e-Prescribing - Join the Revolution

Mark Singleton CPHIMS – March 2009

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Could you Stand it?

- Throughout the United States over 1.5 million people a year have had a reported medication error.
- That is almost one reportable medication error for each person in Salt Lake and Utah Counties (2007 Estimates).
- That is almost 1 error per DEA Licensed Prescriber in the United States.

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Seven Reasons Why Prescribers Should e-Prescribe

- Increased safety
- Increased efficiency
- Increased formulary adherence
- Improved role for prescribers in medication therapy
- Increased prescriber understanding of a patient's pharmacy benefit
- Increased prescriber convenience
- Improved patient satisfaction

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What is e-Prescribing

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Who Provides What

- Presciber
  - Hardware and Software for prescribers to do e-prescribing or Electronic Medical records.
  - Pays cost of hardware & software purchase and support. (help from state and federal government available)
- SureScripts RxHub
  - Infrastructure for communication between Prescriber to the Pharmacy and/or Plan/PBM
  - Infrastructure for communication between Hospital to Plan/PBM
- Plan/PBM
  - System to perform eligibility, formulary and medication history
  - Pays cost of transmitting from prescriber to Plan/PBM
- Pharmacy
  - System to accept and interface to prescriber for e-prescriptions and e-refills
  - Pays cost of transmitting from prescriber to Pharmacy
- Hospital
  - System can send to RxHub for Medication History to be used in the Inpatient setting, what has been used in outpatient.
  - Pays cost of transmitting from PBM to Hospital

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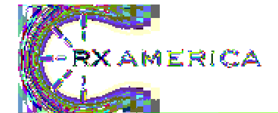
Ways the Pharmacy Receives the Script

Phone | Paper Rx | FAX | eRx

Ways the Prescriber sends the Script

Phone | Rx Pad | EMR with eRx | Stand Alone eRx

Patient Medication History | Chart / Own EMR Medication History | Plan Web Site Formulary | Plan Medication History Formulary



Where the Prescriber gets information

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The Patient Experience

Item	RxPad	Phone	EMR with eRx	Stand Alone eRx
Ordered by Prescriber	No	Yes	Some	Some
Paper Copy of Med Order	Yes	No	Yes	Yes
Faxed Copy to Pharmacy	Some	N/A	Yes	Yes
Received At Pharmacy	Some	Some	Some	Some
Error-free Legibility	No	N/A	Yes	Yes
Error-free Med/Sig	Some	Some	Yes	Yes
Error-free Payer/Formulary	No	No	Some	Some
Documented in Patient Chart	No	No	Yes	No
Med List in Chart Current and Complete	No	No	Yes	No
Patient Picked up Medication Notification	No	No	Some	Some

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e-Prescribing Pros & Cons

- Pro
  - Improved Legibility
  - Access to information at time of prescription generation
  - Ability to access patient medication history
  - Speed of transmission (generally)
  - Ease of refills for Patient & Prescriber
  - Notice of Prescription Pickup
  - Safety & efficiency
- Con
  - Can't eRx for Controlled Substances (this is coming soon though, DEA is looking to approve it)
  - Not all Pharmacies currently on-line
  - Some may still not have links to Plan Formularies (System or Plan)
  - May not list all Medication due to cash or plan limitations
  - May not link to decision criteria – Allergies, DUR, Lab, Weight, etc…
  - Some elements of the system may not be used.

