

Implementing e-Prescribing in the Medicaid/SCHIP Programs: Experiences and Lessons Learned

Event Date: 9/30/2008 1:30 PM ET

I want to welcome everyone on behalf of AHRQ and the AHRQ Medicaid SCHIP Technical Assistance program. This is one of the webinars that has been organized as part of the technical assistance being provided to Medicaid and SCHIP systems under this project. You are all being broadcast by webinar.

My name is Walter Suarez. I am with the Institute for HIPAA/HIT Education and Research. I am a member of the few organizations. One of them is the Health Information Technology Standard Panel (HITSP). I am also a member of the Technical Assistance Team that is under contract with AHRQ to provide support for this project. The Technical Assistance team is directed by RTI International. We are organizing this. This is our tenth session. Almost every month we have been having sessions on specific topics related to health IT adoption and health information exchange activities that effect and relate to Medicaid and SCHIP programs. We are very pleased to bring you today the topic of e-prescribing and how it relates to Medicaid agencies. I will be doing a couple of slides on some of the logistics. Then I will do introductions of our distinguished speakers. Then we will go through their presentations. I will provide you with some guidance on my remarks before we start here on how to post questions. Then at the end of the presentation, I will be going through the questions and posting those questions to our speaker. Then we'll make some closing remarks at the end. Our scheduled time is about 90 minutes.

So before we begin, I just wanted to make a few comments. First of all, you are all going to be on mute. As you join the session you will see the screen and the slides, but your phone line is being put on mute. Only the speakers will have live lines. They will be doing the presentation. We are not going to be using the approach of asking a question by raising your hand. On your screen you can see at the bottom right corner a place where you can type a chat message. Below, there is a send button that you can click with a pull-down menu. What we are asking everyone to do—as the presentations go through—you can post a question by sending it to all panelists. If you pull down the menu, there will be several options. One is the presenter, host, and you can see all the attendees. Another menu option says all panelists. That is the one we would like you to post the questions to. You can type the question right there, and click the send button. We will all see the question. I will be accumulating those questions. At the end of the two presentations, I will be reading the questions and posting the questions. That is the way we will be handling the Q and A portion. As the presentations are being done, if you have a question on a particular point or topic or area of that presentation, please post those. That way we begin to accumulate those questions. It will be a good way to avoid forgetting a particular question after the two presentations. You can e-mail Nicole as you see on the screen there if you would like a copy of the presentation slides. We will be posting all of the materials on the Web at www.healthit.ahrq.gov/Medicaid-SCHIP. We have already posted the

presentations we have completed. We will be posting soon after the session today the presentation of this particular session for people to access. Next slide please.

This project, the Medicaid SCHIP Technical Assistance Project has a listserv. I hope you are participating. If not, you can register by going to this website that is on the screen and then following the instructions. This is the AHRQ website where you can access the Medicaid SCHIP project. You can register to the listserv, and that way you will receive announcements and information about the project. Next slide please.

First, I am going to be introducing our three distinguished speakers that we are very pleased to have with us today. We are very fortunate that we are able to take the time to do these presentations. First we are going to hear from Tony Trenkle. Tony is the director of the Office of E-Health Standards and Services (OESS) at the Centers for Medicare and Medicaid (CMS). OESS, as many of you probably know, is a program within the department responsible for the overall coordination of the e-health initiatives including personal health records. They oversee the regulations and enforcement related to the standards, with the exception of privacy. Privacy is under supervised jurisdiction. And then the office is also responsible for the Medicare Modernization Act and the e-prescribing program. Tony has also recently been named as the senior privacy official and he chairs that agency's data governance board. His office also coordinates major health IT initiatives with a number of other HHS agencies, including the Office of the National Coordinator, coordinating work on a national health initiatives, particularly the American Health Information Community (AHIC) effort, providing support on standards and security and coordinating privacy and security enforcement with the Office of Civil Rights and collaborating with AHRQ and other agencies within that department. Prior to joining CMS in 2005, as an attorney he held a number of leadership roles for several public and private organizations including the Social Security Administration where he oversaw the development of the Social Security Administration's on-line service for the public. So he has very extensive experience in this area. We will also have Andrew Morgan on line. He joined in 2005 as a project officer. He is involved with agency efforts to promote the adoption of e-prescribing. He has worked in both e-prescribing the final rules and was one of the reviewers of the Medicaid transition grants that have an e-prescribing focus in them. He participated in the development organizations related to these initiatives. He and others were recently recognized by the secretary for their work. Then we will be hearing from Jessica Kahn. She joined CMS in September 2007 and works in the Division of Quality Health Outcomes. She currently serves as the project officer for several large grant programs administered by the agency, including the Medicaid Transformation Grants, high-risk pool grants, and emergency diversion grants. Her background includes a master's degree in public health from Tulane, Peace Corps service, and working for USAID in the field of international health. She logged many years in state government with the Louisiana Office of Public Health and the Maryland AIDS administration. She has identified strongly with the state grantees and tried to champion their issues while also being a good steward of federal grant funds. We are very fortunate to have Tony, Andrew, and Jessica. I'll turn it over to Tony for his presentation. As a reminder, if you have any questions, please log them into the tool to submit those questions.

