Pharmacy e-Health Information Technology Collaborative

VIA Electronic Submission to

April 22, 2013

Kelly Cronin,
Health Care Reform Coordinator
Steve Posnack,
Director, Federal Policy Division
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Hubert H. Humphrey Bldg., Suite 729D
200 Independence Ave. SW
Washington, DC 20201

Re: [CMS-0038-NC] Advancing Interoperability and Health Information Technology: Request for Information

Dear Ms. Cronin and Mr. Posnack:

On behalf of the membership of the Pharmacy e-Health Information Technology Collaborative, we are pleased to respond to the *Advancing Interoperability and Health Information Technology: Request for Information*.

The Pharmacy e-HIT Collaborative is supportive of the continued use of electronic health information exchange across providers, as well as ideas that would be effective and feasible to further advance and promote interoperability and health information exchange. We understand that Health and Human Services (HHS) is considering a number of policy levers using existing authorities and programs and that the goal is to develop and implement a set of policies that would encourage providers to routinely exchange health information through interoperable systems in support of care coordination across health care settings.

We also understand that HHS believes this goal could be achieved potentially through a combination of incentives, payment adjustments, and requirements that collectively result in a more coordinated, value-driven health care system over the next one to three years and beyond. Although the Pharmacy e-HIT Collaborative is supportive of this goal, one concern we have is that as health care providers who use electronic health records (EHR) and other electronic health information exchanges (HIE),

pharmacists currently are not eligible providers (EPs) in Centers for Medicare & Medicaid Services' (CMS) Meaningful Use (MU) EHR Incentive Program, and therefore, are not eligible for incentive payments for adopting and using EHR and HIE as are other EPs, eligible hospitals (EHs), and critical access hospitals (CAHs) who communicate electronically with pharmacists.

We strongly encourage CMS to reconsider allowing pharmacists to become EPs under this program. As you will see throughout our comments to the questions posed, allowing pharmacists to become EPs would not only encourage more pharmacists to adopt the use of EHR and HIE, but this would also encourage and advance bidirectional communications among EPs and other health care providers, especially with pharmacists, leading to a more coordinated health care system which ultimately would improve patient care.

The following are our comments to the questions posed for this RFI.

1. What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?

Payment to pharmacists providing patient care services would have a tremendous and positive impact on patient care. Pharmacists providing patient-centered care play an important role, particularly, with regard to medication management. Pharmacists are able to electronically exchange information about medication therapy management (MTM) services during a comprehensive medication review (CMR), especially, at points of transition from one health care setting to another (e.g., hospital to long- term care, hospital to home care, long-term care to hospital care, etc.). Pharmacists' roles in medication management lead to reduced hospital admissions and using HIE improves patient outcomes.

The Pharmacy e-HIT Collaborative believes pharmacists should be paid for the patient-centered services they provide and recommends a payment policy that includes pharmacists.

2. Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

All of the areas mentioned above involve pharmacists who use HIE, though as indicated previously, pharmacists are not receiving incentives or payments to implement the use of HIE because they are not EPs in the MU EHR Incentive Program. The Pharmacy e-HIT Collaborative recommends that CMS reconsider allowing pharmacists to become EPs in the MU EHR Incentive Program. Allowing pharmacists to be EPs in the incentive program would advance the

adoption of EHR and HIE by pharmacists and lead to a more coordinated health care system, which ultimately would improve patient care.

Pharmacists providing patient-centered care, such as MTM and administering medication adherence programs, see reductions in hospital readmissions. [1] By making sure medications are optimized, which aid in reducing hospital readmissions, pharmacists can help improve hospital value-based quality measures and patient outcomes. Similarly, pharmacists play an important role in helping other providers meet their quality measures, although pharmacists are not recognized as EPs for EHR incentives.

Pharmacists also are recognized as care coordinators and help manage patients in medical home settings. When pharmacists are part of the care coordination design, particularly, in programs involving medication management, quality improves across care settings.

We also recommend that Office of the National Coordinator for HIT (ONC) review the work being done by the Agency for Healthcare Research and Quality (AHRQ), particularly, its most recent findings about its patient-centered care through health information technology initiative. AHRQ published results of this initiative in its January 2013 report: *AHRQ Health Information Technology (HIT) Ambulatory Safety and Quality – Findings and Lessons From the Enabling Patient-Centered Care Through Health IT Grant Initiative.*[2]

AHRQ's findings "*add to the evidence of the positive impact on health care outcomes of health IT applications designed to support patient-centered care.*" The studies also highlighted a number of barriers to the use of HIT to deliver patient-centered care. One such barrier cited concerns the challenges of integrating new HIT systems or components into established clinical information systems and workflows.

