technology initiatives and projects:

1. Core privacy principles
2. Sound network design
3. Accountability and oversight[3]

We acknowledge that the recommendations below would significantly stretch current capabilities in many e-prescribing systems and clinical settings, and would therefore require a phased implementation.

• **Connecting for Health** is a public-private collaborative with representatives from more than 100 organizations across the spectrum of health care stakeholders. Its purpose is to catalyze the widespread changes necessary to realize the full benefits of health information technology (HIT), while protecting patient privacy and the security of personal health information. **Connecting for Health** is continuing to tackle the key challenges to creating a networked health information environment that enables secure and private information sharing when and where it's needed to improve health and health care.

[1] See Appendix A for Connecting for Health Steering Group roster.

[2] Federal Register/Vol. 73, No. 224, Nov. 19, 2008/Rules and Regulations, 69847

[3] For a summary of the three attributes, see: Connecting for Health Policy Brief: September 2008. Available online at the following URL: http://www.connectingforhealth.org/resources/20080822_policy_brief.pdf

Opportunity

With increasing strains on Medicare, Medicaid, and the broader economy, there is added urgency to implement policies that encourage clinicians and consumers to make decisions based on the most accurate information available.

The goal of any use of health information technology should not be merely to convert paper processes to electronic processes. The goal must be to support better decision-making for safer, higher-quality, and more cost-effective health care.

The E-Prescribing Incentive Program is an important opportunity to remove the barriers that have stalled progress in this important application of health IT. With this program, CMS has the opportunity to create the market demand for information-rich care that can improve quality and cost-effectiveness.

Now is a critical time. We face increasing health care costs,[4] an aging population, and well-documented gaps in access and quality of care. The demand for medications will grow as the number of Americans with a chronic condition is projected to rise by more than 1 percent per year, resulting in an estimated chronically ill population of 171 million by 2030.[5]

Proposed Modification

Under the proposed final rule, clinicians must use a system capable of retrieving the patient's medication history, pharmacy eligibility, and formulary and benefit information to qualify for incentive payments. However, the proposed rule does not require prescribing clinicians to actually access or use this information to receive the incentives.

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[4] In 2006, health spending was nearly 20 times 1970 levels (inflation adjusted), and it has more than doubled as a percent of GDP, increasing from 7.2% in 1970 to 16% in 2006 according to the Centers for Medicare and Medicaid Services, Office of the Actuary; Bureau of Labor Statistics (CPI-U, U.S. city average, annual figures). The office also projects that health spending will represent a staggering 19.5 percent of the U.S. GDP by 2017.

[5] People with chronic conditions account for 91 percent of prescriptions filled. By 2030, 20 percent of the population will be age 65 and older with chronic conditions, up from 13 percent of the population today. (*Source*: Partnership for Solutions. Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update. URL: http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf Accessed 12/3/2008.)

The proposed final rule cites these benefits of electronic prescribing:

- Reducing illegibility.
- Reducing oral communications.
- Reducing time spent on pharmacy phone calls and faxing.
- Automation of renewals and authorization.
- Providing warnings and alert systems.
- Providing access to patient's medication history.
- Improving formulary adherence.
- Improving drug surveillance and recall.

The final four of these benefits require the use, not mere availability, of information. Experience suggests that mere electronic availability of information does not ensure its use. For example: Through one hub service, approximately 400,000 pharmacy benefit plan eligibility lookups are performed each day by clinicians using e-prescribing systems. Of these lookups, 240,000 (60 percent) successfully return with eligibility information to the requestor, but only 60,000 of these (25 percent) also request available medication history. It's clear that many doctors who have medication history available in their e-prescribing applications do not turn on this functionality, cannot access it, or do not know it exists.

Ultimately, the incentives should help push the market toward providing capability to enable clinicians who access and use information to help them make better-informed prescription decisions, avoid adverse drug events, and encourage patients to adhere to evidence-based medication regimens that could significantly reduce complications and lead to gains in productive years of life.

