



September 23, 2008

Mr. Kerry Weems
Acting Administrator
Department of Health and Human Services
Center for Medicare and Medicaid Services
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20210

Dear Mr. Weems:

The American Medical Group Association (AMGA) represents 335 medical groups and organized systems of care, including some of the nation's largest, most prestigious integrated healthcare delivery systems. More than 91,000 physicians practice in AMGA member organizations, providing healthcare services for nearly 1 out of 4 Americans (including 15 million capitated lives).

We applaud Congress' inclusion of e-prescribing (eRx) incentives in the Medicare Improvements for Patients and Providers Act (MIPPA). Incentivizing eRx furthers Medicare's transformation to a value based purchaser of care. AMGA was the first physician association to support eRx legislation.

However, we are concerned that if the Centers for Medicare & Medicaid Services (CMS) requires claims-based reporting (PQRI measure 125) to qualify as a "Successful Electronic Prescriber" (SEP), many multi-specialty medical groups, which have already made investments in eRx and electronic medical record (EMR) systems, will not be willing or able to participate. This would be contrary to Congress' intent to reward providers who e-prescribe.

Congress specifically provided the Department of Health and Human Services with the statutory authority to receive input from the provider community as it considers and develops quality measures, including eRx measures. We urge CMS to exercise this authority to consider more logical and less burdensome options for reporting eRx usage, such as an attestation procedure that we describe below.

Claims-Based Reporting for eRx

Claims-based reporting presents a major barrier to qualifying as a SEP for multi-specialty medical groups and other organized systems of care with existing EMRs. Claims-based reporting was and remains the only reasonable approach to accept quality data from solo physicians and small group practices. For large multi-specialty medical groups, however, retooling existing, sophisticated, often proprietary software, modifying business processes, and



training personnel is expensive and disruptive. It competes for resources and attention with quality improvement efforts to improve patient outcomes. Estimates range in the hundreds of thousands of dollars to create the necessary interfaces for medical group EMR systems to abstract the required data and to place the corresponding G codes onto claims.

Moreover, large medical groups transmit thousands of electronic prescriptions per month. One of our members, a mid-sized medical group with 125 physicians, electronically transmits 7,000 prescriptions per month. Another AMGA member, a large integrated system with 700 physicians, has transmitted more than three million electronic prescriptions since January 1, 2008. Requiring medical groups with this type of eRx volume to attach G codes to the claims for the encounters where each prescription was generated is highly inefficient and an unnecessary burden. In fact, prescriptions are often generated in the absence of a billable encounter, which underscores the illogic of claims-based reporting.

eRx Measure Requirements

AMGA is also concerned about the requirements of PQRI Measure 125, HIT-Adoption/Use of e-Prescribing. As currently specified, this measure requires providers to have a qualified e-prescribing system that is capable of: generating a complete active medication list incorporating data received from applicable pharmacy drug plan(s) if available; selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks; providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any); and providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

Unfortunately, full compliance with this measure depends on many factors external to physicians, such as the availability of detailed formulary and cost data for individual health plans or the ability of drug plans to process authorizations electronically. In surveying many AMGA members, we learned that many groups could not meet, in the strictest sense, all four numerator elements of this measure. Yet these medical groups are achieving substantial benefits, in terms of patient safety, overall practice efficiency, and even physician and patient satisfaction, from their eRx systems, even though external factors preclude their full compliance with measure 125.

If large multi-specialty medical groups cannot meet the measure's requirements, it is not unreasonable to believe that few physician practices will. We support the legislative intent of MIPPA, to stimulate acquisition, implementation, and use of eRx. We strongly urge CMS to set performance measures at achievable levels, in order to have the maximum effect in terms of promoting policy objectives.

Attestation Mechanism for Reporting Structural Measures

eRx measure #125 is a structural measure. We believe it is illogical to report structural measures on a per-encounter basis. Moreover, the current specifications for both of these measures focus on the *capabilities* of the respective systems, not how they are actually used.



Attestation is a more logical and efficient way to report structural measures, and it could be structured to allow CMS to assess the use of these technologies, not merely their capabilities. AMGA proposes that an attestation process be developed and made available to practices that meet certain criteria, as detailed below.

There is a well-established precedent for attestation in other areas of the Medicare program (including provider-based entity attestation and therapy cap exceptions). CMS could use the criteria offered by AMGA in this letter to determine medical practice eligibility to attest to their use of eRx. This eliminates the barrier to participation that claims-based reporting at the encounter level that using G codes presents, and it allows CMS to recognize advanced modes of practice.

Proposed Attestation Criteria for eRx Adoption and Use

Attestation should be submitted annually to aver and avow that prescriptions are written electronically in at least 50% of instances where permissible by Federal and State law; that the volume of monthly scripts written exceeds 2,000 per medical group or organization; that safety checks are routinely used (i.e., available in the software and not disabled) to address potentially inappropriate dosages, routes of administration, and contraindications; that the system maintains an active list of patient allergies and cross-checks prescriptions against allergies; that the system is capable of generating an active medication list and is capable of incorporating electronic data received from pharmacy drug plans, if available; that information is provided to patients about the availability of lower cost, therapeutically appropriate alternatives, as available; that formulary medications, patient eligibility and authorization requirements are received from the patient's drug plan electronically, or by other timely means, as available.

MIPAA Provision for Reporting eRx through Part D Claims

We note that MIPPA includes another approach to reporting eRx. Section 132(a)(2)(B)(iii) states:

“REQUIREMENT FOR ELECTRONICALLY PRESCRIBING UNDER PART D.—The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).”

This language provides the authority for CMS to utilize Part D claims data to determine if physicians are prescribing a sufficient number of prescriptions electronically. AMGA urges CMS to move forward with implementation of this provision, either in parallel with our proposed attestation mechanism, or as an alternative to it.

This would be an elegant system, a “passive” approach that would allow CMS to gather and extract needed data without prescribers having to key, code or submit data and not requiring per-encounter HCPCS codes for this structural measure. This broadly phrased statutory text implicitly suggests modification of the claim transaction standard to accommodate fields that



would meet the data requirements needed to accomplish such a “passive” system of quality reporting.

We hope CMS will consider these alternatives in order to achieve both the intent and the letter of the law. If we can provide you with any additional information regarding this matter, please contact Chet Speed at 703 838-0033, ex. 364 or cspeed@amga.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher", is positioned above the typed name.

Donald W. Fisher, Ph.D.
President and CEO
American Medical Group Association