THE ENDOCRINE SOCIETY

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March 11, 2010

Charlene M. Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-0033-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: **CMS-0033-P Medicare and Medicaid Programs; Electronic Health Record Incentive Program Proposed Rule**

Dear Acting Administrator Frizzera:

On behalf of The Endocrine Society (Society), representing more than 7,000 physicians in the practice of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) electronic health record (EHR) incentive program proposed rule. The Society looks forward to working closely with the Agency as this proposed rule moves toward implementation.

Founded in 1916, the Society represents physicians and scientists engaged in the treatment and research of endocrine disorders, such as osteoporosis, diabetes, hypertension, infertility, obesity, and thyroid disease. The following comments focus on four areas of particular importance to our members as they relate to implementation and use of EHRs:

1) Computer Physician Order Entry (CPOE)
2) Incorporating Lab Tests into EHRs as Structured Data
3) Generating and Transmitting Prescriptions Electronically
4) Quality Measures

First, we would like to applaud both CMS and the Office of the National Coordinator for Health Information Technology on its ambitious goal of encouraging and incentivizing all physicians and health care providers in the U.S. to adopt health information technology (HIT). The Society agrees that when used appropriately, HIT can help to both increase efficiency and reduce the cost of health care across the spectrum. Unfortunately, a number of the policies that the agency has set forth in its proposed rule are both cumbersome and difficult to implement in the relatively short time frame allotted, and we are concerned that the requirements will end up decreasing productivity and efficiency in the health care system in order for providers to become compliant with the agency's rule.

1. Computer Physician Order Entry (CPOE)
One objective the agency proposes to require eligible professionals (EPs) to meet in order to show meaningful use of an EHR is the use of CPOE for at least 80 percent of all orders. While the use of CPOE is a laudable goal, it seems inappropriate to base physician compliance on something that frequently depends on the participation of outside entities including other providers, laboratories, and radiology centers. Physician practices may not have the benefit of connecting to laboratory groups or radiology centers in all of the areas where their patients reside – particularly if patients live in rural areas. Even if this is a possibility, it is important to note that currently no standardization of laboratory data exists and, other than prescriptions, there is no standard for laboratory result transmittals based on an EHR order. We understand that the agency's goal is not to have eligible professionals merely show use of an EHR, but show *meaningful use*. However, requiring physicians and other eligible professionals to meet this high threshold could very likely end up excluding many EPs, or could discourage these providers from ever trying to participate in the program to begin with. We suggest that the agency reduce the threshold from 80 percent to an attestation statement stating that they have performed at least one test of their certified EHR technology's capacity to conduct CPOE until such time as EPs are able to consistently transmit the orders electronically. This will demonstrate that the EP is capable of entering the information, but will not be overly burdensome.

2. Incorporate Lab Tests into EHRs as Structured Data
The Society contends that the Agency's proposal to require 50 percent of all lab tests whose results are in a positive/negative or numerical format to be incorporated into a certified EHR as structured data is too aggressive for the first year of the EHR incentive program. Providers in small practices or in rural areas do not necessarily have the capability to interface with labs via EHR, and since this implementation is dependent on the both the EHR vendor and the laboratory, it is possible that small and rural practices may never reach a high enough priority to obtain an electronic interface. In addition, while primary care physicians mostly see patients who live locally, subspecialists many times draw their patients from a wide geographic area. The ability to interface directly with labs, radiology centers, and other physicians in such a wide area puts them at an additional disadvantage to meeting these required thresholds. Even if they practice in a metropolitan area, many subspecialists like endocrinologists see patients who travel from very rural areas, so while the endocrinologist may be able to interface locally with labs, many of their patients will require the use of their own local lab centers, pharmacies, etc where even the well-connected physician cannot interface. We suggest providing an attestation statement for eligible professionals to state that they are able to send lab orders electronically but the lab cannot accept electronic data.

