



Response to

**Medicare Program: Proposed Standards for E-prescribing Under Part D**

**A. “Adoption of NCPDP SCRIPT 8.1 as a Final Standard” Proposed Retirement of NCPDP SCRIPT 5.0 and Adoption of NCPDP SCRIPT 8.1 as a Final Standard**

HIMSS appreciates the opportunity to comment on the question. The 2007 report by the Secretary of Health and Human Services based on the Agency for Healthcare Research and Quality (AHRQ) analysis of five E-prescribing pilots found that the NCPDP SCRIPT 8.1 was technically able to convey the information needed to support the E-prescribing function. The report states on page 32, *“This standard is relatively mature, widely adopted by the prescribing industry, and is useful in preventing medication errors, and for understanding medication management compliance. The pilot sites found that the proposed standard is technically well structured, supports the exchange of information, and is ready to be used in Part D prescribing.”*<sup>1</sup>

HIMSS supports adopting NCPDP SCRIPT 8.1 as a final standard and retiring NCPDP SCRIPT 5.0.

**B. “Medication History” Proposed Adoption of an E-prescribing Standard for Medication History Transaction**

HIMSS appreciates the opportunity to comment on the question. The Secretary’s report developed based on the AHRQ evaluation of the E-prescribing pilots mentioned in Section A found that the NCPDP SCRIPT 8.1 was technically able to convey the information needed to support the E-prescribing function. The report states on page 32, *“This standard is relatively mature, widely adopted by the prescribing industry, and is useful in preventing medication errors, and for understanding medication management compliance. The pilot sites found that the proposed standard is technically well structured, supports the exchange of information, and is ready to be used in Part D prescribing.”*<sup>2</sup>

HIMSS realizes that the competing HL7 RDS standard is available and is in use by at least several of our member organizations. However, in the interest of uniform standards adoption, HIMSS supports the recommendation of CMS for the use of the NCPDP SCRIPT 8.1 for medication history in conjunction with E-prescribing.

<sup>1</sup> Agency for Healthcare Research and Quality, “Findings from the Evaluation of E-Prescribing Pilot Sites,” page 32, AHRQ Publication No. 07-0047-EF, April 2007

<sup>2</sup> Ibid, page 32

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**C. “Formulary and Benefit Transactions” Proposed Adoption of an E-prescribing Standard for Formulary and Benefit Transactions**

HIMSS appreciates the opportunity to comment on the question. The Secretary’s report developed based on the AHRQ evaluation of the E-prescribing pilots mentioned in the prior response determined that the NCPDP Formulary and Benefit Standard Version 1.0 was technically able to convey the information needed to support the formulary and benefit information function. The report states on page 29, “*While complex, it has been clearly demonstrated that the standard can technically support the transaction and that it is ready for implementation under Part D. However, as with all standards, the pilot project identified implementation issues that must be addressed in order to achieve the potential benefits, the most important of which is that systems must be able to match patients to health plans, or the formulary and benefits data will not be available.*”<sup>3</sup>

Based on this evaluation, HIMSS supports the recommendation by CMS for the use of the NCPDP Formulary and Benefit Standard Version 1.0 for E-prescribing. See our recommendation regarding timing in response to that question.

**D. “Adoption of the National Provider Identifier” (NPI) as a Standard for Use in E-prescribing Transactions**

HIMSS appreciates the opportunity to comment on the question of the National Provider Identifier and use in the E-prescribing transactions. The “Provisions of the Proposed Rule, Adoption of the National Provider Identifier (NPI) as a Standard for Use in E-prescribing Transactions,” states<sup>4</sup>:

*The NPI is in widespread use by HIPAA covered entities in HIPAA transactions.*

This likely represents an expectation that by now this would be the case. In the April 5, 2005, commentary on the CMS Proposed Rule: “Medicare Program: E-prescribing and the Prescription Drug Program,” HIMSS commented that the National Provider Identifier (NPI) was selected to represent a legal entity and not a physical location or a healthcare location. Providers and payers are struggling to cope with these features of the NPI at this time. Some of the difficulties that organizations implementing the NPI are developing work-arounds to avoid include the following:

1. **Provider identification.** Some large corporate entities (e.g., a large California integrated delivery system has one NPI for its large multi-county system of hospitals, physicians, PT, ancillary services, and many other service providers) initially billed using the corporate NPI which does not identify the type of service

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<sup>3</sup> Ibid, page 29

<sup>4</sup> *Federal Register*, U.S. General Printing Office. 42 CFR 423, II, D, p. 64908.