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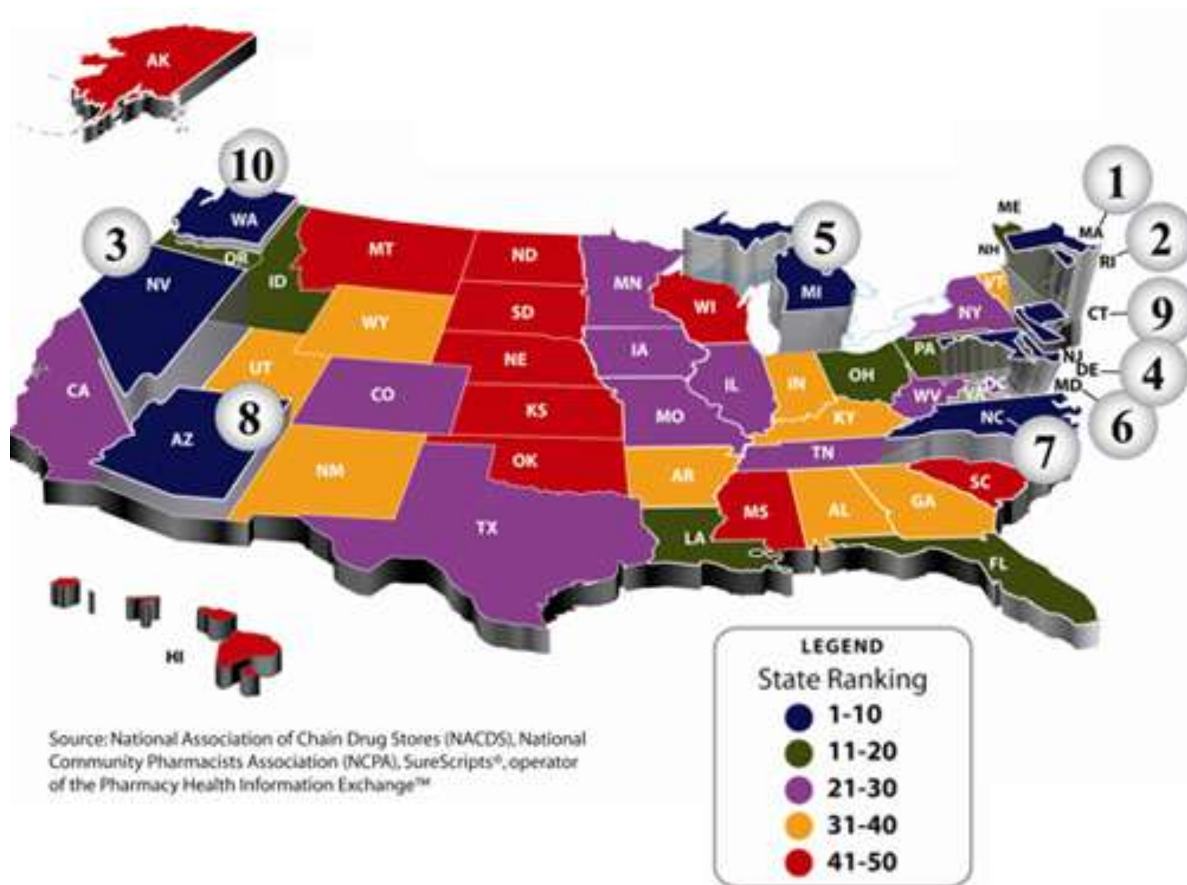
Who Uses e-Prescribing



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How Does Utah Rate?

Safe-Rx Information	2005	2006	2007
Safe-Rx State Ranking	18	19	34
Percent of Total Prescriptions Transmitted Electronically	0.09%	0.39%	0.89%

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Only 132% Improvement!

- **Most States running over 900% Improvement**

E-Prescriptions	2005	2006	2007
New E-Prescriptions	5,948	28,899	70,560
E-Refill Requests	3,022	9,563	19,842
E-Refill Responses	2,667	7,931	17,046
Total E-Prescription Transactions	11,637	46,393	107,448
Annual Growth in E-Prescription Transactions	-	299%	132%

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Prescribers vs Pharmacies

E-Prescribers	2005	2006	2007
Total E-Prescribers in State	27	67	101
E-Prescribers as % of Total Prescribers in State	n/a	2%	3%
Annual Growth of E-Prescribers	-	148%	51%

Note: E-Prescriber Percentage figures compiled through comparison of total e-prescribers in your state and AMA supplied data showing total office-based physicians practicing in your state. AMA 2005 data was not available at time of report issue.

E-Prescribing Community Pharmacies	2005	2006	2007
Total E-Prescribing Community Pharmacies in State	134	318	345
E-Prescribing Community Pharmacies as % of Total Community Pharmacies in State	31%	71%	75%
Annual Growth in E-Prescribing Community Pharmacies	-	137%	8%

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So how can we get Prescribers to e-prescribe?

