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# **Electronic Prescribing Implementation Plan Update**

**As Required By  
H.B. 1966, 81<sup>st</sup> Legislature, Regular Session, 2009 and  
the 2010-11 General Appropriations Act  
(Article II, Health and Human Services Commission, Rider 51,  
S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009)**

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**Health and Human Services Commission**

**December 1, 2010**

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## **Executive Summary**

Pursuant to H.B. 1966, 81<sup>st</sup> Legislature, Regular Session, 2009, and the 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, S.B. 1, Rider 51, 81<sup>st</sup> Legislature, Regular Session, 2009), the Health and Human Services Commission (HHSC) submits this update to the implementation plan submitted December 1, 2009, for electronic prescribing (e-prescribing) in Texas Medicaid and the Children's Health Insurance Program (CHIP).

The goal of e-prescribing within the Vendor Drug Program (VDP) is to support adoption and meaningful use of e-prescribing across Medicaid and CHIP programs that will improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP. With that in mind, HHSC has set and is on target to implement e-prescribing capabilities on February 1, 2011. By doing so, providers that opt to participate in the electronic health record incentive payment program will be afforded the opportunity to meet the e-prescribing meaningful use criteria.

The estimated cost and savings expected from e-prescribing are directly dependent upon increasing its use by prescribers. From 2008 to 2009 the percentage of prescriptions routed electronically for all providers in Texas increased from 3 percent to 10 percent and the percentage of providers routing prescriptions electronically also increased from 10 percent to 15 percent.<sup>1</sup>

The total cost of an e-prescribing program in Medicaid and CHIP in fiscal years 2011 and 2012 is \$935,342 all funds and approximately \$436,000 general revenue. These costs include known contract costs for two stages of implementation and the estimated transaction costs. The estimated financial benefit to the state exceeds the estimated cost in fiscal year 2011, the first year of implementation. The estimated return on investment to the state as a result of e-prescribing for fiscal years 2011 and 2012 is more than \$1.7 million. These cost and benefit estimates are based on certain assumptions directly related to provider adoption. Once the program becomes fully operational and provider adoption can be measured, actual program cost and benefit can be measured.

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<sup>1</sup> State Progress Reports on Electronic Prescribing, December 2009 and September 2010, Surescripts, [www.Surescripts.com](http://www.Surescripts.com)

## **Background**

This updated implementation plan for e-prescribing has been prepared by HHSC in response to the following legislation.

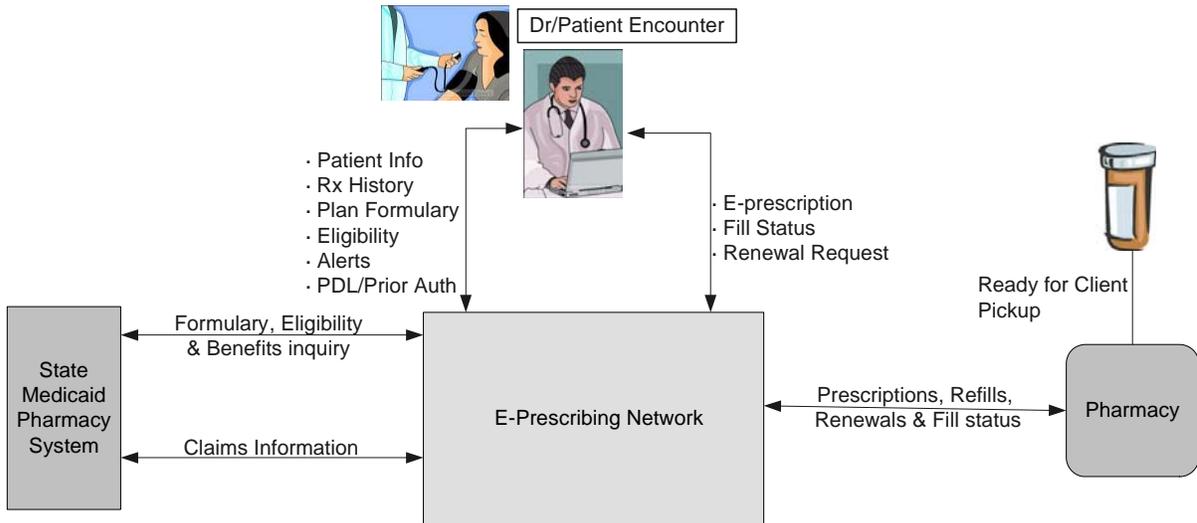
1. H.B. 1966, 81<sup>st</sup> Legislature, Regular Session, 2009, directs HHSC to submit an update to the e-prescribing implementation plan under VDP for Medicaid and CHIP to the Governor and Legislative Budget Board (LBB) by December 1, 2010.
2. The 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, S.B. 1, Rider 51, 81<sup>st</sup> Legislature, Regular Session, 2009) directs HHSC to submit an update on the e-prescribing implementation plan to the Governor and LBB by January 1, 2011.
3. H.B. 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, directs HHSC to develop a health information exchange system for Medicaid and CHIP. This system will support and coordinate the exchange of health information for providers to prescribe medications electronically for Medicaid and CHIP clients. In developing e-prescribing solutions, HHSC must collaborate with providers and stakeholders, including the Health Information Exchange Advisory Committee established in H.B.1218, and identify and develop strategies to overcome barriers to and encourage the use of e-prescribing.

