Case Study

Developing an Electronic Prescribing Incentive Program: Lessons Learned From New York Medicaid

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Technical Assistance for Health Information Technology and Health Information Exchange in Medicaid and CHIP

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Agency Overview

New York State's Medicaid program is the second largest in the country, covering more than 4.5 million New Yorkers (23 percent of the population). Sixty-nine percent of New York's beneficiaries are enrolled in a managed care program. The State's Medicaid program is administered by the Office of Health Insurance Programs (OHIP) under the Department of Health. The State's CHIP program, Child Health Plus, is separate from Medicaid and enrolls an additional 365,000 children.

Project Background

In summer 2008, New York Medicaid began developing an electronic prescribing (e-prescribing) incentive program aimed at reducing medication errors, encouraging practices that support better patient care and outcomes, and reducing costs. Effective May 1, 2010, New York Medicaid is offering incentives to encourage Medicaid providers to use e-prescribing. For each electronically prescribed medication, prescribing clinicians will receive $0.80 and the pharmacy will receive $0.20, contingent upon the patient picking up the prescription. This program is the result of 2 years of work by OHIP staff, working in collaboration with a wide range of stakeholders, to complete preliminary research, obtain legislative support, and implement the program.

Project Details

Planning Process

Led by OHIP, work to develop the e-prescribing incentive program began in summer 2008. A working group, including representatives from Medicaid, the Office of Health Information Technology Transformation (OHITT), the New York State Education Department (New York State Board of Pharmacy), and the Office of Public Health, met during 2008 to brainstorm parameters for the incentive program.

The committee completed extensive research prior to developing the program, including conducting an extensive literature review and financial modeling to predict cost savings. The

committee looked exclusively at the cost savings associated with avoiding medication errors. (For the purposes of the analysis, they did not consider what additional cost savings might accrue as a result of increased formulary compliance.) The committee estimated that each prescription transmitted electronically would save the agency $1.82, which includes the decrease in medication errors and costs of printing official New York paper prescriptions, which are currently distributed free of charge. The total cost savings were estimated based on the total volume of prescriptions dispensed.

The committee proposed that the cost savings be shared across three entities: the Medicaid agency, the prescribing clinician, and the pharmacy, with the prescribing physician receiving $0.80 per prescription and the pharmacy receiving $0.20 per dispensed prescription. This allocation was made with the knowledge that the pharmacies benefit from the increased efficiency associated with the transition to e-prescribing and that the pharmacy incentive would largely need to cover the transaction costs charged by e-prescribing networks and intermediaries, while prescribing clinicians would be responsible for a greater investment in technology. Pharmacies and prescribing clinicians also receive an additional incentive for refill prescriptions. For example, if a patient has a refillable prescription, the pharmacy receives the $0.20 incentive for up to five refills, or a total of $1.20 for the prescription. Prescribing clinicians would receive up to $4.80. If the patient does not pick up the medication, the incentive is not paid. Pharmacies are paid immediately as an add-on to the dispensing fee, and enrolled prescribing clinicians will receive a bundled payment quarterly.

The legislation authorizing the incentive program was passed as part of the 2009–2010 budget with broad bipartisan support. The legislation passed successfully and relatively easily because of several factors: extensive research the committee completed before drafting the legislation; careful review of the costs and benefits of e-prescribing (and presenting this information in a comprehensible and effective manner); and presentation of the solution as a win for all three parties (Medicaid, prescribing clinicians, and pharmacies). Although there was some debate about the allocation of the incentives, the research results allowed the committee to argue effectively for the structure they originally proposed.

Implementation Process

Following the passage of the budget and the legislation authorizing the incentive program, implementation efforts began in summer 2009.

Implementing the program required significant interaction with a wide range of stakeholders. To ensure alignment within the regulatory environment, the agency hosted scores of meetings with the Office of the Medicaid Inspector General (which oversees audits of pharmacies), the Bureau of Narcotic Enforcement, and the State Pharmacy Board, all of which are involved with the regulation of certain aspects of the prescribing process and pharmacists' conduct. Similarly, to ensure alignment across various constituencies, the agency hosted regular meetings with industry representatives, government officials, a major national intermediary, technical staff, policy experts, and lawyers.

