HIT Perspectives
Perspectives and Updates on Health Information Technology

eFormulary

ePrescribing's Formulary and Benefits: At a Crossroad
By Tony Schueth, Editor-in-Chief

Studies have shown that much of the value proposition for ePrescribing lies in providing formulary & benefits (F&B) information at the point of care. Sounds good, but these benefits cannot be fully realized today because of problems with how the F&B standard is used.

How's that again? Due to major variations in how the F&B standard is used to provide coverage information, what is conveyed to ePrescribers may or may not be accurate and can be displayed in ways that are open to interpretation. Other important pieces of information, like co-pays, are apt to be missing. It's no wonder that doctors are widely rumored to distrust what their ePrescribing systems give them and sometimes ignore …

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New Surescripts Report Assesses Progress in ePrescribing Adoption and Use
By Kurt Andrews, PhD

Surescripts published its annual *National Progress Report on ePrescribing and Interoperable Healthcare.* This year's report includes a lot of the adoption and use data we've seen in the past and have come to expect, but more: an analysis of how well ePrescribing is meeting meaningful use (MU) criteria and the results of a Surescripts-sponsored study about the impact of ePrescribing on medication adherence. Significant portions of the report are devoted to the quality and future of ePrescribing. Of particular interest…

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Specialty ePrescribing

Specialty Medication Prescribing Now on the Radar
By Mihir Patel, PharmD, Consultant

Payers and prescribers are beginning to focus on specialty medications, which are costing them plenty in terms of actual expenditure and process issues. Specialty medication adherence is a problem, which is why the prescribing of specialty medications is an emerging issue that Point-of-Care Partners (POCP) will be monitoring closely.

The costs of specialty medications alone are enough to put specialty prescribing on everyone's radar screen. Specialty medications are a growth area …

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ignore the formulary information that is provided. This is unfortunate because it prevents providers from finding the most appropriate and cost-effective medication treatment options for patients based on their pharmacy benefit.

The ePrescribing community is aware of these issues and finds itself at a crossroad. Do we need to use the current standard in better ways? Do we need something different, like a real-time benefits check? Both?

Let's look at the current standard and how it is used. Off the bat, there are problems with granularity and how the information is displayed. Presently, payers use the standard to provide formulary information at the "plan" level instead of the "group" or "patient-specific" level. This information may or may not be reliable at the point of care, depending on a patient's individual circumstances and plan details. Insurers typically provide formulary data for their most popular products, so F&B data in an ePrescribing system may be inaccurate because a patient's coverage could vary considerably from the typical product. Additionally, formulary data are provided in a flat file format, which represents a limited amount of information from a specific point in time and not necessarily tied to the real-time eligibility check. Also, it's not always clear whether a medication is covered under a patient's medical benefit, pharmacy benefit, or both.

Moreover, F&B data in an ePrescribing system may be difficult for the ePrescriber to decipher because of the way they are presented. For example, ePrescribing systems show formulary information as colors or tier designations, which are open to interpretation. Many ePrescribing systems have been coded to display three-tier benefits; however, there are four-, five- and six-tier plans that need to fit into a three-tier display. Also, some terms, like "non-formulary," "not covered" and "non-preferred" can mean one thing to the payer but may be interpreted as something else by the prescriber.

The upshot is confusion and data issues at the point of prescribing. For example, the ePrescribing system may show that prior authorization (PA) is indicated even though it is not required by the patient's plan or the patient has already undergone PA approval. These kinds of problems are magnified when providers manually try to match patients up with a formulary if their ePrescribing systems do not conduct eligibility-driven formulary matches. So, doctors throw up their hands (who could blame them?) and patients end up with an alternative treatment that may not be optimal for them as providers try to avoid prescribing a drug listed as requiring PA.

There also are cost implications for patients because co-pay information usually is lacking in the F&B data, even though the current National Council for Prescription Drug Programs (NCPDP) F&B standard can accommodate it. Why? Most payers do not provide it because of the many factors involved in calculating co-pays, including days' supply and deductibles, which are challenging to put into the flat file protocol. Copays also are difficult to calculate precisely without knowing where the prescription will be dispensed. In addition, payers that do provide co-pay information are doing so based on a

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a representative National Drug Control number, which may not always tie back to the drug being dispensed, and a patient's true out-of-pocket costs.

Providing co-pay information makes a more meaningful formulary statement to physicians and helps them better understand the ramifications of out-of-pocket costs to the patient. For example, co-pays affect medication adherence: out-of-pocket costs are a major reason why patients do not take their medications as prescribed or abandon them altogether. Medication non-adherence, in turn, results in 100,000 unnecessary deaths and $290 billion annually for poor health outcomes, unnecessary hospitalizations and disability.[1]

The industry is currently considering an alternative: a standardized pre-adjudication prescription transaction or "real-time benefits check" as it is commonly known. Its value lies in its ability to provide almost real-time, patient-specific formulary and benefits information at the point of care, including patient-specific utilization management programs (such as PA and step therapy), true out-of-pocket costs for a medication (specific co-pay/coinsurance amount, specific deductible information), and which pharmacy will be most cost effective in light of the patient's insurance coverage and available pharmacy benefit. On one hand, this should result in a cleaner prescription before it hits the pharmacy, which would increase efficiency. On the other hand, there are concerns that using it would add too much time to the ePrescribing work flow, which would serve as a barrier to adoption.