81 (physician, ancillary service, home health, etc.) or which provider rendered the  
82 service. **Solution.** Payers are gradually requiring that the service subunit NPI  
83 (e.g., PT in Fairfield) and the rendering provider's NPI appears on each claim.  
84

85 2. **Location of service.** Some national and regional organizations bill for a function  
86 such as dialysis. The service is authorized for a specific location and the location  
87 may not be discernable from the claim. **Solution.** The address of the service  
88 location is used to determine the service location. This is now a largely manual  
89 process. When most providers submit 9-digit zip codes, this can be automated.  
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91 3. **Line of business.** In many markets, health plans have different contracts and fee  
92 schedules based on line-of-business, e.g., Medicare, Medicaid, commercial, etc.).  
93 **Solution.** Payers determine line-of-business by member number and decision  
94 rules, since some members are covered by several lines-of-business. In the past,  
95 some providers used different provider numbers or codes added to provider  
96 numbers for different lines of business.

97 4. **Type of service.** Some specialty physicians also serve as primary care physicians  
98 and receive a higher rate for specialty services. **Solution.** The Provider Taxonomy  
99 Code on a claim allows the provider to indicate for what specialty the provider is  
100 billing (e.g., primary care or a higher-compensated specialty such as nephrology).  
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102 The NPI structure allows an institutional provider or medical group to require or  
103 recommend that each of its providers obtain a separate provider NPIs but that is not always  
104 implemented. As a result, some institutional provider systems are submitting claims using  
105 the NPI that either  
106

- 107 1. **Must rely upon the inclusion of legacy provider numbers** to determine the  
108 facility or provider actually billing and applicable payment arrangements (and the  
109 legacy provider numbers make them noncompliant with the NPI regulation) or  
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- 111 2. **Are incomplete and cannot be paid** without manual research by the payer, by  
112 soliciting further information from the provider, or rejecting the claim and  
113 requiring resubmission with additional data. Some such claims appear to meet  
114 regulations but cannot be processed because the information provided is  
115 insufficient.  
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117 This above experience with the NPI reflects the need of providers, health plans, and other  
118 payers to work through processes to determine the correct use of the NPI. There are  
119 powerful market incentives driving this accommodation. HIMSS does not believe that  
120 there are inherent problems in the structure of the NPI. Problems being experienced arise  
121 from the wholesale change of existing processes and from lack of advance understanding  
122 of the problems that implementation of the NPI would cause. Two of these are loss of  
123 location specificity and the failure to require 9-digit zip codes in conjunction with the NPI  
124 implementation so that provider-finding could be automated instead of largely manual.

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HIMSS recommends that CMS use this or another regulatory vehicle to clarify general NPI use as follows:

- **NPI of provider rendering the service.** HIMSS recommends that CMS require that every claim for CMS services billed to CMS or to any Part D or Medicare Advantage health plan or payer provide (1) the NPI of the rendering provider and (2) the NPI of the pay-to organization.
- **Guidance for use of NPI.** HIMSS recommends that CMS provide more detailed guidance in proper use of the NPI for billing using its various claim forms and for other functions. For example, the recommended way to bill as a) a provider who is a member of a medical group b) a specialist who provides primary care, c) a specialist (who also provides primary care) to bill as a specialist using the provider taxonomy code, d) organizations (like dialysis centers) constituted as one national or regional entity to use NPIs or 9-digit zip codes to identify individual provider locations, etc.

It makes sense to solve the problems with the existing NPI use as CMS moves to the new E-prescribing environment. These may seem remarkably simple steps but organizations moving to the NPI are stumbling over them.

With respect to the use of the NPI in E-prescribing, HIMSS notes that there are particular requirements if the NPI is to be used in E-prescribing:

1. **Provider specificity.** The NPI used for E-prescribing must uniquely identify the prescriber. Using the NPI of the rendering provider (the prescriber) will accomplish this for practicing physicians, nurse practitioners, physician assistants and midwives.
2. **Residents, interns and fellows.** The sponsoring organizations for these professionals-in-training need to be instructed to apply for NPIs for each of them or they need to be required to apply themselves.

