

Welcome to the AHRQ Medicaid-SCHIP Technical Assistance Webinar –
**Implementing e-Prescribing in the Medicaid/SCHIP Programs:
Experiences and Lessons Learned**

Tuesday, September 30, 2008 1:30-3:00 p.m. Eastern

Presented by:

Tony Trenkle - Director of the Office of E-Health Standards and Services, Centers for Medicare and Medicaid Services, Department of Health and Human Services

Andrew Morgan - Project Officer for the Office of E-Health Standards and Services, Centers for Medicare and Medicaid Services , Department of Health and Human Services

Jessica Kahn, MPH, Medicaid Transformation Grants Project Officer, Centers for Medicare and Medicaid Services

Moderated by:

Walter Suarez - MD, MPH, Institute for HIPAA/HIT Education and Research; Co-Chair, HITSP Security, Privacy and Infrastructure Technical Committee

*** Please note all participants were placed on mute as they joined the session.**

Overview

- **Welcome** – Walter Suarez, MD, MPH, Institute for HIPAA/HIT Education and Research; Co-Chair, HITSP Security, Privacy and Infrastructure Technical Committee
- **Before We Begin** – Walter Suarez
- **Introductions** – Walter Suarez
- **Presentations**
 - *Electronic Prescribing Standards Update*
 - Presented by Tony Trenkle – Director of the Office of E-Health Standards and Services, Centers for Medicare and Medicaid Services, Department of Health and Human Services
 - Presented by Andrew Morgan – Project Officer for the Office of E-Health Standards and Services, Centers for Medicare and Medicaid Services, Department of Health and Human Services
 - *State Medicaid Experiences with e-Prescribing*
 - Presented by Jessica Kahn, MPH, Medicaid Transformation Grants Project Officer, Centers for Medicare and Medicaid Services
- **Question and Answer** – Walter Suarez
- **Closing Remarks** – Walter Suarez

Before we begin...

- Please note all participants were muted as they joined the Webinar.
- If you wish to be unmuted, choose the “raise hand” option to notify the host.
- If you have a question during the presentation, please send your question to ***all panelists*** through the chat. At the end of the presentation, there will be a question and answer period.
- Please e-mail Nicole Buchholz at nbuchholz@rti.org if you would like a copy of today’s presentation slides.
- We are currently in the process of posting all of the TA Webinar presentation slides to the project website.

■ Listserv Registration

- Please register for the listserv to receive announcements about program updates and upcoming TA Webinars.
- To register go to <http://healthit.ahrq.gov/Medicaid-SCHIP>
- Click on “Medicaid-SCHIP Fast Facts” on the left-hand side of the screen.
- There are two ways to register for the listserv:
 - 1. Click the link “[Click here to subscribe to the listserv](#)” which will open a pre-filled e-mail message, enter your name after the text in the body of the message, and send.
 - 2. Send an e-mail message to: listserv@list.ahrq.gov.
On the subject line, type: **Subscribe**.
In the body of the message type: **sub Medicaid-SCHIP-HIT** and **your full name**. For example: sub Medicaid-SCHIP-HIT John Doe.
You will receive a message asking you to confirm your intent to sign up.

Electronic Prescribing Standards Update

Presented by:

Tony Trenkle - Director of the Office of E-Health Standards and Services, Centers for Medicare and Medicaid Services, Department of Health and Human Services

Andrew Morgan - Project Officer for the Office of E-Health Standards and Services, Centers for Medicare and Medicaid Services, Department of Health and Human Services




What is E-Prescribing (E-Rx)?

- Under Part D:
E-prescribing is the transmission of prescription or prescription-related information between prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary using electronic media.
- Employs adopted Part D e-prescribing standards initiated through Medicare Modernization Act of 1999 (MMA).
- E-prescribing is voluntary under Part D.



What is E-Prescribing (E-Rx)?

- Does **not** require manual transcription at either end.
- Traditional faxing is **NOT** electronic prescribing.
- Secure e-mail is **NOT** electronic prescribing.



