

# Off and Running: Current Efforts to Standardize Electronic Prior Authorization

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# Outline

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- Background
- Stakeholder Perspectives on Automated Prior Authorization
- Early Efforts to Automate
- Drivers of Electronic Prior Authorization
- Standardization Efforts
- MMA ePrescribing Pilots



# The Big Picture



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# The Challenge

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**\$1.9T** 2005 US expenditure on Healthcare  
(16% of US GDP, which was \$11.7T in 2005)

**\$3T** Projected cost of US health care by 2011

## The Solution:

Health Information Technology



# Healthcare Information Technology (HIT) is ...

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- ▶ the use of computers & programs to store, protect, retrieve, and transfer clinical, administrative, and financial information electronically **within and among health care settings**.
- ▶ recognized as a **bi-partisan solution** to what is universally viewed as a “broken” health care system
- ▶ expected to have a huge impact on **cost, quality & outcomes**
- ▶ an opportunity **and** threat for different stakeholders
- ▶ a credible and **powerful** channel for physician and patient communications



# Major HIT Trends/Drivers

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- Medicare Drug Improvement & Modernization Act of 2003 (MMA)
  - Estimated cost of \$440B, \$534B, \$720B over 10 years
  - Establishes an ePrescribing program
- President Bush mentioned EHRs in last three State of the Unions
- HHS efforts to support HIT
  - Created the Office of the National Coordinator (ONC) - '04
  - Laid out a **10-year objective of interoperable health records** and Introduced the Framework for Strategic Action - '04
  - Funded pay-for-performance demonstration projects
  - Nearly **\$200M** in Federal grants to support HIT
- Nearly **\$50 million** in State grants to support HIT
- Other substantial investments
  - BCBSMA pledged **\$50M** to support HIT pilot projects
  - Highmark donates **\$26.5M** for ePrescribing projects
- Current Federal HIT legislation
  - Senate – 10 acts / House – 9 acts
- State support of HIT initiatives



# The Pharmacy Component

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**\$209B** Spending for Prescription Drugs

(11% of 2005 healthcare expenditures)

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- ➔ Fastest growing component of healthcare, growing by double-digits in past several years
- ➔ Attributed to higher drug prices, increased utilization, increased use of newer, more expensive agents
- ➔ Growth has slowed recently, perhaps because of employer- and payer-driven initiatives



# Prior Authorization

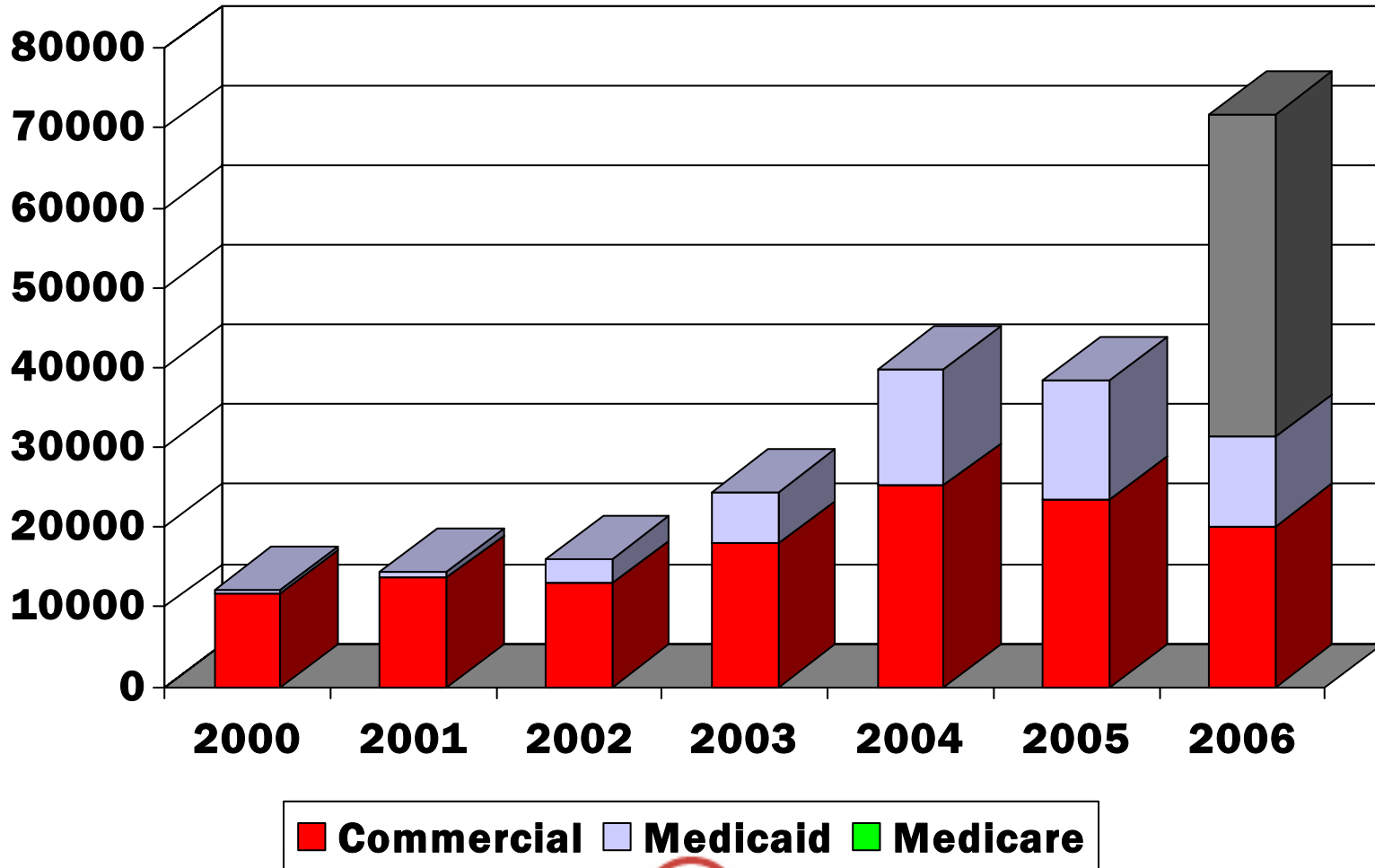
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- ➔ Healthplans and PBMs place prior authorization (PA) requirements on selected drugs to:
  - ➔ Encourage appropriate clinical usage
  - ➔ Manage costs of expensive therapies
- ➔ Criteria is generally developed and endorsed by the plan's P&T committee, based on information from the FDA, manufacturers, medical literature, consultant physicians and appropriate external organizations
- ➔ Advances in MTM, biotechnology, designer drugs, specialty pharmacy and the cost of the pharmacy benefit has **increased the number of PA'd medications**

