
Electronic Prescribing Implementation Plan

**As Required By
H.B. 1966, 81st Legislature, Regular Session, 2009 and
the 2010-11 General Appropriations Act, S.B. 1,
81st Legislature, Regular Session, 2009)
(Article II, Health and Human Services Commission, Rider 51**

Health and Human Services Commission

December 1, 2009

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Executive Summary

Pursuant to H.B. 1966, 81st Legislature, Regular Session, 2009, and the 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, S.B. 1, Rider 51, 81st Legislature, Regular Session, 2009), the Health and Human Services Commission (HHSC) submits this implementation plan for electronic prescribing (e-prescribing) in Texas Medicaid and the Children's Health Insurance Program (CHIP). The goal of the e-prescribing plan is to support adoption and meaningful use of e-prescribing by Medicaid and CHIP providers that will improve the quality, safety, and efficiency of health-care services provided to individuals enrolled in Medicaid and CHIP.

E-prescribing is more than replacing paper prescriptions with electronic prescriptions sent directly by the prescriber to the pharmacy. E-prescribing is the computer-to-computer transfer of prescription, drug, benefit, and patient information among prescribers, pharmacies, and payers. This technology offers benefits to physicians, patients, and payers of health-care services. E-prescribing decreases the inefficiencies inherent in the manual prescription process, saving both time and money for patients, physicians, and pharmacists. Payers will also benefit from improved patient outcomes and greater compliance to program guidelines, which equates to reduced costs.

HHSC's goals for the implementation of an e-prescribing plan are as follows:

- Implement solutions that are widely accepted by stakeholders.
- Preserve provider choice by allowing providers to choose from multiple e-prescribing vendors and solutions.
- Provide information to policy makers and the public on the effectiveness of e-prescribing.
- Provide information and learning opportunities that assist prescribers and pharmacists in using e-prescribing in an effective and meaningful way.

Implementation Plan

In 2010, HHSC will perform the start-up phase and will:

- Obtain input from Medicaid and CHIP stakeholders on the implementation plan.
- Establish policy to:
 - guide implementation of health information exchanges used in e-prescribing;
 - protect patient privacy;
 - ensure patient consent is maintained; and
 - comply with appropriate data security requirements.

Also during 2010, HHSC will begin implementing the following:

- A connection between the Medicaid and CHIP systems and an e-prescribing network to enable sharing of essential health and program information with prescribers and pharmacies.
- A web-based e-prescribing solution that can be used by Medicaid and CHIP prescribers, at no cost, to prescribe medications for clients. This option may be attractive to small practices or rural providers.

In 2011, HHSC will begin the final two phases: evaluation and post implementation. During this process, HHSC will:

- Establish clear metrics and statistics to measure and report e-prescribing use and adoption across the programs.
- Assess program outcomes against expected program costs and benefits. Measures will include tracking:
 - e-prescribing adoption;
 - e-prescribing use; and
 - program changes resulting from e-prescribing (such as medication errors avoided, generic substitutions, etc.).

Based on the results of the evaluation phase and stakeholder input, other incentives will be examined and may be implemented during the post-implementation phase, as needed. In addition, a detailed post-implementation plan will be developed.

The estimated cost and savings expected from e-prescribing are directly dependent upon increasing its use by prescribers. The provider adoption rate is expected to be about six percent during the first year after implementation and 12 percent in the second year. Implementation costs are estimated at a little more than \$3.7 million all funds over the three-year period from fiscal year 2010 through 2012. If assumptions regarding program savings and provider adoption rates prove accurate, the program will begin to achieve a positive return on investment by the end of the third year.

Summary of E-prescribing Cost/Benefit Fiscal Year 2010-2012

	FY 2010	FY 2011	FY 2012
Total Cost	\$667,000	\$1,694,871	\$1,389,742
Total (Benefit)		(\$916,141)	(\$1,833,929)
Total Cost/(Benefit)	\$667,000	\$778,730	(\$444,187)
Federal E-prescribing Cost/(Benefit)	\$355,136	\$414,243	(\$236,264)
State E-prescribing Cost/(Benefit)	\$311,864	\$364,487	(\$207,923)

Introduction

This initial implementation plan for electronic prescribing has been prepared by the Texas Health and Human Services Commission (HHSC) in response to the following legislative direction.