Thank you, Walter. I'm very pleased to be participating once again with AHRQ. CMS and AHRQ have worked extensively over the last several years. We are happy to have with us Jessica from our Medicaid area of CMS because this is really a true partnership between our organizations and also with Medicare and Medicaid. Right now our work is focused on Medicare. As Jessica will point out in her talk, we are definitely getting e-prescribing to be more and more a part of the program. E-prescribing over the last several months has become very hot. We have begun to get recent pledges that we will talk about today as well as a major conference being held in Boston next week that the secretary will be hosting along with our administrator. Just in a little bit in brief on e-prescribing as far as we have been involved. Part of the Medicare Modernization Act, as you can see that definition on the slide is that basically under part B, e-prescribing standards are required. My office was given the overall accountability for that. E-prescribing in itself is voluntary, although plans are required to support e-prescribing as part of the Part D requirements. Next slide please.

E-prescribing does not require manual transcription at either end. Traditional faxing is not considered e-prescribing and secure e-mail is not e-prescribing. We define e-prescribing in our regulations. It will point out to people what it is and isn't. Part D promulgated the standards right now. They are only applicable to Part D payees—the fact that they will be supporting our standards as well. We are pretty familiar with the benefits of e-prescribing. We know it reduces medication errors. We have done another study. Of course with the e-prescribing standards, we get information on formulary-based drug coverage. We are also in the process of medication history, which we recently made a standard, which will be in effect in April 2009. Of course we know that e-prescribing speeds up the process of renewing medication, and it provides instant connectivity between all the players in the prescribing process from the health care provider to the pharmacies, the plans, and other entities. We think that the benefits are very apparent to everyone, and over the last several years, in addition to the standards work, we have also been working actively to provide outreach and also to promote the benefits of e-prescribing. Next slide please.

Over the past 4 years now (it will be 3 years this fall if you count 2005 developing regulations), we have been very active in developing what we call a suite of standards. In 2006 we implemented our first set of standards. In 2007 we conducted pilots. In 2007-2008 we developed new standards, and in 2009 these standards will become implemented. Our approach to building standards -- and next slide please, is to basically look at them not as a one-shot deal.

What is the overall foundation for building a suite of standards? How do we make sure all the functionality is built in and we can continue to grow and develop standards as needed? We are not looking for new standards. We are working closely with the standard development organizations to work from mature standards that have a track record. As time goes on, we want to continue to grow standards as needed. Of course all of this is run through our advisory organization, the National Center for Vital Health Statistics (NCVHS). They have provided us with a lot of support over the last several years to

develop this suite of standards that we have today. If you go back to the website, you can see hearings and letters written in support of e-prescribing. Next slide please.

Our first round of standards, as I mentioned a moment ago, were the foundation standards. These enable the basic functions within the e-prescribing suite, things such as eligibility, exchange of e-prescribing, refill requests, cancellations. These are your basic functions that we put in place in January 2006, the same time the modernization Part D prescription plan went into effect. These standards were not tested before they were put into effect because it was felt they had been around long enough that they were considered mature enough to go through the process. As you can see, they have certain advantages, but these are basic standards to establish the basic eligibility and benefit checks. Next slide please.

In 2006 we ran pilot tests to look at additional standards. These are the initial standards. During the calendar year 2006 we tested five different standards, actually six different standards: formulary and benefits, medication history, Rx fill, Rx norm, Structured / codified Signature, prior authorization. These are run through live tests and also through non-live tests during an amount of time. The idea was to look at these in various types of settings and see if they were ready and mature enough to be adopted as standards. The results were published in a report to Congress. Next slide please.

[The report] came out in April 2007. It was determined at that time as a result of the test, formulary and benefits, medication history, and RX fill were ready for adoption. More work needed on RxNorm, Sig, and Prior Authorization before [they were] ready for adoption. The response we got back was it that it was. We did not initially propose those for adoption at the time. The final rule was published in April 2008. It will be effective April 2009. In a moment we will talk about the standards we have not adopted. Next slide.

In addition to these standards that we mentioned a moment ago, we also retired the NCPDP 5.0 and replaced it with version 8.1. We also have mandated use of the NPI as an individual identifier in transactions. This would basically conclude our initial suite of standards except for the three as I mentioned that need additional work. Next slide please.

The other organizations have been active in the e-prescribing area. The Medicaid Transformation Grants is a 2-year \$150 million program that is giving grants to a number of states to improve health IT. Many of them also incorporate e-prescribing. In addition, the Medicaid area is doing a number of other things to promote e-prescribing. Jessica will talk to you about some of the new initiatives that they are doing there. Also, our Quality Improvement Organizations have adopted their 9th scope of work. One of the things that they have done is to develop several themes to support the work that they do. One is patient safety. One of the projects over the next year is a special study as part of the 9th scope of work to look at how e-prescribing can support patient safety. The work that is being done will also support a lot of the work we have done in the standards world as well because it is looking at some of the standards in terms of supporting long-term care. Next slide please.