E-prescribing not only replaces paper prescriptions with electronic prescriptions, but also includes the electronic transfer of prescription, drug, benefit and patient information among prescribers, pharmacies and payers. The goal of the e-prescribing plan is to support adoption and meaningful use of e-prescribing by Medicaid and CHIP providers that will improve the quality, safety, and efficiency of health-care services provided to individuals enrolled in Medicaid and CHIP.

## E-prescribing Information Flow

The diagram below depicts the interactions among physicians, patients, and payers during e-prescribing.

### **E-prescribing Data Exchange between Prescriber, Medicaid and Pharmacy Systems**



## E-prescribing Strategy for the Vendor Drug Program

### **Goal**

The goal of e-prescribing within VDP is to support adoption and meaningful use of e-prescribing across Medicaid and CHIP programs that will improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP.

### **Objectives**

To successfully implement e-prescribing, the following achievements will need to be met:

- Implement solutions that are widely accepted by stakeholders.
- Preserve provider choice by allowing providers to choose from multiple e-prescribing vendors.
- Provide information to policy makers and the public on the effectiveness of e-prescribing.

- Provide information and learning opportunities that assist prescribers and pharmacists to use e-prescribing in an effective and meaningful way.

## **Opportunities**

- Two new federal incentive programs are generating significant opportunities for Medicare and Medicaid providers to adopt e-prescribing.

The American Recovery and Reinvestment Act (ARRA) allows for the payment of federal incentives to Medicaid and Medicare providers for the adoption and meaningful use of electronic health record (EHR) technology. The use of e-prescribing is included as meaningful use criteria. Therefore, providers may be eligible to receive the incentives when utilizing e-prescribing capabilities within a certified EHR. Under ARRA, providers can apply for incentive payments beginning in federal fiscal years 2011 through 2016.

The Medicare Improvements for Patients and Providers Act (MIPPA) includes an e-prescribing incentive program. Under this program, prescribers are required to meet or exceed the two criteria related to Medicare patient volume and reporting in order to qualify for the annual incentive payment.<sup>2</sup> MIPPA provides incentive payments to prescribers who successfully adopt e-prescribing in 2011, 2012, and 2013. In 2014, Medicare payments will be reduced for Medicare providers who do not adopt e-prescribing. To the extent that some Medicare physicians are also Medicaid physicians, this incentive may increase e-prescribing usage among Medicaid providers.

- The Centers for Medicare and Medicaid Services (CMS) has approved an electronic solution to enable a brand name drug rather than a generic to be dispensed by the pharmacy. The process will include the prescriber indicating *Dispense as Written* with the addition of “brand medically necessary” in the notes field.
- The United States Drug Enforcement Administration (DEA) has removed the restriction on e-prescribing controlled substances.

## **Barriers**

Although the new DEA rules would allow Schedule II prescriptions to be sent electronically, Texas law currently requires the use of “official prescription forms” for Schedule II prescriptions. Schedule II prescriptions account for seven percent of Medicaid and CHIP prescriptions annually.

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<sup>2</sup> <http://www.cms.hhs.gov/pqri/downloads/pqrieprescribingfactsheet.pdf>

### **Compliance with E-prescribing Standards**

The e-prescribing vendor will be responsible for ensuring that all e-prescribing systems connected to the network including provider, pharmacy, and payer systems are certified prior to connection. Certification of e-prescribing capabilities requires compliance with national standards.

### **Targets for E-prescribing Adoption**

At the time of the initial implementation report, Surescripts, the national e-prescribing network provider, reported that in 2008 the e-prescribing rate for all Texas providers was 3 percent (excluding controlled substances). At the end of 2009 the rate had increased to 10 percent (excluding controlled substances). Additionally, the percentage of physicians prescribing electronically increased from 10 percent in 2008 to 15 percent in 2009.<sup>3</sup>

Texas Medicaid anticipates continued increases in adoption of e-prescribing in the coming years and has adjusted e-prescribing adoption targets accordingly. The new targets are 10 percent in 2010 and 15 percent in 2011.

