

March 15, 2010

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
Comments submitted electronically to <http://www.regulations.gov>

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; 75 Fed. Reg. 1,844 (January 13, 2010); CMS-0033-P

Dear Acting Administrator Frizzera:

The 21 undersigned surgical organizations, representing over 270,000 members, welcome the opportunity to submit comments regarding the proposed rule Medicare and Medicaid Programs; Electronic Health Record Incentive Program; 75 Fed. Reg. 1,844 (January 13, 2010); CMS-0033-P, which specifies the criteria that eligible professionals (EPs) and eligible hospitals must meet to qualify for Medicare and Medicaid incentives as meaningful users of certified electronic health record (EHR) technology. Our comments on issues of interest to the undersigned organizations are presented in the order in which they appear in the proposed rule.

STAGE 1 CRITERIA FOR MEANINGFUL USE

The proposed rule includes 25 meaningful use criteria and their related measures for Stage 1 that EPs would be expected to meet, in addition to other requirements, in order to qualify for Medicare or Medicaid EHR incentives. The undersigned organizations are agreed that the proposed criteria and measures for Stage 1 are too numerous, overly ambitious, and will result in very few EPs qualifying for EHR incentives in 2011 or possibly even 2012. EPs face considerable uncertainty regarding future Medicare payments, which will determine how much they can spend on EHRs. If the bar is set so high as to make it almost impossible for them to meet the meaningful use criteria to qualify for the EHR incentive payments, they may be reluctant to take the first steps toward an EHR, including making major investments in EHR technology. As proposed, meeting the meaningful use definition for 2011 will be cost-prohibitive for most surgeons in private practice. As David Kibbe, MD, MBA, Chair of the ASTM International E31 Technical Committee on Healthcare Informatics recently noted, “[m]eaningful-use implementation could prove onerous and overly complicated for doctors in small- and medium-size practices, costing them much more in dollars and productivity than they would gain in incentive payments.” In the current economic and policy context, the undersigned organizations are agreed that the adoption of all of the meaningful use criteria and measures as proposed would be ill advised, is not the most effective approach to implementing the EHR-related provisions of the American Recovery and Reinvestment Act (ARRA), and is not what Congress intended when it adopted the EHR-related provisions of the ARRA.

Among other things, we believe that the proposed rule offers too little information about how the criteria and measures would be calculated (for example, specifying the applicable numerators and denominators), and that a number of the measures appear to be oriented toward primary care physicians rather than members of the undersigned organizations. We also find the proposed rule lacking in guidance regarding what would be expected of EPs who practice in multiple settings. For example, would a surgeon treating a patient in a hospital setting have any EHR “meaningful use” obligations with respect to such patient—and, if so, when—or would these obligations fall upon the hospital? In other words, it is unclear whether such patients would be included in the denominator of the various meaningful use measures applicable to EPs or those applicable to hospitals. Regardless, the Centers for Medicare & Medicaid Services (CMS) should consider revising the meaningful use requirements in a way that would allow physicians who spend a significant amount of time in a hospital, such as certain surgeons and anesthesiologists, yet do not meet the 90% threshold, to still show meaningful use through their facilities’ EHRs. Otherwise, many physicians will “fall through the cracks” and face penalties in 2015.

The undersigned organizations are also agreed that CMS should afford more flexibility to EPs and allow them to qualify for EHR incentives if they meet a minimum number or minimum percentage of meaningful use criteria. Because significant practice variation exists among the specialties, EPs should be given sufficient and real flexibility to select from among the list of meaningful use criteria five criteria that are most relevant to their practice, and should not be expected to meet all 25 criteria in Stage 1. In making this recommendation, we recognize that the requested flexibility would still leave EHR vendors in a quandary about whether to develop EHR technology capable of meeting all the meaningful use criteria or just those that most EPs would be likely to choose over the next few years. Accordingly, another alternative would be to adopt a much smaller set (for example, 10-15) of meaningful use criteria from which EPs can select, focusing on those that appear to be most feasible in the near-term while still moving EHR adoption and use in the right direction. It is critical that flexibility be preserved to make it feasible for a wide range of EPs to participate in the program.

