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April 30, 2009

Mr. Harry Reynolds
Chair
National Committee on Vital and Health Statistics
3311 Toledo Road, Room 2341
Hyattsville, MD 20782

Dear Mr. Reynolds:

I am writing to follow up on my public testimony at yesterday's hearing on meaningful use of electronic medical records (EMRs) under the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA). Before I continue, I would like to congratulate the Committee on a very successful hearing on this critically important topic. The two days of detailed presentations from public- and private-sector leaders provided the kind of substantive input the Federal government will need to create the parameters for this threshold issue.

As I stated yesterday during open comments, there is significant confusion in the marketplace around the relationship of ARRA incentives to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) ePrescribing incentives.

Specifically, we are aware that some industry stakeholders are interpreting ARRA to indicate that if a physician accepts MIPPA ePrescribing incentives, he or she may not accept the ARRA EMR incentives under Medicare. Since the possible compensation for ARRA EMR incentives is much larger[1], we are seeing physicians wait to upgrade their EMRs to more modules that have MIPPA-compliant ePrescribing modules, delay purchasing EMRs or decide not to purchase an ePrescribing system. We do not believe that this was the intention of Congress because it creates policy consequences that will adversely impact Medicare providers and ePrescribing adoption.

**Can the Federal government clarify this?**

There are many reasons why this is important. First, this policy interpretation will penalize providers who adopt stand-alone ePrescribing systems or upgrade to MIPPA-compliant ePrescribing modules, in good faith, using the MIPPA incentive to support this investment. Under this policy interpretation, they will be unable to migrate to EMR —the intent of ARRA—because they will be ineligible for ARRA EMR incentive payments. Without that financial support, they will be unable to afford this expensive technology. At the same time, under ARRA provisions, they will have their Medicare financial payments reduced in the out years if they do not adopt EMRs. This would put Medicare providers in an untenable position that we believe the Congress did not intend. Moreover, Medicaid providers are not similarly impacted, which again disadvantages Medicare providers.

In addition, if this interpretation is correct, it will create a perverse incentive for Medicare providers to not take advantage of the MIPPA incentives and delay ePrescribing adoption until the infusion of the ARRA incentive payments. (Even if they can receive both MIPPA and ARRA incentives, some may wait to see the definition of ePrescribing under Meaningful Use before purchasing

[1] Note: ARRA Medicare incentives can be $44,000 if a physician begins in 2011. On the other hand, we would estimate that an ePrescribing physician with 30% Medicare patients could earn $10K from 2009-11.

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Surescripts testimony attributed the dramatic surge in ePrescribing adoption in 2008 to the MIPPA incentives, so we know the MIPPA incentive payments are working. However, we believe that unless the confusion is clarified quickly and communicated to the provider community, providers may delay ePrescribing adoption.

If this interpretation is accurate, I made the suggestion during my comments that it might be possible to "raise the bar" on ePrescribing under ARRA, thus possibly incenting physicians for reaching new milestones (such as what HIMSS has proposed relative to other components of the definition of "meaningful use" for an EHR). Incentives should be additive, so that a physician who earns, say, $10,000 under MIPPA, could earn an additional $44,000 under ARRA.

Should you choose to "raise the bar," I observed that only one speaker really focused on ePrescribing, that being Rick Ratliff from Surescripts. My recommendations on defining ePrescribing largely mirror what he said in his testimony, though I do go a bit further. Specifically, in my view, you might consider the following definition for ePrescribing:

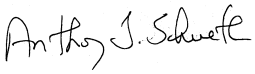
1) checking 75% of medications against a formulary;
2) accessing a longitudinal medication history for 50% of patients, which could also include incorporating the longitudinal history into the ePrescribing process so that the data could be used in drug-to-drug interactions;
3) checking 100% of medications against other medications that the patient is using (drug-to-drug interactions)
4) checking 50% of medications against allergies (drug-to-allergy);
5) transmitting 75% of prescriptions electronically to the pharmacy;

These criteria meet that which was laid out by one NCVHS member: being real, achievable and existing, and, I would argue, measurable.

To that latter point, as I stated in my comments, I would like to point out to the Committee that it is possible to gather this and other kinds of activity data. In fact, Surescripts is facilitating getting such reporting from its ePrescribing and EHR clients on behalf of its pharmacy benefit manager (PBM) clients. This file could easily be modified to add a broader set of information than ePrescribing data. As the project manager for the Southeastern Michigan ePrescribing Initiative (SEMI), we are leveraging such data to determine the return on investment for our employer and payer clients, and identify which physicians should receive our incentive money which, like ARRA, is provided for use of the clinical system.

Thank you for your consideration of this important issue. We would be happy to with you and CMS in finding a resolution.

Respectfully,



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