1. H.B. 1966, 81st Legislature, Regular Session, 2009, directs HHSC to develop an electronic prescribing (e-prescribing) implementation plan under the Vendor Drug Program (VDP) for Medicaid and the Children's Health Insurance Program (CHIP). The plan is to be submitted to the Governor and the Legislative Budget Board (LBB) by December 1, 2009. The bill also requires HHSC to submit an update on the implementation plan by December 1, 2010.
2. The 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, S.B. 1, Rider 51, 81st Legislature, Regular Session, 2009), requires an e-prescribing implementation plan be submitted to the Governor and the LBB no later than January 1, 2010. The bill also requires HHSC to submit an update on the implementation plan by January 1, 2011.

The legislation tasks HHSC with:

- Developing standards for e-prescribing systems used by pharmacists, prescribing practitioners, pharmacy benefit managers, and health plans. These providers must comply when transmitting prescriptions and prescription-related information electronically.
- Establishing timeframes for e-prescribing systems to come into compliance with standards set by HHSC.
- Projecting expenditures and cost savings anticipated as a result of implementation of the e-prescribing plan for the 2010-11 biennium.

A third piece of e-prescribing legislation is H.B.1218, 81st Legislature, Regular Session, 2009, which directs HHSC to develop a health information exchange system for Medicaid and CHIP. The system will support and coordinate the exchange of health information for providers to prescribe medications electronically for Medicaid and CHIP clients. In developing e-prescribing solutions, HHSC must collaborate with providers and stakeholders, including the Electronic Health Information Exchange System Advisory Committee established in H.B. 1218, to ensure that e-prescribing solutions are integrated with standardized e-prescribing tools and systems currently in use by providers. HHSC may establish information exchanges with national e-prescribing networks and consider providing access to an Internet-based e-prescribing tool. H.B. 1218 further directs HHSC to identify and develop strategies to overcome barriers to and encourage the use of e-prescribing.

Background Information on E-prescribing

E-prescribing is the electronic transfer of prescription-related data among prescribers, pharmacies, and payers. It does not include the use of a facsimile or fax transaction. It supports

electronic messages regarding new prescriptions, prescription changes, refill requests, prescription fill status notification, prescription cancellation, and medication history.¹ E-prescribing also allows prescribers to obtain eligibility, drug coverage, and formulary information from the patient's insurer or payer.

E-prescribing reduces the potential for errors and increases safety by eliminating problems such as illegible handwritten prescriptions, data entry errors at the pharmacy, and reliance upon limited information about other medications the patient may be taking. E-prescribing is also more efficient as it can significantly reduce the need for calls between pharmacies and prescribers, and the wait associated with these call times. It can also reduce costs for payers since formulary information helps prescribers select drugs that are within the payer formulary requirements and substitution guidelines.

E-prescribing systems utilize a communication network to facilitate communication among pharmacies, prescribers, and payers. E-prescribing systems provide important information to the prescribers at the time of care. This capability helps prescribers make informed treatment decisions when prescribing medications for patients. The e-prescribing system may inform prescribers of limitations on prescription drug coverage, drug costs, and preferred drug information. Prescribers can use the system to access and review a patient's prescription drug history to ensure that any new prescriptions can be safely used with, and are non-duplicative of, existing prescriptions.

E-prescribing can be a stand-alone tool or included as a component of an electronic health record (EHR). Stand-alone tools are more affordable and offer significant benefits over written prescriptions, such as decision-support information, convenience, and increased quality and safety.