Benefits of E-Prescribing

- Actively promotes appropriate drug usage
- Reduces medication errors
- Provides information about formulary-based drug coverage, including formulary alternatives and copay information
- Speeds up the process of renewing medications
- Provides instant connectivity between the health care provider, the pharmacy, health plans/PBMs, and other entities



Key CMS Standards Activities

- Foundation standards implemented
January 1, 2006
- E-prescribing pilots conducted CY 2006
- Report to Congress delivered April 2007
- Final uniform standards published April 2008, effective April 2009



Approach – Building Suite of Standards

- Not a “one-shot deal”
- Look for mature standards with a track record
- Work with industry to “grow” other standards as needed
- National Committee on Vital and Health Statistics (NCVHS) as advisor/convenor



Standards – Round One

- Foundation standards effective January 2006
- Enabled basic functions
 - Prescriber and pharmacy checking patient's eligibility with plans
 - Exchange of new prescriptions, refill requests, cancellations, and changes between prescribers and pharmacies
- Advantages
 - Eliminates errors associated with handwriting and miskeying
 - Reduces administrative costs associated with phone calls



Standards – Round Two

- 2006 Pilot Test looked at additional standards
 - Formulary and benefits
 - Medication history
 - Rx-fill
 - RxNorm
 - Structured / codified Sig
 - Prior Authorization

Standards – Round Two (cont'd)

■ Results

- Formulary and benefits, medication history, Rx-fill ready for adoption
- More work needed on RxNorm, Sig and Prior Authorization
- Final Rule published on April 7, 2008
- Effective April 1, 2009

Final Rule

- Published April 2008, effective April 2009
- CMS adopted the following standards
 - Medication History
 - Formulary and Benefits
 - RxFill
 - Retired NCPDP 5.0 and replaced with version 8.1
 - Use of National Provider Identifier (NPI) as an individual identifier

Other CMS Initiatives

- Medicaid Transformation Grants: 2-year, \$150M program that grants funds to states for adoption of innovative methods to improve effectiveness and efficiency through e-prescribing and other health IT initiatives
- Quality Improvement Organization (QIO) 9th Scope of Work: will allow development of e-prescribing special studies that support patient safety initiatives

MIPPA E-Prescribing Provision (Section 132)*

- Incentives for successful e-prescribers
 - 2% in 2009-2010
 - 1.5% in 2011-2012
 - 0.5% in 2013
- Payment adjustments for non-e-prescribers
 - 1% reduction in 2012
 - 1.5% reduction in 2013
 - 2% reduction for 2014 and later
- Further information to be included in Physician Fee Schedule final rule with comment

* MIPPA = Medicare Improvements for Patients and Providers Act of 2008




Next Steps – Standards and Adoption

- Re-test RxNorm and Structured / Codified Sig and test new Standards
 - Modifications made as a result of 2006 pilot and February 2008 industry experts meeting on next steps for standards that were not ready for adoption
 - RAND awarded contract to pilot test RxNorm and Structured / Codified Sig NCPDPT SCRIPT 10.5
- Continue to develop prior authorization business process and standards
 - Partnership with AHRQ
- Future standards work as need is identified



E-Prescribing of Controlled Substances

- DEA NPRM-Comment period closed September 25, 2008
- Advocates a technical solution, for example:
 - Two-factor authentication
 - In-person proofing
 - Two-minute timeout
- HHS will continue to work with DEA on integrating e-prescribing of controlled substances in a way that is:
 - Interoperable with existing e-prescribing systems
 - Scalable to work throughout the health care system without imposing an undue burden
 - Promotes overall e-prescribing adoption



Next Steps – Computer-Generated Fax

- 2005 Standards regulation gave an exemption from use of SCRIPT standard for entities using computer-generated fax technology
- Exemption tightened in last year's Physician Fee Schedule (PFS) regulation to apply only to temporary transmission problems, effective January 1, 2009
- New information raised concerns about unintended consequences regarding refills
- In this year's PFS NPRM, proposed retaining exemption for prescription refill requests
- Final rule to be published November 2008, effective January 2009



Where Do We Go From Here?

- From a standards perspective
 - Finish the initial standards suite
 - Work with the DEA to develop a saleable, interoperable, commercially viable solution to e-prescribing and controlled substances
 - Look at lifting the long-term care exemption
 - Determine the best approach with the computer-generated fax exemption
 - Continue to monitor the effective use of standards
 - Work with the Service Data Objects (SDOs) and NCVHS on additional standards requirements



State Medicaid Experiences with e-Prescribing

Presented by:

Jessica Kahn, MPH, Medicaid Transformation Grants Project Officer, Centers for Medicare and Medicaid Services (CMS)

Funded by the Agency for Healthcare
Research and Quality

Background

Medicaid Transformation Grants (MTGs)

