



January 28, 2019

The Honorable Donald Rucker, MD  
National Coordinator for Health Information Technology  
Department of Health and Human Services  
200 Independence Ave, S.W.  
Washington, DC 20201

The Honorable Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.P Box 8016  
Baltimore, MD 21244

**Surescripts supports strategy to reduce regulatory and administrative burden and urges CMS and ONC to support reform of current system that delays critical innovation of eRx and ePA standards**

Dear Dr. Rucker and Administrator Verma:

We appreciate the opportunity to comment on your Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. Surescripts serves the nation with the largest health information network, built to increase patient safety, lower costs and ensure quality care. Founded in 2001 to enable electronic prescribing, today we are drawing on that experience to exchange many other kinds of actionable patient intelligence—including medication histories, prior authorizations and other complex clinical messages. The Surescripts Network Alliance includes virtually all electronic health record (EHR) systems, pharmacy benefit managers (PBMs), pharmacies and clinicians, plus an increasing number of health plans, long-term and post-acute care organizations and specialty pharmacy organizations. In 2017, we transmitted 13.7 billion secure health data transactions—including 1.74 billion e-prescriptions and 1.46 billion medication histories—and connected 1.47 million healthcare professionals, who rely on a master patient index covering 71% of the U.S. population. Additional information about Surescripts is available at [surescripts.com](https://surescripts.com). For more data on how we're advancing nationwide health information exchange, please see our National Progress Report, available at <https://surescripts.com/report>.

We commend CMS and ONC for your leadership in this effort and we provide comments below on four specific items described in the draft strategy document. Related to each of these items is a larger issue that we believe must be resolved if we are to meet the Secretary's goals: The current process for updating standards for e-Prescribing (eRx) and electronic prior authorization (ePA) is broken and has resulted in years of unnecessary delays in adoption of new technology designed to reduce provider burden and enhance patient care.

2800 CRYSTAL DRIVE  
ARLINGTON, VA 22202  
T: 703.921.2121 F: 703.921.2191

920 2ND AVENUE SOUTH  
MINNEAPOLIS, MN 55402  
T: 866.267.9482 F: 651.855.3001

**SURESCRIPTS.COM**

CMS currently has the sole authority under the Medicare Modernization Act of 2003 to update the e-prescribing standards used by prescribers, prescription drug plans, and pharmacies when servicing Medicare beneficiaries. Since CMS first adopted the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard for electronic prescribing in 2005, CMS has only updated its selected version of the standard two times. The standard that is currently effective under CMS rulemaking (version 10.6) was first published by NCPDP in October 2008.

In early 2016, NCPDP requested CMS to adopt the newest industry-approved e-prescribing standard. After missing several publication deadlines, on April 16, 2018 CMS finalized an update to the SCRIPT standard (as part of the agency's MA and Part D rule). This update to the SCRIPT standard will not become effective until January 1, 2020. This means that the standard now in effect contains technology that is 10 years old. In the same time frame, NCPDP has published 24 versions of the standard since version 10.6, with each containing new innovations – new innovations that no one is permitted to use until 2020.

Examples of critical innovations that have been delayed under the current system include:

- (1) Prescriptions for specialty and compound pharmacy drugs cannot currently be sent electronically, and must instead be communicated by fax machine or traditional written or oral prescriptions. NCPDP SCRIPT 2017071, the standard that becomes effective January 1, 2020, provides support for communicating instructions for specialty and compound pharmacy drugs in a standardized fashion, permitting prescribers to prescribe these drugs electronically like other medications. This feature has been ready for adoption since March 2009.
- (2) The adoption of NCPDP SCRIPT 2017071 will also allow prescribers to use standardized data fields to communicate allergy and substance use history to pharmacies – a tool that would be useful for pharmacies and prescribers to combat the opioid epidemic. This feature has been available since July 2015.
- (3) NCPDP SCRIPT 2017071 also includes fields that allow prescribers to report to PDMPs using the existing medication history transactions that are currently part of the prescriber's work flow. This feature has been available since 2016.

When the new standard becomes effective in January 2020, it will have taken CMS nearly four years to respond to the industry request to update and implement the new eRx standard, with all of its improved functionalities. It is important to note that the current CMS rulemaking process has never resulted in a single substantive change to the NCPDP-published standard. The outdated requirement for CMS rulemaking has only impeded the piloting and timely adoption of newer standards. **We urge you to support efforts to reform the current system.**

Comments on specific strategies follow:

**(1) Clinical Documentation, Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes:**

Surescripts expertise regarding prior authorization processes is specific to prior authorization for drug benefits. We strongly endorse this proposed strategy and we are equally supportive of the mandate in the 2018 SUPPORT Act that requires adoption of the NCPDP electronic prior authorization standard transactions by Part D plans effective January 1, 2021. The goal of the new law is to ensure that all Part D drug plans accept electronically transmitted prior authorization requests submitted by prescribers.

