

HIT Policy Committee
Information Exchange Workgroup

January 25, 2010

9:00 a.m. – 1:00 p.m. (Eastern)

HHS Humphrey Building, Room 505A

200 Independence Ave, SW

Washington, DC 20201

Instructions and Questions for Panelists

BACKGROUND

Testimony from this hearing will help the Information Exchange Workgroup formulate recommendations to the HIT Policy Committee and National Coordinator on issues related to electronic prescribing and the electronic exchange of prescription data. If you have any questions feel free to contact Jonathan Ishee at 202-205-8493 or jonathan.ishee@hhs.gov.

Format of Presentation:

The Workgroup respectfully requests that panelists limit their prepared remarks to five (5) minutes. This will allow the Workgroup to ask questions of the panelists and allow every presenter time to present his or her remarks. You may submit as much detailed written testimony as you would like (see below), and the Workgroup members will have reviewed this material in detail before the hearing.

Pre Presentation Questions/Themes:

The questions below represent areas the Workgroup intends to explore at the hearing. Please feel free to use them in preparing your oral and written testimony; the Workgroup recognizes that certain questions may not apply to all presenters.

The Workgroup respectfully requests panelists to provide written testimony by **January 20, 2010**. Please submit the testimony to Jonathan Ishee and Judy Sparrow at jonathan.ishee@hhs.gov and judy.sparrow@hhs.gov

Presenter Biography

In addition, the Workgroup requests that all presenters provide a short bio for inclusion in the meeting materials. Please send your short bios to Judy Sparrow, judy.sparrow@hhs.gov

THEMES

General Themes:

1. How would you describe the current state of electronic prescribing?
2. What are the technological challenges surrounding electronic prescribing?
3. What are the business case impediments to electronic prescribing?

Medicaid agencies in most cases initiated their e-Rx programs through one-time grant funding (exceptions: TN and FL). Because of this initial funding flexibility, they were able to not only offer their providers free access to e-Rx tools but often also offered additional incentives, such as PDAs or notebooks-plus significant training and technical assistance. So the business case dilemma they face now is how to sustain what they've stood up as a Medicaid-only "public utility" free model, once their grant funding has been depleted. Will they continue to offer it for free? Will they subsidize transaction costs for a time delineated period for high volume prescribers? What about the hardware incentives-will they go away? Will they implement payment policy reform and offer a higher reimbursement for e-prescriptions, similar to the Medicare e-Rx incentives and recognize providers' on-going costs that way?

Another business case challenge they've noted deals with the reluctance of some small/independent pharmacies to participate in e-Rx because of the transaction costs-which are not subsidized for the pharmacies. In part to alleviate this problem, Alabama Medicaid has submitted a State Plan Amendment to CMS to increase its reimbursement rates for pharmacists who are participating in e-Rx.

Furthermore, most providers are not willing to use one system for Medicaid and another system for their other patients and/or are adopting EHRs that have e-Rx

functionality. So will Medicaid pay for the interfaces between a variety of EHRs/e-Rx and their MMIS system?

4. What are the operational impediments to electronic prescribing?

In terms of approaches, some States created interfaces between the Medicaid claims data and existing e-Rx software in use in their State so that regardless of what the provider is using, they can access the Medicaid information on their system. This has been successful where e-Rx adoption is already burgeoning. However, where there is not much e-Rx, especially in rural areas, State Medicaid agencies were also offering home-grown e-Rx solutions via Internet portals. Given the HITECH legislation and the inclusion of e-Rx as part of meaningful use of certified EHR technology, what will happen to those homegrown systems? Will certified EHRs seek interfaces with the Medicaid claims engines (MMIS) so that the e-Rx connections are still there for Medicaid providers? How will providers feel about having to learn new systems? What about the sunk costs by the State Medicaid agencies into home-grown e-Rx systems? How can they be leveraged, given HITECH?

5. What are the regulatory impediments to electronic prescribing?

The inability to e-Rx for controlled substances remains a frequently noted barrier to encouraging broad adoption among Medicaid providers. This should change since the DEA is close to publishing its Final Rule on e-prescribing of controlled substances. Other barriers often noted is a lack of a full suite of standards for e-prescribing (i.e. Electronic Prior Auth, Structured and codified Sig, RxNorm)

6. What's a priority to facilitate easier/broader adoption and use of electronic prescribing systems even if not immediately actionable?

Linking use of e-Rx (and HIT for that matter) to provider payment policies. Offer providers enhanced reimbursements for e-Rx (i.e. value-based purchasing.)

7. What best practices would you recommend in this area?

Include automated pre-authorization and other administrative functions to streamline business processes for providers and enhance the overall system appeal.