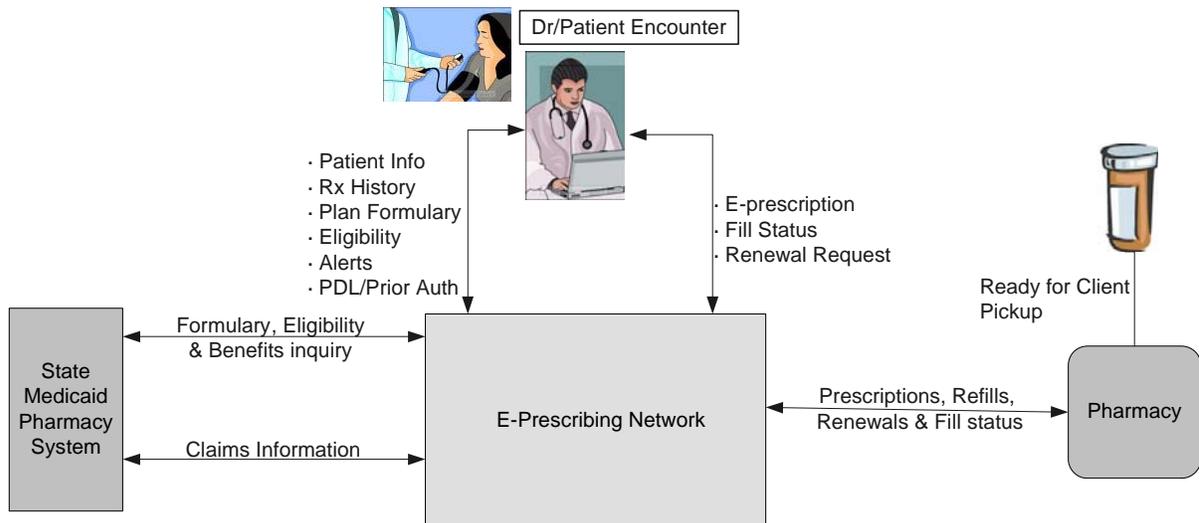
When e-prescribing is integrated with an EHR, the prescriber realizes increased efficiencies and effectiveness. For example, the prescriber is automatically alerted to relevant patient history such as drug allergies or history of adverse drug events. Because prescription drug documentation is automatically included in the patient's electronic health record, a prescriber has access to information not available with traditional, hand-written prescriptions. For instance, a prescriber can check the status of a prescription to see if it has been filled by the pharmacy and if it has been picked up.

¹ http://www.ncdp.org/pdf/Eprescribing_fact_sheet.pdf

E-prescribing Information Flow

The diagram below depicts the interactions among physicians, patients, and payers during electronic prescribing.

E-prescribing Data Exchange between Prescriber, Medicaid and Pharmacy Systems



Prescriber Adoption of E-prescribing

E-prescribing activity has been tracked by a national vendor, Surescripts, an e-prescribing network provider that operates nationwide. The network provider tracks and reports e-prescribing statistics by state based on the transactions that run on their network. In 2008, Surescripts reported that e-prescribing activity nearly tripled for Texas, rising to three percent of all prescriptions from just under one percent in 2007.² Nationally, the e-prescribing rate reported by Surescripts rose to almost five percent in 2008 from two percent in 2007. The e-prescribing network facilitates the three types of transactions described below. The level of activity for each transaction is tracked and reported to participating health plans, providing critical information for evaluating the level of adoption and use of e-prescribing.

- **Prescription Routing:** Prescribers can electronically route the prescription to the patient's choice of pharmacy. When the patient runs out of refills, the pharmacist can electronically send a renewal request to the prescriber's office for review and approval.
- **Prescription Benefit:** The ability for prescribers to electronically exchange information with payers and health plans. Prescribers can obtain drug coverage information (plan benefits) for clients enrolled in participating health plans.
- **Prescription History:** With patients' consent, prescribers can electronically access the patient's prescription history from payers and pharmacies.

² State Progress Report on Electronic Prescribing, December 31, 2008, Surescripts, www.Surescripts.com.

Approximately three percent of all prescriptions issued in Texas in 2008 were routed electronically between prescribers and pharmacies. Also in 2008, Texas prescribers submitted electronic requests for prescription benefit information for approximately seven percent of their patient visits.³ However, they only received responses for approximately half of those requests. The disparity between the numbers of electronic requests and corresponding responses shows that the number of health plans providing information to the network is not sufficient to provide a higher match rate on clients through the e-prescribing network. As more payers provide benefit information to the e-prescribing network, the variance between these two metrics should decrease. The metrics for prescription history requests and responses were not tracked by Surescripts prior to 2009. However, Surescripts began tracking prescription history transactions in 2009 and will begin publishing the results in early 2010.

A number of other state Medicaid programs have introduced programs aimed at increasing adoption of e-prescribing. Below is a summary of some of the approaches.