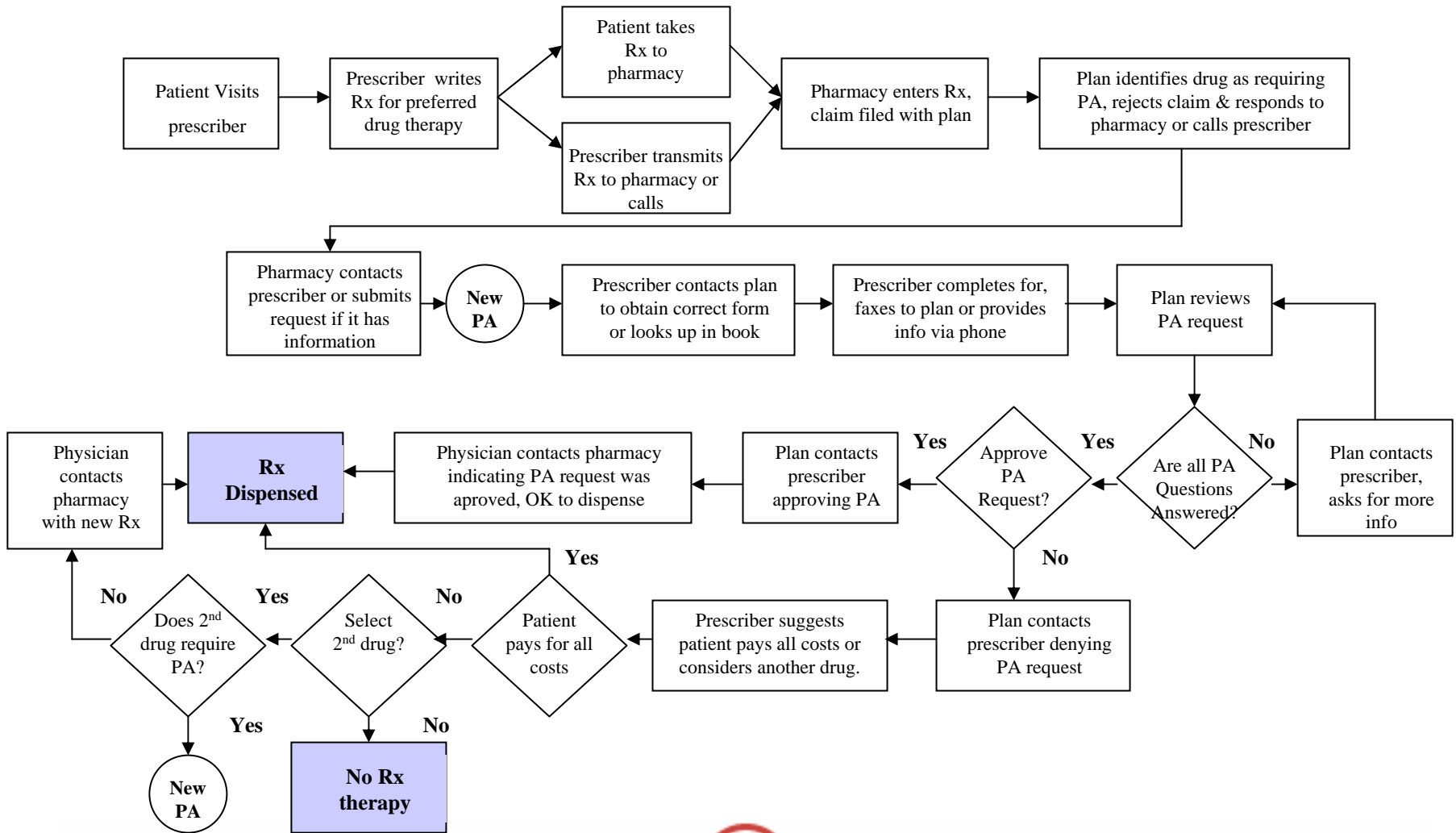


# Dramatic Increase in PA

Source: MediMedia



# Current (Paper) Flow



# What's Wrong With This Picture?

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- ➔ Patient hassle and treatment delay
  - ➔ No one knows drug requires PA until patient has already left prescriber's office
  - ➔ Treatment might be delayed for days
- ➔ Pharmacy hassle
  - ➔ Pharmacy must call prescriber's office, and sometimes the plan
- ➔ Prescriber hassle and disruption
  - ➔ Gets called back from pharmacy, must call plan, wait for faxed form, completes form and sends it back
  - ➔ Turnaround time can be 48 hours or more
- ➔ Healthplan inefficiency
  - ➔ Expensive and labor intensive process that creates animosity