- Help the prescribers understand the need
- Help the prescriber realize the need for a EMR system verse just a stand-alone e-prescribing system
- Help the prescribers find systems that match their needs, without recommending specific systems
- Help prescribers and practices find funding to off set the cost of systems (appx $9k for individual prescribers and $25k for mid size practices)
- Help prescriber groups to implement new systems
- Get the prescribers to understand their part in the process. A good way is the "A Clinician's Guide to Electronic Prescribing" available at: http://www.ehealthinitiative.org

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Government Agencies Involved in ePrescribing

- Centers for Medicare & Medicaid Services (CMS) - Medicare Part D ePrescribing requirements
- Agency for Healthcare Research and Quality (ARHQ) promote standards
- Drug Enforcement Agency (DEA)
- State/Territory Regulations
  - Tamper proof and/or serialized prescription pads increase cost of handwritten scripts
  - Use of DEA number outside of controlled substance dispensing and reporting
  - Restricted drug lists

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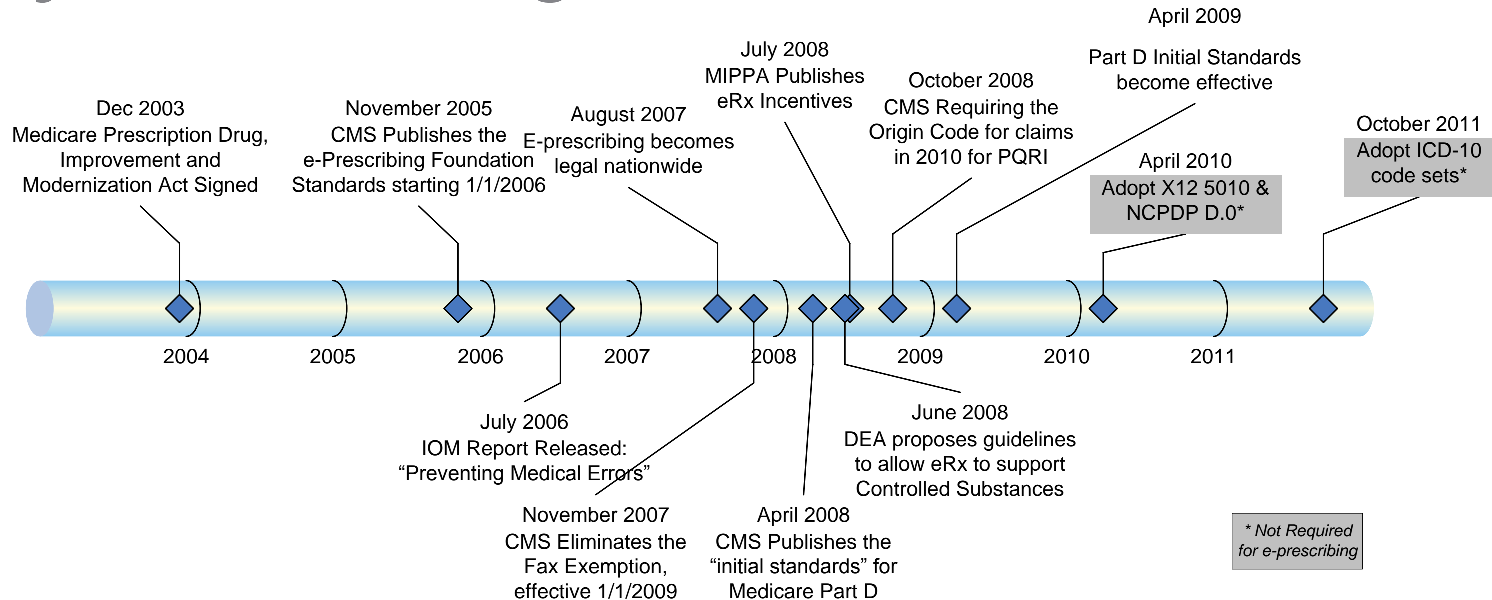
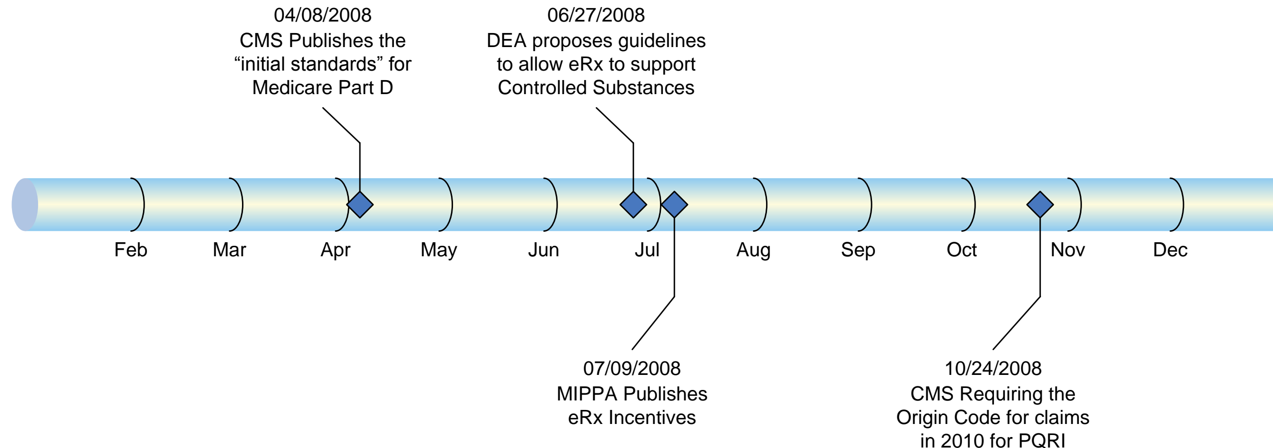
Key ePrescribing Events – 2003 - 2007