- Providing a web-based solution, which is available to all Medicaid and CHIP providers free of charge when prescribing for a Medicaid or CHIP client.
- Offering e-prescribing assistance directly to Medicaid and CHIP providers for successful adoption of e-prescribing. This may include assistance with software and/or hardware selection, installation, and customization; staff training; workflow analysis; and change management. Assistance with e-prescribing solution(s) offered to Medicaid and CHIP providers may be either partially or fully subsidized by Medicaid depending upon the provider's level of Medicaid business. Under this approach, Medicaid contracts with a technology vendor to consult with providers. Medicaid could use this approach to target specific providers such as high-volume Medicaid prescribers, small practices, or rural providers.
- Developing a preferred vendor list for Medicaid and CHIP providers to purchase e-prescribing solutions. Under this option, the state would issue a Request for Offer with specific state-defined criteria that would pre-qualify vendor solutions. Criteria may be based on network certification status, vendor discounts on cost, financial stability, quality assurance, or technical and operational support.
- Convening an e-prescribing consortium, with pharmacies, providers, and health plans to collaborate on e-prescribing adoption and use. Under this option, several entities would provide seed money and staffing to support consortium activities.

Overview of the Texas Vendor Drug Program

The Vendor Drug Program (VDP) provides outpatient prescription drug benefits for clients across the state through contracts with more than 4,200 pharmacies. The program covers clients enrolled in Texas' Medicaid program, CHIP, the Kidney Health Care (KHC) program, and the Children with Special Health Care Needs (CSHCN) Services Program. In fiscal year 2009, approximately 52,000 prescribers wrote 28 million prescriptions for 2.6 million eligible Texans. As a result, VDP paid claims total more than \$2.1 billion.

³ State Progress Report on Electronic Prescribing, December 31, 2008, Surescripts, www.Surescripts.com.

VDP functions are supported by systems that are currently operated and maintained by a vendor that serves as the pharmacy claims and rebate administrator (PCRA). The PCRA is responsible for processing pharmacy point-of-sale claims, billing for rebates, and performing all related activities including system and technical support. Four key sets of data are maintained by the PCRA that must be accessible electronically to support e-prescribing: pharmacy, client eligibility, client medication history, and covered drug information (also known as prescription benefit information). The PCRA system must be modified to provide this data to the e-prescribing network so that it can be accessed by and delivered to prescribers electronically.

First Health was awarded the PCRA contract in August 2005. In September 2009, HHSC announced that the PCRA contract has been tentatively awarded to Affiliated Computer Services (ACS) State Healthcare, LLC. The transition to the new vendor is expected to occur in September 2010. Therefore, enhancements to support e-prescribing will be implemented by the new PCRA vendor.

E-prescribing Strategy for the Vendor Drug Program

Goal

The goal of e-prescribing within VDP is to support adoption and meaningful use of e-prescribing across Medicaid and CHIP programs that will improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP.

Objectives

To successfully implement e-prescribing, the following achievements will need to be met:

- Implement solutions that are widely accepted by stakeholders.
- Preserve provider choice by allowing providers to choose from multiple e-prescribing vendors.
- Provide information to policy makers and the public on the effectiveness of e-prescribing.
- Provide information and learning opportunities that assist prescribers and pharmacists to use e-prescribing in an effective and meaningful way.

Opportunities

Two new federal incentive programs are generating significant opportunities for Medicare and Medicaid providers to adopt e-prescribing.

In 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which includes an e-prescribing incentive program. Under this program, prescribers are required to meet or exceed the two criteria related to Medicare patient volume and reporting in order to qualify for the annual incentive payment.⁴

The annual incentive payments are based on the e-prescriber's total annual Medicare payments. MIPPA provides incentive payments to prescribers who successfully adopt e-prescribing in

⁴ <http://www.cms.hhs.gov/pqri/downloads/pqrieprescribingfactsheet.pdf>

2011, 2012, and 2013. In 2014, Medicare payments will be reduced for Medicare providers who do not adopt e-prescribing. To the extent that some Medicare physicians are also Medicaid physicians, this incentive may increase e-prescribing usage among Medicaid providers.

In February 2009, Congress passed the American Recovery and Reinvestment Act (ARRA). It includes federal stimulus funding for Medicare and Medicaid providers who adopt and use electronic health records in a meaningful way. The federal government will adopt “meaningful use” measures to qualify providers for incentives. Meaningful use will include the use of e-prescribing. Under ARRA, providers can apply for reimbursement payments beginning in federal fiscal years 2011 through 2016.