### **Privacy and Security Policy**

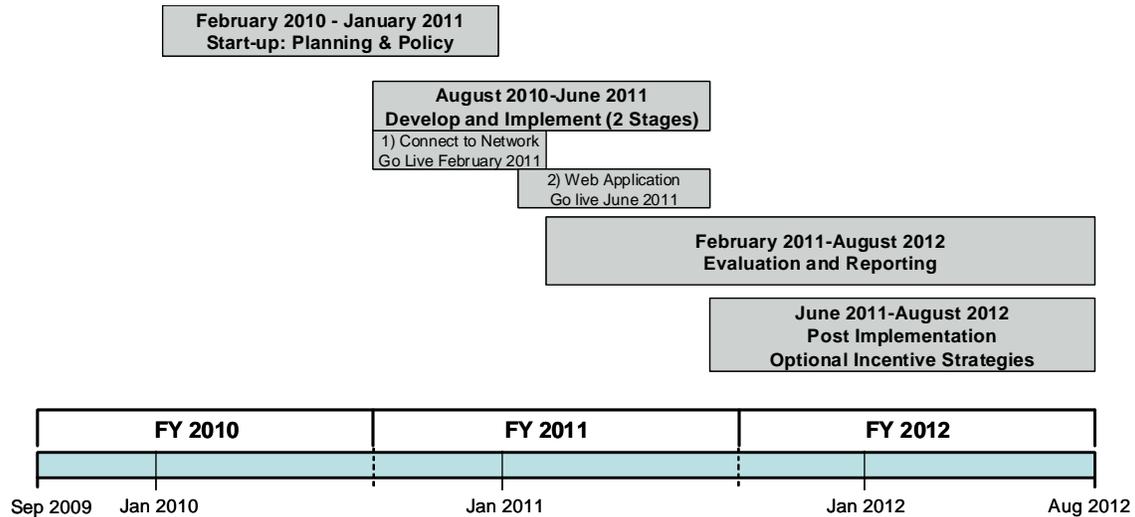
Since e-prescribing is considered a health information exchange, the Medicaid Privacy and Security Workgroup reviewed and evaluated the e-prescribing use case and recommended an opt-out consent process. This consent process follows a hybrid consent model that requires providers to obtain clients' signed consent to request their Medicaid health information. It also provides clients with the option to opt out of sharing Medicaid health information exchange with providers if they do not want Medicaid to share their health information electronically. Opting out does not impact the provider's capability of e-prescribing, but blocks prescribers' from accessing client medication history from Medicaid.

Medicaid clients will be informed of their right to opt out prior to e-prescribing implementation. Clients will be able to submit their opt-out requests to Medicaid by phone or Internet.

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<sup>3</sup> State Progress Reports on Electronic Prescribing, December 2009 and September 2010, Surescripts, [www.Surescripts.com](http://www.Surescripts.com)

## Timeline for E-prescribing Implementation by Phase



### E-prescribing Implementation Activities

The updated implementation timeline is shown above. The transition and implementation of the pharmacy claims and rebate administrator (PCRA) functions originally scheduled to be completed by September 2010 has been moved to November 2010. Additionally, a new prescription prior-authorization vendor will be implementing and connecting to the PCRA in December 2010. To ensure all PCRA functions are operating successfully, e-prescribing functionality will implement February 2011.

A summary of implementation plan activities by phase is included below.

#### **Start-up Phase (February 2010 – January 2011)**

Accomplishments to date:

- Finalized the implementation plan.
- Developed and submitted appropriate advance planning documents to CMS to secure approval for enhanced federal funding on costs associated with implementing e-prescribing tools and related e-learning tools.
- Established health information exchange policy that is in compliance with e-prescribing standards.

- Established opt-out policy for health information exchanges, including e-prescribing.

Continued efforts:

- Develop a stakeholder communication plan that supports ongoing input and feedback on the e-prescribing implementation plan from the Health Information Exchange Advisory Committee and other stakeholder groups.
- Develop options to overcome e-prescribing barriers including, but not limited to, state requirements for handwritten prescriptions for class II controlled substances.
- Update/develop provider handbooks and companion guides for e-prescribing.

### **Implementation Phase (August 2010 – June 2011)**

Accomplishments to Date:

- Developed opt-out processes including client notifications and request mechanisms by phone and Internet.
- Stage one: The business user requirements and the functional design have been approved by the PCRA vendor, Surescripts, and HHSC.

Continued Efforts:

- Stage one: Develop, test, and implement interfaces that connect the PCRA system to an e-prescribing network.
- Perform continuous outreach on the e-prescribing program to providers.
- Stage two: Design, develop, test, and implement a web-based, certified e-prescribing tool that can be utilized by any prescriber to e-prescribe for Medicaid and CHIP clients free of charge. This phase may also include the implementation of an e-learning tool.
- Provide help desk support for troubleshooting e-prescribing network connections and web-tool assistance.