We are also concerned that CMS’ proposal for many of the measures to utilize numerator and denominator data to establish that a measure has been met could heavily restrict the ability of EPs to meet the incentive program requirements. Manually calculating numerators and denominators would impose a significant burden on EPs, so we recommend deferring percentage threshold to a time when EHRs have the ability to automatically calculate the required metrics to be reported.

In addition to the general comments above, we offer the following input regarding specific meaningful use criteria and their associated measures.

Computerized Provider Order Entry: Although we support the use of CPOE, the 80 percent threshold for the CPOE criterion for EPs is much too high. In addition, we remain unclear about the denominator for this measure. We presume that the intent is to limit the measure to orders entered in a physician's office rather than elsewhere. The proposed rule also requires clarification as to whether midlevel professionals, in addition to the EP, are allowed to enter orders into the EHR. If not, this could significantly disrupt work flow in some practices. Because of the uncertainty surrounding this measure, we recommend that CMS revise the measure for Stage 1 to indicate that EPs only are required to attest having performed at least one test of certified EHR technology's capacity to conduct CPOE.

With respect to eligible hospitals, the CPOE criterion would be met if CPOE were used for at least 10 percent of all orders for patients for whom the place of service code is 21, inpatient facility/department. For this measure, we would encourage CMS to include in both the numerator and the denominator orders for patients for whom the place of service code is 23, Emergency Room, Hospital. A significant proportion of inpatient admissions originate in hospital emergency departments and it is important that orders written there are part of the inpatient record to help ensure that medications and other treatments and diagnostic tests are neither missed nor duplicated in the transition to inpatient care.

Drug-Drug, Drug-Allergy, Drug-Formulary Checks: We support the enabling of automated drug-drug, drug-allergy, and drug-formulary checks; however, given the large volume of alerts that could result from the many potential drug-drug interactions, we suggest that this measure be clarified to specifically allow EHR adjustment of levels of risk of drug-drug interactions (rather than a simple "on-off" switch as seems to be assumed by the proposed measure for this criterion). Even EHRs that are set at the highest levels could still lead to "alert fatigue," which could potentially cause physicians to miss some of the most relevant warnings. Thus, we support this measure, but ask that the final rule make clear that the enabled checks may still be adjusted based on risk level.

Maintain an up-to-date problem list of current and active diagnoses: For Stage 1, the proposed rule requires that at least 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data. To make this requirement feasible, a necessary component of all EHRs would be an ICD-9 "translator" to convert common medical terminology used by clinicians into the appropriate ICD-9 codes. In addition, given the burden of manually calculating numerators and denominators, we recommend replacing the 80% threshold requirement with a requirement that EPs attest that the problem lists for patients seen during the reporting period are up-to-date.

E-prescribing: For Stage 1, the proposed rule specifies that at least 75 percent of all permissible prescriptions written by the EP must be transmitted electronically using

certified EHR technology. We consider the proposed 75 percent threshold much too high, especially in the case of surgical specialists who commonly write prescriptions where electronic transmission is not permissible (that is, for controlled substances). This criterion would require such specialists to simultaneously use dual prescribing systems, electronic and non-electronic, for a large proportion of their patients. This would create work flow disruptions and would also be confusing for the affected patients, who might prefer to have paper prescriptions for all their medications, not just some of them. Until the Drug Enforcement Administration (DEA) has adopted a workable policy allowing electronic submission of prescriptions for controlled substances, CMS should not adopt e-prescribing requirements that create additional complications for the physicians and patients affected by current DEA rules. In addition, the proposed 75 percent threshold will not be feasible in areas of the country where relatively few pharmacies are prepared to accept prescriptions electronically, or when the predominant patient preference is to receive a hard-copy prescription, which gives patients the opportunity to shop for the best price or to take their prescription to another pharmacy if the first pharmacy does not have the medication in stock.

Recording Patient Demographics: We question the decision to treat this functionality solely as an integral part of EHR technology since many physician practices now use their administrative systems to record patient demographics. We recommend removing this criterion from Stage 1.

