



MASSACHUSETTS

Written Testimony

Testimony of Steven J. Fox
Vice President, Provider Network Management and Contract Operations
Blue Cross Blue Shield of Massachusetts
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HIT Policy Committee Information Exchange Workgroup

Introduction

I am pleased to be here to discuss our experiences with electronic prescribing and share lessons learned. I hope my testimony will help the Information Exchange Workgroup formulate recommendations to the HIT Policy Committee and National Coordinator on issues related to electronic prescribing.

Blue Cross Blue Shield of Massachusetts

Blue Cross Blue Shield of Massachusetts (BCBSMA) is a not-for-profit organization that was founded 70 years ago by a group of community-minded business leaders. Our history – and our future – is one of collaboration with the community to improve the health of our members and the quality of care in the Commonwealth. At BCBSMA, our vision is a transformed health care system that provides safe, timely, effective, affordable, patient-centered care for all.

Electronic Prescribing Experience

BCBSMA has several years' experience with e-prescribing. As a founding member of the eRx Collaborative, a multi-health plan collaboration in Massachusetts to promote and enable the usage of electronic prescribing, we played a lead role in increasing provider adoption of electronic prescribing technology. Our contribution has led the state of Massachusetts to set a national benchmark: since 2007, Surescripts has ranked Massachusetts the #1 state in the nation for eRx volume. In 2009, Surescripts honored Blue Cross Blue Shield of Massachusetts specifically with the Safe-Rx Evangelist award, noting our leadership to raise awareness of e-prescribing, reduce medication errors, and promote adoption of the technology.

Since the eRx Collaborative's inception in 2003, we have sponsored over six thousand providers with e-prescribing technology. These providers have sent nearly twenty million electronic prescriptions over six years. Within the BCBSMA network, the percent of prescriptions written electronically has increased from 5.5% in 2005 to 13% in 2009.

Separate from the eRx Collaborative, BCBSMA has offered a provider pay for performance program for e-prescribing to encourage the adoption of this technology. Through this program, we have evaluated numerous stand-alone eRx systems and electronic health records, adding to our knowledge of the market and vendor capabilities.

e-Prescribing aligns with BCBSMA's goal of a transformed health care system. In an effort to support this goal BCBSMA introduced an initiative in October 2008, requiring all providers who prescribe medications to electronically prescribe in order to qualify for any of its providers incentive programs effective January 1, 2011.

Through this combined experience, we have learned a great deal from many stakeholders- providers, pharmacies, health plans, pharmacy benefit managers, and Surescripts- about the challenges and successes of e-prescribing and how to manage our e-prescribing incentive program successfully. We have

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also learned what drives the value of e-prescribing and we continually emphasize its benefits and work with the community to enhance the e-prescribing experience.

Benefits and Outcomes

The key features of e-prescribing that drive prescription affordability and patient safety include the ability to:

- Check prescription benefits in real-time
- Access formulary to know what's covered on what tier and any lower cost alternatives
- Pull in external dispensed drug history to enable the checking of potential drug-drug, drug-allergy interactions or duplicate therapies
- Electronically transmit prescriptions to retail and mail-order pharmacies, which reduce errors due to hand-writing, interpretation, or keying in data. It also increases the efficiency of the process so that providers spend more time delivering care and less time managing the prescription process.

Through our collaborative program, individual efforts and involvement in external research that used our program data, our program has demonstrated the following key results:

- BCBSMA-sponsored research showed that accepted drug-drug interaction alerts prevented over 400 adverse drug events in one year (based on a sample size of 2,300 ambulatory clinicians and 280,000 alerts). These alerts prevented hospitalizations, emergency department visits, office visits, and telephone calls to clinicians, resulting in an annual savings of \$403,000. The potential to significantly impact patient safety and health care costs could be even greater if all Massachusetts prescribers were to e-prescribe: the researchers estimated that e-prescribing could prevent more than 6,700 ADEs—including 50 deaths—and result in a cost savings of approximately \$6.7 million per year.¹
- Use of Tier 1 drugs increased 6.6% when physicians used eRx; use of Tier 2 & 3 drugs decreased. Per 100,000 patients, full use of e-prescribing with formulary decision support could save \$4 million annually in Rx drug spending.²
- 71% of eRx Collaborative prescribers say e-prescribing saves time for office staff with the majority saving 1-2 hours each day.

The full benefits of e-prescribing go well beyond the scope of research cited here: additional benefits result from the availability of medication history when checking for potential interactions, legible electronic prescriptions, lower co-pays, and patient satisfaction and convenience.

Priority Issues and Barriers to Adoption

While e-prescribing has become more widespread, issues that need to be addressed remain, particularly as electronic health record adoption increases and more providers e-prescribe within their EHRs.