# Stakeholder Perspectives on Prior Authorization



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# Physician Perspective

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- ➔ Most painful formulary-related contact: prior authorization (1999 Medco survey, n=20)
- ➔ Most desired feature of ePrescribing: “decreasing hassles with prior authorization” (2004 SureScripts survey, n=2,391)
- ➔ Most requested ePrescribing feature enhancement of physician software customers: prior authorization (2005 POCB survey, n=20)
- ➔ Findings from 2004 PDR online survey (n=3,529):
  - ➔ 63% of prescribers write some Rx's that require PA
  - ➔ 71% of Family Medicine/68% of Internal Medicine practitioners have been discouraged from prescribing the most appropriate medication due to pre-auth requirement



# Health Plan Perspective

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- ➔ Findings from 2004 POCP survey of AMCP pharmacy dir., 92% of whom manage PA (n=25)
  - ➔ 96% support automation of prior authorization to:
    - Increase clinically appropriate prescribing (76%)
    - Decrease administrative costs (76%)
    - Increase member satisfaction (40%)
  - ➔ 84% expected no/small ↑ in PA'd drugs as a result
  - ➔ Just 44% believed the drugs requiring PA would ↑
  - ➔ Barriers to automating prior authorization:
    - Lack of physician office technology (88%)
    - Lack of electronic standards (84%)
    - Lack of PBM business model (60%)
    - Organizational buy-in (24%), Insufficient ROI (36%)



# PBM Perspective

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- ➔ “We do recommend that there be standards associated with requests or authorization codes” (Medco executive, NCVHS, July 29, 2004)
  - ➔ “What’s (complicated) is the discussion on how to qualify the Rx”
- ➔ “The assumption seems to be that automating PA is a good thing but that is from the physician perspective. Looking at it from a Medicare or payer perspective, it may not be a good thing because PA helps reduce costs.” (ESI executive, Pink Sheet, Aug. 23, 2004)
- ➔ “If MDs say 99% of criteria is the same & 1% is different, plans will listen. (Cigna exec, Jan 3, 2005 eMail)



# Other Perspectives

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- ➔ “The crafters of the MMA took care to insist the ePrescribing pose no undue burden on physicians, but current transactions do little to address some areas where physicians feel the greatest administrative burden (e.g. PA).” (Pfizer exec, NCVHS testimony, July 29, 2004)
- ➔ “Diagrams presented by the PBMs today reinforce my thinking that PA is used to obstruct behavior more than a tool to encourage the right thing clinically.” (Pfizer exec, NCHVS testimony, July 29, 2004)
- ➔ “Automating processes like PA is what computers were designed for.” (MediMedia exec, NCVHS testimony, Aug 22, 2004)



# **Early Efforts to Make Prior Authorization Electronic**



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# Component of Formulary Database

- ➔ For years, formulary aggregators (RxHub, MediMedia) have provided a PA flag
- ➔ ePrescribing, EHR companies use it to alert prescribers
- ➔ Vendors use different, symbols
- ➔ Some PBMs don't supply this data

The screenshot shows the Allscripts eRx interface for a patient named Bell, Douglas. The interface includes a navigation menu, patient information, and a medication list. A pop-up window titled "Medication" is overlaid on the list, showing a detailed view of the medication list with columns for status, name, and quantity. The list includes:

Status	Medication	Quantity
☺	Amoxicillin 250 MG Capsule	
☺	Increlex 40 MG/4ML Solution	
☺	Percocet 10-325 MG Tablet	
☺	Percocet 2.5-325 MG Tablet	
☺	Viagra 100 MG Tablet	



# Custom, Non-Standard Solutions

- ➔ There are solution providers who have created custom, non-standard solutions for health plans
- ➔ Failed because not in prescribing workflow
- ➔ Simple html forms

**NaviMedix** Plan Central Office Central Action Items Customer Service Online Training Log Off

Drug Prior Authorization > Member Search > Provider/Drug Selection > Request Form

Drug Prior Authorization Information  
Submission Status: Incomplete  
Receive Date: 05/04/2005  
Date of Service: 05/04/2005  
Drug Name: Flolan (Epoprostenol)

Please answer the following questions prior to submission:  
If you need an option not listed in the form below, please provide additional information in the text box at the bottom of the page.

What is the prescriber's specialty?  
Cardiology   
Pulmonology   
Other (If other, please provide additional information in the text box at the bottom of the page)

Does the patient have primary pulmonary hypertension?  Yes  No  
Does the patient have secondary pulmonary hypertension?  Yes  No

Please list the treatments tried and their associated outcome

Anticoagulants	<input type="checkbox"/>
Effectively treated condition	<input type="checkbox"/>
Ineffectively treated condition	<input type="checkbox"/>
Unacceptable side effects	<input type="checkbox"/>



# Drivers of Electronic Prior Authorization



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# Drivers of Electronic Prior Authorization

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- ➔ Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)
  - ➔ Establishes an ePrescribing program
    - Encourages HIPAA transactions, including X12N 278
- ➔ IOM Studies on Patient Safety
  - ➔ *To Err is Human: Building a Safer Healthcare Systems* (1999)
  - ➔ *Crossing the Quality Chasm: A New Healthcare System for the 21<sup>st</sup> Century* (2001)
    - 46,000 to 98,000 medication errors per year
  - ➔ *Preventing Medication Errors* (2006)
    - 1.5M preventable medication errors, not counting errors of omission
- ➔ Constant pressure from payers to be more efficient, drive down admin costs



