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The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Donald Berwick, M.D.  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Secretary Sebelius and Administrator Berwick:

HIMSS is pleased to submit our comments regarding the proposed rule Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revision to Part B for CY 2011, [Docket number CMS-2010-0205] that was posted in the *Federal Register* on June 25, 2010.

HIMSS is a cause-based not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the United States. HIMSS represents more than 30,000 individual members, of which two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 470 corporate members and more than 85 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, and research initiatives designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care.

As an organization, we are committed to supporting the best use of information and management systems, across the healthcare continuum, to achieve greater patient safety, improved office efficiency, better quality of care, and improved cost effectiveness of care delivery and access to care. E-prescribing and the adoption of Quality Measures and Electronic Health Records (EHRs) foster an environment where these improvements can be maximized.

HIMSS has previously responded to several federal requests for public comment on e-prescribing. In particular, we have responded to several public comment opportunities through the Centers for Medicare and Medicaid Services (CMS) and the DEA's 2008 Notice of Proposed Rule Making of Electronic Prescriptions for Controlled Substances. To ensure that this response reflects the broadest level of industry experience, HIMSS has leveraged the subject matter expertise of the members of our Patient Safety & Quality Outcomes Committee, Ambulatory Information Systems Committee, Physicians Committee and the Electronic Health Record Association. The viewpoints of these groups,



along with their industry colleagues, ensure HIMSS fulfills its requirement to offer a coordinated voice to the national discussion on these important healthcare issues.

HIMSS appreciates CMS's effort to support and drive adoption of quality measures and e-prescribing that permit health care practitioners to write, and for pharmacies to receive, dispense and archive electronic prescriptions, and for the revisions to the FY 2011 Physicians Quality Reporting Initiative (PQRI). HIMSS would like to compliment CMS's efforts and revisions as described in the proposed rule and commend CMS for soliciting industry feedback.

HIMSS would like to bring forward some key items of concern and affiliated recommendations related to expectations of functionality and timing that HIMSS would like CMS to take into consideration prior to release of an Interim Final or Final Rule.

#### **General Comments:**

HIMSS commends CMS for the work done to integrate the Incentives for Electronic Prescribing and the Electronic Prescribing Incentive Program.

HIMSS members are concerned that a single quality metric has little value relative to the quality of health care. The greatest value is in quality measures that are based on clusters related to condition(s). Significant weight should be given to measurement sets rather than isolated measures. It would be helpful if CMS would consider requiring the reporting of standard measure sets. Treatment inertia is the biggest road block to optimal patient care, which results in the creation of discomfort for the patient and unnecessary expense to the healthcare system.

#### **Requests for Guidance and/or Clarification:**

1. Section 132: Incentives for Electronic Prescribing (eRx) The Electronic Prescribing Incentive Program. TOC: Section 132 of the MIPPA: Incentives for Electronic Prescribing (eRx) - the eRx Incentive Program p24

HIMSS requests clarification for the following scenarios and guidance as to what information can be excluded from the calculation of the denominator.

How will CMS perform audits for the program, specifically how will it be measured? Many pharmacies are required to keep at least some portion of their records on paper, or are required to transform their electronic records into a paper hardcopy for audit purposes. The concordance between the derivative paper hardcopy and the electronic record is purely a function of the pharmacy's software and varies across software vendors. Since the CMS definition of electronic prescribing encompasses both the electronic sending and the electronic receipt of the prescription, understanding how this process would be audited is necessary in order to provide comment on the relative strengths or weaknesses of the proposed incentive. Will the audit involve pharmacy records? Will the paper hardcopy or the original electronic record be audited? There are many instances – such as a pharmacy that doesn't participate in electronic prescribing or a patient instruction field that exceeds the character limit – where an Eligible Professional (EP) may submit an electronic prescription and it is subsequently received as a fax at the pharmacy. Through no fault of their own, the EP may use



electronic prescribing 100% of the time in an area where none of the pharmacies receive electronic prescriptions and be considered unsuccessful under the current definition of electronic prescribing. For the purposes of determining reimbursement for the incentive that is given to providers, would CMS consider a modified definition of a successful electronic prescriber to include the sending of an electronic prescription according to the current required standard and forgo the requirement for electronic receipt by the pharmacy?