- States doing e-Rx with an MTG: **AZ, NM, DE, TN, CT, AL, FL**
- No state matching dollars required
- 24-36 months
- Evaluation requirements include clinical improvements and cost savings to Medicaid

First Steps

- Assess environment for e-prescribing and provider rate of adoption
 - Who is e-prescribing?
 - With what software?
 - How often?
 - Geographic distribution?
- Determine what functionalities are needed (i.e., most attractive to providers)

Stakeholder Involvement

- Access provider groups
 - Example: In **New Mexico**, they are working with the NM Prescription Improvement Coalition, a statewide organization to collaborate on provider outreach and training and to construct a e-Rx interface across payers
 - Provider Advisory Groups
 - State Medical Director or Medicaid Medical Director
 - Get out in the field and ask face-to-face



Stakeholder Involvement (cont'd)

Lessons learned:

- Ask for input early
- Show them demonstrations as you build
- Pilot with the early adopters/high-volume prescribers
- Provider blitz at kickoff
- Monitor usage by functionality, by prescriber, etc.

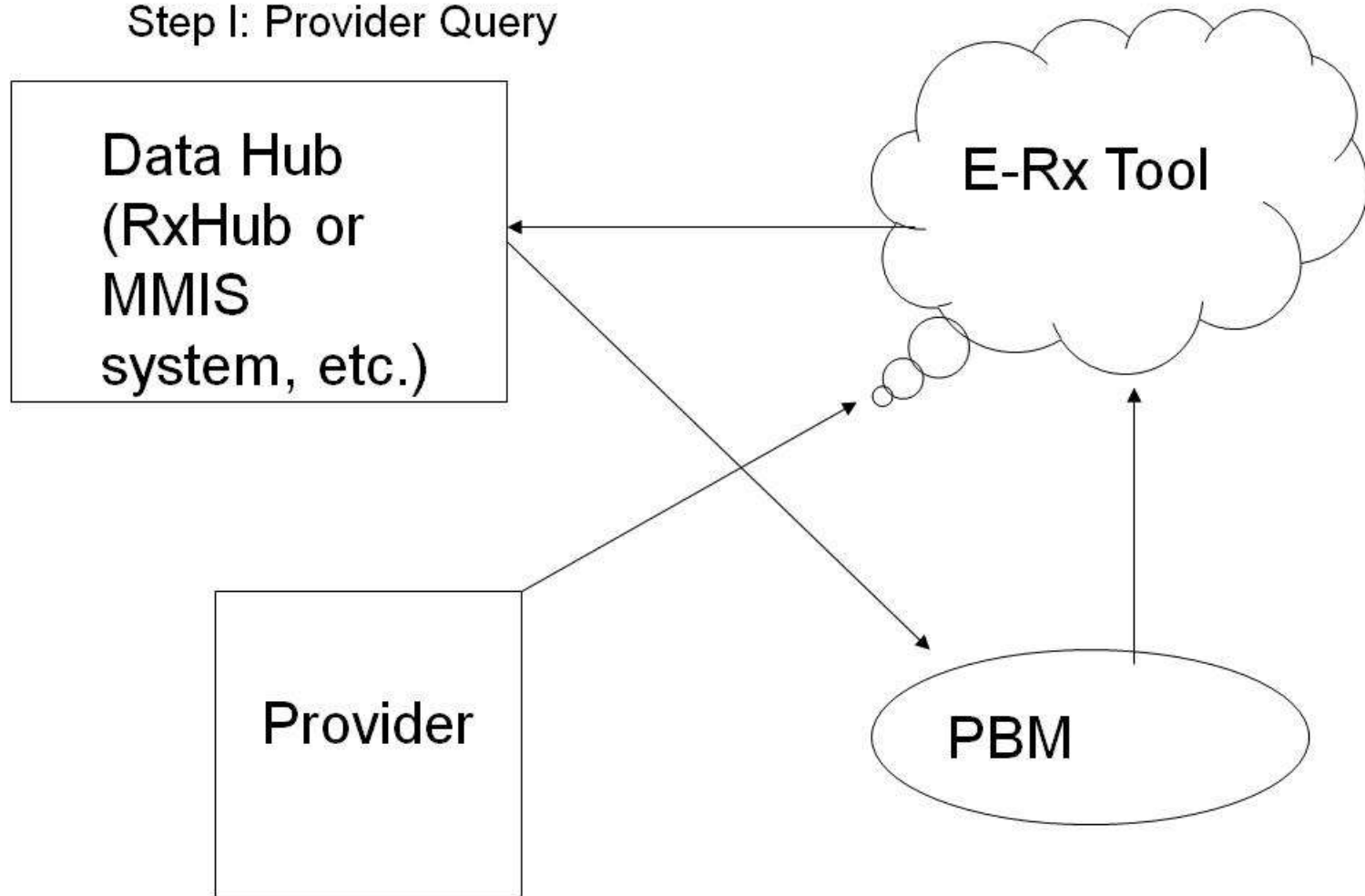
What's Included in e-Rx? (and what isn't!?)