The most recent part of e-prescribing that has gotten a lot of people's attention is the MIPPA e-prescribing provision. It is legislation that was recently passed with Medicare changing some of the rules of Medicare. One of the things that it did provoke is what is known as incentives and disincentives related to e-prescribing. As the slide says, beginning in January 2009 there will be incentives for successful e-prescribing. These will be at 2% over the next 2 years. That will drop over the years following. Beginning in 2012 there will actually be negative adjustments for non e-prescribing subscribers. What this is intended to do is provide a tipping point to move e-prescribing to the mainstream. This is a very popular program. A lot of providers are very interested. We are going to be including further information at the conference next week and also with the physician fees schedule final rule, which will be coming out shortly and will be effective January 1. Next slide please.

In the meantime we also continue to do the work with standards and adoption. As I've mentioned a few moments ago, there were three standards that weren't adopted in the original Standard regulation that we put out this past April. The RXNorm and the Structured Sig, we just contracted for additional pilot testing take a look at those. We are hoping as a result of that testing that there will be additional standard work in those areas that we can go ahead and adopt through regulation process. That probably won't happen for another year or so once we get through the testing. We are working closely with AHRQ and others to develop the prior authorization business process standards. That is going to require more work. Drew (Andrew Morgan) told me it will probably be at least several years before that is ready. Of course we will continue to work on future standards as needs are identified. Two areas I want to spend a couple more minutes on are kind of tied to the standard area. One is e-prescribing of controlled substances. Next slide please.

That is actually the Drug Enforcement Administration (DEA). As many of you know, the DEA recently put out a notice of proposed rule this week. The DEA and CMS as well as others and the Department of HHS have worked a number of years. We have been trying to work with the DEA to get them to work closely with us in the e-prescribing area. The concern is we do not want to develop a separate way of doing business with controlled substances. Nor do we want the e-prescribing controlled substances to be such an onerous process is that it discourages adoption of e-prescribing. The DEA came out with a proposed rule, as I said, that advocates a technical solution. We do have some concerns about that. It proposes two-factor authentication with a hard token, in-person proofing, and a 2-minute timeout that would require full authentication to get back in. We are concerned at the impact that would have on industry. I'm sure industry has certainly sent in a number of comments. Now the DEA has closed the comments time frame and is reviewing. They have between 160 and 200 comments. Many of them are quite lengthy. We want to continue to work with the DEA. We really have three goals in mind when we work with them as it says on the slide. We wanted to be interoperable with existing e-prescribing systems. We want it to be scalable so it can work throughout the health care system without posing an undue burden. We want it to promote overall e-prescribing adoption. We will be happy to work with the DEA on the final rule that will probably be coming out sometime in the next year. Next slide please.

The final area I want to just mention briefly is computer-generated fax. In 2005, our original Standard regulation gave an exemption from the use of a strict standard for entities using computer-generated fax technology. And after several years we did talk with the physicians. We did put an exemption in the physician fee schedule in which we said it would only apply to temporary transmission problems. So effective 2009 we were trying to at least partially lift this exemption. However, we got comments during the regulation process and afterward about the unintended consequences in terms of refills that this would actually cause a lot of people to revert to manual prescribing as opposed to e-prescribing. So in this year notice of proposed rule making, we proposed to retain an exemption for the refill request as well as an exemption for the transmission problems. We are now in the process of getting to the final rule. We have received comments. Was it 52 comments? We are in the process of reviewing them and getting the final clearance to determine whether we should continue to have the exemption and whether it should be lifted. If we proposed lifting the exemption now at this point with the legislation, the question is whether we need to lift the exemption or wait several years to see the impact of the incentive program. Just to finish up from where we go from here, I think there are about five key areas: to finish initial standards to get the final three standards ready for adoption; to work with DEA to get a scalable solution; to lift the exemption on long-term care and e-prescribing; to determine the best approach with computer-generated fax exemptions; and to continue to monitor the effective use of standards. Of course, as part of that work with SDOs and NCVHS on additional standard requirements. Let me just mention for a moment that the next to last bullet I have. I think it is fortunate to promulgate standards and put them out there, but it is also critically important to monitor how well they are being used, what are some of the issues, to the support adoption, what are some additional standards? I turn it over to Jessica to talk about the Medicaid side and the work they have been doing with the transformation grants and other types of incentives.

Yes. Thank you so much. As a reminder, if you have any questions, you can type them on the chat feature of your session display at the bottom right side of the corner. You can type that question in and send it to the panelists. As you can see on the screen hopefully, I have been sending some of the websites that Tony was referring to, some of the committees, the National Committee on White House statistics and the upcoming National e-prescribing conference. That is how we would like to begin to see some of the questions coming, but I'll turn it now to just go for her presentation on the state Medicaid experience with e-prescribing. Jessica.