HIMSS notes that some industry experts argue that an alternative to clearing up ambiguous NPI numbers (not for a specific provider) is to use the DEA number to clarify the identity of the prescribing provider when the NPI number is not adequately specific, e.g., is that of an integrated delivery system or medical group. This has the following limitations:

1. **Multiple DEA numbers for some providers.** There are 10 million DEA numbers and fewer providers. This needs to be reconciled but would be complex since prescription histories tied to any DEA numbers that are retired need to remain valid. Retired DEA numbers would need to be retained and cross-referenced to the active DEA numbers for the same provider.

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2. **DEA numbers for residents, interns and fellows.** Residents, interns and fellows have DEA numbers assigned from a block of teaching hospital DEA numbers. Once these residents, interns and fellows leave the teaching hospital, the numbers are reassigned. When residents, interns and fellows go to a new position or get a new fellowship at the original institution or at a new institution or move into private practice, they get a new DEA number or numbers (several fellowships or affiliations). The reassignment of DEA numbers for residents, interns and fellows make tracking E-prescribing history problematic.

Thus, the DEA number is not a good candidate for clarifying non-specific NPI numbers. It is up to CMS to assure that regulations specify the correct use of NPIs for E-prescribing.

HIMSS recommends that the regulation require that each prescriber, including residents, interns, and fellows, have and use his/her personal NPI for E-prescribing, not an organizational NPI.

### **E. Proposed Compliance Date**

HIMSS appreciates the opportunity to comment on the proposed compliance date. As an organization, HIMSS is an active supporter of the universal use of E-prescribing solutions to improve the safety, quality, cost effectiveness, and efficiency of healthcare delivery in the U.S. CMS is well aware of the IOM and RAND studies that address the benefits E-prescribing brings to healthcare delivery.

In looking at the April 1, 2009 compliance date, HIMSS is concerned the date will impose a challenge for parts of industry. There are several reasons to institute broader healthcare industry education over the next 12 months:

- The additional standards introduce new procedures in the prescriber's work flow.
- It will take vendors more time to incorporate the new standard transactions into their products.
- Prescribers will then need time to acquire or upgrade their information systems to support these standards as well as time to train office staff.

The industry needs time to overcome the financial burden, or provider adoption of E-prescribing will continue to lag. One of the proposed standards, NCPDP Formulary and Benefits, was approved in July 2005 and is not widely used in the industry. It introduces a new procedure in the prescriber's work flow and is predicated on the checking of Medicare Part D eligibility when the patient presents and making that information available at the time of E-prescribing. Issues identified with this transaction include;

- difficulty matching the patient to their Prescription Drug Plan,
- variation from PDP to PDP in the information provided,
- lack of timely updates to PDP systems when patients change enrollment.

213 Proceeding with E-prescribing without standards for *signatura* (SIG) and drug naming may  
214 further hinder adoption. The pilot projects found that neither these standards were ready to  
215 support use in Medicare Part D E-prescribing. The lack of these standards do not make E-  
216 prescribing infeasible but do require use of remarks rather than standards for  
217 communication of some information. HIMSS believes that E-prescribing will still deliver  
218 on the promised benefits of simplification, accuracy improvement and efficiency in the  
219 ordering and dispensing processes. The biggest hurdle faced by E-prescribing is adoption  
220 by prescribers. This issue is primarily at the provider level, not at the pharmacy level.  
221 Until providers can see the productivity and cost reduction benefits of E-prescribing, they  
222 will not make the changes required to implement E-prescribing – investment and workflow  
223 changes.

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225 HIMSS recommends that CMS work with the Healthcare Information Technology  
226 Standards Panel (HITSP) and other concerned parties to refine the three E-prescribing  
227 standards that were not accepted by the pilots on a priority basis. CMS should then retest  
228 the three initial standards that did not pass in the pilots, as these have been so refined. This  
229 process will bring the complete set of six standards to operational readiness as soon as is  
230 feasible.