These two federal incentive programs are aimed at accelerating provider adoption of e-prescribing. Since e-prescribing benefits are dependent upon the successful adoption of e-prescribing among prescribers, it is expected that these incentive programs will translate to increased benefits and savings to the e-prescribing program.

Barriers

The following conditions have been cited by prescribers as deterrents to adopting e-prescribing solutions in the practice and must be addressed in order to achieve HHSC’s e-prescribing goal:

- The Drug Enforcement Agency (DEA) regulates the prescribing of controlled substances. Currently, DEA rules do not allow e-prescribing of controlled substances. According to the Texas Medical Association, controlled substances account for about 20 percent of all the prescriptions written in the United States (including those covered by both public and private payors).⁵
- The Centers for Medicare & Medicaid Services (CMS) rules require a prescriber to include a handwritten message on the face of each Medicaid prescription when the brand name drug, and not the generic, is to be dispensed.
- CMS has adopted limited foundation standards for e-prescribing. However, these standards are relatively new and may change. In addition, several standards are yet to be adopted by CMS.
- Even with incentives, some providers will continue to resist adoption of electronic tools such as e-prescribing. This reluctance is due to the:
 - potential cost of purchasing, implementing, and supporting the tools; and
 - short-term disruption to current workflows and service delivery practices.

Compliance with E-prescribing Standards

The e-prescribing standards currently adopted by CMS for Medicare Part D (the Medicare drug coverage benefit) will be the baseline standards for e-prescribing for Medicaid and CHIP. All Medicaid and CHIP providers in Texas, including contracted pharmacies and prescribers, are strongly encouraged to move toward e-prescribing, but are not required to do so at this time. However, any providers who choose to utilize e-prescribing tools to prescribe or dispense drugs to Medicaid patients will be required to maintain compliance with CMS-adopted standards and

⁵ E-Prescribing Information for Patients and Physicians, Texas Medical Association, Austin, TX, 2009. http://www.texmed.org/uploadedFiles/Practice_Management/Computers_And_Software/ePrescribingEducation.pdf

timelines. Uniformity with the CMS standards and compliance timelines assures effectiveness of e-prescribing systems across the state and nationally. Details of the standards can be found on the CMS website.⁶

The tools and/or systems used by pharmacies, prescribers, and program benefit managers (including the VDP PCRA) must be connected to an e-prescribing network in order to exchange e-prescribing information. To ensure the integrity of the network, all e-prescribing, pharmacy management, and payer systems must be certified prior to connection to the network.

E-prescribing Implementation Approach

The implementation plan is a phased approach that spans three fiscal years - 2010, 2011, and 2012. Year one will include the start-up phase and begin the system implementation phase. The start-up phase includes working with stakeholders and developing e-prescribing policies. The system implementation phase includes two separate implementations. Each implementation will have planning and development activities in 2010. Both will become operational early in fiscal year 2011. The first implementation will connect the PCRA systems to an e-prescribing network. The second implementation will introduce a web-based e-prescribing tool. The evaluation and post-implementation phases will be initiated during fiscal year 2011 and continue through fiscal year 2012. These phases will focus on evaluating the e-prescribing program and incentives to encourage provider adoption and meet program goals and objectives.

Since e-prescribing requires the exchange of health information, HHSC's implementation plan starts with the development of program policies for health information exchange. HHSC plans to engage stakeholders in the development of policies to ensure that provider needs and concerns are taken into consideration. In particular, HHSC will seek the input of the recently-established Medicaid and CHIP Electronic Health Information Exchange System Advisory Committee. (H.B. 1218, 81st Legislature, Regular Session, 2009.)

In addition, HHSC must establish appropriate policies to ensure that e-prescribing tools can effectively and efficiently exchange health information, and also comply with current state and federal laws including, but not limited to, laws related to client privacy and data security. Medicaid and CHIP programs must also establish policies addressing e-prescribing standards for providers who choose to utilize e-prescribing. These providers will have to be in compliance with CMS standards. The policies that address health information exchange and standards compliance for e-prescribing will be included in the update of the Texas Medicaid Provider Procedures Manual, which is distributed to providers annually.