During the initial rollout, it became clear that there was substantial confusion as to what e-prescribing actually entails. For example, there was extensive discussion about whether electronic faxes counted as e-prescribing (e.g., if the fax was sent and received via computer.)

After much discussion, the pharmacy and medical societies accepted the definition put forth by the agency.[1] Faxes are still a legal method of transmitting prescriptions, but faxed prescriptions do not qualify for incentive payments. In addition, pharmacy software vendors were not uniformly aware of Medicare Part D standards that had recently come into effect, requiring the use of a prescription origin code and the prescriber's individual national provider identifier (NPI). The agency also encountered resistance from the State medical society regarding the use of the NPI in the e-prescribing program.

Once the definition for e-prescribing was settled, the agency turned to the logistics of implementing the program, specifically, how would the pharmacies report the receipt of electronic prescriptions to receive the incentive payment? Coincidentally, Medicare Part D requires what is called a "prescription origin code" that identifies how a prescription was transmitted.[2] In order to receive the incentive payment, the prescription origin code as reported on the corresponding pharmacy claim would have to denote an electronic prescription (e.g., list a prescription origin code of 3). The State was able to leverage the fact that Medicare already announced that it would require a prescription origin code effective January 2010; by requiring it for Medicaid pharmacy claims as well, the agency was able to achieve compliance with all vendors in New York. As of July 1, 2010, Medicaid will deny pharmacy claims that are submitted without a valid prescription origin code.

New York Medicaid also strategically mandated the use of Medicare Part D data standards, thereby pushing the software industry toward a universal standard in New York. This strategy harmonizes nicely with the Office of the National Coordinator for Health Information Technology interim final rule (IFR), titled Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, for the Health Information Technology for Economic and Clinical Health Act (HITECH) program, which also requires the adoption of Medicare Part D data standards for the HITECH Medicare and Medicaid incentive programs. Hence, eligible professionals who participate in the New York Medicaid e-prescribing incentive program will have a jumpstart on meeting the e-prescribing component of meaningful use once the HITECH program goes live.

Next Steps

As the program moves forward, New York Medicaid will continue to address authentication issues and review other potential changes to the Federal regulatory environment that may impact the program, including DEA's final rule related to the electronic prescription of controlled substances.

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[1] New York Medicaid defines e-prescribing as: "a prescription created electronically and transmitted via encrypted, interoperable, computer-to-computer electronic data interchange in machine readable (non-facsimile) format that is compliant with Medicare Part D data standards and requirements and New York State Pharmacy Regulations." For additional information, please see the April 2010 New York State Medicaid Update, available at http://www.health.state.ny.us/health_care/medicaid/program/update/2010/2010-04_special_edition.htm

[2] The reference codes are numbered 0 through 4 and include not specified, written, telephone, electronic, and facsimile.

Lessons for Other Medicaid Agencies

New York Medicaid's success in building the incentive program was supported by the extensive research that was completed at the outset. The research enabled them to quantify the costs and savings of the incentive program and provided a neutral point of reference when questions arose about how the incentives should be structured. The research also proved useful in discussions with members of the State Assembly and Senate by allowing New York Medicaid to present the situation as a win-win-win for the State, providers, and pharmacies.

Intensive, repeated stakeholder engagement was also a key component to the success of the program. Because of the diverse, and at times divergent, interests of the stakeholder groups, frequent meetings were required to share concerns and make revisions to the program that were palatable and feasible for all parties.

Finally, New York Medicaid leveraged work at the Federal level, specifically the Medicare Part D standards. Since the prescription origin codes were already slated to be required for Medicare claims, it was straightforward for pharmacy software vendors to use the same standards for Medicaid claims as well. The vendor community was pleased with this requirement because it did not require compliance with a second set of standards.

Additional Information

For additional information about this case study, please contact Medicaid-SCHIP-HIT@ahrq.hhs.gov or call 1-866-253-1627.