## 2. Section 131: Physician Payment, Efficiency and Quality Improvements [p458]

HIMSS requests clarification related to 2015 penalties. Are the penalties cumulative? Is the penalty on gross allowable or on Medicare payment? Is it 2% for PQRI and 2% for e-prescriptions and are they deducted from the allowable or from the payable charges? Will other disincentives be added with the MIPPA penalty? How is adherence audited and/or monitored for determination of penalty? For example, there is a state Medicaid incentive for electronic prescribing in New York that requires the provider to be the sender of the electronic prescription, yet the pharmacy-generated hardcopy that is audited does not identify the sender of the prescription – that information is only found in the original electronic record. In a similar audit process, pharmacies are getting fined for processing electronic prescriptions of supply items where the diagnosis code (a requirement of the prescription) is not present on the hardcopy reproduction that is audited, but is present in the original electronic prescription which the auditors do not review. Would a CMS audit be based on a hardcopy reproduction or the original electronic record?

## 3. Proposed 2011 Reporting Periods for Individual EPs [p463]

HIMSS members are generally concerned most providers will not decide to participate in the PQRI program. Given the current status of the industry in trying to meet 5010/ICD10 regulations and incentive requirements for achieving the meaningful use of EHR adoption, the additional reporting requirements will serve as a disincentive.

## 4. Table 50: Proposed Processes for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting of Data on Quality Measures by Group Practice by GPRO II [p512]

HIMSS is concerned that the denominator is unnecessarily restricted through the association of a prescription with a patient visit. The vast majority of prescriptions in an internal medicine or family practice office are generated outside of a patient visit through the prescription renewal workflow while new prescriptions – the minority – are often coincident with the patient visit. This sets up a cascade of filters that may prevent many otherwise successful providers from meeting the denominator criteria: All practice patients > Medicare patients > Fee-for-Service (FFS) Medicare patients > FFS Medicare with a prescription need at the time of visit. Pharmacies either have, or can easily acquire, the capability to report the manner in which the prescription was received. Would CMS consider a determined number of pharmacy claims of electronic prescriptions for Medicare beneficiaries, where the prescriber and manner of prescription delivery are clearly defined, as acceptable minimum criteria to determine a successful electronic prescriber? The infrastructure to support this is laid in the requirements that Medicare D claims be submitted electronically to CMS and would allow CMS the



ability to identify successful electronic prescribers independent of office-generated claims containing the G-codes, decreasing the burden asked of providers and increasing accuracy simultaneously.

5. Table 52: Proposed 2011 Measures Selected From the 2010 PQRI Quality Measure Set Available for Registry-Based Reporting Only [p533]

HIMSS acknowledges that many of the PQRI measures for 2011 are similar to those in previous years. The majority of measures submitted in 2011 will still be claims based, but the trend will be definitely towards registry based reporting. We are very encouraged by the changes that CMS is making to the reporting of providers who submit data. This has been a problem for physicians in the past. Many physicians submit data to CMS and do not know if it was received or if it was adequate. The website reporting is a great enhancement.

Claims-based reporting will eventually be phased out. The timing on this may impact providers' ability to participate in PQRI. An example is the "remote charge". Most specialists who practice at multiple sites, that is, Hospital Outpatient Departments (HOPDs), Ambulatory Surgical Centers (ASCs) are providing services that are not recorded within their own EMR. Given that these services still need to be recorded as PQRI 185 and billed, registries will need to have options for quality data input (e.g., an ASP-based charge capture tool that integrates PQRI questions and automatically creates CPT2 codes). Therefore, there will continue to be a need for encounter-based PQRI for some time. Further clarification around the timing for phasing out claims-based reporting may assist in providers' decision-making around how and when to implement various parts of an electronic health record or registry.

6. Table 71: Measures for Physicians Groups Participating in the 2011 PQRI Group Practice Reporting Option (GPRO I) [p548]

HIMSS again encourages CMS to consider group measurement sets rather than isolated measures. It would be helpful if CMS required reporting of required standard, clustered measure sets. Isolated metrics do not have a great value towards stimulating quality.

7. Incentive Payment Adjustment for Quality Reporting [p551]

HIMSS requests clarification and examples on how the calculations are determined. Please explain what is meant by "allowable".