The first system implementation, which supports a number of e-prescribing solutions currently in use, will establish a connection between the PCRA system and a standardized, existing e-prescribing communications network in the nation. Currently, a significant number of payers, prescribers and pharmacies in Texas are already connected to a network. By connecting the PCRA system to the network, providers who are already using a network-certified e-prescribing tool can immediately obtain prescription support information from Medicaid and CHIP, such as prescription history and formulary information, when they submit e-prescribing requests for prescription benefits. As new networks become available, HHSC will evaluate their viability,

⁶ <http://www.cms.hhs.gov/eprescribing>

standards compliance, geographic coverage and number of subscribed providers to determine if it would be beneficial to include additional networks as part of the Medicaid/CHIP e-prescribing program.

In the second system implementation, Medicaid and CHIP will implement a web-based e-prescribing tool that can be used by any recognized and authorized Medicaid and CHIP prescriber with Internet access to electronically prescribe medications for Medicaid and CHIP patients. Since the web-based tool will be a relatively low-cost, low-technology solution, it may be particularly attractive to small practices and rural providers. Ideally, prescribers will access the tool through the Medicaid Eligibility and Health Information System (MEHIS). MEHIS is a new initiative that HHSC plans to implement in summer 2010. MEHIS will replace the current paper Medicaid identification form with a permanent plastic card. By using this card, health-care providers will be able to verify an individual's Medicaid eligibility and view the individual's Medicaid claims history electronically. By integrating the access, providers can use the features of MEHIS and e-prescribing with a single sign-on.

The implementation plan also includes an evaluation phase to establish measures and processes for monitoring and reporting e-prescribing activity, adoption rates, prescribing patterns, and program expenditures and savings. The results of the evaluation phase will assist HHSC in identifying the need for changes, including additional incentives to achieve e-prescribing targets.

During the post-implementation phase, Medicaid and CHIP will develop and roll-out additional incentive programs if needed. Options may include, but are not limited to the following.

- Pre-qualifying vendors that will offer low-cost, customizable e-prescribing solutions to prescribers. These solutions can be utilized for all patients, not just Medicaid and CHIP. This option could be partially subsidized by Medicaid and CHIP, but requires the provider to directly purchase from vendors.
- Providing financial incentives for pharmacies that enable e-prescribing. Financial incentives may include paying pharmacy transaction fees or subsidizing application upgrades.
- Providing a "per transaction" incentive to both pharmacies and prescribers. For example, the prescriber and pharmacy would be eligible for a small incentive payment for each Medicaid or CHIP e-prescription dispensed to the patient.
- Encouraging Medicaid managed care health plans to work with and reward providers who adopt e-prescribing.
- Contracting with one or more vendors to do outreach and provide technical assistance to prescribers and pharmacies that wish to e-prescribe. This option may require the vendors to focus on high-volume providers and/or providers in underserved areas of the state. Alternatively, the program may require providers to qualify for assistance by showing that they operate in an underserved area or meet a defined threshold of serving people receiving Medicaid and CHIP benefits.

Targets for E-prescribing Adoption

HHSC will establish target rates for use of e-prescribing and provider adoption. At a minimum, metrics to demonstrate e-prescribing usage will be tracked within Medicaid and CHIP. According to Surescripts, in 2008 the e-prescribing rate across all patient populations in Texas

was three percent (excluding controlled substances).⁷ For the purpose of this implementation plan, HHSC assumes e-prescribing rates will continue to rise in 2010, and could reach six percent by fiscal year 2011. HHSC also assumes that federal incentives will push the rate to 12 percent in 2012.

Prescriptions for controlled substances or for which a brand name is medically necessary cannot be routed electronically at this time. However, measurements that track the use of other e-prescribing transactions, such as eligibility verification, medication history, and formulary inquiries, would indicate the level of decision support being utilized for all prescriptions including prescriptions that cannot be routed electronically.

HHSC plans to obtain information on the use and adoption metrics to evaluate the e-prescribing program. These metrics include the number and percent of:

- client visits where medication history was delivered;
- client visits where formulary information was requested/delivered;
- total prescriptions routed electronically including new and renewed prescriptions;
- physicians routing e-prescriptions; and
- contracted pharmacies activated for e-prescribing.

