

Incentives for Improved Patient Care and the Impact on Pharmacies

by Michelle Klagos

Healthcare is a topic that affects everyone at every level, whether it be the medical care of your family, the physicians providing the care, the companies paying for the care, or the government setting standards for the care. As healthcare costs skyrocket, new ideas for fixing our 'broken' system seem to pop up almost daily. Getting significant consideration and attention today are regulations set forth by the HITECH Act (within 2009's American Recovery and Reinvestment Act) (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=fh1enr.pdf) and the Affordable Care Act, (<http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>) which was passed earlier this year. These laws lay the groundwork for the future of our nation's health care. There is nothing in the laws that prohibits these incentives from becoming mandatory. The HITECH Act propels physicians to adopt and implement electronic health records (EHRs). The Affordable Care Act illustrates the importance of quality and efficiency metrics, demanding improvement in patient health outcomes, with the intent that the measurement of these outcomes be influential to future Medicare and Medicaid payments and physician continuing medical education (CME) credits. History demonstrates that private payers eventually follow what the Centers for Medicare & Medicaid Services (CMS) initiates; therefore any employer, health plan or patient may eventually be affected by these laws.

Change of this magnitude will be extremely difficult. These two major pieces of legislation have added urgency for practices to incorporate EHRs into their daily activities. Hence, the CMS has made incentives available to eligible professionals to help ease the adoption of

EHRs. Incentives offered by CMS currently include electronic prescribing, the Physician Quality Reporting Initiative (PQRI) and Meaningful Use incentives. At the same time, if a practice is noncompliant, penalties in the form of reductions in Medicare Part B and Medicaid fee-for-service payments will be imposed. As these and future incentive programs are developed and implemented, pharmacists will find opportunity to become even more closely involved in patient care while developing the team approach necessary for effective continuity of care.

E-PRESCRIBING

Federal incentives for electronic prescribing (e-prescribing) have been in the works since 2003 when e-prescribing was introduced in the Medicare Modernization Act of 2003 (<http://www.ustreas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf>).

E-prescribing gained steam in 2006 when the Institute of Medicine "Preventing Medication Errors" Report indicated that e-prescribing has the potential to reduce medical errors. (<http://www.iom.edu/Reports/2006/Preventing-Medication-Errors-Quality-Chasm-Series.aspx>) Fast forward to 2010: the CMS e-prescribing incentive is now a free-standing incentive that provides a 2 percent incentive payment to a provider's Medicare Part B fee-for-service charges. This can be substantial for a physician with a high population of Medicare patients.

E-prescribing can be accomplished with a stand-alone system, or it can be embedded into an EHR, but the e-prescribing system must be able to send an electronically-generated order to a pharmacy electronically. Originally, many EHRs were set up to order prescriptions electronically, but orders then were faxed to the pharmacy. This does not meet the federal requirements for receipt of e-prescribing

incentives. Instead, the prescription must arrive at the pharmacy electronically so it can be incorporated into the pharmacy's documentation and distribution system. By eliminating the human data entry factor, errors can be reduced.

To be a successful prescriber, an eligible provider must have and use a 'qualified' e-prescribing system and report to CMS on its use, demonstrating that it has been used at least 25 times during the year. If a pharmacy is not yet capable of accepting e-prescriptions, a provider can still count a transaction as successful if he or she prescribes electronically using the appropriate system though the order is sent to the pharmacy via fax. Pharmacies have been slow to transition to electronic systems not only because of the implementation costs involved, but also because of issues that arise when not all physicians are e-prescribing. It is hoped that as more physicians start e-prescribing, it will become easier for pharmacies to make the switch.

PQRI

A second incentive offered to eligible professionals by CMS is the Physician Quality Reporting Initiative (PQRI), which has been evolving since 2006. Eligible professionals who satisfactorily report data on quality measures will receive a 2 percent incentive on their Medicare Part B fee-for-service charges. These quality measures are grounded in evidence-based medicine, and each year measures are reviewed, retired, added or adjusted to reflect the ongoing changes in care. Like e-prescribing, to receive the incentives, eligible professionals must meet criteria specified by CMS. The purpose of the incentives is to encourage physicians to make substantial enough changes that allow the quality practices to become a part of the physician's daily activity, resulting in increased compliance with evidence-based

medicine. CMS has offered a variety of reporting methods (claims, registry process or through the EHR) for 6 or 12 months. Eligible professionals can choose three individual measures or a measure group that has at least four measures pertaining to a common disease. New measures being developed are primarily for registry or EHR submission only, as CMS is realizing the need to use patient data to drive improvement efforts. While claims data reflect completed procedures (e.g. lab tests), registry and EHR reporting go a step further by allowing submission of the lab result with subsequent indication if improvement is needed.

