Medicare Adopts e-Prescribing Standards
For Formularies—But More Tweaking Needed

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I hate to be a cynic, but the announcement by Medicare that it has finalized four “foundation” electronic prescribing standards was something a bit short of the monumental development that Department of Health and Human Services Secretary Mike Leavitt proclaimed it to be. He said that the new standards would “help pave the way for the widespread adoption of e-prescribing throughout the medical community.”

I’m not so sure. The truth is that the four standards, adopted for e-prescribing within the Medicare Part D outpatient pharmaceutical prescription program, have been in place and in use for a number of years. They are already the basis of the software products that are available to pharmacies and physicians who are brave enough to step into the wilds of e-prescribing. So there is nothing revolutionary about the Medicare endorsement.

Just for the record, the four newly “crowned” Medicare standards are (1) formulary and benefits, (2) medication history, (3) fill status notification, and (4) identification of health care providers.

There is no need to get into the technical mumbo jumbo inherent in these standards, all of which had previously been approved by the National Council for Prescription Drug Programs (NCPDP). Suffice it to say, each NCPDP information exchange standard will need additional tweaking if it is to provide the full range of information that pharmacists and physicians require.

That’s the case with the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1. It gives pharmacy benefit payers (i.e., Medicare Part D spon-
sors) a way to communicate a range of formulary and benefits information electronically to prescribers and pharmacies via point-of-care systems.

Lynne Gilbertson, Vice President of Standards Development for the NCPDP, says that the NCPDP Formulary and Benefits Standard allows for formulary information to be integrated into the physician’s clinical decision support and e-prescribing workflows, ostensibly with greater efficiency and detail than traditional pharmacy benefit payer (PBP) Web sites and provider manuals. However, everyone, including Medicare, realizes that the formulary standard has some important shortcomings:

First, the standard is designed for PBPs to transmit plan-level formulary and benefit information. This is important, because plan-level benefit data might or might not be reliable, depending on the individual patient’s circumstances. Thus, there is a need for “real-time” responses that address patient-specific benefits.

Second, the formulary standard is loosely constrained, because some PBPs have expressed an inability or an unwillingness to provide detailed coverage information via the standard. Inconsistency in the level of detail provided from one payer to the next obviously presents challenges at the point of care.

Ms. Gilbertson acknowledges that a balance needs to be struck between comprehensiveness and adoptability. The NCPDP task group, headed by Jeff Mays of MediMedia in Yardley, Pa., has worked hard to clarify guidance and enhance the Formulary and Benefit Standard beyond version 1.0.

“More input is continuously sought, and you don’t have to be a member of NCPDP to join the task group,” she notes.

Of course, standards don’t make much of a difference if no one buys the software that is built upon the standards. Right now, physicians who care for Medicare patients don’t have to use e-prescribing. If they do use it, they must use software that incorporates these new foundation standards. Again, most of the software already available does use NCPDP standards.

The problem isn’t related to the standards or the software but, rather, to the puny number of physicians and pharmacists who are technologically capable of prescribing electronically. It’s commonly reported that only 10% of physicians are using electronic health records, which generally have e-prescribing capability as one of their components.

Congress has been tossing around two different bills that would be helpful.

The Wired for Health Care Quality Act (S. 1693), sponsored by Senator Edward Kennedy (D-Mass.), passed a Senate committee last November and has been awaiting Senate floor action. The bill actually passed in the Senate in 2005; however, the House passed a different form of the bill, and the two houses could not agree on a compromise version. The legislation authorized $139 million in grants for fiscal year 2008 and 2009 to health care providers to buy software and hardware.

The other bill hasn’t even gotten out of the starting gate. The Medicare Electronic Medication and Safety Protection (E-MEDS) Act of 2007 (S. 2408) would give physicians up to $2,000 in its first two years to buy equipment as long as they use e-prescribing for a “threshold” level of prescriptions; however, this level is not defined in the bill. After January 1, 2011, the bill would reduce Medicare payments by 10% for evaluation and management of Current Procedural Technology (CPT) codes for physicians who could have written—but did not write—an electronic prescription.

Ms. Gilbertson says it might take time for the standards to get to the level they need to be and for the technology to become available to the people who can make the most of it.

“We are in what is like the early days of cell phones as far as e-prescribing,” she says. “In 10 years, it will be a no-brainer.”