Overall, the findings lend support of pharmacists providing patient-centered care, as well as lending support of pharmacists to become EPs in the MU EHR Incentive Program. As we continue to note throughout our comments, pharmacists are an integral part of the health care system and users of EHR and HIE.

3. To what extent do current CMS payment policies encourage or impede electronic information exchange across health care provider organizations, particularly those that may be market competitors? Furthermore, what CMS and ONC programs and policies would specifically address the cultural and economic disincentives for HIE that result in "data lock-in" or restricting consumer and provider choice in services and providers? Are there specific

[1] Koehler BE, Richter KM, Youngblood L, et al. Reduction of 30-day postdischarge hospital readmission or emergency department (ED) visit rates in high-risk elderly medical patients through delivery of a targeted care bundle. J Hosp Med. 2009;4(4):211-218.

[2] Agency for Healthcare Research and Quality, Office of the National Coordinater for HIT, *AHRQ Health Information Technology (HIT(Ambulatory Safety and Quality – Findings and Lessons From the Enabling Patient-Centered Care Through Health IT Grant Initiative, January 2013.*

ways in which providers and vendors could be encouraged to send, receive, and integrate health information from other treating providers outside of their practice or system?

Because pharmacists are not eligible for MU EHR incentives, this may impede the adoption of EHR by pharmacists and the electronic exchange of information for medication management between pharmacists and EPs. As noted previously, we strongly encourage CMS to include pharmacists in the MU EHR Incentive Program. Removing this impediment for pharmacists would encourage further adoption and implementation of the use of EHR, electronic health information exchange, and advance the interoperability of HIE, especially with regard to electronic bidirectional communication among EPs and other health care providers, and leading to a more coordinated health care system.

As part of Medicare Part D, for example, Medicare beneficiaries are provided the opportunity to interact with pharmacists as part of the medication management program. Under Part D, pharmacists providing annual comprehensive medication reviews (CMR) are required to provide active medication lists to their patients. To fully accomplish this, pharmacists must be able to communicate electronically with providers to ensure the medications prescribed have appropriate problem identifications.

The payment model for this program, however, is through health insurers and not by payment directly to pharmacists. Since pharmacists are not directly receiving Medicare payment for Part D MTM program, this payment model doesn't have clinical quality measures related to the national MU of EHR objectives. Pharmacists providing patient care services do not receive payments directly from Medicare and this leads to nonstandard proprietary processes and therefore has a tendency to interrupt the pharmacist involvement in the electronic exchange of medication related information. The Pharmacy e-HIT Collaborative has worked with standards groups (e.g., HL7 and NCPDP) to encourage pharmacists to adopt HIE across provider organizations.

We support and encourage the harmonization of standards, such as the HL7 and NCPDP (i.e., SCRIPT and Telecom) standards in this area. This would encourage EPs, EHs, and CAHs to submit electronically and uniformly. A standard for an MTM medication action plan following specific Medicare Part D requirements using consolidated clinical document architecture (cCDA)-structured document is currently under ballot with HL7 and NCPDP. CMS has recognized this work by encouraging Part D plan sponsors to adopt standardized HIT for documentation of MTM services documents as noted in the CMS Calendar Year 2014 MTM Program Guidance and Submission Instructions letter.[3]

[3] CY 2014 Medication Therapy Management Program Guidance and Submission Instructions, page 12, accessed April 5, 2013 http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Memo-Contract-Year-2014-Medication-Therapy-Management-MTM-Program-Submission-v040513.pdf.

Additionally, pharmacies receiving e-prescriptions from hospitals and physicians who are receiving MU incentives have been burdened with the prescription transaction cost of these programs without the full ability to exchange information bi-directionally with prescribers. This bidirectional exchange of information by the pharmacist would encourage more beneficial electronic information and increase patient quality measures.

4. What CMS and ONC policies and programs would most impact post acute, long term care providers (institutional and HCBS) and behavioral health providers' (for example, mental health and substance use disorders) exchange of health information, including electronic HIE, with other treating providers? How should these programs and policies be developed and/or implemented to maximize the impact on care coordination and quality improvement?