MEANINGFUL USE

Currently PQRI is paying for reporting, but finalization of the Meaningful Use rule means that incentives for performance are just around the corner. Created out of the HITECH Act, the purpose of meaningful use is to offer incentives to physicians for not only adopting electronic health records (EHRs), but also using them in a meaningful manner that will improve patient care and reduce associated costs. In the National Committee for Quality Assurance's State of Health Care Quality Report 2003, it was noted that for each 1 percent reduction in hemoglobin A_{1c}, the risk of developing blindness, kidney failure or leg amputation drops by 40 percent (http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2003.pdf). Imagine the possibilities when combining quality improvement with an efficiently-used EHR.

Meaningful use is based on five health outcomes created by the Office of the National Coordinator. Objectives for each of these outcomes are met by completion of measures that are derived from PQRI and the National Quality Forum. There are 3 stages of meaningful use: Stage 1 is to capture data electronically with functionality that sets the groundwork for continuous quality improvement and ease of information exchange. Stage 2 is expected to expand Stage 1 with the exchange of structured information, such as the transmission of orders or tests. Stage 3 will concentrate on improving health outcomes with integration of decision support, patient management tools and use of patient-centered information exchanges. Professionals who demonstrate meaningful use of their EHR may receive either a percentage of their Medicare Part B fee-for-service as an incentive (up to \$44,000 over 5 years) or up to \$67,000 if they have a substantial Medicaid population.

THREE INCENTIVE PENALTIES

These incentive plans are compounded by the fact that CMS has incorporated penalties for professionals who are eligible but do not attempt to meet the adoption timeline. Beginning in 2012, services reimbursed from the Physician Fee Schedule will be penalized starting with 1% if not e-prescribing and up to 3% if not a meaningful user by 2017. (See Table 1.)

The Affordable Care Act authorizes PQRI incentives to continue at least through 2015. This should give practices that have not yet reached meaningful use the opportunity to still receive incentives for PQRI. In the proposed rule under the Medicare Part B Physician Payment Fee Schedule for 2011 (http://aghealthreform.com/wp-content/uploads/2010/06/2010-15900_PI.pdf), CMS states its intent to integrate PQRI and the Meaningful Use incentive program. Thus, PQRI could transition into meaningful use.

IMPACT ON PHARMACIES

It is clear that physicians have much to lose by not implementing EHRs and e-prescribing, but these changes will impact the pharmacy world as well. Pharmacies will need to implement electronic pharmacy systems in order to be able to electronically communicate with the physician regarding refills or medication changes. As pharmacies have experienced, this translates to choosing an electronic system or upgrading the current claims adjudication system to accommodate the required changes. Expect future communication with physicians to be via secure electronic message, which may also impact pharmacy workflow. With electronic changes required in the clinics, patients may look to pharmacists for additional consultation that the physician did not have time to share. The opportunity for a team approach to patient care can be enhanced.

Pharmacists should still expect human errors related to e-prescribing, but they will be a new set of errors, and training both physicians and pharmacists to catch these errors is necessary. The interim final rule describing the required standards to permit electronic prescriptions for controlled substances was recently released. Both pharmacy claims adjudication systems and physicians will have to adjust to the required two-step authentication process, which will substantially change workflows. Care must be taken by both clinics and pharmacies to design concise workflows to ensure there are no gaps or workarounds that could enable drug abuse

(http://www.deadiversion.usdoj.gov/fed_regs/rules/2010/fr0331.pdf).

The PQRI measures also offer an opportunity for pharmacists to work collaboratively with the physician in pursuit of attaining measure goals. There are numerous PQRI measures that pharmacists can impact, and working with physicians to target certain measures can positively impact patient care.

Lastly, there is a meaningful use measure related to medication reconciliation during transition of settings of care (for example, hospital discharge to primary care) that can impact pharmacists. Though originally

TABLE 1: CMS INCENTIVE PENALTIES

Year	CMS Reduction % of Medicare Part B FFS
2012	1% if not e-prescribing
2013	1.5% if not e-prescribing
2014	2% if not e-prescribing
2015	Either 1% (if e-prescribing) or 2% (if not e-prescribing) if not a meaningful user
2015	1.5% if not participating in PQRI
2016	2% if not a meaningful user
2017	3% if not a meaningful user

required, the measure is now one of the optional measures to choose from, which offers an opportunity for the pharmacist to develop strategies to enhance this reconciliation process. The pharmacist is the resource between the patient leaving the hospital and the physician follow-up visit and can be a great asset for an already taxed physician practice with limited time to spend with patients that need extra assistance reconciling and understanding their medications.

The writing is on the wall: The world of health care will be in transition mode as it complies with new legislation. Time will be needed to make calculated changes to the many aspects of health care; all stakeholders will need to make adjustments. What we cannot forget is that the patient deserves the best care possible during this bumpy ride. Physicians and pharmacists are on the front line for patients and have the opportunity to work cohesively in this time of transformation to ensure that patient care remains the top health care priority. ●

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