# MMA (Medicare Part D) & ePrescribing

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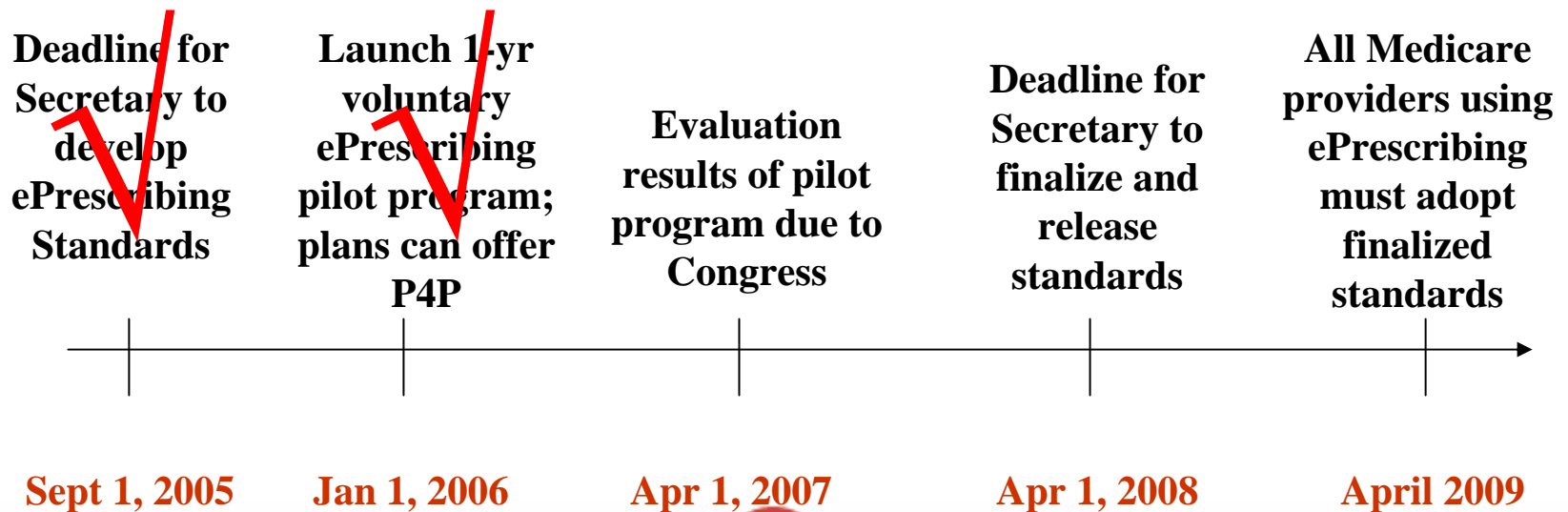
- ▶ MMA establishes a real-time ePrescribing program to be used by prescribers, plans, pharmacies and pharmacists who serve Medicare patients
  - ▶ No mandate, but if ePrescribe, **standards must be followed**
  - ▶ Standards via National Committee on Vital and Health Stats (NCVHS)
- ▶ NCVHS tasked with identifying foundation standards required for January 2006 implementations.
- ▶ Directs HHS to conduct a voluntary eRx pilot project in 2006, for areas where industry experience is insufficient
- ▶ Other components:
  - ▶ Discretionary grants to be made available to prescribers
  - ▶ Plans, hospitals, groups may purchase hardware for MDs
  - ▶ Plans may pay additional fees for reduced medication errors, improved formulary compliance & fewer adverse drug events



# MMA (Medicare Part D) & ePrescribing

## ➔ Progress-to-date

- ➔ Issued final rule naming foundation standards (11/05)
- ➔ Awarded 5 grants for ePrescribing pilots (12/05)
- ➔ New ePrescribing Rules (7/06)
  - Exception to Stark (Physician Self-Referral Prohibition)
  - Anti-kickback Safe Harbor



# **Efforts to Standardize Electronic Prior Authorization**



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# Multi-SDO Task Group

<i>Founded</i>	November 18, 2004 (NCPDP Fall Workgroup Meeting)
<i>Objectives</i>	<ul style="list-style-type: none"> <li>▶ Promote standardized automated adjudication of prior authorization</li> <li>▶ Coordinate the further development and alignment of standards</li> <li>▶ Identify additional needed standards</li> </ul>
<i>Organizations Participating</i>	<p>Standards Development Organizations: NCPDP; X12; HL7;</p> <p>Health Plans/PBMs: Wellpoint; HealthNet; Excellus Blue Cross Blue Shield; BCBSMA, Express Scripts, Caremark, Medco, Argus, Prime Therapeutics</p> <p>Physicians/Providers: AAFP, Lifespan</p> <p>Others: Achieve (long-term care); Pfizer; Dr. First; ZixCorp; Allscripts</p>
<i>Task Group Leader</i>	Tony Schueth, Managing Partner, Point-of-Care Partners, LLC