8. Section 132: Incentives for E-Prescribing: The Electronic Prescribing Incentive Program [p564]

For reasons of clarification, HIMSS requests that the government state whether the electronic prescription function is E-Prescribing, which requires the patient's pharmacy benefits information, or E-Prescription Writing, which does not.



9. The Reporting Denominator for the Electronic Prescribing Measure [p573]

HIMSS requests clarification, as the proposed rule references Medicare Part B restrictions and also references Medicare fee-for-service in different parts of the document. HIMSS appreciates the government clarifying if the examples provided are applicable to both programs.

10. Required Functionalities for a "Qualifies" Electronic Prescriber System [p575]

HIMSS commends CMS for expanding the required functional qualifications of electronic prescribing systems to include non-transactional components such as clinical decision support (interaction checking, allergy checking), formulary support (tiered formulary listing), and documentation features (generating a patient medication list).

11. Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of Electronic Prescribing Measures by Group Practice [p586]

HIMSS supports the view that the success of Group Practices to meet the criteria for successful reporting will be dependent upon the timing of the final regulation. Should the final rule be published in the fall of 2010 the criteria should be achievable for group practices.

12. Significant Hardship Exemption [p593]

HIMSS members request guidance for physicians whose patients participate in the Medicaid PACE program and use a contracted pharmacy that may not be able to receive electronic prescriptions. Will these physician visits be excluded from the requirements of the PQRI program?

13. Public Reporting of Names of Successful Electronic Prescribers [p595]

HIMSS commends CMS for wanting to recognize those EPs who have successfully met the requirements of the E-Prescribing program. HIMSS understands that there is a population of the provider community that is very mobile. A number will work in either one practice (and have to cover for another EP), or multiple practices/locations. Identification of a successful EP is frustrated by current technology limitations that associate one provider with one vendor product for electronic prescribing. A provider who practices in two separate locations, which are separate business entities with different software solutions for electronic prescribing, is unable to use both systems and is constrained to send prescriptions electronically through a single system. HIMSS is concerned that a subset of providers who actually do use electronic prescribing successfully will not be represented in such a posting as proposed. In some cases, this may result in unintentional consequences for the EP's practice as the public may use such a posting when making choices regarding their primary care provider.

HIMSS' members are concerned that the general public will not correctly identify a reported successful electronic prescriber as having met the PQRI requirements for electronic prescribing. Such a posting may instead lead to unrealistic expectations of electronic prescribing use that encompass no transactional system capabilities and a higher frequency of electronic prescribing than is represented by



the PQRI requirements. It is our understanding that in order for an EP to meet the intent of the initiative, EPs must submit data on 25 patients. However, some EPs may be able to meet this requirement in one week and may not use the e-prescribing technology for the rest of the year. Another scenario may be an office that only processes renewal requests electronically but generates all new prescriptions on paper. A patient should come to expect e-prescribing technology is fully used in a consistent manner from EPs who are posted as qualified under this program.

We recommend CMS consider reporting successful electronic prescribing users that meet the criteria that are consistent with meaningful use e-prescribing Stage 1 requirements. Adopting this criteria is consistent within the PQRI program, preserves the incentive for EP that are beginning to electronically prescribe, and recognizes successful electronic prescribers in a way that is consistent with a public interpretation of “successful electronic prescriber”.

14. The Affordable Care Act Provisions [p688]

HIMSS is concerned that the Department has underestimated the research time to implement an e-prescribing system is underestimated. Our members indicate that there is a significant time and resources that are required to install and set up an E-Prescribing system – in addition to the training requirements of the physician and staff that should also be considered.

In summary we commend CMS’s effort to support and drive adoption of quality measures and E-Prescribing by that permit health care practitioners to write, and pharmacies to receive, dispense, and archive, electronic prescriptions and for the revisions to the FY 2011 Physicians Quality Reporting Initiative (PQRI). We ask that you consider our recommendations and request for guidance and clarification as related to these sections of the Payment Policies under the Physician Fee Schedule and Other Revision to Part B for CY 2011.

If you have any additional questions please contact [Mary P. Griskewicz](#), Senior Director, Ambulatory Information Systems, 203.421.8317 or [Thomas M. Leary](#), Senior Director, Federal Affairs, 703.562.8814. Thank you for consideration of these comments which represent the input from our membership.

Sincerely,

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