- Allergy alerts
- Preferred drug list
- Benefit limitations
- Pharmacy copays
- Pre-authorization requirements
- Encouragement of generics
- Clinical decision support
- Patient history
- Drug to drug interaction alerts
- Therapeutic duplication alerts
- Dosage alerts
- Tracking drug over- and under-utilization

Some of Medicaid's Approaches to e-Rx

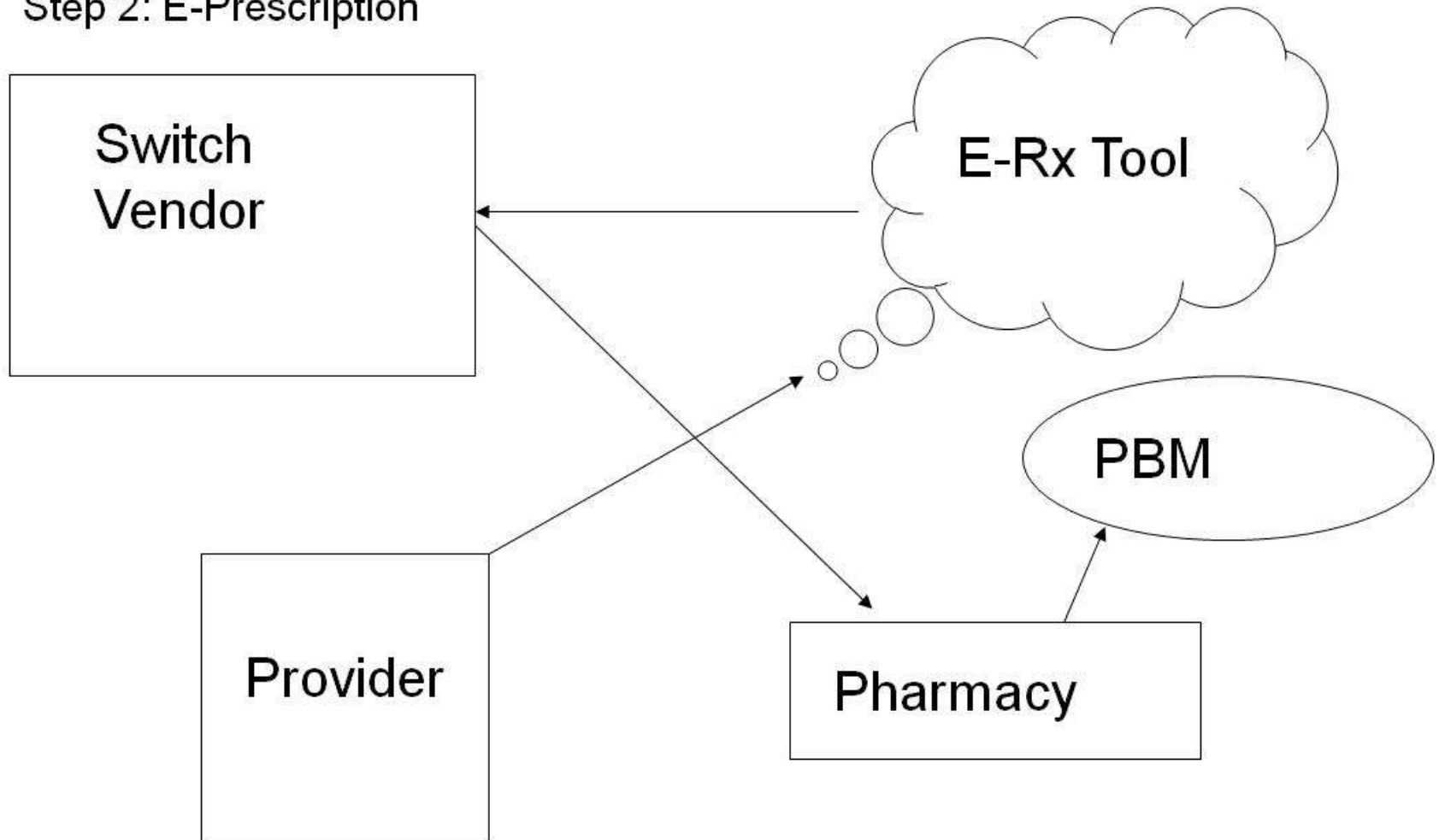
1. Web-based e-Rx utility/tool (**FL, AL, AZ, TN, DE, MO, WY**)
 - Secure login
 - No provider software required, just Internet access
 - Advantage: can be co-located with other utilities (electronic claims payments, etc.) to increase convenience
 - PDAs, desktops, laptops, etc.
 - Various bells/whistles (prior slide)
 - Linked to claims data warehouse