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232 Finally, the benefits of E-prescribing are expected to be substantial in lives saved through  
233 avoided medication errors, cost saved in formulary compliance, and time saved in  
234 prescribing and reordering. Therefore, HIMSS supports the April 1, 2009 compliance  
235 date, but encourages CMS to consider the challenges the deadline may impose on some  
236 provider organizations, and the necessary education that may need to occur over the next  
237 12 months to minimize adverse impacts on providers, patients, and industry initiatives.

### 238 239 **III. Collection of Information**

#### 240 241 **A. “Regulatory Impact Analysis” Overall Impact**

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243 HIMSS appreciates the opportunity to comment on the regulatory impact analysis section  
244 of this rule. Healthcare providers – hospitals, employed and private practice physicians –  
245 recognize the positive contribution to healthcare quality afforded by automation. While  
246 hospitals and health systems are largely adopting automation to support improved  
247 outcomes and reduce costs, solo and small group physician practices struggle to afford the  
248 financial means to implement and maintain such systems given the current healthcare  
249 environment.

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251 Healthcare providers recognize E-prescribing as a valuable and natural extension of base  
252 electronic medical record and practice management systems that support patient safety and  
253 quality care. The prospect not only of improved prescription accuracy, but the ability to  
254 verify that the prescriptions were filled and appropriately refilled, assures providers that  
255 patients understand and follow the medical care plan.

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259 In that E-prescribing works best as add-on function to computer systems that register  
260 patients, track their medical histories and document treatment plans, the larger healthcare  
261 provider organizations are well-positioned to adopt E-prescribing. Stand-alone E-  
262 prescribing software may be useful for physician practices that do not currently employ  
263 electronic medical record systems.

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265 Healthcare providers appreciate the federal government's role in establishing efficient  
266 technical standards to facilitate installation and insure sound investment of precious  
267 healthcare dollars.

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## 269 **B. Costs**

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271 HIMSS appreciates the opportunity to comment on the cost analysis section of this rule.  
272 All systems implementations have related costs regardless of the status of system  
273 standards. System implementations require the analysis, and implementation and support  
274 costs as well as lost opportunities for practices during the implementation and training  
275 periods. In addition hardware costs and annual system support for upgrades are additional  
276 costs for provider organizations. Hence providers will remain cautious in the adoption of  
277 health information technology including E-prescribing. Smaller "Physician Groups" are  
278 implementing the "E-prescribing solution" at a much lower level of integration with the  
279 EMR. The level of integration has and will continue to have a direct impact on the  
280 utilization of the E-prescribing solution. Costs for implementation of the E-prescribing  
281 standards will impact Retail Pharmacies, Medical Practices, Vendors, Payers and  
282 Clearinghouses.

283 The two main additions to the standard, Formulary and Benefit Information, and  
284 Medication History change the work-flow of the clinician significantly, since these two  
285 features directly impact point of care processes. As with any major functionality, there  
286 will be a disruption to productivity of the clinicians until the workflow associated with  
287 these two functions is incorporated.

- 288 • The AHRQ report, entitled, "Findings From the Evaluation of E-prescribing Pilot  
289 Sites," highlighted the complexity of the Formulary feature given the lack (or  
290 limited) implementation by the payers). This leads to addition integration by the  
291 physician practice in order to yield the benefits of this feature. From the Executive  
292 Summary, page vii: *As with medication history, however, there are important  
293 implementation issues. First, systems must adequately match patients to health  
294 plans, or the formulary and benefits data will not be available. Second, payers vary*

295 *in the level of information that they provide, and data elements can be difficult to*  
296 *interpret even when they are transmitted accurately.*<sup>5</sup>

297 • The Findings also highlight that practice staff play a significant role in the E-  
298 prescribing process, which suggests that the process is not dependent on a single  
299 person and a simplified process, but one requiring coordination and integration.  
300 *Page ix: One finding that was consistent across all sites was that prescribers' staff*  
301 *played a much more important role in the E-prescribing process than most pilot*  
302 *sites had anticipated. The evaluation team recommends that future E-prescribing*  
303 *efforts take the role of these staff, or "surrogate prescribers" into account in their*  
304 *planning.*<sup>6</sup>

