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May 3, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Attn: ACO Legal Issues
Mail Stop C5-15-12
Baltimore, MD 21244-1850

**Re: Implementation of Medicare E-Prescribing Incentive Program
payment adjustment**

Dear Dr. Berwick:

The American College of Cardiology (ACC) is extremely concerned regarding the implementation by the Centers for Medicare and Medicaid Services (CMS) of the mandated 2012 payment adjustment for those failing to e-prescribe. The College is a 40,000-member nonprofit medical society composed of physicians, nurses, nurse practitioners, physician assistants, pharmacists and practice managers, and bestows credentials upon cardiovascular specialists who meet its stringent qualifications. The ACC is a leader in the formulation of health policy, standards and guidelines, and is a staunch supporter of cardiovascular research. The College provides professional education and operates national registries for the measurement and improvement of quality care. We urge CMS to reconsider its current the details and timing of its current position with regard to e-prescribing and to thoroughly consider the effects of this position on specialists such as cardiologists.

The College supports e-prescribing and encourages cardiovascular specialists to adopt e-prescribing technologies. The many benefits of e-prescribing are well-documented. Because of this, the ACC has launched a major initiative aimed at educating cardiovascular specialists regarding the rapidly approaching June 30 deadline for avoiding the e-prescribing penalty. E-prescribing articles will be featured in all upcoming ACC publications, and a peer-to-peer education effort is also underway. The ACC in Touch blog will have a series of pieces written by clinicians and practice staff from their various perspectives. ACC Chapters will be assisting in this outreach. Despite our efforts, we remain concerned that many practitioners are unaware of the pending deadline of June 30. In today's economic climate and the threat of a 30 percent reduction in the sustainable growth rate, even a one percent penalty for e-prescribing may be tantamount to forcing the closure of

The mission of the American College of Cardiology is to advocate for quality cardiovascular care — through education, research promotion, development and application of standards and guidelines — and to influence health care policy.

a cardiovascular practice. The ACC urges CMS to delay the June 30 deadline for writing at least 10 prescriptions electronically at the time of an office visit.

Statutory intent and implementation of the payment adjustment

The Medicare E-Prescribing Incentive Program was created as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) with the intention of incentivizing practitioners to adopt e-prescribing technology. The first few years included a bonus payment, while the later years require a penalty for those who do not e-prescribe. CMS claims that the statute requires a six month reporting period in the first half of 2011 for implementation, and yet, the language describing the years for which practitioners are eligible for bonus payments is essentially the same as that used to describe the years for which there is to be a penalty. Given this, CMS' claim would seem to be inaccurate and only serves to add to administrative burdens of practitioners at a time when they can ill afford the additional costs associated with those burdens. As stated in previous letters, ACC opposes the penalty reporting period as currently defined as contrary to legislative intent.

Moreover, defining the reporting period in this manner is contrary to the manner in which CMS has implemented the bonus component of both the Medicare E-Prescribing Incentive Program and the Physician Quality Reporting System. To date, CMS has defined the reporting period as the current year and paid the bonus in the following year. Suddenly, CMS has opted to upend this process and is defining the reporting period as the year preceding that which is listed in the statute with the intention of applying the penalty in the year listed in the statute. This has complicated attempts to educate practitioners about the penalty. Additionally, it is further complicated by the fact that 2011 is also the reporting period for those interested in qualifying for the 2011 bonus payment. It is easy to confuse what must be done to qualify for the 2011 incentive with what actions must be taken in 2011 to avoid the 2012 penalty. The ACC urges CMS to delay the reporting period to make it less complex for practitioners and more likely that they will be understand the requirements and be able to avoid the penalty.

Uniqueness of cardiovascular care

Cardiovascular specialists in particular may have difficulty reaching the 10 prescription requirement. Many prescriptions may not be written at the time of a visit listed as a denominator code. Cardiologists may respond to refill requests or telephone calls during that time, but these prescriptions do not count toward the minimum of ten because they are not written at the time of the visit. Some drugs may be prescribed based on the results of a particular diagnostic test, but the codes for diagnostic tests are also not denominator codes. Considering only prescriptions written at the time of an office visit may have the unintended consequence of increasing the number of office visits because physicians will be forced to schedule a visit rather than simply writing the required prescription in the normal course of business in order to meet the measure and avoid the e-prescribing penalty.