# Industry Analysis (NSAIDs/Cox2s)

Drug/Criteria	Health Plan A	Health Plan B	Health Plan C	Health Plan D	Health Plan E	Health Plan F	Health Plan G
<b>NSAIDs</b>							
<i>[Celebrex, Bextra] - COX2 Inhibitors</i>							
Drug			N/A				
Strength	•	•					•
Dose	•	•					•
Diagnosis	•	•					•
Expected duration	•	•					•
Previous therapy and dates	•	•					•
Response to previous therapy (inadequate response, adverse effects, comments)	•						•
Pt age: 65 or older							•
Pt has documented Hx of ulcer disease or prior evidence of GI hemorrhage (ICD-9 if available)	•					•	•
Pt has concurrent use of corticosteroids		•			•	•	•
Pt has concurrent use of anticoagulants or antiplatelets (Ticlid, Aggrenox, Plavix)	•	•		•	•	•	
Pt has concurrent use of NSAIDs	•	•		•	•	•	
Pt has anti-ulcer agent (H.Pylori eradication agents) - Helidac or Prevpac		•					
Pt requires NSAID use > 21 days (list drug and dose)	•						
Pt previously unable to tolerate 2 different NSAIDs	•					•	•
Shrt-trm Tx (<21d) hi-risk pts NSAID induced adv GI event w/2 different	•				•		
Shrt-trm Tx (<21d) hi-risk pt anticoag, antiplatelet, chronic oral corticosteroid	•						
Hx of PUD, NSAID-related ulcer or clinically significant GI bleed	•					•	•
Pt has hereditary or acquired coagulation defect (eg: hemophilia or Von Willebrand's, protein C or S deficiency, thrombocytopenia or chronic renal failure)	•			•			
Celebrex coverage for reducing number of adenomatous colorectal polyps in pts w/Familial Adenomatous Polyposis (FAP)	•						•
Coverage not provided for prevention of cancer, prev or tx of Alzheimer's or in presence of ASA >325 mg/day	•						
Benefit approval duration: 12 months (grandfather existing users)	•						

Criteria varies by plan, wording non-standard



# Sample Form: Celebrex

- ➔ Observations
  - ➔ Organized by therapeutic category
  - ➔ Patient, physician data required should be in vendor system
  - ➔ Previous medications (med hx) required
  - ➔ Rules included on form
  - ➔ Conditions required



**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**Celebrex (celecoxib) Prior Authorization of Benefits (PAB) Form**  
 Complete form in its entirety and fax to:  
 Prior Authorization of Benefits (PAB) Center at (888) 831-2243

<b>1. PATIENT INFORMATION</b> Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient is: <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>2. PHYSICIAN INFORMATION</b> Prescribing Physician: _____ Physician Specialty: _____ Physician DEA#: _____ Physician Phone#: _____ Physician Fax#: _____
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<b>3. INDICATE DIAGNOSIS</b>			
Diagnosis:	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Primary Dysmenorrhea
Strength:	Celebrex 200mg	Celebrex <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg	Celebrex 200mg
Max Qty Limit:	30 per 30 days	60 per 30 days	11 per 30 days
OA or RA: Must meet criteria below in 4A OR 4B OR 4C		Must be female and meet criteria below in 4A OR 4B AND 4C	
<input type="checkbox"/> FAP Familial Adenomatous Polyposis Celebrex 400mg 60 per 30 days Only diagnosis required			

**4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**  
 Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST

**A.  Yes  No Patient has major NSAID-induced GI complication risk factors: ONE OF THE FOLLOWING MUST BE PRESENT**

Yes  No Active non-menstrual bleeding or bleeding disorder  
 Yes  No Concurrent anticoagulation therapy Please note: bleeding events and increased prothrombin time have been reported in patients taking COX-II Selective NSAIDs concurrently with warfarin. INR monitoring is still necessary in COX-II.  
 Yes  No Patient has previous documented history of NSAID-induced gastropathy

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**B.  Yes  No Patient has other NSAID-induced GI complication risk factors: TWO OR MORE OF THE FOLLOWING MUST BE PRESENT**

Yes  No Age ≥ 65 years old  
 Yes  No Chronic major organ impairment \_\_\_\_\_ (please specify) or active Rheumatoid Arthritis  
 Yes  No Concomitant chronic systemic corticosteroid therapy  
 Yes  No Chronic high-dose NSAID therapy (e.g. 2-3 times the standard dose to achieve therapeutic effect)  
 Yes  No Anti-platelet agents for vascular prophylaxis

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**C.  Yes  No Patient has documented trial and failure of 2 or more prescription-strength NSAIDs (Must specify trials below)**

NSAID #1: \_\_\_\_\_ NSAID #2: \_\_\_\_\_

**5. PHYSICIAN SIGNATURE**

Prescriber or Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician, only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential; the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent of the sender, you should not disseminate, distribute or copy this e-mail. Please notify the sender immediately by e-mail if you have received this e-mail by mistake. Contact your supervisor immediately if you have any questions concerning the above. Thank you for your cooperation.



# Sample Form: Growth Hormones

- ➔ Add'l Observations
  - ➔ Laboratory test results required
  - ➔ Data that might be in EMR, but not ePrescribing, solution requested

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Growth Hormone Prior Authorization of Benefits (PAB) Form**

Complete form in its entirety and fax to:  
Prior Authorization of Benefits Center at (888) 723-5479



**1. PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date of Rx: \_\_\_\_\_

**2. PHYSICIAN INFORMATION**

Prescribing Physician: \_\_\_\_\_

Physician Specialty: \_\_\_\_\_

Physician DEA#: \_\_\_\_\_

Physician Phone#: \_\_\_\_\_

Physician Fax#: \_\_\_\_\_

**3. MEDICATION REQUESTED (Maximum quantity limit allowed: 28 injections per 28 days)**

<input type="checkbox"/> Genotropin	<input type="checkbox"/> Humatrope	<input type="checkbox"/> Nutropin, Nutropin AQ	<input type="checkbox"/> Serostim	<input type="checkbox"/> Tev-Tropin
<input type="checkbox"/> Geref	<input type="checkbox"/> Norditropin	<input type="checkbox"/> Protropin	<input type="checkbox"/> Saizen	<input type="checkbox"/> Zorbtive

**4. DIAGNOSIS**

<input type="checkbox"/> Short Stature	<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Short Bowel Syndrome
<input type="checkbox"/> HIV Wasting Syndrome	<input type="checkbox"/> Panhypopituitarism	<input type="checkbox"/> Turner's Syndrome
<input type="checkbox"/> Idiopathic Growth Hormone Deficiency		
<input type="checkbox"/> Other (please specify): _____		