305 • Most physician practices are small, and the Findings note that there may be  
306 productivity loss due to decrease in verbal communications for the office processes  
307 in these small practices. This suggests that CMS should analyze cost and benefits  
308 based on practice size. *The Findings state, Page ix: Finally, preliminary findings*  
309 *suggest that E-prescribing tools may decrease reliance on verbal orders and*  
310 *generate certain efficiencies for small physician offices. The analysis needs to fully*  
311 *identify the costs associated with disruptions to updating existing E-prescribing*  
312 *capabilities to the new capabilities, as well as the cost of implementing new sites to*  
313 *incorporate the new capabilities, since we know from actual E-prescribing*  
314 *implementation practices suffer productivity loss, which results in temporary loss*  
315 *in patient volume and increased labor costs to cover minimize impact to practice*  
316 *volume.*<sup>7</sup>

#### 317 a) Workflow Impact

318 The NPRM states on page 64911, B. Costs: We assume that implementation of the NCPDP  
319 SCRIPT standards would not significantly affect the implementation cost; to implement  
320 the foundation standards and these two standards is not significantly higher than the cost of  
321 implementing the foundation standards alone.

322 The two main additions to the standard, Formulary and Benefit Information, and  
323 Medication History change the work-flow of the clinician significantly, since these two  
324 features directly impact point of care processes. As with any major functionality, there will  
325 be a disruption to productivity of the clinicians until the workflow associated with these  
326 two functions is incorporated.

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328 Sites," highlighted the complexity of the Formulary feature given the lack (or

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<sup>5</sup> Agency for Healthcare Research and Quality, "Findings from the Evaluation of E-Prescribing Pilot Sites," page vii, AHRQ Publication No. 07-0047-EF, April 2007

<sup>6</sup> Ibid, page ix.

<sup>7</sup> Ibid, page ix.

329 limited) implementation by the payers). This leads to addition integration by the  
330 physician practice in order to yield the benefits of this feature. From the Executive  
331 Summary, page vii: *As with medication history, however, there are important*  
332 *implementation issues. First, systems must adequately match patients to health*  
333 *plans, or the formulary and benefits data will not be available. Second, payers vary*  
334 *in the level of information that they provide, and data elements can be difficult to*  
335 *interpret even when they are transmitted accurately.*<sup>8</sup>

- 336
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338 prescribing process, which suggests that the process is not dependent on a single  
339 person and a simplified process, but one requiring coordination and integration.  
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341 *played a much more important role in the E-prescribing process than most pilot*  
342 *sites had anticipated. The evaluation team recommends that future E-prescribing*  
343 *efforts take the role of these staff, or "surrogate prescribers" into account in their*  
344 *planning.*<sup>9</sup>
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346 productivity loss due to decrease in verbal communications for the office processes  
347 in these small practices. This suggests that CMS should analyze cost and benefits  
348 based on practice size. *The Findings state, Page ix: Finally, preliminary findings*  
349 *suggest that E-prescribing tools may decrease reliance on verbal orders and*  
350 *generate certain efficiencies for small physician offices. The analysis needs to fully*  
351 *identify the costs associated with disruptions to updating existing E-prescribing*  
352 *capabilities to the new capabilities, as well as the cost of implementing new sites to*  
353 *incorporate the new capabilities, since we know from actual E-prescribing*  
354 *implementation practices suffer productivity loss, which results in temporary loss*  
355 *in patient volume and increased labor costs to cover minimize impact to practice*  
356 *volume.*<sup>10</sup>

## 357 **b) Incomplete Physician Savings calculation**

358 Table 3 suggests savings associated with Administrative and Physicians and Medical  
359 Office Staff that use E-prescribing. The NPRM recognizes that there are costs associated  
360 with the implementation of E-prescribing, but states that they are minimal. Based on the E-  
361 prescribing Pilot Findings and experience from real E-prescribing implementations, CMS  
362 should include an analysis of the real costs associated with the implementation of E-  
363 prescribing, and factor those costs into the calculation to determine a more accurate Net  
364 Savings value. Costs include additional staff and physician labor needed to compensate for  
365 lost productivity, vendor or consultant labor needed to resolve integration issues between  
366 PBM's or E-prescribing suppliers providing accurate formulary and medication history  
367 information and lost revenue associated with loss of patient volume. Several studies

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<sup>8</sup> Ibid, page vii.