Thank you. I know that was really helpful. I know a lot of the Medicaid agencies were very interested in hearing what was going on with standards and particularly the issue with controlled substances and the DEA. They often ask me and I don't have the most up-to-date information. That was great to share. That represented a large portion of the prescriptions they would like to see done through e-prescribing. Two quick things: one is I am generalizing the experiences that I have observed through state Medicaid programs and e-prescribing. If there is a particular model or question you have and there is a representative from the state on the call, I encourage them to participate in helping me answer the questions. The other thing I wanted to mention is really very much

serendipitous. We are starting to pull together between the Medicaid and Medicare world. We can feed on each other. We can bring to this discussion the experiences that Medicaid has had. Part of the timing of this also has to do with a state Medicaid director letter, which is going to come out any day now. And what that is going to do for the agency is a couple things. First is I am going to talk to you about transformation grants. That is one source of funding. It was one-time funding. We would love to have more. We are looking at other ways to fund health IT. So what this letter is going to do is clarify for everyone where CMS feels like it can provide federal matching funds and at what level of federal matching funds for the development enhancement of the Medicaid Management Information System (MMIS) capacity to support e-prescribing. So it will start to lay out for the states a blueprint of under what conditions and what standards we would provide enhanced match prices 50% and so forth. As Tony mentioned, one of the things we would be looking for is the inclusion of the to Medicare's standards, intractability. It has to do with governments, whether this is something that is squarely within their purview or whether they are one of many partners at the table exchanging information. All of that will be included. That will be followed up in a couple months by a much more detailed document that will specifically lay out all of the standards, all of the caveats and strings so states can see the options and how they decide to design their project will have an impact on what level of federal matching funds would be available. That is the document that our regional offices will rely on when they receive advanced planning documents to determine how to approve them, if to approve them, and if so, to award them what level of federal matching funds. Look for that. It should come out soon. That will be discussed at the conference as well as what I am about to share with you.

Okay. So the majority of what I will share is from the transformation grant. That has been the largest source of funding, though there are a few notable exceptions; a few states have been able to pursue e-prescribing through other funding. I'll touch on that briefly. Starting with transformation grants, there are seven that are doing e-prescribing with the transformation grant. It's either as a standalone project or as part of a larger electronic health record health information exchange effort. These grants, as was mentioned, were awarded in 2007. There is no federal match. It is entirely federally funded. I think 99% the grants will ask for an extension. They could stretch as far as 3 years. The evaluation requirements that Congress passed on to us and thus passed on to the grants are to monitor the impact of these grant projects on clinical improvement and the beneficiary health status and any cost savings and return on investment so to speak for the state agencies. Once the grants are over, they have final reports that will address those topics. We are working with them on an ongoing basis as to how to measure them. [I will] share some of the first steps that were taken—and this is what took up most of the first year, was assessing the environment and the provider rate of adoption. Some have high prescribing rates. Some do not. Some have high electronic health record use. Some do not. They have had to assess who is prescribing, with what software, how often they use it and whether there is a geographic distribution. Rural versus urban. Then they have to determine (and they have done this) what functionality they are looking for. There are a lot of bells and whistles, a lot of options. They have to figure out for each state whether they are doing it in the pilot area, within each area and target provider group, what is the most attractive set of functions for those providers to encourage adoption?

They figured that out by having a large stakeholder involvement in these grants. For example, the New Mexico Medicaid program is working with the prescription improvement coalition, a statewide organization that collaborates on provider outreach and training. Both public and private payers are trying to construct an e-prescribing interface across all of these. Other states have worked with provider advisory groups (if they have advisory groups) and their Medicaid agencies. They are working closely with the state Medicaid director or the Medicaid Medical director. And in some states they tell me they are just out on the road literally stopping in to providers and talking to them face-to-face and making site visits to gather information on what is in use and what are the barriers. Next slide.

Here are some of the lessons learned from that process, that initial process. One is to ask for input to very early because it can have a big impact on what direction you take. The second is to show the providers demonstrations of what you are doing as you build it. Don't just take the input and then bring them the finalized Cadillac at the end of the project. They need to see mockups and demos. This field is changing so rapidly, they need to stay in touch during implementation with the providers. Most states have found also that it is worthwhile to start working your pilot with the early adopters and high volume prescribers. Go with people who are most interested and/or those who will get the most bang for your buck. This is interesting. I have one state that had a lot of provider input, a lot of stakeholder input, and is still having slow adoption after a month of going live. You cannot forget the blitz even if you thought you were touching base with them all along. You need a lot of press and momentum. Another lesson learned is to monitor the usage by functionality by prescriber. Don't just build it, but see how they are using it, what kind of providers are using it, what functions are using it the most and keep going back and tweaking. Next slide.

This slide shows probably the most exhaustive list of what is included in e-prescribing from the Medicaid agency perspective. I won't go through all of this. It is a mix, you'll see, of political and administrative functions. This is to make it as attractive as possible to providers so that they have a more one-stop shop as a function at their disposal when using the system. It can do everything from the clinical side in terms of early alerts and drug-to-drug interaction alerts and so forth, but it can also link to the preferred drug list. It can remind the provider of pre-authorization requirements. You can encourage use of generics. In terms of a quality improvement perspective it helps them look at the drug over-and under-utilization over time. That is good data for the Medicaid agencies to look at in an aggregate sense. That is a long list of functions. Nobody is really starting with the whole shebang. People are picking and choosing based on what they feel like as much importance to start out with. Next slide

I'm going to outline a few approaches in Medicaid for e-prescribing. These are most common. The first one is a web based e-prescribing utility or tool. I've listed the states using something like that tool (FL, AL, AZ, TN, DE, MO, WY). The idea is that providers don't need to purchase software. All they need is Internet access. They can log in and access e-prescribing utility through the Web. So the advantage here is that if it is something they create on the Web, as I mentioned, one of the bells and whistles included

could be linking it to other utilities like electronic payments or pre-authorization to increase the provider's convenience. It could be done through PDA, desktop, laptop, and is linked to the Medicaid Management Information System Data warehouse. Next slide.