Pharmacists play an important role at points of transition of care in assuring orders created by EPs are correct, especially, in post acute and long-term care settings. Pharmacists are involved in the transition of care and medication reconciliation for patients, making it vitally important that pharmacists have access to current problem lists at the points of transition to match medications for patients to use. This is particularly important for MTM services pharmacists provide under Medicare Part D.

Programs and policies should include payment/incentives for pharmacists and be developed to advance the implementation of electronic bidirectional exchange between pharmacists and other health care providers. This would aid in improving care at transitions.

Having pharmacists electronically exchange cCDA using HIE also will increase care coordination and improve quality outcomes.

5. How could CMS and states use existing authorities to better support electronic and interoperable HIE among Medicare and Medicaid providers, including post acute, long-term care, and behavioral health providers?

CMS and states should include pharmacists in HIE so that true interoperability and interconnectivity can be advanced by pharmacies in all practice settings, including post acute, long-term care, and behavioral health. CMS and state programs will benefit from pharmacists serving as members of the health care team, having access to fully integrated EHR systems, and having connectivity through HIE.

The Pharmacy e-HIT Collaborative members include pharmacists in these settings. Pharmacists providing patient-centered care, especially, at points of transition, will assure patients' medication histories and active medication lists are appropriately exchanged in all pharmacy practice settings.

By including pharmacists and employing their expertise, CMS and states' programs could achieve appropriate medication use for patients; decreased emergency department (ED) visits, hospitalizations, readmissions, and associated costs; improve transition of care, and expand access to public health services.

A few states, such as Connecticut, Colorado, and Minnesota have been testing models and implementing programs, maximizing the impact of pharmacists through optimization of HIT solutions, with proven results.[4] Other states should be encouraged to move in this direction and to include pharmacists.

6. How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in over time? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

Changing CMS regulatory requirements to recognize and include pharmacists as eligible providers in the MU EHR Incentive Program will help accelerate the adoption of electronic interoperable HIE. Pharmacists providing medication patient care in SNF and home health care should be included in regulatory requirements of health interoperability. As we have noted throughout our comments, pharmacists are not EPs in the MU incentive program, and they are not receiving incentives for using EHR.

Physicians, facilities, and pharmacies in the LTPAC setting do not normally use the same electronic medical records or electronic documentation systems. Having the ability to coordinate these three segments of care via three-way electronic communication will improve interoperability. We also see some regulatory policy problems that affect LTPACs' EHR systems. As an example, DEA's regulatory policies do not recognize the nurse as the agent of the physician nor do they recognize the facility's system as the legal entity. This causes an inability to coordinate the e-prescribing MU EHR program in the LTPAC setting. Recognizing these entities as separate, yet needing coordination will help improve interoperability.

Having CMS require bidirectional exchange of medication information by LTPAC pharmacists by using HIE and e-prescribing will help LTPAC accelerate medication information exchange and adoption, particularly, when changes in payments are part of it. LTPAC e-prescribing adoption is low because CMS exempted LTPACs from receiving e-prescribing and

[4] Smith M, Giuliano MR, Starkowski MP. In Connecticut: improving patient medication management in primary care. Health Aff. 2011; 30(4):646-654; McGaw J, Conner DA, Delate TM, Chester EA, Barnes CA. A multidisciplinary approach to transition care: a patient safety innovation study. Permanente J. Fall 2007. http://xnet.kp.org/permanentejournal/Fall07/transition_care.html. Accessed May 16, 2011, and Egervary, A. MTM, Minnesota Style. Pharm Today. March 2010. http://apha.imirus.com/Mpowered/book/vpt16/i3/p1. Accessed May 16, 2011.

MU incentives.

7. How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program. For example, could the attestation process capture provider identifiers that could be accessed to enable exchange among participating EPs?

The Pharmacy e-HIT Collaborative encourages CMS to look at e-prescribing networks as a possible model for identifying providers. Through registration, these private networks are successful, and pharmacists have not had a problem in exchanging information. Pharmacy management systems are the standards that drive query activity with external provider directories. For example, when receiving an electronic prescription, the pharmacist must verify the prescriber through an external directory.

8. How can the new authorities under the Affordable Care Act for CMS test, evaluate, and scale innovative payment and service delivery models best accelerate standards based electronic HIE across treating providers?