<sup>9</sup> Ibid, page ix.

<sup>10</sup> Ibid, page ix.

368 analyzing E-prescribing and EMR implementation have quantified a net loss to a practice  
369 ranging from nine to 14 months. The administrative savings also may provide benefits, but  
370 the savings also needs to reflect the start-up costs to deal with the implementation of the  
371 features that change the practice workflow, similar to the costs incurred by the physician.  
372 Administrative costs are more tangible for large practices than small practices. Several E-  
373 prescribing studies highlight the reduction in chart pulls, calls to confirm benefits, refill  
374 information, etc., by office staff, to the extent that in large practices they have eliminated  
375 FTE's that were no longer needed to perform these tasks once E-prescribing was  
376 implemented. However, for small practices, the elimination of some of these tasks may not  
377 allow small practices to realize similar savings. Therefore, in addition to quantifying the  
378 costs to determine Net Administrative Savings, CMS should considering scaling the  
379 savings to practice size. Furthermore, given the above discussion on workflow impact  
380 related to "surrogate prescribers" described in the pilot findings report, the saving should  
381 be minimal in the early years of deployment.

382 **c) Clarifying Administrative Physician Office and Pharmacy Savings associated with**  
383 **E-prescribing in Total Benefits Roll-up**

384 Table 6 compiles the savings / benefits for the various stakeholders in the E-prescribing  
385 process, represent total societal benefit. We suggest that CMS clarify this table to ensure  
386 that policymakers do not construe that these savings directly correlate to savings to  
387 Medicare or the private payers when E-prescribing is implemented. This is especially  
388 important in the wake of efforts to incentivize adoption of E-prescribing to reduce  
389 Medicare costs: in order to make appropriate policy decisions the costs and benefits, direct  
390 costs and direct benefits that can be realized by CMS must be identified, with other  
391 benefits characterized as positive externalities of implementing E-prescribing. Physician  
392 Office and Pharmacy benefits do not roll up to benefits for CMS. These benefits are cost  
393 savings that may be instructive in determining future reimbursement or E-prescribing  
394 adoption policies by CMS, but they are not direct benefits in the same manner that real  
395 savings associated with generic drug use ( versus name brand) provide, or the cost  
396 avoidance associated with eliminating adverse drug events (ADE's).

397 **d) CMS E-prescribing Costs should reflect increase Rx cost due to increased patient**  
398 **compliance of script fulfillment**

399 In the discussion of benefits, CMS does not include the likelihood that actual drug costs  
400 will increase due to increase volume related to improved patient compliance. A study by  
401 Walgreens, SureScripts and IMS identified that retail pharmacies that deploy electronic  
402 prescribing saw an 11% increase in prescriptions.<sup>11</sup> The study also cites that 20% of  
403 all prescriptions go unfilled. Retail pharmacy drug costs totaled \$201 billion; according to  
404 a February 2007 GAO study citing CMS data. That means the potential cost of full  
405 compliance could have been as high as \$251 billion, a \$50 billion increase. That means the

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<sup>11</sup> "New Research Suggests That, When Sent Electronically, More New Prescriptions Make it from Doctor's Office to Pharmacy to Patient," Press Release by SureScripts, Walgreens, and IMS, October 15, 2007

406 number of Medicare E-Prescriptions in Table 1 needs to reflect an increase number of  
407 prescriptions due to the use of prescriptions and the increased transaction costs. In  
408 addition, CMS should include the increased cost associated with increased drug  
409 prescription fulfillment that is attributable to E-prescribing. Note that the original E-  
410 prescribing Final Rule CMS-0011-F did not identify increased prescription volume and its  
411 associated costs related to E-prescribing.

## 412 **1. Retail Pharmacy:**

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414 Retail pharmacies in general like e-prescription due to its ability to improve the quality,  
415 safety and reduce overall costs of care. However, some pharmacies experience  
416 challenges with the timeliness and delivery of prescriptions due to system reliability,  
417 and network architecture issues. These issues must be addressed to enable the adoption  
418 of E-prescribing with retail pharmacies.