On this slide I have made an attempt to very simply demonstrate this. We are starting at the bottom left. The provider locates and uses the tool that sends the query to the data hub, which is missing an arrow. (That always happens. You are my test for this presentation. I have to make it again in Boston.) The provider has to have an arrow because that is where the system transmits it to the pharmacy benefit manager (PBM) to verify eligibility and so forth. Eventually it goes to the next step. The provider will review whatever results come back to him /her and submit the prescription. A switch vendor, such as SureScripts, then transfers the prescription to the pharmacy, which fills the prescription and bills the PBM with point-of-sale software. That is basic step one, shown in the diagram. Next slide.

Continuing on this Web utility approach, we see differences in whether the bill is just for Medicaid or across other payors. For example, for what Alabama is building as part of their electronic health records system (which also includes clinical decision support and e-prescribing), they have the data in there for Alabama Medicaid and four Alabama Blue Cross Blue Shield participants. They can use one with the basic utility, which obviously is an advantage for them. The two agencies can do joint provider outreach and so forth and Blue Cross Blue Shield in Alabama is the big player in the sandbox. Between the two they have a huge portion of the state's residents in this data warehouse. The providers then have a very high incentive to use it just for convenience sake if not for anything else. Next slide.

On this slide you see where this data hub is Medicaid governed. It includes data. They are sending it to the hub that Medicaid governs. That data is then transmitted through the Web utility, whether it came from Blue Cross Blue Shield or Medicaid into the Web utility and providers. It moves back and forth that way. And that is important for down the line where a state that was following a similar model to ask for federal matching funds. The way it is currently regulated, if it is governed by Medicaid, it is a higher matching rate than if it is a shared utility where Medicaid is just one of the partners at the table contributing and allocated cost. Okay. So another approach is to build an interface for off-the-shelf e-prescribing tools. Say you are in a state that has a lot of e-prescribing tools already and the providers are using a handful of e-prescribing software. They really aren't interested in your utility because they don't want to log in two different systems and use different tools for different time into five kinds of clients. For example, New Mexico Medicaid is working with that coalition that I mentioned. The Prescription Improvement Coalition is also working with the QIO which does outreach and education. Next slide.

They are working with the safety net providers to enable e-prescribing. They are going to pay for their choice of software from an approved list. They are working 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. Then maybe in the next year it will go subsequently down to nothing. The idea is to really incentivize the early

adopters to get everybody on board. This is a public-private partnership approach. The advantage is inspiring multiple payers, which can have a positive impact on sustainability. It targets particular provider groups. They go for real hard-to-reach providers. At the same time they're making it widely available. It is addressing this issue of provider incentives. Next slide.

This shows how the provider would use the tool by sending the query to the data hub. The idea is that this data hub is RxHub as opposed to a Medicaid-covered data hub, which is in the Alabama example. Next slide.

A variation of this interface kind of approach is to use existing hubs to integrate software into your own data warehouse. We know that New Hampshire is doing this. Mississippi is doing this, and Nevada is supposed to do this. This is where the provider's home practice management software interacts with the MMIS system. Also a Surescript software has been integrated. The providers get back the same kind of information they would get in these other settings in terms of formulary eligibility, history, and so forth. The benefit is that it is building upon the hub that is already there. In this case Surescripts is running it—building it right into the MMIS system. In the Mississippi example, they are recruiting 1 million or more per month they say. In the case of Nevada their assessment is 70% or more of their pharmacies are already technically ready to be able to do this. In that sense, if they are looking at what might be the solution if they could add to their MMIS system, this is what made sense. These are just examples. And the questions that the states are asking themselves in order to derive which model they want to go with mostly has to do with sustainability. Next slide.

I put these out there about saying we have the answers because it's going to vary, but who pays transaction fees? For example, Tennessee offers e-prescribing and electronic health records at no fee to the providers. They just need Internet connectivity, as I mentioned. How long are you going to offer those kind of incentives or waive those fees? They proposed doing it for a limited time. Delaware will be offering computers for its initial doctors who are interested, but beyond that what is going to happen? Timing of the use of incentives has a big impact on how they are looking at their cost across time and when they will be able to measure a return on investment. And then I think there are folks from Connecticut on the phone. They can probably articulate this better than I. There is a question about what the incentives are for these small, independent pharmacies. The big chains did it and have more capacity, but there is some resistance from these small independent pharmacies over transaction fees. Next slide.

Another rationale in deciding on the model that we are hearing about has to do with provider uptake and what is going to take to get an option to bid it is and what is just available but is being discernible. In areas that have a low overall penetration such as rural Tennessee, they decided to offer utility with no transaction fee. They drive from place to place and sit down with providers and talk and show them the system and enroll them county by county in rural areas. In a state that might have medium-high utilization, they might be looking at gathering providers by offering an e-prescribing utility with multiple functionality—the administrative and clerical capacity or the interface to

existing off-the-shelf products if that is what providers are already using. Either offer them enough reason to use yours or find a way to interface what they already have. And the other rationale that I am hearing is focusing on target populations. The target population is providers and prescribers. Are you looking at rolling this out to everyone or just the high-volume users? Who you really want to work with on this? Particularly in a focus area. If you are asking for federal matching funds, it can be rolled out but it has to be a statewide endeavor. We might have different average approaches depending upon the type of provider. That is something to consider. Okay. Next slide.