3. Generate and Transmit Prescriptions Electronically
The Society is concerned that the EHR requirements for e-prescribing may cause significant confusion with the requirements set forth under the Agency's e-prescribing (e-Rx) demonstration program. Under the e-Rx program, providers need only e-prescribe 25 times in order to meet the threshold requirement. Under the EHR proposed rule, physicians must e-prescribe 75 percent of the time. Again, while we appreciate the need for eligible professionals to show *meaningful use* of EHRs, these two different requirements may cause significant confusion and render EPs who are otherwise able to qualify for EHR incentives ineligible. We request that the Agency reduce the e-Rx requirements under this rule to match the e-Rx incentive program already in existence.

In addition, the Society is concerned that the agency may be overlooking the desires and needs of patients in its effort to require EPs to show meaningful use of EHRs. Many patients, particularly

those in the Medicare program trying to navigate through the Medicare Part D prescription drug "donut hole", choose to shop around for the best price on their medications, and would require a paper prescription in order to find the most affordable price for their budget. Even patients who use mail order pharmacies may require a paper prescription, as many of those programs do not accept e-prescriptions at this time. As mentioned previously, subspecialists usually draw patients from a wide geographic area and the requirement to interface directly with labs, radiology centers, and other providers places subspecialists at an additional disadvantage to meeting the requirements set forth in the proposed rule.

Endocrinologists and other eligible professionals treating patients with diabetes sometimes face an additional issue related to the electronic transmission of prescriptions for insulin. Because quantity is sometimes difficult to explain, products such as insulin pens (e.g., Is the Rx for 5 insulin pens, 15 mls of insulin, or 1 box of pens?), are not easily submitted electronically. For an endocrinologist seeing patients using insulin, this could significantly limit their ability to reach the 50 percent threshold. We encourage CMS to revise this requirement by allowing physicians prescribing certain drugs to attest to the number of times they could not e-prescribe due to system and drug limitations.

4. Quality Measures

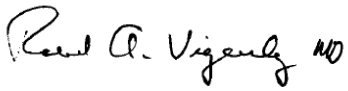
The Society is deeply concerned with the quality measure requirements set forth in the Agency's proposed rule. While we agree that quality measurement is an important part of achieving efficient health care, it seems inappropriate to base the quality reporting requirements for the EHR program on the Physician Quality Reporting Initiative, a program that is widely seen as fundamentally flawed. Expanding the use of these measures, most of which have e-specifications that have not yet been tested, seems shortsighted for a program that is slated to significantly alter the way health care is provided in this country. We encourage you to thoughtfully consider this issue and consider limiting the use of quality measures in the first years of this program to those whose specifications have already been tested, and expand the use of these measures as more testing is completed.

In addition, the Society is concerned with the specialty-specific measure requirements associated with endocrinology. The majority of endocrinology related measures in the proposed rule are specific to those physicians treating patients with diabetes. While many – perhaps most – endocrinologists see patients with diabetes, some endocrinologists do not treat any patients with diabetes, instead focusing on other important endocrine conditions such as thyroid disease, osteoporosis, obesity, and others. It is not clear from the proposed rule what eligible professionals are expected to do if they fall into a specialty specific measure group like endocrinology but do not perform any of the measures indicated. In a meeting with specialty societies in late January, CMS staff stated that there are no minimum denominators that EPs must indicate when reporting quality measures, and while this may be the case, what this information means to EPs and how they will be impacted needs to be clearly and consistently explained to the participating professionals in the EHR program. We would also point out that if this is the case, it seems particularly inefficient for participants to be required to report on things they do not do, rather than those things they are doing and doing consistently. We hope that the Agency considers the implications of these requirements moving forward.

In conclusion, the Society appreciates the opportunity to submit these comments regarding CMS' EHR proposed rule, and strongly encourages the Agency to consider the weight of these requirements on the efficiency of the entire health care system. As always, the Society is grateful to CMS staff for the hard work that went into drafting this document. Please do not hesitate to contact

Holly Whelan, Associate Director, Health Policy at hwhelan@endo-society.org, if we may provide any additional information or assistance as CMS moves forward.

Sincerely,



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