**5. PROVIDE THE FOLLOWING INFORMATION AS APPROPRIATE Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST**

Date:	List and attach copy of Growth Hormone Stimulation Test Results and Reagents Used	
Patient's Height:	Reagent 1:	Reagent 2:
Patient's Bone Age:	Results #1:	Results #1:
Patient's Chronological Age:	Results #2:	Results #2:
Growth Velocity:	Results #3:	Results #3:
IGF-1 Results:	Results #4:	Results #4:
	Results #5:	Results #5:

**6. PHYSICIAN SIGNATURE**

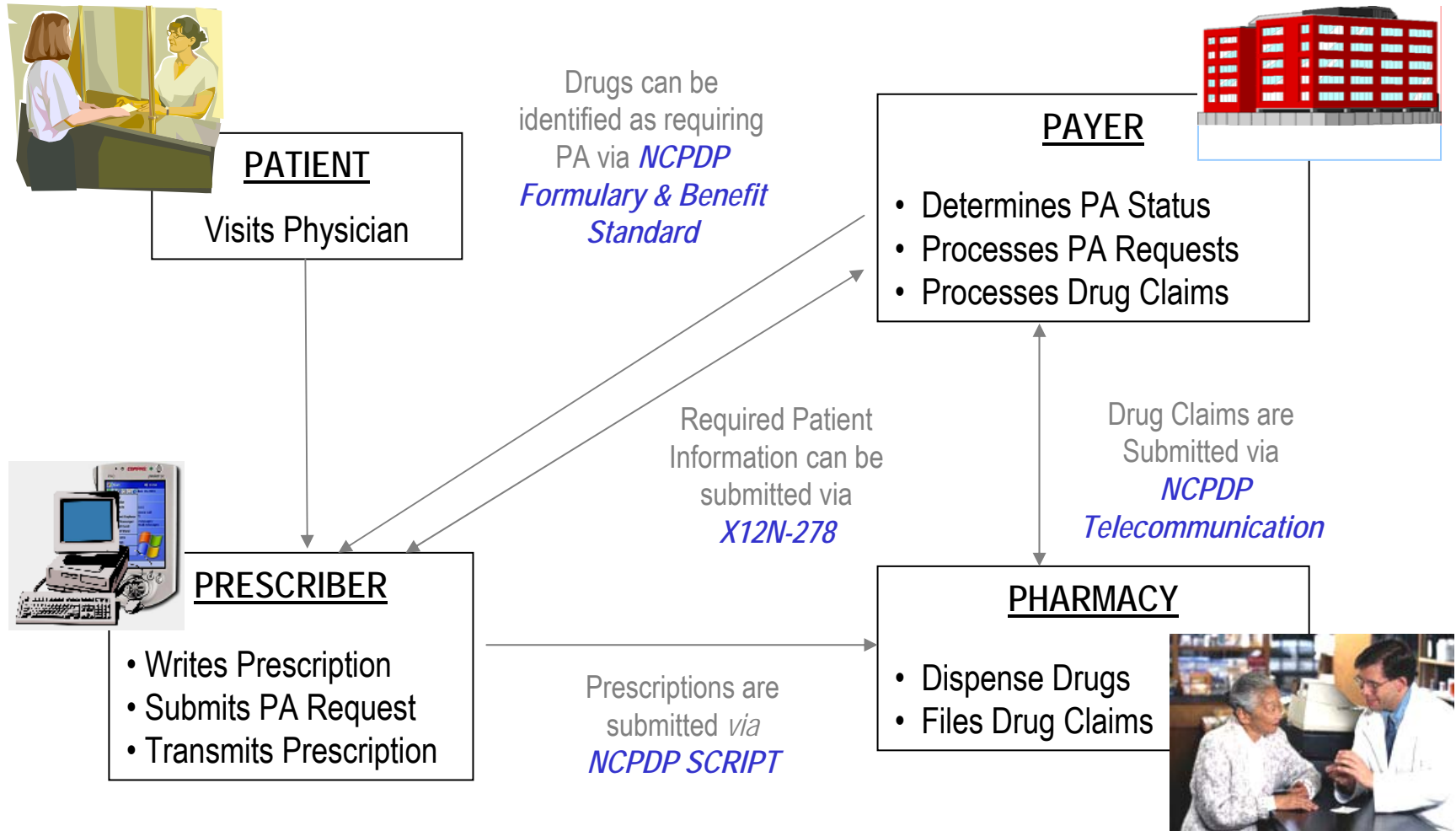
\_\_\_\_\_  
Prescriber or Authorized Signature