- December 2003: Medicare Modernization Act (MMA) established mandatory standards for physicians, pharmacies and health plans using ePrescribing for Medicare Part D beneficiaries
- November 2005: CMS requires three e-Prescribing "foundation standards" by January 1st, 2006.
  - SCRIPT 5.0 (later upgraded to 8.1)
  - Eligibility (270/271 v40101a)
  - NCPDP Telecommunication Standard v5 release 1 for eligibility between Medicare Part D sponsors and dispensers
- July 2006: Institute of Medicine (IOM) report calls for all prescriptions to be written electronically by 2010
- August 2007: Alaska becomes 50th state to legalize ePrescribing
- November 2007: CMS eliminated the fax exemption so that all eligible electronic prescriptions must be sent electronically with an effective date of 1/1/2009, except for renewal requests. This was delayed on 11/30/2008. The new deadline is 1/1/2012.

Key ePrescribing Events 2008



- CMS requires Medicare Part D Plans meet specific ePrescribing "initial standards" as of 4/1/2009
  - **NCPDP Formulary and Benefits Standard** provides representative information about patient's benefit
    - Formulary Status, Drug Alternatives, Benefits Coverage (e.g. Quantity Limits, Age Limits, Prior Authorization, etc), Benefit Copay List, Drug Class Lists
  - **NCPDP Script 8.1**
    - Medication history conveys patient's dispensed drug history (DDH) electronically
    - Fill status notification will allow providers to receive an electronic notice from the pharmacy regarding dispensed status of the prescription they wrote
  - **National Provider Identifier (NPI)** requires providers (at an individual level), dispensers, and Medicare Part D sponsors to use NPI
    - Use of NPI in all transactions will be critical to Plan Sponsor/PBM ability to track and report ePrescribing activity

Key ePrescribing Events 2008

- DEA proposal regarding ePrescribing of controlled substances 6/27/2008 (excerpts below, more information in Appendix A):
  - In-person identity proofing of prescriber
  - Two-factor authentication and hard token to prove prescriber is using the system
  - Two minute auto logout
  - Prescriber must accept responsibility of prescription (non-repudiation)
  - Monthly script log audit
  - Pharmacy must validate DEA number weekly and keep audit trail
- Responses were due 9/25/08
  - CVS Caremark submitted its response (along with many others in the industry) requesting less expensive and more practical security requirements
  - Recommend working with industry groups and elected officials to get realistic standards

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Key ePrescribing Events 2008

- MIPPA (7/9/2008) calls for Medicare Part B incentive payments for ePrescribing of 2% in fiscal 2009 and 2010, 1% in 2011 and 2012, and 0.5% in 2013
  - Legislation also requires reporting of any ePrescribing quality measures established under Medicare's physician reporting system
  - Beginning in 2012, payments to physicians not electronically prescribing would be reduced by 1%, then 1.5% in 2013 and 2% in subsequent years
  - More information in Appendix B and at http://www.cms.hhs.gov/pqri/
  - 11/03/2008 – For 2009, Physicians and other eligible professionals who adopt and use qualified e-prescribing systems to transmit prescriptions to pharmacies may earn an incentive payment of 2 percent of their total Medicare allowed charges during 2009.