The Pharmacy e-HIT Collaborative supports the use of electronic standards for the exchange of health information. Ensuring that pharmacists exchange medication-related information electronically and receive incentives will help accelerate the value of HIE and standardized HIE access to providers. Medication management supports an HIE pharmacist provided patient-centered care model.

9. What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and programs to maximize beneficiary access to their health information and engagement in their care?

Part of the Medicare Part D January 1, 2013, requirements is an annual CMR for eligible patients provided by pharmacists. This requirement provides patients access to their medication information and affords them the opportunity to interact with their pharmacists. The patients will use the information provided as a means to ensure that their medications are used appropriately and to follow up with their pharmacists and providers regarding these medications. Having the information documented by using cCDA, provides patients with the ability to not only print the information in a human readable form but also integrate it into a structured PHR.

Additionally and related to the use of EHRs, pharmacists support the bidirectional exchange of clinical information as the focal point of transition of care in all practice settings, especially, with regard to medication problem lists (particularly more current updated problem

lists) to which providers (e.g., EPs, EHs, CAHs) may not have access. It is vitally important that pharmacists have access to current problem lists at transitions of care to match medications for patients to use. This is particularly important for MTM services pharmacists provide under Part D. Care coordination with the CMR and the physicians' Medicare Annual Wellness visit is noted in the CMS Calendar Year 2014 MTM Program Guidance and Submission Instructions letter. [5]

Under Part D, pharmacists providing annual CMRs are required to provide active medication lists, including noting contraindications of the medications on the lists. To fully accomplish this, pharmacists must be able to communicate electronically with providers to ensure the medications prescribed are matched to appropriate patient medical problems. Pharmacists engaging patients in their care will guarantee appropriate medication use. The Pharmacy eHIT Collaborative also is a committed member of the Standards and Interoperability Framework's Automated Blue Button Initiative (ABBI) and supports the objectives for providers, including pharmacists, to adopt Blue Button programs.

10. What specific HHS policy changes would significantly increase standards based electronic exchange of laboratory results?

Pharmacists providing patient-centered care must have access to laboratory results. Pharmacists need to be recognized as EPs and meaningful users to access these laboratory results. The Pharmacy e-HIT Collaborative recommends that HHS reconsider its position and include pharmacists as EPs and meaningful users.

The Pharmacy e-HIT Collaborative has worked over the past three years to ensure that information can be exchanged electronically. The Pharmacy e-HIT Collaborative supports standardized vocabulary (e.g., LOINC) that would assure access to laboratory results through HIE networks.

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The Pharmacy e-HIT Collaborative, including pharmacy professional associations, the Pharmacists Services Technical Advisory Coalition (PSTAC), MTM intermediaries, and the National Council for Prescription Drug Programs (NCPDP), are defining the pharmacist's role in HIT. Pharmacists in all practice settings provide patient-centered services and document those services manually and electronically. During the electronic exchange of clinical information, components can be shared between providers by means of a continuity of care document (CCD) using cCDA. It is evident that access to HIT solutions can enhance the pharmacist's ability to improve the overall medication-related safety and quality of patient care in coordination with other health care providers and improve performance measure attainment.

[5] CY 2014 Medication Therapy Management Program Guidance and Submission Instructions, page 11, accessed April 5, 2013 http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Memo-Contract-Year-2014-Medication-Therapy-Management-MTM-Program-Submission-v040513.pdf.

Formed in the fall of 2010, the Collaborative's focus is to assure the meaningful use (MU) of standardized EHR that supports safe, efficient, and effective medication use, continuity of care, and provides access to the patient-care services of pharmacists with other members of the inter-professional patient care team.

The Pharmacy e-HIT Collaborative seeks to ensure pharmacist-provided patient care services are integrated into the National HIT interoperable framework. The Collaborative's founding organizations represent pharmacists in all patient care settings and other facets of pharmacy, including pharmacy education and pharmacy education accreditation. The Collaborative's Associate Members represent e-prescribing networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. The Collaborative was founded by nine pharmacy professional associations representing over 250,000 members and includes six associate members from other pharmacy related organizations. For additional information, visit www.pharmacyhit.org

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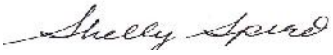
On behalf of the Pharmacy e-HIT Collaborative, thank you again for the opportunity to comment on the *Advancing Interoperability and Health Information Technology: Request for Information.* For more information, contact Shelly Spiro, executive director, Pharmacy e-HIT Collaborative, at shelly@pharmacyhit.org.

Respectfully submitted,



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