Early lessons learned. I can't say this enough times obviously since I felt the need to repeat it. Provider enrollment is slow across all of these models. It just takes time because it involves the workflow redesign. It involves a lot of initial input and thought and attention from the providers. While they might have resistance to workflow and initial implementation, the data that is out there [show] that some of the functionality lost tapers off over time. They go back to the same level of efficiency once they get the hang of it. We cannot ignore this workflow redesign issue. That should be part of any technical assistance package. Not just showing them, but helping them think through how to integrate the use of e-prescribing into their work day. That is why some prefer PCD because they take it with them, but for some providers that is not an option. They must think about how they get back to that desktop computer. These incentives matter. We have seen that. We see it across the board, whether they are financial or you can convince them the incentives matter. There are a host of reasons, but you have to look at it from the providers' perspective. The one-stop shops tend to be the most attractive. That's not a shocker. They want multiple reasons to use the tool. Information from more than payors would be great. The next slide has more information. If you think of something you need or want you can e-mail me directly. I think we are going to do questions for both myself and Drew.

Yes. Exactly. And I think we do have a few questions so we are going to jump into questions. Thank you, Jessica, for that presentation. I hope many of the states on the line would be interested in asking some of these questions about how to take advantage of some of the experiences that the early adopters are around e-prescribing are basically sending out and showing and helping document some of the ways they have been approaching. We do have a couple questions. The first one probably goes to Drew. It relates to a point on the standards. The question deals with the ability or the possibility of including within the e-prescribing standard and the ability to codify and the origin that identifies in the script with the script was sent on paper fax or electronically by the payer or PGM. And the point being made is that this would help track how many scripts were generated by a provider electronically during or through other means. It could help actually document some of the e-prescribing incentive programs and help measure some of the adoption process is. So is that something that you think the standards can incorporate, Drew? How would that be possible?

Currently in one of the foundation's standards that we named back in 2005, the NCPDP telecom 5.1 standard which is the eligibility piece which is also the piece that the pharmacy sends for claim payment. There is an optional field at this time that pharmacist

can input how they received that claim. It has some shortcomings. From what I'm told the new version, the updated version, the telecom and D will have that the prescription origin code in it. So currently I think it is in the standard as well as an optional field. It's something we should go back and look at to see if it's something that the software providers are automatically going to populate.

All right. Thank you. The next question is about the states that are using the web-based function. This question is probably for Jessica. The question is, for those states that are using a web-based function, what vendors have they used in the development? The person asking the question points out that Oregon is going to a new MMIS system, which in December from EDS. They are wondering if they could plug into the EDS system. So it's a question about what vendors have been used by those entities using a web based function and how much some of the interfaces they are building can be plugged into the MMIS system.

That is good question. I can answer it in two parts. First, I do think that we are going to see more states putting this functionality into their overhaul enhancements. For the states that have done a self-assessment, Medicaid information technology architecture. If they have done a self-assessment and are looking at this in terms of service-oriented architecture and where they wanted to go, we ought trying to say to the ensuing guidance documents that this would be seen in most models, most serious to be an acceptable part of that redesign, redevelopment, enhancement. In that sense if you were at the point where you were writing an RFP, I would certainly talk to your regional office about integrating some of this work into that so that whoever were to win the bid could do it. In terms of the vendors who are currently doing it from the transformation grant, they both come to mind. EDS and ACS come to mind. That is not an exhaustive list. There are a few others doing it as well. IBM. Let's see. Microsoft. It is also worthwhile looking at who is working with RHIOs to build this capacity in general. In terms of linking to MMIS, I think that if you have already put it out for bid and if EDS the company that will be building your system you can talk to the regional office and make a pretty sound case for including this into that contract. If it is another state, obviously we support competitive procurement. They would have to put it out for a bid to help you feel comfortable getting a number of vendors who could either do this as part of the board or as a subcontract. The idea is really just that. We are trying to say that this could be a logical build-on.

So the standards are out there. The capacity for vendors to build the applications and to interfaces applications and systems is a matter of matching the two through whenever a state is going to be putting an RFLP for the MMI as system included in the scope of work.

Right. For example, at the recent conference I know several vendors did demonstrations of what they developed for other agencies. You could call. Say, Alabama, we would love to have a demo of what you're doing. Whoever has been doing it for a while. Ask them who there vendor was. Ask them if they have been satisfied. Asked them about the functions. How did they design it? From the federal government perspective, we want to

pay each and every time the vendor builds it in each state over and over again. We would like to see some lessons learned and some design elements transferred from state to state with the vendors being able to then tailor it to that state's needs and set it up. There is a certain amount of expertise already out there, but it is a question of figuring out what you want. The best way to do that is to talk to other agencies that are doing it. They are very willing and open to do this. It's an element of the transformation grant. These are meant to be demonstrations. Part of their scope of work is being willing to share their challenges and lessons learned in hindsight with other states.

