July 25, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare program: Proposed changes to the Electronic Prescribing (eRx) Incentive Program; RIN 0938-AR00

Dear Dr. Berwick:

The Medical Group Management Association (MGMA) is pleased to provide these comments to the Centers for Medicare & Medicaid Services (CMS) proposed rule on the electronic prescribing (eRx) incentive program payment qualifications and adjustments. While we appreciate the attempt by CMS to expand the scope of exceptions to the 2012 payment adjustment, we believe that the program’s current and proposed reporting periods are flawed and additional corrections and modifications must be incorporated. Failure to do so will result in unfair Medicare payment adjustments in 2012 and 2013 for a significant number of eligible professionals (EPs) and could discourage physicians to see Medicare patients.

MGMA, founded in 1926, is the nation’s principal voice for medical group practice. MGMA’s nearly 22,500 members manage and lead 13,600 organizations, in which 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. MGMA’s core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians’ time and resources.

Originating legislation

Issue: Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Public Law 110–275, authorized the Secretary of Health and Human Services to establish a program to encourage the adoption and use of eRx technology. Implemented in 2009, the program offers eligible professionals (EPs) a combination of financial incentives and payment adjustments, defined under section 1848(k)(3)(B) of the Social Security Act.
In particular, MIPPA includes the following language in Section 132 pertaining to the payment adjustment process:

“(b) INCENTIVE PAYMENT ADJUSTMENT.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

“(5) INCENTIVES FOR ELECTRONIC PRESCRIBING.—

“(A) ADJUSTMENT.—

(i) IN GENERAL—Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012 or any subsequent year, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).”

“(iii) REPORTING PERIOD.—The term ‘reporting period’ means, with respect to a year, a period specified by the Secretary.”

**Recommendation:** We do not believe that Congress intended for CMS to establish an incentive program that would both reward and penalize an EP for their e-prescribing activity in the same year. We assert that MIPPA grants the Secretary considerable latitude in determining the appropriate reporting period for payment adjustment purposes. We urge CMS to exercise this statutory discretion and modify its current policy regarding the 2012 incentive program reporting period and the assignment of payment adjustments. Medicare pays the eRx incentive program payments retrospectively, the assignment of payment adjustments should conducted in a similar manner.

### 2012 payment adjustments based on 2012 reporting

**Issue:** CMS has developed a two-tiered reporting period for purposes of the 2012 and 2013 payment adjustments. EPs were required to submit a minimum of 10 qualifying e-prescribing events, on claims, from Jan. 1, 2011 to June 30, 2011 to avoid the 2012 payment adjustment and are required to submit evidence of 25 qualified e-prescribing events from Jan. 1, 2011 to Dec. 31, 2011 using any of the three approved methods: 1.) claims; 2.) use of a registry; or 3.) direct from the electronic health record (EHR).

**Recommendation:** We strongly recommend not imposing payment adjustments in 2012 and 2013 for 2011 e-prescribing activity. We assert that payment adjustments should be made in 2012 and 2013 based strictly on the EPs and group practice’s e-prescribing activity in 2012 and 2013 respectively. For the 2012 incentive program and payment adjustment, this could be done either by developing a Jan. 1, 2012 to Dec. 31, 2012 reporting period, or alternatively, a Jan. 1, 2012 to Oct. 31, 2012 reporting period. For purposes of the 2013 incentive program and payment
adjustment, the reporting period could be Jan. 1, 2013 to Dec. 31, 2013, or alternatively, Jan. 1, 2013 to Oct. 31, 2013. Just as the incentive program payments are, the payment adjustments can be assigned retroactively. Modifying the reporting periods will provide additional time for CMS, trade associations and professional societies to educate EPs on the eRx program requirements.

Alternative 2011 reporting periods

**Issue:** While we applaud CMS for providing additional hardship exemption categories in 2011 for EPs and group practices so that they can avoid the 2012 eRx payment adjustment, we believe that in addition to these new exemption categories, CMS must revisit and revise the reporting periods themselves.

**Recommendation:** CMS identifies a “successful” EP e-prescriber in 2011 as one who submits a minimum of 25 e-prescriptions from a qualified system to Medicare patients. The reporting period for submitting these e-prescriptions is from Jan. 1, 2011 to Dec. 31, 2011. It appears patently unfair to impose a payment adjustment in 2012 on an EP who was a fully successful e-prescriber in 2011 and potentially in 2012 as well. We therefore recommend that if the agency does not utilize a 2012 reporting period for purposes of determining the 2012 payment adjustment, at a minimum, the agency should extend the reporting period for purposes of the 2012 payment adjustment from Jan. 1, 2011 - June 30, 2011 to Jan. 1, 2011 – Dec. 31, 2011. Payment adjustments can always be calculated in 2012 and applied retroactively based on actual 2012 payments.