In addition, there will be a number of other evaluation activities aimed at determining the impact e-prescribing has on prescribing patterns and program outcomes. Measures may be established to evaluate the prescribing safety and prescribing behaviors that impact prescription drug costs, such as the:

- Number and percentage of alerts delivered to the prescriber by alert type and prescriber response.
- Level of compliance to the VDP preferred drug list (PDL) among providers that e-prescribe compared to PDL compliance among providers who do not e-prescribe.
- Level of generic utilization among providers that e-prescribe compared to the generic utilization among providers who do not e-prescribe.
- Average number of prescriptions per patient per month.

E-prescribing Implementation Activities

A summary of implementation plan activities by phase is included below, followed by a timeline of the implementation plan.

Start-up Phase (December 2009 – August 2010)

- Finalize the implementation plan.
- Develop a stakeholder communication plan that supports ongoing input and feedback on the e-prescribing implementation plan from the Health Information Exchange Advisory Committee and other stakeholder groups.

⁷ State Progress Report on Electronic Prescribing, December 31, 2008, Surescripts, www.Surescripts.com.

- Develop options to overcome e-prescribing barriers including, but not limited to, federal requirements for handwritten prescriptions.
- Develop and submit appropriate advance planning documents to CMS to secure approval for enhanced federal funding on costs associated with implementing e-prescribing tools and related e-learning tools offered.
- Establish health information exchange policy to include compliance with e-prescribing standards.
- Update/develop provider handbooks and companion guides for e-prescribing.

Implementation Phase (March 2010 – November 2010)

- Perform continuous outreach and promulgate information on the e-prescribing program to providers.
- Stage one: design, develop, test, and implement the interfaces that connect the PCRA system to an e-prescribing network.
- Stage two: design, develop, test, and implement a web-based, certified e-prescribing tool that can be utilized by any prescriber to e-prescribe for Medicaid and CHIP clients free of charge. This phase may also include the implementation of an e-learning tool.
- Provide help desk support for troubleshooting e-prescribing network connections and web-tool assistance.

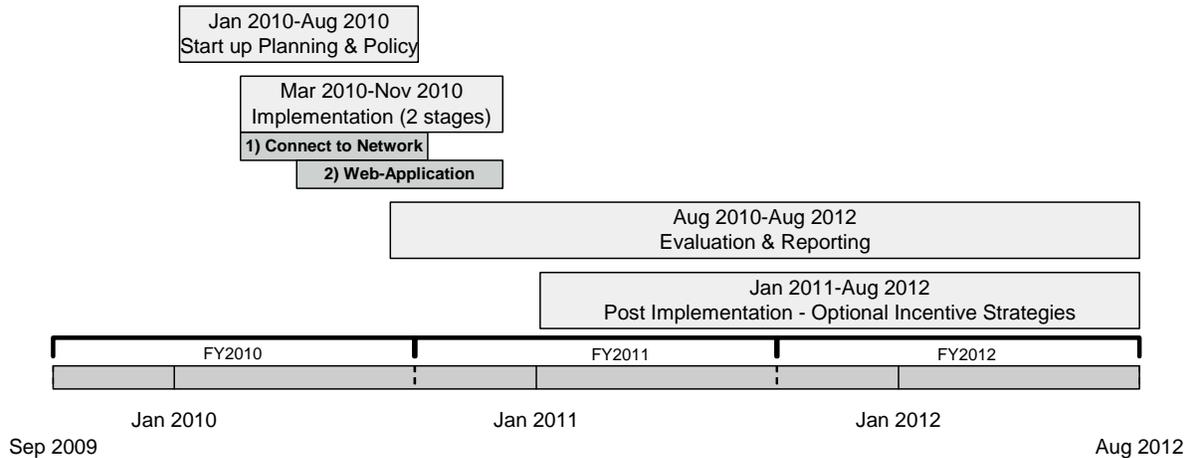
Evaluation Phase (August 2010 – August 2012)

- Obtain provider feedback throughout the implementation and post-implementation phases.
- Establish mechanisms for measuring and reporting adoption and usage rates, prescribing behaviors, and program savings.
- Establish baseline measures.
- Evaluate and report results throughout the evaluation and post-implementation phases.
- Prepare an updated implementation plan for submission to the Governor and the LBB as required by H.B. 1966 and the 2010-11 General Appropriations Act.

Post-Implementation Phase (January 2011 – August 2012)

- Manage e-prescribing contracts as necessary.
- Develop programs as necessary to encourage further adoption and use, including incentives.