And that is especially true if the state has the same technical vendor as another state that has already done this. They have already defined this other state has already built that type of interface—the benefit of building and not reinventing the wheel.

Right.

And we see that happening already. We see some of the vendors work in some of the states to have been doing it for a year and a half already. They are starting to make presentations in other states, which is the kind of cross-state fertilization we want to see. If you want to make sure, it is the vendors showing in other states what they have been able to do and we encourage states to talk directly to their peers to say, okay. You built this. If you have to do it all over again would you do it differently? You hear it from both sides.

Exactly.

Okay. We have another question from a pharmacy technician in Connecticut who was working on the Connecticut transformation grant's team. On September 23rd at the Department of Social Services, there was the panel discussion about e-prescribing with a number of stakeholders. Two of the members were spokespeople for the Medicare physicians in Connecticut. And they were both doctors. They both reported that they have been sending prescriptions via e-prescribing for 2 years. Both of them told the panel that they have requested from the large chain pharmacies such as CVS and Walgreen's that they activate e-prescribing so that the doctors could transmit information. It seems like the Connecticut pharmacies have refused to do so. They cite expensive fees associated. We also echo the concerns of the pharmacies, what they have been hearing is this issue. Do you guys want to take a stab at this point? What are your comments and reactions on some of these large chains not yet turning on the e-prescribing capability because of the concerns around expenses?

This is true. As Tony pointed out in one of the slides, under Part D the e-prescribing is voluntary for pharmacies and physicians. The plans must support the standards if either one of those two entities decide to e-prescribe. The pharmacy has every right not to implement it. We feel that is probably not the right way to go about it. We have had studies where economists have looked at it and actually shown where that transaction fee that is being charged to the pharmacy that is e-prescribing, they have saved money in other areas. The improved workflow. They are able to do other things that free them up

from that transcribing of the prescription into their dispensing software. So there are benefits for those pharmacies to implement. And we are hoping that with the onset of implementation and as physicians get more and more prescribing electronically that the amount of electronic claims that are coming across will also help lower those fees. Because as you know, the more and more of these transactions that come across, we are in a better place to lower those fees through contracts. Some guidance recently went out from CPC talking about the new suite of standards that we just adopted back in April. They are said you need to look at the contracts with your entities and maybe you need to adjust. I think all players need to work together to work some of these issues out. I have always heard that small pharmacies are the ones that aren't in the position to take on these extra, added fees. Most of the big chains are on board with e-prescribing. At least that is what they have told us.

I have heard this issue. I don't think it is unique to Connecticut. What I have been hearing from other states is that the big chains have been the earlier adopters. It is the small pharmacies that have been more resistant. It is interesting how the same change in one state might have a different perspective on the cost saving that the change in the other state might have. That is partly where I would encourage states to talk to one another. All these have had to get these pharmacy partners in the room and talk to them. These are key stakeholder groups obviously. What folded in Arizona where they have a high uptake? What is it that makes it's a win-win in those states? What was the argument that could demonstrate the workflow redesign or the staff redirection to be able to do other activities that draw in money. And then maybe it of those arguments and show that its data to those chains, their counterparts in Connecticut and the other states that are seeing this issue come up. I cannot imagine it is unique to Connecticut. It is a flip-flop of what we are usually doing.

Yes. We heard the health statistics presentation from of the National 25 I'm going to forget about the name. The National Council of State Legislatures, I believe is the name. Anyway, of course they keep track of all the initiatives at the state level, legislative initiatives. This year, one of the most active teams was e-prescribing. In a number of states there have been state laws that are requiring the adoption of e-prescribing. One of those states is Minnesota where there is a state law that requires the adoption of e-prescribing by 2011. So certainly another side of the adoption and implementation 25. I think states are probably going to begin to look into things like that in order to push for the adoption of e-prescribing. It could require some additional, local, legislative initiatives. I just wanted to bring that up. I don't know if either of you have seen other approaches, but I know that legislatively states are moving in a little bit of this direction of pushing for the adoption of e-prescribing by requiring it within the state.

So, in summary, it looks like there are a couple of different approaches. One is a state legislative approach if that is a possibility. The other is the dispensing fees need to be looked at. The third is doing outreach to the big pharmacy chains with a real business plan, a real description to them of what are the elements if the savings in e-prescribing that would offset these higher transaction costs which could be based on what has been effective business plans in the eyes of their counterparts in other states. I can certainly

continue to work with Connecticut and the other e-prescribing grantees to get a handle on all three of these approaches, who is doing what and what is effective in which area.

Okay. I wonder if there are any other questions. At this point we don't have any more. But we will perhaps wait for maybe one or two more to come through. I wanted to ask if you have any comments as well about the development of some evaluations on these early adaptors who could assist other states. A document of evaluation at the end of this process. I know the Medicaid transformation grants include evaluation -- very strong in evaluation components, but I was wondering if you had or are planning to gather some of that evaluation information and share it with states, state Medicaid agencies to assist them, perhaps, in the direction that they would want to take on how to approach the adoption of the e-prescribing? Do you have any comments on the evaluations?

That is good idea. Profiling who are their early adopters in which area and what are the things that sold it for them.

Exactly. Exactly. Creating those type of evaluations exactly.

