DHHS Pushes to Expand E-Prescribing
Accessing Formularies in Health Plans Is a Major Problem

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Pharmacy groups are already jostling over requirements for Stage 3 of the electronic health records (EHRs) meaningful-use (MU) program. The standards do not go into effect until 2016. This past November, however, the Health Information Technology Policy Committee (HITPC) within the Department of Health and Human Services (DHHS) published a detailed list of potential Stage 3 (MU3) upgrades (from Stage 2). The possibilities include major challenges in compliance for hospitals and pharmacies, including in areas not covered by Stage 2 (MU2), such as formulary checks (i.e., selecting drugs according to the patient’s health plan). The Centers for Medicare and Medicaid Services (CMS) will decide how many of the HITPC’s final recommendations to include in a proposed rule. Stage 2 goes into effect on January 1, 2014.

Stage 2 and 3 requirements are part of the 2009 economic stimulus bill that included about $30 billion of incentive payments to physicians and hospitals—the “eligible providers”—over a period of 5 years to help them purchase software and hardware that would enable them to use EHRs efficiently and effectively. The incentive payments can run more than $1 million per year per hospital to start. These payments decrease each year over a 5-year period. Hospitals that qualified in 2011 will receive the highest total payments.

Retail and hospital pharmacies do not qualify as eligible providers, but they play an important role in helping hospitals and freestanding physician practices meet their core objectives in many required areas. This is because pharmacies not only serve as repositories for drug and formulary information but also as transmission points, as MU standards move from hospital and physician offices out to the home. For Stage 2, hospitals must comply with all 16 core objectives and must choose three menu objectives from a list of six. These include meeting measures in computerized prescriber order entry (CPOE) of medications and generating electronic prescriptions (e-prescriptions).

Stage 3 recommendations from the HITPC concerning pharmaceuticals are controversial. For e-prescribing, the Stage 2 standard says that more than 50% of all prescriptions written by eligible providers must be requested for a drug formulary and transmitted electronically. Stage 3 would keep the 50% requirement but would expand it slightly by adding the need to review the formulary for generic-brand substitutions.

At the macro level, two major problems concern whether physicians and hospitals will be able to obtain accurate formulary and benefit information for patients. First, EHR vendors that provide e-prescribing capability often use proprietary formulary software. Physicians, both in private practice and at the bedside in a hospital, may have difficulty connecting to a specific health plan, not to mention the patient’s pharmacy if outpatient status is involved.

Second, health plans have numerous formularies, maybe hundreds, for individual employers and individual plans, according to the state or locality. Even when physicians do connect to the health plan, they might not be able to view the patient’s formulary; some health plans might post only a couple of generic formularies.

One industry source says, “CMS should either choose a formulary and benefit standard that provides patient-specific formulary and benefit information that [e-prescribing] vendors must use or lay out the functionalities that the vendors need to meet in order to provide patient-specific formulary and benefit information.”

Another upgrade in Stage 3 would involve requests for prescriptions upon hospital discharge. In Stage 2, this is a menu item; hospitals may choose whether or not to meet the 10% floor. In Stage 3, this would become a mandatory core standard, and the 10% threshold would be increased to 30%. Pharmacy groups see this as a potential “in” for them. They want this requirement to be expanded to say that pharmacists should review medication orders and report that the orders were reviewed at the time of the transition, especially before e-prescriptions are transmitted. The Pharmacy e-Health Information Technology Collaborative also wants the CMS to mandate electronic bidirectional exchange in Stage 3 between pharmacists and physicians so that pharmacists do not have to call physicians to correct formulary mistakes.

Formulary checking is definitely a touchy issue. Many parties are pressing in different directions for expanding required electronic capabilities. Paul Uhrig, Chief Administrative Officer at SureScripts, supports formulary compliance but wants patients (through prescribers) to be able to override a formulary check—if in fact the physician can actually obtain the patient’s exact formulary. For example, a patient would be able to pay out of pocket for a brand-name drug without going through a timely, costly prior authorization process. That would save health plans, physicians, and hospitals a lot of money.

Hospitals are indeed worried about the cost of compliance with Stage 3 standards. Chip Kahn, President and Chief Executive Officer of the Federation of American Hospitals, says: “While we support continuing to advance meaningful use, we are concerned that so many of the objectives recommended in this Stage 3 Request for Comments will require significant additional investment by providers.”

Others with less self-interest are also raising questions about the cost of implementing MU, as noted in a recent Washington Post editorial.1 If this notion about cost gains widespread support, the CMS will have to crimp its MU3 proposal.

REFERENCE