Step I: Provider Query



Provider uses the Tool, which sends the query to the Data Hub, which transmits the query to the PBM to verify eligibility, formulary, etc.

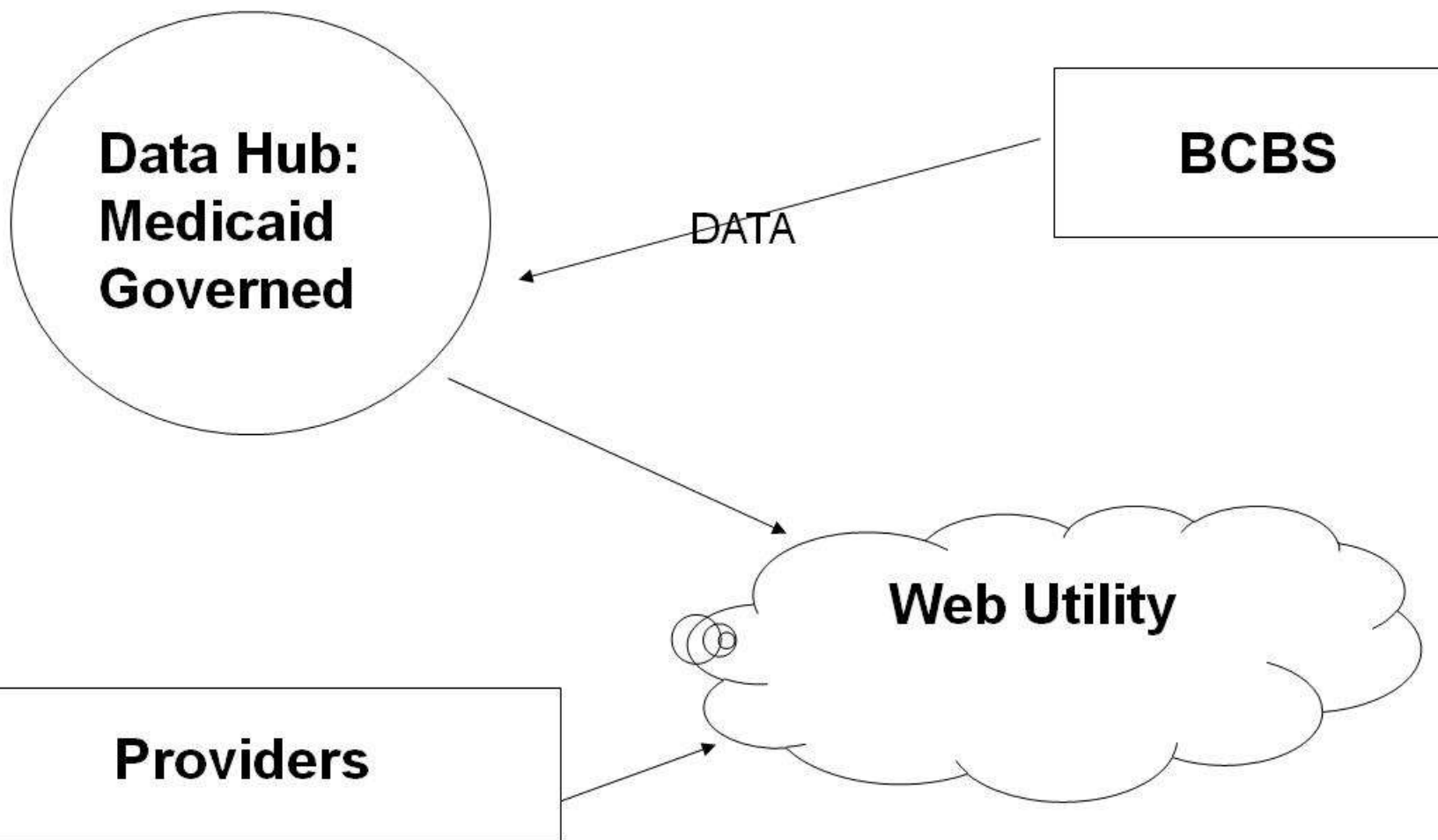
Step 2: E-Prescription



Provider views results and then, using the Tool, submits the prescription. A switch vendor, such as SureScripts, transfer the prescription to the pharmacy. Pharmacy then fills the prescription and bills the PBM with point-of-sale software.

Web-Utility Approach (cont'd)

- Web-utility for just Medicaid or across payers?