Addressing the burden associated with prior authorization has been a high-priority goal for industry and policymakers for some time. It is a critical issue for patients, many of whom are a higher risk of abandoning treatment when a prior authorization is required. Surescripts is one of several vendors who now provide Real Time Benefit Tools (RTBT). Our tool allows prescribers to view patient-specific prescription price and therapeutic alternative information, integrated with their EHR software at the point of care. It also provides a full range of decision support elements, including prior authorization requirements. Prescribers who use our RTBT see whether medications displayed require prior authorization and are given the opportunity to select an alternative medication. Last year, in 24 percent of such cases, providers changed to a drug with no prior authorization requirement.

As use of electronic prior authorization grows, the industry will have an opportunity to evaluate and improve the current NCPDP standard. But updating the standard in the future will face the same barriers that exist today: an outdated requirement for CMS notice and comment process. If that process is not modernized, future delays in updates will prevent industry from improving the usability of electronic prior authorization applications and services in a timely manner.

**(2) Health IT Usability Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden and Strategy 4: improve health IT usability by promoting the importance of implementation decisions for clinical efficiency satisfaction and lowered burden.**

One of the consequences of CMS's current system for approving NCPDP published standards, is that prescribers must leave the EHR workflow and use a paper-based process to prescribe certain compound and specialty drugs. This is an excellent example of the unnecessary burdens your proposed strategies aim to eliminate. If not for the current CMS process, this burden could have been eliminated 10 years ago. NCPDP SCRIPT

201707, which was not approved by CMS for use until January 1, 2020, provides support for communicating instructions for specialty and compound pharmacy drugs in a standardized fashion, permitting prescribers to prescribe these drugs electronically like other medications. As mentioned previously, this feature has been ready for adoption since March 2009.

**(3) Public Health Reporting Strategy 1: Increase Adoption of Electronic Prescribing of Controlled Substances (EPCS) and retrieval for medication history from state PDMP through improved integration of health IT and provider workflow**

Regarding the proposed strategy for supporting state PDMP through improved integration of health IT and provider workflow, we again point out that CMS-related delays are responsible for perpetuating barriers to integration. New standard 2017071 includes fields that allow prescribers to report to PDMPs using the existing medication history transactions that are currently part of the prescriber's work flow. Proposed by NCPDP in 2016, CMS has delayed adoption of New standard 2017071 until January 1, 2020.

Regarding the goal of increasing adoption of EPCS, Surescripts strongly endorses this strategy. One of the most promising technology tools for prevention of opioid-related disease is EPCS. Up to nine percent of drugs diverted for abuse are tied to fraud or forgery of paper prescriptions'. Broad adoption of EPCS could reduce the supply of illegally diverted drugs by eliminating paper, and improve accountability and surveillance by creating an electronic record of controlled substance transactions. Surescripts has been working with ONC and our industry partners since 2015 to support enactment of EPCS mandates at both the state and federal levels.

EPCS is now legal in all states and the District of Columbia and 15 states have enacted laws that mandate electronic prescribing for controlled substances. The SUPPORT Act requires EPCS for the Part D program beginning January 1, 2021. But while EPCS use has grown over the past three years, it still remains a fraction of the rate of e-prescribing for all drugs. This relatively low national rate is a consequence of slow adoption among prescribers. Over 90 percent of retail pharmacies are enabled to receive electronic prescriptions for controlled substances. In contrast, only 32 percent of prescribers are enabled to send them. Going forward, Surescripts is committed to work with our industry and government partners to grow prescriber adoption across the nation. One of the contributions we make to that effort is regular reports on adoption and use by state.

An additional tool that addresses the opioid epidemic is Surescripts Medication History service which is widely adopted by nearly all EHRs and can supplement PDMP data for prescribers at point of care.

The Honorable Donald Rucker, MD  
The Honorable Seema Verma, Administrator  
January 28, 2019  
Page 5

Surescripts delivers nearly 7 million HIPAA-compliant medication histories securely across our network every day. Our data covers 85% of U.S. patients nationwide, and offers providers access to their patients' dispensed medication history, including controlled substances, over the previous 12 months. Our data is refreshed daily and sourced from claims data from our commercial, Medicare, and Medicaid PBM partners, and dispensed data from our community, retail and independent pharmacy partners. We deliver our data through providers' EHR systems, which configure it and create user interfaces for seamless use by the provider without having to leave their workflow.

There are significant differences between PDMP reports and Medication History: (1) Medication History is not limited to controlled substances; (2) Medication History is delivered through the provider's EHR within the workflow, rather than a separate stand-alone PDMP service; (3) Medication history is sourced nationally rather than by state, so providers see the same patient history data, regardless of location or prescribing physician; (4) Surescripts uses a master patient index built upon the backbone of our network that allows us to match nearly 250 million patients with their records; and (5) Surescripts is fully interoperable, with all network participants using the same standards and held to the same degree of network quality.

Our service is not a substitute for the PDMP system. We do not have universal state-level coverage as the PDMP program does, nor is our service accessible to law enforcement and the array of organizations that PDMPs serve at the state level. But we believe it is a powerful tool, and an important supplementary source of information for providers who treat patients at risk of opioid-related illness.

Thank you for the opportunity to comment on your proposed strategy to reduce regulatory and administrative burden. We look forward to working with you as you implement the strategy.

Sincerely,



Mary Ann Chaffee  
Vice President  
Policy and Federal Affairs