Claims-based reporting and the 2012 payment adjustment

**Issue:** CMS required EPs to report a minimum of 10 e-prescribing events to Medicare patients using the claims-based reporting approach between Jan. 1, 2011 and June 30, 2011 in order to avoid the 2012 payment adjustment. Use of registries or direct submission from an EHR is not permitted. Requiring submission of the G codes on claims runs contrary to the expressed goal of Congress and the Administration in developing this and other health information technology (HIT) incentive programs.

**Recommendation:** We urge CMS to revise its policy regarding the 2012 payment adjustment reporting period and recognize that in order to harmonize the various HIT incentive programs, it must permit EPs and group practices to submit the appropriate G codes using claims, registries or directly from an EHR.

Certification and qualifying systems

**Issue:** CMS proposes expanding the definition of a qualifying eRx system so that EHR technology under the Medicare/Medicaid EHR incentive program can be recognized as a qualifying system under the eRx program. For the purposes of reporting the current eRx quality measure during 2011 for incentives and for
avoiding the 2012 eRx penalty, CMS has indicated that nothing precludes eligible professionals (or a group practice) who already have certified EHR technology that meet the four functionalities described above from using that technology for the eRx Medicare incentive program. CMS further indicates that if it finalizes the proposed rule later this year, using certified EHR technology will be acceptable for eRx in future reporting years even if the certified EHR does not meet the four specific functionalities.

**Recommendation:** We strongly support CMS’ proposal to recognize EHR technology certified under the Medicare/Medicaid EHR incentive program as a qualifying system under the eRx incentive and penalty programs. This recognition is an example of the importance of synchronizing the overlapping eRx and EHR programs so that EPs do not have to purchase an eRx system just to avoid penalties, and can invest in certified EHR technology that does more than just enable eRx. However, we strongly encourage the expansion of this provision to include the purchase in 2012 of EHR technology certified under the Medicare/Medicaid EHR incentive program to either qualify for the eRx incentive program bonus in 2012 and/or avoid the 2012 payment adjustment.

**Additional hardship exemption categories**

**Issue:** The proposed rule identifies additional hardship exemption categories. These include:

- The EP is registered to participate in the Medicare or Medicaid EHR incentive program and has adopted certified EHR technology.
- The EP is unable to e-prescribe due to local, state, or federal law or regulation.
- The EP infrequently prescribes (e.g., prescribe fewer than 10 prescriptions between January 1, 2011 – June 30, 2011).
- There are insufficient opportunities to report the eRx measure due to program limitations.

**Recommendation:** We support both the existing exemption categories and each of the new proposed exemption categories for EPs. We also support the creation of more general exemption categories and CMS’s to assessment of exemption requests on a case by case basis given that EPs have varying practices and must comply with varying state and local requirements. However, we recommend CMS expand these exemptions categories to include the following:

- “Registered to participate in the Medicare or Medicaid EHR incentive program and has adopted certified EHR technology,” exemption category - EPs who have registered to participate in the EHR incentive program in 2012 and have adopted certified EHR technology should not be subject to a 2012 payment adjustment. This would help in further harmonizing the two incentive programs. In addition, EPs should be permitted to provide the serial number or certification number of the certified EHR technology or any
other appropriate information to verify that the specific EHR product has been purchased in 2011 or 2012 for the Medicare or Medicaid EHR incentive program.

Further, an EP who attests to being a meaningful user under the CMS Medicare or Medicaid EHR incentive program should be exempt from any payment adjustment under the eRx incentive program. Finally, those EPs who have attested to being a meaningful user for purposes of the Medicare or Medicaid EHR incentive program should not be required to submit a hardship exemption form. As CMS is clearly requiring the interoperability of provider systems, the agency itself should develop the capability to harmonize the capturing and processing of provider information to and from multiple CMS-administered incentive programs.

- “There are insufficient opportunities to report the eRx measure due to program limitations” exemption category - We believe it is imperative that the agency permit an EP that e-prescribes for their patient but the e-prescription does not occur on the same day of the encounter with the patient would be eligible to apply for this eRx exemption. This should also include but not be limited to situations such as where surgical specialties utilize global billing and anesthesiologists or pain physicians submit claims for outpatient or office visits to Medicare, but do not normally write any prescriptions associated with those visits.

- “Inability to electronically prescribe due to local, state, or federal law or regulation” exemption category - We encourage CMS to permit EPs who are unable to e-prescribe controlled substances because their e-prescribing software is not yet compliant with the DEA and/or state requirements to apply for this exemption.

Submission of the hardship request

**Issue:** CMS proposes to permit EPs or group practices to submit a hardship request via a Web-portal tool by Oct. 1, 2011. While we appreciate the additional time provided by the agency to submit these requests, we believe it is important to highlight an important issue. When we raised our concerns in late 2010 regarding the CMS decision to identify Jan. 1, 2011 to June 30, 2011 as the reporting period used to calculate the 2012 payment adjustment, agency officials responded repeatedly by saying that they required a full six months to capture the data and determine what EPs would be subject to the penalty adjustment. In this rule, CMS proposes an Oct. 1 deadline for submission of hardship requests, making it clear that it has the capability of completing this calculation in far less time.