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420 Pharmacists also work with physicians, prescribers, and other health professionals as  
421 medication use experts. The real-time patient medical information described in the  
422 preamble can truly enable the ability of pharmacist services to improve health, increase  
423 quality, and reduce both drug and overall health costs. Robust literature also supports  
424 pharmacists educating prescribers about new drugs, evidence- based medicine, and  
425 formulary and benefit design. These activities - provided during or in addition to the  
426 dispensing process - will rely on the proposed standards required of all "dispensers,"  
427 and may have a role in overcoming shortcomings experienced in the pilots. The  
428 evolution of electronic prescribing to support all aspects of pharmacy practice will help  
429 align incentives for the continuity of care. Patients and providers alike benefit from  
430 innovations in drug therapy, patient education, and disease management.

431  
432 In addition, HIMSS appreciates the opportunity to provide the impact on private and  
433 non-retail chain pharmacies. Although e-prescribing is voluntary, the impact to private  
434 pharmacy practices (non-retail chain) will require upgrades to the retail pharmacy  
435 systems s in order to accommodate e-prescribing. Costs associated with such an  
436 upgrade will be passed on or absorbed in the private pharmacy practice.

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438 In the community health center setting, in-house pharmacies often maintain the  
439 formulary for the community health center and the formulary would not be available  
440 through the proposed system standards. In these settings, e-prescribing transactions  
441 sent through outside clearinghouses will introduce additional costs to obtain  
442 prescriptions from ambulatory EMR systems into a pharmacy system. The pharmacy  
443 transaction standards will help community health centers avoid the transaction costs of  
444 outside clearinghouses by re-using the technology to go directly between the  
445 ambulatory EMR and the pharmacy system.

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449 **2. Medical Practices**

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451 Medial practices have the same types of hardware, software costs and costs for  
452 broadband Internet connections as other facilities. As discussed earlier in our response,  
453 workflow changes required to use e-prescribing usually can result in decreases in  
454 productivity, which are most difficult to absorb in small practices. The major cost  
455 savings associated with e-prescribing for a medical practice do not occur until refills  
456 can be handled electronically eliminating phone calls. This feature is often not turned  
457 on in e-prescribing systems imbedded in electronic health records and pharmacies do  
458 not change work flow to electronic refill requests until sufficient numbers of physicians  
459 and prescriptions are sent electronically. Although physician practices bear the burden  
460 of the costs associated with buying, implementing and supporting electronic  
461 prescribing, they may not see significant cost savings for months to years with small,  
462 rural practices taking the longest.

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464 **3. Vendors**

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466 The rule suggests that costs for development and testing to bring products into  
467 compliance are minimal and come under the cost of doing business. For vendors of  
468 stand-alone E-prescribing systems and ambulatory EMRs, the cost may be minimal  
469 since they support the foundation standards. However, even those systems that have  
470 obtained CCHIT and other certifications may not yet support the Formulary and  
471 Benefit transaction and will incur cost for development and testing.

472  
473 **Conclusion**

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475 HIMSS is grateful to CMS for allowing us the opportunity to provide comment to CMS'  
476 Proposed Final Rule "*Medicare Program; Proposed Standards for E-prescribing Under*  
477 *Medicare Part D; Proposed Rule*" (**CMS Reference Number: CMS-0016-P posted in**  
478 **November 2007**). We commend CMS for issuing the final uniform standards for the  
479 electronic prescription drug program.

480  
481 HIMSS members represent more than 20,000 individual, 330 corporate members, and 47  
482 chapters nationwide. HIMSS seeks to shape healthcare public policy and industry  
483 practices through its educational, professional development, and advocacy initiatives  
484 designed to promote information and management systems' contribution to quality patient  
485 care. Providing comment on this rule aligns with our mission to lead change in the  
486 healthcare information and management systems field through knowledge sharing,  
487 advocacy, collaboration, innovation, and community affiliations for healthcare IT  
488 professionals and providers represented by our membership. We are dedicated to work  
489 with Industry and Government leaders by providing comment on issues and rules that  
490 impact the delivery and quality of care provided to all patients.

492 Should you have any additional questions please contact Mary Griskewicz, Senior  
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