\_\_\_\_\_  
Date

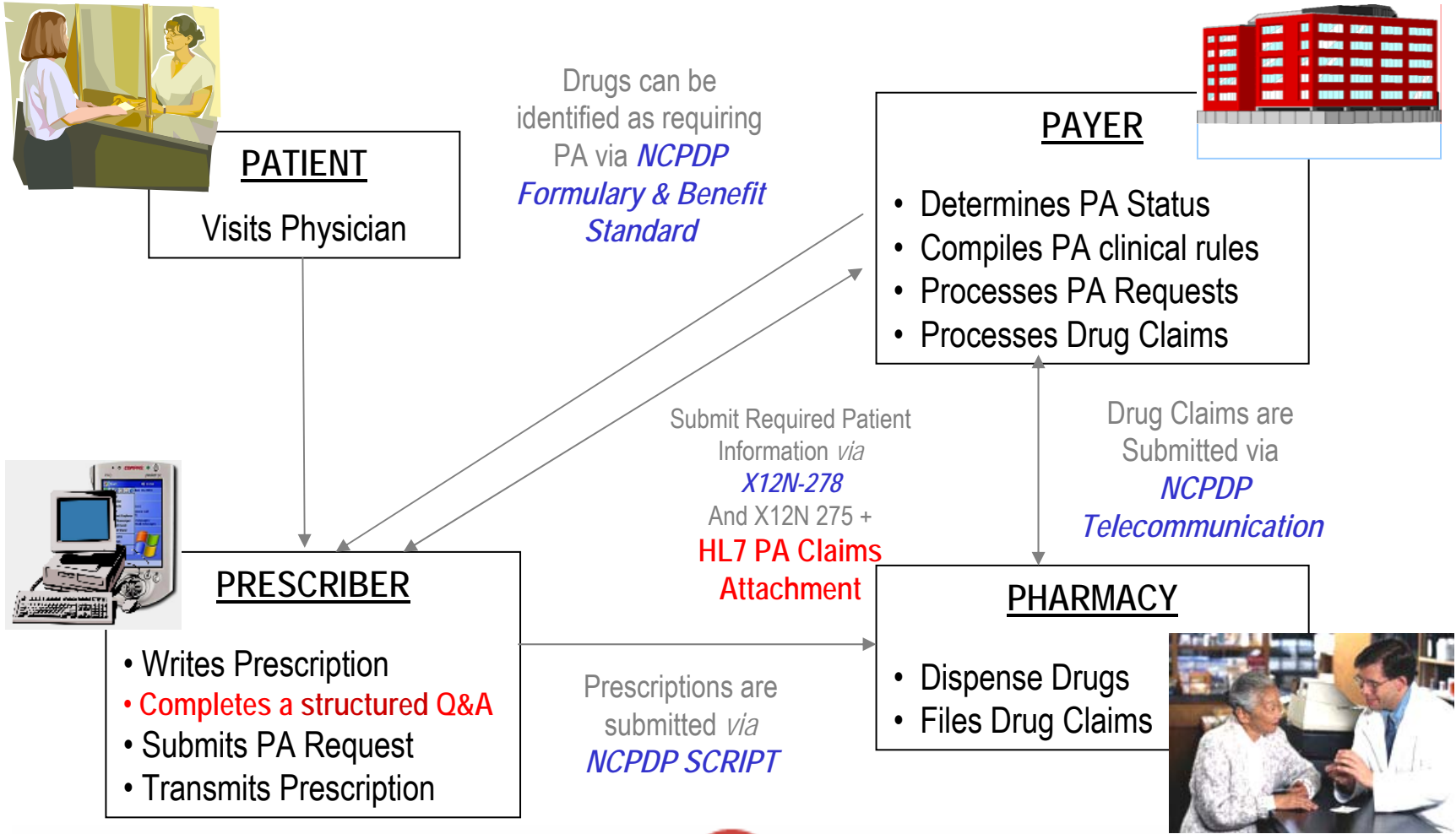
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician, only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.



# Existing ePA-Related Standards



# Straw Model



# Task Group Accomplishments

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- ▶ Mapped current prior authorization workflow
  - ▶ Ambulatory Environment
  - ▶ Long-term Care (LTC) Environment
- ▶ Leveraged AHRQ grant to analyze PA forms
  - ▶ Created database to support analysis
  - ▶ 350 forms / 1,750 questions / 53 payers
- ▶ Leveraged additional AHRQ grant to normalize data in the following therapeutic categories:
  - ▶ Erectile Dysfunction      - AntiFungals      - NSAIDs/Cox2s
  - ▶ Growth Hormones      - PPIs      - Opioid Agonists
  - ▶ Unspecified
- ▶ Formed separate task group to address PA in LTC
- ▶ Responded to CMS NPRM in support of claims attachments
- ▶ Developed guidance document, cross-reference for MMA pilots



# Task Group Accomplishments (cont.)

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- ▶ Chose five additional therapeutic categories for analysis/normalization
  - ▶ Antineoplastics - Respiratory Agents
  - ▶ Autonomic & CNS Medications - Topical Agents
  - ▶ Genitourinary Drugs
- ▶ Supporting the MMA ePrescribing pilot project PA initiatives
  - ▶ Held training session for how to read HL7 attachments & walk-through of PA Attachment
  - ▶ Encouraged and Facilitated Plans, PBMs joining task group
  - ▶ Production testing of PA trans in MMA pilots
- ▶ Supported modifications to X12N 278, 275
- ▶ Adjudicated ballot for HL7 PA Attachment



# Current Task Group Activities

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- Evaluating NCPDP F&B Standard for ability to carry criteria from plan to physician software system
- Normalizing additional therapeutic categories/drug sets
  - Tend to be focused commercially on high-volume, low-cost
  - CMS is providing list of its high-volume, low-cost
  - CMS has also asked that we look at high-cost, low-volume
- Reaching out to include other efforts to standardize paper PA forms (AMA, CMS two we're aware of)



# Other Standardization Activities

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- AHRQ-sponsored initiatives to research viability of using HL7 ANSI-accredited standard, Guideline Expression Language – Object-Oriented (GELLO) for:
  - Presentation of prior authorization criteria
  - Query mechanism to extract clinical data from HER
- Ad hoc team from Harvard, InferMed, POCP, Pfizer working with input from the FDA, National Library of Medicine, Department of Defense, Oracle, HL7
- One concept being tested: extracting criteria from the Structured Product Label
- Payers & PBMs continue to designate which drugs require PA, define information prescribers must submit



# MMA ePrescribing Pilots



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# Overview

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- RFAs released in September 2005
- Key components:
  - Must be conducted in CY 2006
  - \$6M available, no more than 9 funded, no award > \$2M
  - Cooperative agreements (coalitions)
  - Proposals evaluated by peer group
- At least 25% of population Medicare-eligible
- Testing EDI (vs fax) is critical
- Test the interoperability of Foundation and Initial Standards