**Recommendation:** Should CMS not adopt the more reasonable approach of utilizing 2012 e-prescribing activity to determine the 2012 payment adjustment, we strongly encourage the agency to extend the time period in which EPs and group practices can submit hardship requests to Dec. 31, 2011. Further, CMS should permit EPs to...
submit their hardship requests using phone, in writing, and directly via a web portal. In addition, we support the proposal to limit the information that an EP or group practice would be required to include in an exemption application. It appears reasonable to require identifying information (e.g., TIN, NPI, name, mailing address and e-mail address of all affected eligible professionals), one or more of the significant hardship exemption categories that apply, a brief justification statement, and an attestation of the accuracy of the information provided. We also concur that once CMS has completed its review of the EPs request for an exemption, that it notifies the EP or group practice within two weeks.

In addition, we strongly encourage CMS to develop a process that permits EPs and group practices to designate an individual responsible for submission of all to submit hardship exemption applications for multiple EPs at once.

Further, we are very concerned about the proposal to permit EPs and group practices only five business days following publication of the final rule (assuming it is published after Oct. 1, 2011) to submit a hardship exemption request. It takes a significant amount of time to educate EPs and group practices on this type of comprehensive CMS policy modification. We recommend extending the time period to submit a hardship exemption to 180 days.

Establishment of an appeals process

**Issue:** Currently, CMS offers no appeals process for EPs and group practices it deems to not to have met the eRx incentive program requirements and/or denied their hardship request.

**Recommendation:** We encourage the agency to establish a process that would permit EPs and group practices to appeal their eprescriber designation or their rejected hardship request. This appeals process should be automated and streamlined to the greatest degree possible and permit EPs and group practices to submit appeal requests by phone, in writing, and directly via a web portal.

Good Faith Incentive Program participation

**Issue:** EPs and group practices who participated in the eRx Incentive Program in good faith, but encountered problems in their use or submission of G codes. It is important to note that CMS prohibits the resubmission of claims for the purpose of correcting an improper G code.

**Recommendation:** Prior to incurring a payment adjustment, EPs and group practices should be provided the opportunity to explain that they participated in the incentive program in good faith but were unable to meet the program requirements due to data submission errors. These EPs and group practices should be permitted additional time submit the appropriate G codes to qualify for the incentive and/or be exempt from the 2012 payment adjustment.
Increased incentive program harmonization

**Issue:** EPs are increasing their adoption of EHRs into their practices. The harmonization of federal HIT incentive programs will be critical to their overall success. This sentiment was clearly articulated in the Government Accountability Office’s (GAO) February 2011 report *Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology.* In that report, the GAO concluded that CMS must encourage physicians and other providers in the eRx incentive program to adopt certified technology and that CMS should expedite efforts to remove the overlap in reporting requirements for EPs who may be eligible for incentive payments or subject to penalties under both programs. As stated previously, we strongly encourage CMS to develop the capability to harmonize the capturing and processing of provider information to and from multiple CMS-administered incentive programs.

**Recommendation:** We believe it is critical for CMS to adopt the GAO’s recommendations and pursue reasonable, achievable requirements aligned with those for the various incentive programs currently underway to simplify the process for all EPs, and coordinate educational outreach efforts.

Provider education

**Issue:** We believe that significant provider outreach and education will be critical to ensure EPs’ awareness of the significant modifications to the eRx program requirements, including the additional exemption categories.

**Recommendation:** We urge CMS to collaborate with MGMA and other provider organizations to develop uniform outreach materials in a timely manner as the October 1, 2011 deadline rapidly approaches.

Conclusion

In conclusion, we appreciate the additional flexibility CMS has proposed adding to the eRx incentive program. However, we remain concerned that methodology developed by the agency to assign payment adjustments will unfairly penalize EPs and group practices and must be substantially revised. We strongly encourage CMS to avoid establishing reporting periods in one year for application to the next year. Any payment adjustment assigned to an EP or group practice should appropriately reflect the eprescribing activity in that particular year.

In addition, should CMS not revise the current 2012 reporting period, we believe it is imperative to modify the current hardship exemption categories and processes to grant EPs and group practices additional opportunities to avoid the 2012 payment adjustment. Finally, CMS should take the necessary steps to harmonize the myriad
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of federal HIT incentive programs to avoid duplication of effort in reporting requirements for EPs who may be eligible for incentive payments or subject to penalties under both programs.

We thank you for the opportunity to provide comments on CMS' proposed changes to the eRx incentive program. Should you have questions about these comments, please direct your inquires to MGMA's senior policy advisor Robert Tennant at rtennant@mgma.org or 202.293.3450.

Sincerely,

[Signature]

William F. Jessee, MD, FACMPE  
President and Chief Executive Officer