EHR Functionality

- According to Surescripts data from 2008, only 30% of EHR software includes full e-prescribing services, namely prescription benefit (checking eligibility and formulary), prescription history from payers/PBMs or pharmacies, reporting to payers/PBMs, and electronic routing (compared to 80% of stand-alone eRx software). As stated above, these are the services that drive the full value of e-prescribing for payers, patients, providers, and pharmacies.
- EHR vendors vary significantly in their approach to embedding e-prescribing functionality, with some offering seamless integration and others creating cumbersome workflows and/or requiring providers to update and upgrade their systems on a regular basis. Our experience suggests that providers are most successful when e-prescribing is seamless, requires just a few

¹ Weingart et al. An Empirical Model to Estimate the Potential Impact of Medication Safety Alerts on Patient Harm, Utilization, and Cost in Ambulatory Care. *Arch Intern Med.* 2009;169(16):1465-1473.

² Fisher et al. Effects of Electronic Prescribing with Formulary Decision Support on Medication Use and Cost. *Arch Intern Med.* 2008;168(22):2433-2439.

“clicks”, and updates, such as monthly formulary changes, are pushed to providers automatically, relieving them of remembering and executing additional work to maintain a fully functional system.

Reporting

- e-Prescribing utilization data on an individual prescriber level is necessary for payers, PBMs and providers to understand and report on utilization. This is an essential component of a successful incentive program. Based on our experience administering e-prescribing incentives to providers, providers cannot easily access their own data from EHRs and it cannot be extracted and filtered by PBM, payer, formulary or other important unique identifiers that indicates to whom the prescription belongs (i.e. Part D, private payer, Medicaid).
- Only 30% of EHRs are reporting usage to payers/PBMs through Surescripts suggesting that many EHRs still lack basic reporting capabilities. Even for those that are reporting many challenges remain.
- The use of Prescription Origin Code is the optimal way to measure utilization for all payers and would eliminate many of these challenges, but is currently only mandated for Part D starting 1/1/2010 and standards are not yet in place.
- The reporting issues described above are current barriers for BCBSMA in managing our incentive programs and I believe it will be a barrier for providers needing to report eRx utilization to CMS.

Controlled Substances

- Due to federal regulations, controlled substances still cannot be electronically prescribed, requiring providers to maintain a separate process for these drugs.
- While we encourage providers to still enter the prescription into their system and then print and sign to be in compliance with the law, BCBSMA continues to hear this limitation cited as a primary reason to not adopt e-prescribing.

Meaningful Use

The requirement for providers to demonstrate meaningful use in order to qualify for Medicare and Medicaid incentives offers an opportunity to ensure robust e-prescribing functionality is enabled and in use by providers nationwide.

Blue Cross Blue Shield of Massachusetts recommends the following considerations for future Meaningful Use and EHR standards and certification criteria. This functionality will result in increased patient safety, affordability, and efficiency.

- *Meaningful Use Criteria:* We recommend that providers demonstrate real-time eligibility checking and use of external medication history, the latter is especially important for drug to drug and drug to allergy checks. We also suggest that prescription renewal requests be generated and transmitted electronically, functionality common in the market today. This bi-directional connectivity with pharmacies optimizes the efficiency for providers, patients, and pharmacies and avoids multiple workflows for all.
- *EHR Standards and Certification Criteria-* Corresponding to meaningful use criteria, we recommend that the standards and EHR certification criteria include checking eligibility and importing external medication history. Eligibility checking may be inferred for Stage 1; however, we suggest it be explicitly included. Similar to above, we suggest that the criteria include the functionality to process prescription renewal requests electronically.

Future of e-Prescribing within EHRs

In order to continue the momentum of e-prescribing nationally, we believe that 100% of EHRs should offer full e-prescribing services commonly available in stand-alone eRx systems. These include prescription benefit, external medication history, electronic routing, and utilization reporting. We also believe that e-prescribing within EHRs will facilitate advanced clinical decision support because additional information will be available to make informed clinical decisions. For instance, using

diagnosis, lab results, and conditions will help providers select the most appropriate medication for the patient's problem.

Key Recommendations

BCBSMA continues to support e-prescribing technology as one way to improve the quality, affordability, and efficiency of care for our members. There has been tremendous progress in recent years with adoption levels and vendor solutions. To continue that progress, we recommend the following:

- Standardize the use of the Prescription Origin Code for all eRx to facilitate accurate utilization reporting, easing burden on providers to report usage and increasing the accuracy of reporting.
- Require EHRs to provide transparent and easily accessible utilization reports for providers allowing them to easily extract and query their data (e.g. by payer, patient, drug, etc)
- Provide technical resources to help with the selection, implementation and ongoing maintenance for EHRs, such as the Regional Extension Centers are intended to do.
- Consider increasing the criteria for meaningful use and EHR standards and certification to maintain the value of e-prescribing as more providers transition from stand-alone systems to EHRs. Applying the same robust standards to EHRs will increase the availability of fully-functional e-prescribing within an EHR.

Thank you for the opportunity to share our experience and this testimony with you.