Year	Incentive	Penalty
2009	2.0%	0.0%
2010	2.0%	0.0%
2011	1.0%	0.0%
2012	1.0%	1.0%
2013	0.5%	1.5%
	0.0%	2.0%

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Key ePrescribing Events 2008

- For eprescribing reporting, prescribers will use CPT and HCPCs G codes to report ePrescribing activities as part of a program similar to PQRI (10/30)
  - Per the 2009 CMS Call Letter, the Prescription Origin Code (POC) remains voluntary through 2009
  - CMS has added a voluntary POC reporting field to the 2009 PDE record so Plan Sponsors can report if able to do so though the data is not required for 2009
- The POC is expected to be required beginning 01/01/2010 per the 2010 Call Letter that will be released during 2009
- Pharmacies will have to submit by 1/1/2010 an "origin code" on every Medicare Part D claim to support e-prescribing incentives.
  - Origin codes for electronic, printed, telephone, etc…

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Key ePrescribing Events 2008

- CMS is "encouraging" Plan Sponsors to reimburse Network Pharmacies differential dispensing fees to encourage uptake of ePrescribing usage
  - CMS is being advised to make differential dispensing fees mandatory across all Plan Sponsors to level the playing field since Plan bids are so acutely competitive
  - The individual NPI and POC will be used by CMS to track prescriber activity, but also compliance with recommendation to implement differential dispensing fees

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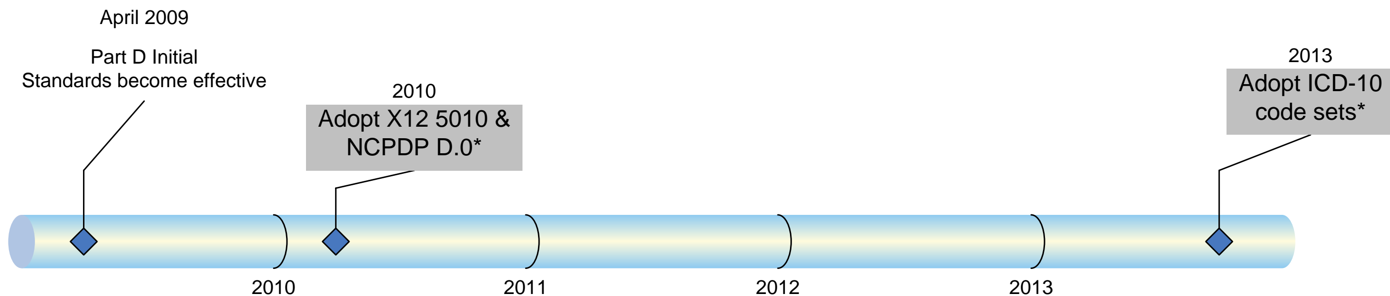
Key ePrescribing Events Expected for 2009 and Beyond



** Not currently Required for e-prescribing*

- Adopt X12 5010 and NCPDP D.0, effective April 1, 2010
- Adopt ICD-10 code sets, effective October 1, 2013, delayed two years due to industry comments
  - ICD-10 likely will be required in the future for diagnoses on eRxs, prior authorization and P4P
- E-prescribing Indicator on Provider and Pharmacy Directories. This includes indicating which providers are e-prescribing (2010 Call Letter)
- Both regulations may be viewed at www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage
- Does not apply to Part D Sponsors, yet.