Timeline for E-prescribing Implementation by Phase



Detailed Expenditures and Savings

Estimated Costs

Estimates of implementation expenditures include the following:

- Design, development, and implementation of the e-prescribing network connection and associated transaction fees.
- Design, development, and implementation of a web-based e-prescribing tool that includes e-learning.
- Outreach and ongoing education program and training for providers.
- Help desk support.

Estimated Benefits

Estimates of financial benefits associated with implementation of e-prescribing are dependent upon reaching the target rate of e-prescribing for each year. Savings estimates are conservative and are based on an analysis of national data and other states' experience with e-prescribing. Financial benefits are based on the following measures:

- Medication errors avoided due to e-prescribing.
- Increased compliance with the PDL.
- Increased generic utilization.
- Reduction in average number of prescriptions written per patient per month.

The total estimated implementation cost of an e-prescribing program in Medicaid and CHIP in fiscal year 2010 through fiscal year 2012 is just over \$3.7 million all funds. After accounting for federal matching funds, the estimated cost over the three-year period is just under \$500,000 general revenue. In fiscal year 2012, the estimated financial benefit to the state exceeds the estimated cost indicating that the state will begin to achieve a positive return on investment. It

should be noted that the cost and benefit estimates are based on certain assumptions. Once the program becomes fully operational, these assumptions will need to be monitored and adjusted to match actual program cost and benefit.

Cost/(Benefit) for E-prescribing Implementation for FY 2010 - FY 2012

	FY 2010	FY 2011	FY 2012
e-Rx Adoption Rate	0%	6%	12%
Estimated Costs			
Implementation Stage 1: Connection to network and related transaction fees	\$267,000	\$94,871	\$189,742
Implementation Stage 2: Web application with e-Learning	\$400,000	\$600,000	\$200,000
Provider education, training, help desk, and support		\$400,000	\$400,000
Post Implementation: Financial incentives/programs		\$600,000	\$600,000
Total Cost	\$667,000	\$1,694,871	\$1,389,742
Federal e-Prescribing Costs*	\$355,136	\$901,582	\$739,205
State e-Prescribing Costs*	\$311,864	\$793,289	\$650,536
Estimated Benefits			
Medication Errors Avoided		(\$156,000)	(\$312,000)
Improved Generics		(\$83,565)	(\$167,323)
Improved PDL Compliance		(\$60,600)	(\$121,200)
Fewer Prescriptions Written		(\$615,976)	(\$1,233,405)
Total (Benefit)		(\$916,141)	(\$1,833,929)
Federal e-Prescribing (Benefit)*		(\$487,339)	(\$975,469)
State e-Prescribing (Benefit)*		(\$428,802)	(\$858,460)
Total Cost/(Benefit)	\$667,000	\$778,730	(\$444,187)
Federal e-Prescribing Cost/(Benefit)*	\$355,136	\$414,243	(\$236,264)
State e-Prescribing Cost/(Benefit)*	\$311,864	\$364,487	(\$207,923)

* These amounts are based on the standard 50/50 federal/state match rate. However, HHSC intends to apply to CMS for enhanced matching funds that would result in a higher federal match rate.

The e-prescribing program will be funded with a combination of state and federal funds and program savings. The funding strategy includes:

- Utilizing funds received from a pharmacy benefit agreement with a pharmaceutical manufacturer in lieu of a PDL supplemental rebate to fund the state share of the e-prescribing program.

- HHSC will seek enhanced federal matching funds from CMS for the web-based e-prescribing solution as part of the Medicaid Management Information System (MMIS).
- Additional funding for the e-prescribing program, including incentives if needed, will be drawn from program savings.

Summary

HHSC has determined that e-prescribing will improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP. With this plan, HHSC demonstrates its intention to adhere to industry standards and develop e-prescribing capabilities that encourage and support provider adoption and meaningful use across the Medicaid and CHIP programs. A keystone of the e-prescribing plan is provider involvement. Throughout the implementation plan, HHSC will work collaboratively with providers to ensure successful and sustainable adoption. HHSC will implement an e-prescribing infrastructure that allows providers to choose from a variety of solutions. The e-prescribing implementation includes continuous evaluation so that the plan can be adjusted as necessary to achieve annual savings by the third year after implementation.