A proprietary pre-adjudication transaction has been integrated into some of the electronic prior authorization (ePA) pilots that are under way. Surescripts has committed to bringing the underlying standard forward to NCPDP. However, this transaction would be used after a medication has been selected by the physician, not as an aid in selecting the best medication for the patient.

Consequently, we are at a crossroad. Consider the PA use case. Do we bring forward another standard to check benefits prior to PA or do we improve the F&B granularity to provide more accurate indicators and co-pay information? Some would argue that both routes are needed to provide improved co-pay information to the physician and a validation of the need for ePA. Alternatively, if F&B information is improved and a robust prior authorization capability developed, the need for the crutch of a pre-adjudication transaction will be mitigated.

Where do we go from here? Is there a real need for a pre-adjudication standard? Should we better use the current F&B standard? Both? Time will tell. As a leader in ePA and ePrescribing, Point-of-Care Partners is closely monitoring how all of this develops and sorts out. Let us keep you updated.

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[1] See NEHI. (2009). *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease.*

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are discussions of problems with incomplete prescription information, difficulties with ePrescribing for controlled substances and the renewed interest in electronic prior authorization. (Downloads of the report, press release and prerelease Webinar are available [here](#) on the Surescripts Web site). Here are some highlights.

ePrescribing by the Numbers

In looking at ePrescribing adoption and use, the report found:

- The number of electronic prescriptions in 2011 increased by 75% to 570 million, up from 326 million in 2010. At the end of 2011, approximately 36% of eligible prescriptions were sent electronically, up from 25% at the end of 2010.
- Approximately 390,000 prescribers routed prescriptions electronically by the end of 2011, compared with 234,000 at the end of 2010. This represents about 54% of all office-based prescribers.
- Roughly 82% of active ePrescribers used an electronic health record (EHR) rather than a stand-alone ePrescribing system to prescribe electronically in 2010, slightly higher than 79% in 2010.
  - Compared with those who used a separate ePrescribing product, EHR users tended to write more prescriptions, a greater percentage of which were electronic.
- ePrescribers are increasing their use of eligibility, formulary and medication history information as well.
  - While prescription benefit requests increased 87% and medication history requests increased 72%, only 47% of EHRs were certified by Surescripts for eligibility, formulary and medication history.

ePrescribing and Meaningful Use

MU is currently the major driver of health information technology (HIT) adoption, and the progress of various industry sectors in meeting MU criteria is of major interest to the public and private sectors alike. Using data from a Surescripts-sponsored study, this year's *progress report* provides the first snapshot to date. Results are encouraging: 60% of individuals who began ePrescribing in 2008 met stage 1 ePrescribing criteria and 38% met stage 2 criteria. The numbers differed significantly by specialty, providing additional evidence that the practice of medicine is not uniform.

ePrescribing and Physician Adoption

Updated analyses of physician adoption of ePrescribing have shown the highest rate (55%) to be among smaller practices with six to 10 physicians. This rate is about the same for practices having two to five physicians, with a 53% adoption rate. Solo practitioners experienced the most significant growth in adoption, jumping from 31% in

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2010 to 46% in 2011. When examined by specialty, ePrescribing adoption rates are highest among internists at 81%, endocrinologists at 78%, cardiologists at 76% and 75% for family practitioners. While the aforementioned specialties have some of the highest adoption rates, primary care providers generally have higher adoption rates than specialists.

ePrescribing and Medication Adherence

Surescripts recently partnered with pharmacy benefit managers (PBMs) and retail pharmacies to assess the impact of ePrescribing on medication adherence. The results of this study should go a long way toward providing clarity: with ePrescribing, patients will pick up 10% more prescriptions. According to the study, this increase in "first fill" medication adherence coupled with other ePrescribing benefits (such as improved efficiencies and patient safety) could save between $140 billion and $240 billion in health care costs and improved health outcomes over the next 10 years.

ePrescribing and the Future

While the report acknowledges the collaborative efforts of the industry in moving ePrescribing forward, it points to three areas where the industry should double down. The first is ePrescribing for controlled substances (EPCS). Although it is now legal, uptake has been minimal. Surescripts makes suggestions for how prescribers, vendors and pharmacies can address some of the remaining technical and implementation issues. A second area for collaborative improvement is electronic prior authorization (ePA). Efforts are under way by a range of stakeholders to bring a standard to fruition. The third area is continued collaboration to align standards and improve interoperability.

Interoperable Health Care

A long-time advocate of ePrescribing, Surescripts has recently expanded its advocacy and business model into adjacent areas. Two years ago, "interoperable healthcare" was first included in the title of the report. Last year also saw significant coverage of the Surescripts clinical data exchange platform. While the themes of collaboration and open standards are woven throughout the report's background, little attention is devoted to the Surescripts' clinical data exchange, with even fewer details about how it — or anyone else — has been doing in this area.

