Advancing Medicaid Patent Safety & Preventing Fraud/Abuse through e-Rx: Early Lessons from the Medicaid Transformation Grants

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Presentation Overview

- Pitfalls to Avoid
- Successes to Mimic
- Expectations to Mirror
- Outcomes to Enjoy
CMS Medicaid Transformation Transformation Grants

- Derived from the 2006 Deficit Reduction Act
- $150m awarded in 2007 to 35 States, DC and Puerto Rico
- 2/3 of the grants are for Health Information Technology-related projects (HIE, e-Rx, EHRs, Clinical Decision Support, etc)
- Funding for 24 months, however timelines were extended through 2010
E-Prescribing!!

- Advocates of e-Rx say that when used, this tool can:
  - Reduce adverse medical events through prescription errors
  - Improve coordination of care and/or avoid “doctor shopping” and/or drug-drug interactions by identifying for the prescriber what other medications the patient might be using
  - Reduce medication costs per patient by increasing prescribers’ likelihood to select preferred or generic drugs
  - Reduce admin costs by reducing unnecessary pre-authorization requests
From Purchase to Outcomes

- Are these outcomes achieved by just *purchasing and installing* E-Rx?

- No
  - Provider training
  - System tweaks
  - Provider retraining
  - Provider incentives
  - System tweaks
  - Provider retraining
  - Etc
  - Etc
  - Etc
Delaware

- System developed by EDS
- Uses SureScripts-RxHub and DrFirst
- Prescribers can use any Point of Care vendor for e-Rx/EHR technology
- Receive DE Medicaid Rx history, eligibility, pre-auth info, formulary
DE’s Program Continued

» Program included a pilot during which they offered 50 high volume Medicaid providers a PDA as an incentive

» All providers were offered training...and retraining
Lessons Learned in DE

- Need to require that all claims note the prescription origin code to be able to discern electronic prescriptions vs. other types
- Allow eligibility determinations for next day’s office visits
- Don’t reject requests for pharmacy history longer than available parameter, just give data as available
Important Lesson Learned: Look Deep in the Data

- Initial DE results did not show an average medication cost/beneficiary improvement due to improved adherence to the Preferred Drug List.
- The reason?
  - A change was made in the PDL at the same time that e-Rx was implemented that affected 3 drug types that had allowed for continuation of established drug regimen.
  - With sufficient time, a more realistic trend towards improved PDL adherence and subsequent cost savings is showing up.
Important Lesson Learned: Know Where to Look

Data derived from:
- The MMIS
- DUR (Drug Utilization Report)
- Manual statistics
- Point of Care vendor reports
- SureScripts-RxHub transaction logs
Delaware’s Successes

- System live since November 2008
- 16% of all Medicaid prescriptions submitted are electronic as of March 2009 (11% of all providers, up from 8%)
- After an alert regarding the PDL, 40% of prescriptions are changed/cancelled
- After a drug-drug alert, 26% of prescriptions are changed/cancelled
- 15% reduction in manual pre-authorization requests in 5 months
New Mexico

» System provides Medicaid medication history, formulary benefit and eligibility data to FFS prescribers
» Included a pilot with rural, non-profit providers with sponsored implementation fees and a PDA
» Collaboration with all major NM health plans
NM’s Program Continued

» Collaboration with SureScripts-RxHub
» Extensive provider training
» Challenge: the delivery of eligibility and medication history response transactions by RxHub to AllScripts vendor software (used by NM Public Health clinics)
Lessons Learned in NM: Question Assumptions

- Timelines were too short because working across multiple payers involved lengthy stakeholder participation and legal review.
- Programs should assess provider readiness—don’t assume everyone is sold on e-Rx.
- Don’t over-estimate provider knowledge about e-Rx.
- Implementing an e-Rx program requires “sales & marketing” to providers.
Medicaid programs should establish relationships with vendors with the highest compatibility levels with related service providers in order to extend maximum flexibility to providers in choosing software packages.