### **Evaluation Phase (February 2011 – August 2012)**

- Obtain provider feedback throughout the implementation and post-implementation phases.
- Establish mechanisms for measuring and reporting adoption and usage rates, prescribing behaviors, and program savings.
- Establish baseline measures.

- Evaluate and report results throughout the evaluation and post-implementation phases.

### **Post-Implementation Phase (June 2011 – August 2012)**

- Manage e-prescribing contracts as necessary.
- Develop programs as necessary to encourage further adoption and use, including incentives.

### **Estimated Benefits**

Estimates of financial benefits associated with implementation of e-prescribing are dependent upon reaching the target rate of e-prescribing for each year. Savings estimates are based on an analysis of national data and other states' experience with e-prescribing. Financial benefits are based on the following measures:

- Medication errors avoided due to e-prescribing.
- Increased compliance with the Medicaid preferred drug list (PDL).
- Increased generic utilization.
- Reduction in average number of prescriptions written per patient per month.

The total cost of an e-prescribing program in Medicaid and CHIP in fiscal year 2011 through fiscal year 2012 is \$935,342 all funds. These costs include contracted costs for both stages of implementation and estimated transaction costs at the targeted e-prescribing rates. After accounting for federal matching funds, the estimated general revenue cost over the two-year period is just under \$436,000. However, the estimated financial benefit to the state exceeds the estimated cost in the first year of implementation. The estimated return on investment to the state as a result of e-prescribing for fiscal years 2011 and 2012 is more than \$1.7 million. It should be noted that the cost and benefit estimates are based on certain assumptions. Once the program becomes fully operational, these assumptions will need to be monitored and adjusted to match actual program cost and benefit.

**Cost/(Benefit) for E-prescribing Implementation for FY 2011 - FY 2012**

	<b>FY2011</b>	<b>FY2012</b>
<b>E-prescribing Adoption Rate</b>	<b>10%</b>	<b>15%</b>
<b>Estimated Costs</b>		
Design, Develop, Implement SureScripts	\$258,529	\$0
Design, Develop, Implement E-prescribing Web App	\$49,439	\$0
Estimated Transaction Costs	\$130,985	\$196,478
Education, Training, Help Desk and Support	\$148,969	\$150,941
Financial Incentives/Programs	\$0	\$0
<b>Total Cost</b>	<b>\$587,922</b>	<b>\$347,419</b>
Federal CHIP Costs	\$65,175	\$38,572
Federal Medicaid Costs	\$248,876	\$147,067
<b>Federal E-prescribing Costs</b>	<b>\$314,051</b>	<b>\$185,640</b>
State CHIP Costs	\$24,995	\$14,712
State Medicaid Costs	\$248,876	\$147,067
<b>State E-prescribing Costs</b>	<b>\$273,871</b>	<b>\$161,779</b>
<b>Estimated Benefit</b>		
Medication Errors Avoided	(\$260,000)	(\$390,000)
Improved Generics	(\$177,472)	(\$298,889)
Improved PDL Compliance	(\$101,000)	(\$151,500)
Fewer Prescriptions Written	(\$1,305,546)	(\$2,039,524)
<b>Total (Benefit)</b>	<b>(\$1,844,018)</b>	<b>(\$2,879,912)</b>
Federal CHIP Savings	(\$200,321)	(\$312,720)
Federal Medicaid Savings	(\$780,599)	(\$1,219,108)
<b>Federal E-prescribing (Benefit)</b>	<b>(\$980,920)</b>	<b>(\$1,531,829)</b>
State CHIP Savings	(\$82,498)	(\$128,975)
State Medicaid Savings	(\$780,599)	(\$1,219,108)

<b>State E-prescribing (Benefit)</b>	(\$863,098)	(\$1,348,083)
<b>Total Net Cost/(Benefit)</b>	<b>(\$1,256,096)</b>	<b>(\$2,532,493)</b>
Federal CHIP Cost/(Benefit)	(\$135,146)	(\$274,148)
Federal Medicaid Cost/(Benefit)	(\$531,723)	(\$1,072,041)
<b>Federal E-prescribing Net Cost/(Benefit)</b>	<b>(\$666,869)</b>	<b>(\$1,346,189)</b>
State CHIP Cost/Benefit	(\$57,503)	(\$114,263)
State Medicaid Cost/Benefit	(\$531,723)	(\$1,072,041)
<b>State E-prescribing Net Cost/(Benefit)</b>	<b>(\$589,226)</b>	<b>(\$1,186,304)</b>

HHSC has received approval for federal matching funds from CMS for the web-based e-prescribing solution as part of the Medicaid Eligibility Health Information Systems (MEHIS).

**Conclusion**

HHSC has determined that e-prescribing will improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP. With this updated plan, HHSC demonstrates its intention to implement e-prescribing capabilities that adhere to industry standards and support provider adoption and meaningful use across the Medicaid and CHIP programs.