What Does It Mean?

Surescripts data are useful as a temperature check for the industry. No longer is it necessary to talk about the day when ePrescribing will become mainstream. ePrescribing has arrived and regardless of the upcoming Supreme Court decision, its impact will only grow as adoption and utilization increase over the next few years. For ePrescribing to realize its full potential, three things stand out:

- **EPCS needs to be easier.** Some states and boards of pharmacy have yet to embrace EPCS. This is especially detrimental to those practitioners who prescribe lots of controlled substances. Even for those practitioners who don't prescribe very

many controlled substances, the two-factor authentication process is too burdensome.

- **Electronic prior authorization is a standard whose time has come.** (See the article in this issue of *HIT Perspectives* on specialty medications for a clear use case). While widespread adoption of the ePA process is admittedly several years away, states are beginning to require its use and pilots are under way to test a new ePA standard. Point-of-Care Partners (POCP) has been leading the charge in this area for several years, including heading a National Council for Prescription Drug Programs ePA workgroup.

- **ePrescribing quality needs to improve.** As Surescripts points out, improving the quality of ePrescriptions is important. But, the issue is broader than its examples:
    - Formulary and benefits information presented to prescribers is representative and not exact. Only when this information is linked to the individual can the full value be realized.
    - ePrescribing is a different process than paper prescription writing. As such, it comes with different issues. One is that a product cannot be prescribed easily unless it is in an electronic health record's drug database. There can be a delay for the availability of product information, making it impossible in some instances for a prescriber to complete an electronic prescription.
    - Medication history is still not part of most office visits. Only by reviewing medication history can prescribers have a clearer picture and do a better job of avoiding duplicate or contraindicated therapy.

For those looking for even more detailed insights, consider subscribing to our paid information service, *HIT Insights*, in which we provide detailed Sentinel Event Alerts on timely health information technology (HIT) topics. POCP also conducts customized analyses of ePrescribing events, trends and related topics. Let us do one for you.

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due to the rise of chronic diseases and wide range of medication treatment options being developed to treat them and other conditions. While specialty medications account for just 15% to 17% of the current drug spend, outlays for them have grown significantly in recent years and are estimated to comprise 40% of drug expenditures in the United States by 2014. According to one pharmacy benefit manager, only 1% of employees use specialty drugs but account for nearly half the total medication cost across both pharmacy and medical benefits. The average annual cost to payers for a single specialty medication is $23,000.[2]

Then there are the process issues that cost everyone time and administrative overhead. Specialty prescribing is mired in paper and yesterday's processes. It is outside today's ePrescribing process, with an infrastructure currently unable to provide additional clinical

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data to justify the specialty prescription as well as support an electronic version of the current manual, paper-intensive processes and forms required by individual pharmacies, health plans and drug manufacturers for the use of specific drugs. As a result, prescribers and pharmacies are confused as to which drugs are preferred or need prior authorization (PA) — a requirement for about a third of specialty medications. It is difficult for prescribers and pharmacies to tell whether specialty drugs are covered under a patient's medical benefit, pharmacy benefit or both. This fragmentation in the specialty prescribing process often leaves prescribers, pharmacies and patients in the dark about therapy management programs that may be available, which would save both payers and patients a lot of money and reduce work-flow hassles for pharmacies. The end result is extra costs and administrative burdens for prescribers, plans, patients and specialty pharmacies alike.

Not surprisingly, patient compliance is a problem, according to participants of an April 11 AIS Health Webinar.[3] Out-of-pocket costs are a major factor, but side effects and injection and treatment anxieties also are contributors. Addressing adherence can save money and improve outcomes, which are key to payers given the costs of specialty medications. According to data from OptumRx's specialty designated network program presented at the Webinar, a 50% improvement in adherence to oral oncology therapy translates to savings of more than $19,600 per patient in the first year. Although drug costs rise by $3,300, medical savings of nearly $23,000 more than make up for it through fewer emergency room visits and hospitalizations and reduced drug waste.

- Guidelines, protocols, and best practices must be integrated into the prescribing process for specialty medications.

- A clear next step is to bring specialty prescribing into the electronic age and make it part of the ePrescribing process. Standardized elements and forms must be created and technology fixes are needed so they can be handled through the ePrescribing infrastructure. Consensus needs to be reached as to which standards and technical issues must be addressed so information can be shared electronically among payers, providers and pharmacies. Current work on electronic prior authorization (ePA) may be leveraged for issues related to process flows and content standardization for requests for specialty medications.

- Payers should consider benefit design restructuring to better align cost sharing across their medical and pharmacy benefits. Standardized forms and clinical criteria are needed. Outreach strategies for therapy management programs should be developed for providers, specialty pharmacies and patients.

POCP's team of experts is uniquely suited to help payers and pharmacies address the management of specialty pharmacy issues. As a leader in ePrescribing — and particularly ePA — POCP can help the industry move forward with ePrescribing of specialty medications. Let us know how we can help you.

[1] Block J. Rising specialty pharma costs mean insurers must take action. *Health Plan Week*. 2012;22(14). http://aishealth.com/archive/nhpw041612-03.
[2] *Ibid.*