Concerns of cardiovascular subspecialists

Additionally, while the requirement of writing 10 e-prescriptions may not seem like an insurmountable hurdle, there are certain subspecialties where writing prescriptions is fairly rare. Typically, electrophysiologist, interventionalists and other non-office based cardiovascular subspecialists do not write many prescriptions. In fact, for some, the requirement of 10 within a six-month period is excessive. Instead, these subspecialists largely focus on providing consultations and performing procedures. Patients of these subspecialists may be on multiple medications – diabetes medications, cholesterol-lowering agents, etc. – but these medications are generally prescribed and managed by other physicians, including general cardiologists, primary care physicians and others. However, because consultations are now billed as office visits, generally of the type within the denominator, these physicians will be subject to the penalty. Congress presumably did not intend to punish subspecialists who do not write many prescriptions over the course of the year in this manner. For CMS to do so may have the unintended consequences of encouraging subspecialists to attempt to prescribe and manage medications already managed by others. Thus, the ACC urges CMS to expand the opportunities for practitioners to report the use of e-prescribing, including refills and prescriptions written based on the results of diagnostic tests.

Interaction with Electronic Health Record (EHR) Incentive Program

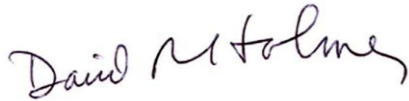
As a component of the American Recovery and Reinvestment Act of 2010, Congress made the decision to encourage adoption of EHRs. The ACC has long been a supporter of EHR adoption and were pleased that Congress chose to incentivize physician behavior in this manner. However, the differing timelines on the two programs have added to the complexity. When done correctly, EHR implementation – from the decision to purchase an EHR to selecting the EHR to actual adoption, training, etc. – requires a significant investment of time. Many practitioners chose to begin the process in 2011, anticipating that they would have enough time to implement a system correctly and still qualify for the maximum bonus from the EHR Incentive Program; however, this did not take into account the Medicare E-Prescribing Incentive Program penalty. Instead, these practices will either need to quickly purchase and implement an EHR – an expensive and risky proposition, one not to be taken lightly or quickly – or invest time and money in a standalone e-prescribing system that they will likely eliminate upon adoption of the complete EHR. This second option requires the practice take on additional administrative burden and costs and essentially implement e-prescribing twice within a short period of time. Given that Congress intended that practices should have until 2012 to e-prescribe before penalizing those who do not and that adoption of an EHR in 2012 still qualifies practitioners for the maximum EHR incentive, the ACC urges CMS to reconsider the timing and requirements for avoiding the e-prescribing penalty.

Even further complicating matters is the e-prescribing requirement of the EHR incentive program. Participants in that requirement must report on a completely separate measure of e-prescribing than those attempting to either qualify for the 2011 e-prescribing incentive or avoid the 2012 e-prescribing penalty. This means that those participating in

the EHR Incentive Program must still report the e-prescribing measure for the Medicare E-Prescribing Incentive Program. Given that electronic technology is supposed to reduce administrative burdens and streamline healthcare, the decision by CMS not to standardize the e-prescribing measure is absurd and needs to be remedied. The ACC urges CMS to do so quickly and to allow 2011 participants in the EHR Incentive Program to use the e-prescribing required in that program to avoid the 2012 Medicare e-prescribing penalty or the Medicare E-Prescribing Incentive Program measure to meet the e-prescribing requirement of the EHR Incentive program.

The ACC urges CMS to reconsider the pending June 30 deadline for writing 10 prescriptions electronically and to apply a deadline that makes more sense. Additionally, the ACC urges CMS to allow for increased flexibility and opportunities for physicians to meet the e-prescribing requirements. We would welcome the opportunity to discuss these concerns further. Please direct any questions or concerns to Lisa P. Goldstein at (202) 375-6527 or lgoldstein@acc.org.

Sincerely,



David R. Holmes, Jr., M.D., F.A.C.C.
President

Cc: Jack Lewin, M.D. – CEO, ACC