Therefore, the incentives program should be expanded and/or extended to place reward for actual use of information by the prescriber, as opposed to establishing electronic system capabilities that may or may not be used.

Informed Prescribing Attributes

The goal is that ***before*** clinicians electronically transmit a new prescription or a renewal, they already have taken into account:

- The medications a patient is already currently taking, by any authorized prescriber.

- Potential drug interactions, duplications, contraindications, dosing and dosages, and allergies.

- Therapeutic equivalents and their costs based on the patient's pharmacy benefit.

- Evidence-based guidelines to support high-quality health care.

This requires an e-prescribing service that is capable of:

- Pulling current medication history when made available for review and reconciliation by both doctor and patient.

- Allowing the prescribing clinician to check potential drug-drug interactions, dosage, contraindications, and allergies.

- Allowing the prescribing clinician to check therapeutic equivalents/most cost-effective alternatives, based on the patient's pharmacy benefit.

- Providing functionality, at the time of prescribing, to support quality goals and evidence-based protocols.

CMS should also continue exploring how it can be influential in encouraging adherence for certain medications that are well-documented to improve patient outcomes.[6] The recent Medicare e-prescribing pilots tested the standard for transmitting medication fill information. We believe these transactions have potential to support better patient adherence. A lack of market demand for the "no fill" information, and difficulties defining this event, were among the barriers cited in the report on the pilots.[7] The E-Prescribing Incentive Program may provide opportunities to improve standardization of these transactions and to create market demand for information to support adherence.

In the near future, we urge CMS to explore the addition of functionality to support medication adherence to its definition of qualified e-prescribing systems. As examples. CMS could consider such functionality as:

- Sending patients secure reminders to fill a new prescription, and/or notifying appropriate members of patients' care teams when certain prescriptions

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[6] Medication non-adherence costs an estimated $100 billion a year in the US and leads to thousands of serious adverse events or deaths each month. (*Source*: O'Connor, P. Improving Medication Adherence: Challenges for Physicians, Payers, and Policy Makers Arch Intern Med. 166:1802-1804, 2006).

[7] Report available at the following URL: http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_1248_227312_0_0_18/eRxReport_041607.pdf. (Accessed 12.3.08)

known to be highly effective in the treatment of chronic conditions have not been filled.

- Enabling clinicians to track their patient population panels, such as querying hypertensive medication prescriptions and adherence for all of their patients with high blood pressure).

Clearly, the electronic prescribing application and EHR industries generally do not support all of these functions efficiently or effectively for busy clinicians. Further, advanced medication management functions would require costly upgrades for practices that have already invested in e-prescribing capability. The incentives should be staged to help push a marketplace evolution toward systems that make timely, accurate information more accessible and actionable.

Conclusion

We encourage CMS to modify the rule as soon as feasible to add expanded rewards for demonstrated information access and use, particularly of medication history, formulary, and cost-effective therapeutic alternatives based on the patient's pharmacy benefits.

We also encourage CMS to further explore how information can support better adherence to certain medications known to be cost-effective in the treatment of chronic conditions.

We acknowledge that this approach will present challenges to CMS to develop means to verify that information is appropriately used for medication management without undue burdens on medical practices. Incentives for accessing and using information in the prescribing process will likely require an evolution of electronic prescribing systems to make timely information more meaningful and actionable for prescribing clinicians. We anticipate that this will require a phased approach to move from rewarding use of tools, to rewarding use of information, to ultimately rewarding outcomes.

At the same time, medication costs and effectiveness will become an increasingly critical national economic and health issue as the aging population adds to Part D coverage and the prevalence and cost of chronic conditions continue to rise.

It is critical to build upon the proposed Final Rule to promote information use and innovation for more optimal medication management and outcomes.

Appendix A: CONNECTING FOR HEALTH STEERING GROUP

The following members of the Markle Foundation's Connecting for Health Steering Group support the above comment. *Support by the following individuals does not imply endorsement by their respective organizations.*

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*Note: Federal and state employees collaborate but make no endorsement