There are two venues. One is from the state's evaluation and what they have learned. At this point it is somewhat anecdotal what I hear from them. It varies. And those lessons learned are probably the same—those profiles are the same for electronic health record adoption as they are for e-prescribing from the provider side. They are going hand-in-hand. If the evaluations aren't due until the end of the grant, it will be eligible until we get to that point. The other venue for getting that kind of information is the multistate collaboration for health IT that is primarily made up of Medicaid transformation grantees states, but not exclusive to them. They are having it in January. The point of the collaboration and summit and ongoing discussions is to share this kind of information back and forth. There are electronic health record working groups, not a e-prescribing, but these things go hand in hand with the kind of outreach they are doing because it is usually a web-based utility that includes e-prescribing. That would be a really good question for that group to say how you are assessing who is using it, who is not, and what would describe by state and who your early adopters are. At this point I heard anecdotally from a few places that there is a generational gap, particularly in rural areas. Then I have also heard it is easier to work with providers who to fight safety net providers to also get funding like federally qualified health centers and so forth because they are seeing this emphasis on health IT from multiple fronts. So they are kind of getting universal pressure to do this. But we don't have anything definitive at this point. They are still figuring out who those early adopters are and whether it was due to just sort of clinically the right thing to do for your patient or avoid adverse effects, events, whether it had to do with financial incentives to use it. That has a lot to do with it. There is a variance there. Who is swayed by which argument. We will continue to check, and I encourage participation. We want to impose these kinds of questions and see what we can learn. Most have a contract with an external evaluator who is supposed to be evaluating not just the outcome but these kinds of implementation questions.

Just to link this to the upcoming e-prescribing conference, I think there is going to be a lot of valuable information on the experiences and benefits and lessons learned on implementation, correct?

That's correct. There will be several tracks that are geared just for pharmacies. There will be tracks that are geared for the physician. One of the last tracks is bringing prescribers and dispensers together. What are the lessons learned in each of their areas so that they can kind of try to work together to implement e-prescribing, so that they can become better working partners. Just to answer the one question about how things are implemented. AHRQ has contracted to create an implementation tool kit. I don't know when that's coming out, but it's in process. It incorporates best practices and what has been learned over the last couple years.

Right. AHRQ already has a e-prescribing evaluation tool kit. This is a good companion tool kit to that. The states want to know what kind of questions we should be asking in terms of evaluating the process and implementation. The toolkit on the national website is really good.

We have one more question. This is about the connectivity that is being used. There is a web-based connectivity that is sort of a public network Internet. What other connectivity has been seen promoted or utilized besides the Internet? Is it another private state network that is being used? Point-to-point connections? What other connectivity options have you seen used when implementing e-prescribing?

Well, one example I could give— and not a whole lot of others come to mind, but one example is in Kentucky there is what they called the Kentucky information highway, which is run by AT&T. It is secure access, point-to-point server based. It is not through the Internet. They do call it the information highway. It is used for a number of different things. They are the key to build e-health activities. People feel like there is more trust with providers with that secure setting. I don't know how, that is.

Yes. I think there is probably a wide variety of options besides the Internet. There are all these emerging health information exchange and regional networks that are sponsored by states that are connecting multiple providers. So there is still a lot of private type networks that are being used besides the Internet to conduct this transaction. Is that your sense as well?

Yes. Some of the local networks. Mostly it is going to end in a traffic right now.

That brings up one point, which is Internet access: the fact that we live in a very geographically diverse country that does not have universal Internet access everywhere. A couple of states were recipients of grants from the Federal Communication Commission; they gave a number of different states with large rural areas the grants last year to increase bandwidth in certain areas. West Virginia and Hawaii, whatever they are building, they are building it in concert with that. They bring Internet access at the same

time that they bring these health IT tools and utilities because, without it, the whole point is moot.

Yes. Okay. Well, I think we have reached the end of our session. I don't see any more [questions] coming through. I'm going to just take a minute to remind everyone about a couple of things. For the Medicaid technical assistance project, the screen [gives you] where information, comments, and recommendations about new topics on presentations and technical assistance can be submitted. There is a toll-free number you can call as well as the Web site that contains information about the technical assistance project. We will certainly continue—this is one of the topics that have been generally highlighted with priority area for support from this project. I am sure that we will be continuing over the coming months to provide information including, possibly, once we learn more about the evaluation from the early adopters, sharing some of that information as well. Certainly the project is also working with and participating in the multistate collaborative so there is a lot of cross-communication around this project. You will be seeing coming up more information about this from this project. If you have any other ideas or suggestions please do send those to us. I think that's our last slide. Is that correct? That is the last slide.

That's correct.

So I want to take this opportunity to thank Tony and Drew and Jessica for joining us today. I think it has been a very productive set of presentations and conversation. We all hope that you have found the information that has been provided very, very useful. If you want a copy of the presentation slides, please send an e-mail to Nicole. The slides will be uploaded to the project website; in fact, the website address is on the screen still. So any other information, please feel free to send an e-mail, give us a call. I think with that we are going to end our call today. Again, thanks to our speakers and thanks certainly to Nicole for coordinating this. Thank you all for taking the time to participate in today's session. We conclude today. Have a wonderful rest of the afternoon.

[event concluded]