Leverage efforts to increase provider adoption of e-Rx by partnering with other payers/state healthcare interests.

Not easy to track/measure adverse events (reference DE’s eval measure on changed/cancelled scripts after alert).
New Mexico’s Successes

- 273 to 414 participating providers over 12 months (10% of all NM prescribers)
- 13% increase in pharmacy participation over 12 months (now at 70%)
- Monthly Medicaid eligibility transactions increased from 4 to 400 over 12 months
- Pilot has 43 rural providers (extensive training and average cost of $1500/provider)
Alabama

» Offering an integrated Electronic Health Record with e-Prescribing, Clinical Decision Support and Chronic Care Management tools

» All online, free access to Medicaid providers

» The EHR also pulls secure info from AL Blue Cross/Blue Shield and 2 major labs
AL’s Program Continued

» Exploring additional option of integration with 3 major EHR systems for push/pull capacity

» System offers interoperability with other State agencies for client info, care plans, real-time messaging, etc.
Lessons Learned in Alabama

- System Tweaks & Timing are Key
  - In 2nd six months, tweaked system to allow providers to input data, not just read-only
  - Providers reported that they would have preferred e-prescribing capacity at debut
  - Program changes now broadcast messaging to all providers and for prescribers to get pre-authorization and refill messages
More Lessons Learned from Alabama

- In 9 months, have issued 3 full and 1 upgrade iteration of the EHR tool.
- More than 100 individual providers were trained in initial ("pilot") roll-out
  - Not all used the system, despite having participated in the design and training phases
  - Increases in utilization from same providers using MORE CONSISTENTLY, not new providers adopting the tools
- Hiring a full-time outreach person for providers to stimulate utilization (note: for a free system with a lot of bells & whistles and data from the other large payer in AL)
Important Lesson Learned in AL: Not Just an IT Project

- A state should spend as much time designing their provider deployment system as they do on the actual system.
- It is critical that resources be dedicated to recruitment, training and follow-up.
Alabama’s Successes

- Major system upgrades and enhancements
  - Next one is focused on provider training
- Involvement of other payers & state agencies
- Within first 3 weeks of e-prescribing implementation, had 300 e-prescriptions. A month later, almost 700 e-prescriptions
- With the ARRA in mind, will seek CCHIT certification for their system
Connecticut

» Mirroring its e-prescribing project after Delaware’s
» Interactive and batch transaction-based interface connecting their MMIS to the SureScripts-RxHub network
CT’s Program Cont’d

» The UConn and the CT Pharmacists Association is working with the Department to build a comprehensive, active medication profile, develop an E-Rx quality pilot program and assess the quantitative and qualitative impact of the E-Rx medication information exchange within the HIE/E-Rx project.
Lessons Learned in CT

- When collaborating with different organizations and institutions, the question of “ownership” of intellectual property needs to be defined.

- Recruitment of patients for medication therapy management can be difficult.
Lesson Learned in CT: Consider the Pharmacists’ Perspective on e-Rx

- The CT Pharmacists Assn has voiced concern for small independent pharmacies having to pay high cost transaction fees for multiple transactions going back and forth on 1 prescription.
- There will be transaction fees between the pharmacist & prescriber associated with data requests to support the 3 new business functions associated with the implementation of e-Rx.
- The business functions are: medication hx request, refill request and new prescription request. It has been industry’s current business model to have the pharmacy assume the transaction cost for these business functions.
- According to the CPA, these multiple transactions and their associated fees will greatly impact smaller independent pharmacies
- In addition to the above transaction costs, there will be fees that either the payer or provider will have to assume for the transaction into the payer for the medication history that resides at the payer (e.g the CT MMIS).
Connecticut’s Successes