# Foundation & Initial Standards

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## Foundation Standards

- ▶ SCRIPT (new Rx, renewal, change, cancel, admin functions)
- ▶ ASC X12N 270/271
- ▶ NCPDP Telecommunication

## Initial Standards

- ▶ Medication History
- ▶ Formulary & Benefits
- ▶ Structured & Codified SIG
- ▶ Prior Authorization (X12N 278)
- ▶ RxNorm (new Rx, renewal, cancel)
- ▶ SCRIPT (fill status)



# MMA Pilot Awardees

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- 1. SureScripts (Florida, Mass., New Jersey, Nevada, Rhode Island, Tennessee)**
  - ▶ Brown University, Allscripts, DrFirst, Gold Standard, MedPlus/Quest Diagnostics, ZixCorp, Brooks, CVS, RiteAid, Wal\*Mart and Walgreens
- 2. New Jersey ePrescribing Action Coalition**
  - ▶ RAND Corporation, Horizon Blue Cross Blue Shield, Caremark (PBM, mail, iScribe), Allscripts, RxHub, SureScripts, UMDNJ and Point-of-Care Partners, LLC
- 3. Brigham & Women's (Massachusetts)**
  - ▶ Brigham & Women's Hospital, Partners Healthcare, MA-Share, CSC, BCBSMA, RxHub, SureScripts
- 4. Achieve Healthcare -Long-term Care (Minnesota)**
  - ▶ Achieve, RNA Health Information Systems, Benedictine Health System, Preferred Choice Pharmacy, RxHub, Prime Therapeutics, BCBSMN
- 5. Ohio KePRO-UPCP**
  - ▶ University Primary Care & Specialty Physicians (UPCP), Ohio KePRO, InstantDx, NDC Health, RxHub, SureScripts, Qualchoice, Aetna, MGMA Center for Research and the University of Minnesota



# Early PA Pilot Observations

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- ➔ Pent-up demand among ambulatory physicians for ePA
- ➔ Plan pilot participant openness to modifying back-end PA systems, depending on findings, including standard
- ➔ Struggle between plan pilot participants who want maximum flexibility and SDOs who want standardized transactions
- ➔ Organizing drugs has proven to be a challenge:
  - ➔ No standard definition of therapeutic categories
  - ➔ Criteria may vary by drug by indication
  - ➔ Other variables: gender, age
- ➔ Desire for “yes/no” questions in normalized data set



# Early PA Pilot Observations (cont.)

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- Some LTC plan formularies have as many as 50% of drugs requiring PA
- In the LTC, PA is hypothesized to drive ePrescribing
- Source for coded indications not settled
  - ICD-9s won't work for one pilot
- Uncertainty over criteria “ownership,” change process
  - Standards development process lengthy & burden-some; PBMs have contractual commitments to their plan sponsors
- Should how data transmitted be the same as presented?
- Question as to whether, where to run rules
  - Sequence number added to transmission set



# Summary

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- ➔ Growth in healthcare spending is considered unsustainable, and HIT is viewed as a solution
- ➔ The pharmacy component has slowed, perhaps because of cost-containment efforts like PA.
- ➔ The PA process is inefficient and ripe for process improvement.
- ➔ Early efforts to automate PA have been ineffective because they were outside the prescribing process.
- ➔ The MMA is a key driver of ePA, leading to the formation of a task group and pilot testing.
- ➔ Findings may lead to ePA requirements, if prescribing electronically.



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# Appendix



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# ePrescribing by the numbers...

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**13%** MDs prescribing electronically

(Secretary Leavitt, 2006)

**85%** Pharmacies enabled for ePrescribing

(SureScripts, Medavant, eRx Networks, RxHub)

**5%** US hospitals using CPOE for Rx orders

(KLAS, 2005)

**24%** Outpatient EMR use

(National Center for Health Statistics, 2006)

**170 million** Lives for whom formulary & benefits are available through RxHub

**\$29 billion** Potential annual ePrescribing savings

(Center for Information Technology Leadership, 2004)



# Barriers to Widespread Adoption Still Exist

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- ➔ Who pays? There are still outstanding questions about the business model for ePrescribing
- ➔ Which vendors will succeed? No one wants to repeat the dot.bomb experience
- ➔ Standards development takes time
  - ➔ Stakeholder objectives often at odds
  - ➔ Development and approval process is painstaking
- ➔ Adoption/utilization still lagging. Critical mass exists in only a few regions
- ➔ ePrescribing is not yet an expected standard of care



# A Partial List of eRx Vendors

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- AllScripts
- Gold Standard
- Dr. First
- ZixCorp
- Medavant
- iScribe
- MedPlus
- Purkinje
- eHealth Resources
- Instant Dx
- RxNT
- HealthVision
- EZ Script
- Relay Health
- Axolotl
- Recare
- Phytel
- RxRite
- SafeMed
- Prematics
- Synamed
- DAW Systems
- OA Systems
- Bluefish



# A Partial List of Ambulatory EMR Vendors

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- Allscripts/A4Health
- EPIC
- GE Centricity
- NextGen
- Misys EMR
- Allmeds EMR
- AthenaHealth
- ComChart EMR
- Companion Tech
- Docs, Inc.
- Digichart
- eClinicalWorks
- Greenway
- iGreat
- iMedica
- Emdeon Intergy
- JMJ  
EncounterPro
- LSS EMR  
(Meditech)
- Physician  
Microsystems
- Medent
- MediNotes
- Synamed
- Acermed
- Bond
- Wellogic
- Digichart
- MedicWare
- Pulse
- MDanywhere
- Chartconnect