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What the Med D Requirements Mean to the a Part D Sponsor

- There are standards and they work well today
- CVS Caremark already meets/exceeds most standards and will complete the remaining ones
- The government is actively involved in ePrescribing and will continue to push the market
- ePrescribing will continue to grow and evolve – encouragement coming from both industry and government
  - RxNorm
  - Codified SIG
  - Electronic Prior Authorization (ePA)
  - Real Time Benefit Check
  - SCRIPT 10.x

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Appendix A: DEA Ruling to Support ePrescribing for Controlled Substances

- Comments on the proposed rules for sending controlled medications via electronic prescribing were due September 25th
- According to SureScripts-RxHub, it is that the proposed rules would place a substantial burden on prescribers and vendors of physician ePrescribing systems, whether stand-alone or integrated in more robust EHRs[1]
  - There is a significant burden on pharmacies and intermediaries as well, but the most significant burden falls on the prescriber side
- Examples of the burden on prescribers include, but are not limited to, the following
  - In-person identity proofing at hospital or law enforcement office – one time only
  - Two-factor authentication prior to each and every prescription being written and one must be hard token, such as a flash drive or USB stick
  - Prescriber must maintain sole possession of hard token
  - Two-minute time out rule
  - Digitally sign and archive before transmission

[1]*Appendix A from SureScripts-RxHub Workgroup Presentation 10/10/2008*

Appendix A: DEA Ruling to Support ePrescribing for Controlled Substances

- Examples of requirements on vendors of prescribing systems:
  - Must confirm both state license and DEA certification to be current and in good standing
  - The system must require at least two-factor identification
  - System must have an automatic lockout if unused for more than two minutes
  - Authentication must occur immediately prior to signing
  - System must present a warning before transmission that the practitioner understands that he is signing the prescription being transmitted. If the practitioner does not so indicate, by performing the signature function, the prescription cannot be transmitted.
- Sample of requirements imposed on pharmacies:
  - Pharmacy or last intermediary must digitally sign
  - Pharmacy or intermediary must check for valid DEA registration
  - Pharmacy must conduct daily internal audits
  - Pharmacy system must be audited annually using third-party audit that meets the requirements of Systrust or SAS70

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Appendix A: DEA Ruling to Support ePrescribing for Controlled Substances

- Next Steps
  - Wait for Final Rule
    - There is no set time frame or a requirement that the DEA act on the comments
    - Will not likely happen until after the presidential election
    - Industry trade groups are lobbying for realistic standards
  - Political Pressure will be applied
    - Legislative
      - **Senator Whitehouse (RI)**
      - **Senator John Kerry (MA)**
    - Executive
      - **Secretary Leavitt (Secretary of Health and Human Services)**
      - **Kerry Weems (Acting Administrator, CMS)**
    - Governors
      - **State Alliance for E-Health**
      - **National Governor's Association**

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Appendix B: Medicare Improvements for Patients and Providers Act (MIPPA) of 2008

- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
  - Established as part of the 2006 Tax Relief and Health Care Act
  - Provides physicians with annual bonus payments based on a retrospective review of claims
  - Incentives based on **self-reported** data on quality measures furnished to Medicare beneficiaries for 2009 (but may be extended depending on the Point of Origin availability)

Year	Incentive	Penalty
2009	2.0%	0.0%
2010	2.0%	0.0%
2011	1.0%	0.0%
2012	1.0%	1.0%
2013	0.5%	1.5%
	0.0%	2.0%

- CMS recently announced the average PQRI incentive payment was more than $600 for individuals and $4,700 for group practices over a six-month period

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Appendix B: MIPPA Eligibility & Qualifications

- How will an eligible prescriber be determined?
  - Regularly use a qualified ePrescribing system (see qualifications below)
  - Report on at least 50% of eligible patients
  - At least 10% of total allowed charges (denominator) must be for CPT or G-codes making up ambulatory services
  - Starting in 2010, CMS will require plans to submit reports on how many of the prescriptions were submitted to the pharmacies electronically
  - Pharmacies must submit an “origin code” on every Medicare Part D claim that records how the script was received
  - Physicians Quality Reporting Initiative (PQRI) will not be used but a separate but similar program will be set-up to administer incentives

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Appendix B: MIPPA Eligibility & Qualifications (cont.)

- PQRI Requirements for a "Qualified System"
  - Generate a medication list, select medications, transmit prescriptions electronically and conduct safety checks
    - Includes automated prompts with information on selected drug, potential inappropriate dose or administration, drug-to-drug interactions, allergy concerns and warnings
  - Provide information on lower cost alternatives
  - Provide information on formulary or tiered formulary medications, patient eligibility and authorization requirements received electronically from the patient's drug plan
  - iScribe® ePrescribing is a qualified system

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