• Partnering with eHealthConnecticut links them into a pilot HIE that offers a master patient index, master provider index, record locator service, privacy/security features and other e-Rx components such as:
  ▪ services to route medication orders and refill requests between prescribing providers and pharmacies
  ▪ a capability to make eligibility, formulary, and medication history information available to prescribers and pharmacists during the e-Prescribing and refill processes
The UConn/CPA comprehensive medication profile will include current Rx, otc’s, herbals, supplements, allergies, SIG info for past twelve months. The UConn E-Rx quality pilot program to evaluate:

1. Optimization of medication therapy outcomes – duplicate therapy, drug interactions, dosage range screening, under/overutilization, med errors, generic utilization, PDL/alternative meds, prior authorizations, cost savings

2. Improvement of medication adherence
<table>
<thead>
<tr>
<th>User Application</th>
<th>Providers</th>
<th>Patients</th>
<th>Payers</th>
<th>Purchasers, Employers</th>
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<tbody>
<tr>
<td>E-Prescribing</td>
<td>Able to automate without major capital investment, able to use tool to increase care quality and efficiency</td>
<td>Satisfaction of knowing “my provider is high tech”, faster drug refill orders, fewer medication errors, better care</td>
<td>More rapid adoption of technology at point of care leads to more efficient health care environment sooner, enables payers to automate manual processes, reduce administrative costs</td>
<td>High tech, high quality health care environment makes Connecticut a great place to work, enhances recruiting and increases retention</td>
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Summary of Pitfalls

- Timelines too short to accommodate multiple stakeholders’ input, legal and privacy issues and system tweaks
- Providers’ ability and motivation to utilize the system was overestimated.
- Underestimated resistance due to workflow challenges and the impact of not being able to e-prescribe for controlled substances
Pitfalls Continued

- Assumed all pharmacies were on board
- Promised to decrease adverse events with e-Rx before determining if data on medication-related adverse events was uniformly collected and available
Summary of Lessons Learned

• Emphasize, plan for, budget for and be mentally prepared for EXTENSIVE efforts in the area of provider training... and retraining... and...

• Measure outcomes for both cost AND quality (analyze data carefully) but only after sufficient time has elapsed to detect real trends
Lessons Learned Cont’d

- Partner with other payers and other eHealth stakeholders but identify roles, ownership and business rules up front
- Packaging e-Prescribing with electronic health records and health information exchanges can make it more appealing to providers to adopt
Last Lesson Learned

• Don’t assume that offering an e-Prescribing tool at no cost to providers – and free training – and including their input in the design will result in fast adoption or consistent utilization. IT’S TRICKY (but doable with time, as is true with most new technologies)
Summary of Successes

- Solid and frequent communication with prescribers will lead to meaningful system tweaks and greater utilization

- Building upon existing networks and data warehouses (e.g. SureScripts-RxHub and state MMIS) decrease capital investment

- E-Prescribing alerts DO result in prescribers changing or canceling their prescriptions (in other words, easy to measure safety and cost savings)
Successes Continued

- E-Prescribing can serve as the Providers’ bridge over the digital divide and open up their practices to additional HIT tools
- Prescriber utilization rates will increase, albeit slowly overall
  - And if the DEA rules change to allow e-Rx for controlled substances, may speed up adoption
Other Notable Medicaid e-Rx Efforts

• While not funded by Medicaid Transformation Grants, both Florida and Mississippi’s Medicaid programs have implemented e-Rx and have measured significant cost savings due to increased PDL adherence and reduced duplicative therapies
Why Look to the MTG?

- Implementation paths, timelines, budgets and results were not exactly as expected when the awards were made—**that is the point of demonstration grants**!

- Much discussion of e-Rx implementation focuses on the IT side and/or financial incentives (Medicare)… **And yet the MTG have demonstrated that provider utilization is highly associated with training and workflow issues**
AHRQ and HRSA both have e-Prescribing implementation and evaluation guides free and online.

Contact one of the state Medicaid agencies with e-Rx experience: DE, TN, FL, MS, NM, CT, AL (list not exhaustive).
Questions about the MTG?

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