 - Example: **Alabama**'s utility (includes an electronic health record, clinical decision support, and e-prescribing function) includes all the claims histories for Alabama Medicaid beneficiaries AND Alabama Blue Cross/Blue Shield participants.
 - Advantage: Joint provider outreach; more reasons for a provider to use the utility because between the two payers; represents the majority of AL residents





Approaches to E-Rx (cont'd)

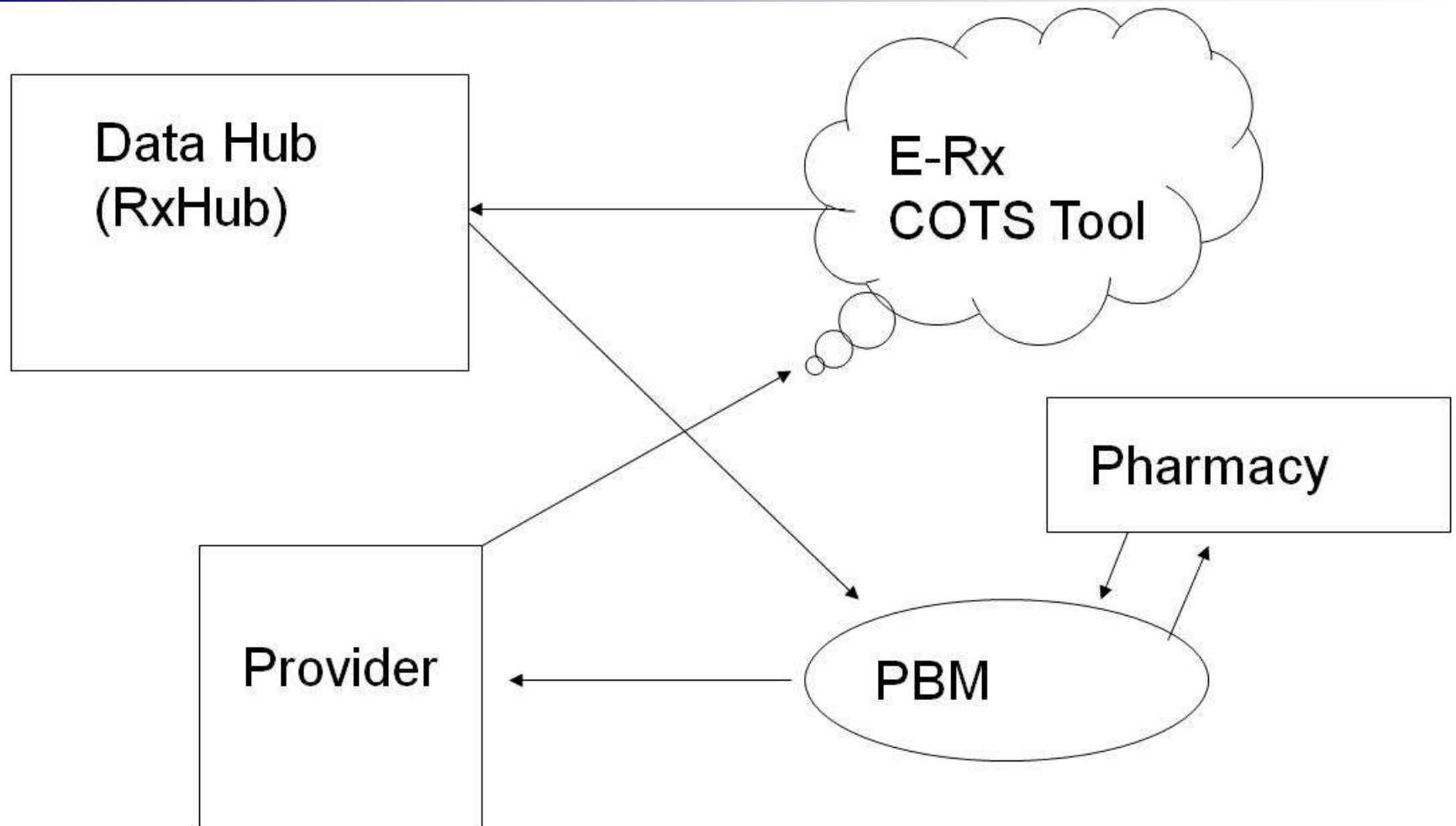
2a. Build an interface for COTS e-Rx tools