Specific Themes:

8. Where can e-prescribing help with medication reconciliation and adverse drug interaction detection? What works today, and how can this be improved going forward?

e-Rx when HIE-enabled can help with medication reconciliation and adverse drug interaction avoidance. If all prescribers are not utilizing the same system so each does not have the full picture of the patient's medication history, the e-Rx system is not going to be the panacea for this issue. Detection of medication adverse events is challenging via e-Rx if not linked to an EHR with clinical data. It's easy to track "near misses" by tracking when the system alerts a prescriber of a possible drug-to-drug interaction or dosing error or allergy and the subsequent change in prescription by the provider. But we haven't have seen reports of Medicaid agencies' e-Rx systems having the capacity to collect and report on actual drug-related adverse events.

9. Where are the main barriers to greater adoption likely to be found?
- a. With the workflow and eRX software applications that physicians use?
 - b. In the network connecting physicians to pharmacies?
 - c. In the workflow and pharmacy software applications that pharmacists use?

Medicaid agencies have reported that the barriers tend to be with a) workflow integration. There are several States that have tracked utilization and probed with providers when it has been lower than expected and the usual response has to do with challenging workflow patterns and/or the time it takes for the clinical staff to become adept with the software.

9. Is affordability of an electronic prescribing system a barrier to adoption?

Several Medicaid agencies felt like affordability was a barrier in areas with low adoption, especially rural areas, and therefore many undertook projects to make e-Rx tools available and accessible at no-cost to Medicaid providers (DE, FL, TN, AL, AZ).

10. How can a Drug Enforcement Administration (DEA) proposed rule on electronic prescribing of controlled substances help in the widespread adoption and use of e-prescribing? Another way to phrase might be: in What actions should DEA take to promote the electronic prescribing of controlled substances while also meeting their law enforcement needs?

Although a DEA final rule will go a long way towards additional e-prescribing adoption it will not be the magic bullet everyone is thinking it will be. The ability to prescribe controlled substance electronically will allow prescribers put away the prescription pad and use one system for their prescribing needs. However, it will create new workflow issues based around the security requirements that the DEA rule creates. There will need to be a concerted effort from the DEA with HHS as partner to provide guidance and outreach to help prescribers reengineer their workflow and understand

the new security requirements.

11. What are the biggest successes and challenges in the implementation and use of e-prescribing systems?

Medicaid agencies have identified workflow redesign and the need for on-going and often, in-person, provider training for e-Rx adoption to be the primary challenge. It's not as simple as making the software available, even setting aside the cost issue. Many Medicaid programs focused on the IT side/technical requirements and did not allocate adequate time or staffing resources for the intensive technical assistance that they have had to give to providers. With each tweak and improvement to the system, more TA is needed. They've found that using physician champions to work with other physicians has been successful.

Other successes include reduced number of manual/phoned-in prior authorization requests (saved time and \$); reduction in the number of reported provider call-backs per pharmacy logs (saved time); increased adherence to preferred-drug lists and use of generics (saved \$); reduced duplicative therapies (saved \$); changed prescriptions at expected rates or higher after system alerts; increased use of system for eligibility determination (increased access for benes, saved time for providers' staff)

12. Please describe your (or your organization's) experience adopting and using e-prescribing systems. Was the adoption experience user friendly? How could it have been made better?

14. Please describe your experience with the following eRX transactions

- a. Prescribing
- b. Retrieving and using formulary information
- c. Retrieving and using medication history from claims
- d. Retrieving and using dispensed drug history from pharmacies
- e. Patient initiated electronic refills from the pharmacy

13. How does electronic prescribing help fill status notification?

14. How can electronic prescribing help with prior authorizations?

Delaware Medicaid has seen a steep drop in the number of manual prior authorization requests since their e-Rx system went live in 11/08, resulting in concrete program savings as they pay a per-transaction cost to a contractor.

15. What are your views surrounding stand alone vs. integrated EHR solutions?

Medicaid agencies have reported successes from both perspectives. In some cases, such as rural Tennessee, e-Rx was the way to introduce HIT to the providers and then they were offered a full-claims presentation or EHR system. However, since the enactment of HITECH, it would seem that the focus should be on integrated EHR solutions-at least for eligible professionals. However, if States want to still reach out to non-eligible professionals and encourage HIT adoption, they could promote e-Rx as a first step by offering the enhanced reimbursement rates for electronic prescriptions as I mentioned before. So have a multi-tiered approach instead of choosing between stand-alone or integrated.

16. What are your views surrounding the creation, adoption, and widespread use of a standard interface for drug formulation?

17. How do you see the future of e-prescribing and enhanced or secondary uses of prescription data?