- Example: **New Mexico** Medicaid is working with NM Prescription Improvement Coalition (NMPIC) to reduce the negative health effects of inappropriate drug treatment in Medicare beneficiaries. Goal: education, clinical guidelines for appropriate treatment of people with chronic disease and drug utilization
 - NMPIC includes the NM QIO which does outreach and education on e-Rx and Medicare Part D
 - Can offer peer-to-peer support/training



Interface Approach (cont'd)

- Will equip 50 rural Federally Qualified Health Center and Native American tribe providers with technology to enable e-prescribing—paying for their choice of e-Rx software from a list of approved vendors
- Working with RxHub to develop a multi-vendor approach
- Medicaid and the other payers will offset the costs for providers in Year 1 who participate in the NMPIC and use the system
- Provides an incentive for early adoption and is a public/private partnership approach
- Advantage: Brings together multiple payers, targets key provider groups, addresses provider incentives up front



Provider uses the Tool, which sends the query to the Data Hub, which transmits the query to the PBM to verify eligibility, formulary, etc. Provider views results and then, using the Tool, submits the prescription. A switch vendor, such as SureScripts, transfer the prescription to the pharmacy. Pharmacy then fills the prescription and bills the PBM with point-of-sale software.



Approaches to e-Rx (cont'd)

2b. Use existing hubs and integrate software into your data warehouse (NH, NV (proposed), MS)

- Providers' practice management software interacts with the Medicaid Management Information System (MMIS) and integrated SureScripts software
- Providers get data back (formulary, eligibility, history, etc.), make appropriate decision, submit prescription
 - Fewer rejected claims
 - Fewer queries from pharmacy to MMIS and to provider
 - = reduced transaction cost
 - Advantage: In NV, 70+% of pharmacies are technically capable of this change



Questions: Cost & Sustainability

- Who pays transaction fees? Other costs?
 - **Tennessee:** pays all the fees, no cost to providers. Providers pay for Internet connectivity
- How long are incentives offered?
 - **New Mexico:** just for Year 1, early adopters
 - **Delaware:** PDAs for initial pilot adopters
- What is incentive for small, independent pharmacies?
 - **Connecticut:** has voiced this as a challenge, i.e., resistance from pharmacies over transaction fees.



Rationales: Provider Incentives/ Uptake

- Low overall penetration = offer a utility with no transaction fees
- Medium to high penetration = offer a utility with multiple functionality (administrative & clinical) OR offer an interface to existing COTS e-prescribing software products
- Focus on target population: All prescribers? Highest volume prescribers? Rural/safety net prescribers?

Early Lessons Learned

- Provider enrollment is slow
- Provider enrollment is slow 😊 (smiley face)
- Incentives matter
 - Financial or workflow/efficiency or both!
- One-stop shop model is most attractive
 - Multiple reasons to use the tool/platform
 - Information from more than one payer
 - Administrative functionality
 - Electronic health record



Medicaid Transformation Grants

- For more info on the MTG overall, go to:

<http://www.cms.hhs.gov/MedicaidTransGrants/>

Or contact:

Jessica.kahn@cms.hhs.gov



Comments and Recommendations for Future Sessions

- Please send your comments and recommendations for future sessions to the project's e-mail address:

Medicaid-SCHIP-HIT@ahrq.hhs.gov



Project Information

Please send comments and recommendations to:

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