Recording Vital Signs: The proposed 80 percent threshold for this criterion is too high for Stage 1. More important, this measure would require EPs to record patient height, weight, and blood pressure, calculate body mass index (BMI) for all patients, and plot a growth chart for children ages 2 to 20, which may be an ideal measure for a primary care physician (internist, family physician or pediatrician), but it is an unreasonable requirement for many or most members of the undersigned organizations as they generally see patients for acute or specific conditions during a discrete period of time. We find it problematic to require all specialists to record vital sign information solely for the purpose of qualifying for EHR incentives or eventually to avoid penalties, especially when certain specialists do not typically capture this vital sign information under normal circumstances. For example, an ophthalmologist would not typically weigh his or her patients or take their blood pressure since this information is of little or no relevance to the medical problem(s) being addressed by the specialist physician. The required recording of information now viewed as “extraneous” to the medical problems at hand would lead to productivity and work flow challenges. It would also lead to increased cost due to the additional work that would not normally be included in a typical office visit and additional equipment needed in the office and exam rooms. As a result, we recommend removing this criterion from the health IT functionality requirements for Stage 1.

Incorporating Lab Test Results: While we agree that lab results are an important part of the electronic health record, this requirement poses a problem for those specialties that only order small numbers of lab tests. These specialists typically do not purchase lab interfaces, and labs themselves usually do not provide electronic interface with specialty-specific EHR vendors because it is not cost beneficial to create interfaces for data exchange. Because there is no requirement for labs to electronically interact with all types of EHRs, the labs have no incentive to invest in the infrastructure or to make themselves compatible with their low volume users. A national EHR vendor charges approximately \$6,000 per lab interface, with ongoing maintenance fees, but laboratories will often subsidize the costs of interfaces for organizations that order a high volume of lab tests. In any case, specialists should not be prevented from meeting meaningful use criteria simply by virtue of their failure to acquire a costly laboratory interface. It is equally important not to require such physicians to enter lab test results manually into their patients' EHRs in order to qualify for EHR incentive payments. Thus, until there is greater uniformity in how laboratories report test results to physician practices using EHR technology, we believe the proposed criterion and its associated measure should be re-examined.

Reporting Ambulatory Quality Measures: Our detailed comments regarding this proposed criterion are provided in the following section of these comments.

Patient Reminders: This is another criterion that may not be appropriate for all specialists. For example, it would make sense for a primary care physician to send reminders to his or her patients with one or more chronic condition, but not for a surgeon who treated a patient for some acute, time-limited condition, such as appendicitis, acute otitis, or a traumatic injury such as a fracture. Thus, the proposed 50% threshold for reminders for patients that are 50 and over would be much too high for many specialists. In addition, because physicians use many forms of communication in issuing patient reminders, for Stage 1, the reminders should be flexible enough to allow for reminders to be provided via multiple methods such as telephone calls, voice mail messages, emails, or printed reminder notices provided after the initial visit.

Decision Support Rules: The undersigned organizations fully appreciate the intent behind this criterion, but are less certain about how it would be met in the near term. EHR vendors are in no position to specify which decision support rules should apply to EPs in different specialties. Further, it is not clear to the undersigned organizations whether and how any decision support rules that an EP or practice might identify would be supported by available EHR technology in the near term. Appropriate clinical decision support rules must be derived from scientific evidence, much like quality measurement development. Gaps in care, preferred practice patterns, and requirements specific to each specialty should be evaluated, which may not be possible by 2011. In

addition, once the decision support rules are created, the incorporation of such rules into EHRs will take some time for vendors to implement. We recommend that this criterion be deferred to Stage 2 or, at the very least, we would recommend that a much smaller number of decision support rules be required.

Checking Insurance Eligibility: This criterion is probably not feasible for EPs to meet in 2011. In many practices, checking insurance eligibility electronically is a function of existing practice management software, not EHR software, and we question the value of imposing requirements (including certification requirements) relating to functions already being accomplished outside of an EHR. Also, it is not clear how many insurance companies are prepared to accommodate electronic insurance eligibility determinations, and this may vary from locale to locale and from practice to practice. Moreover, even if an insurance company is so prepared, electronic eligibility checking may not be sufficient. Under certain circumstances, a phone call to an insurance company may nevertheless be required (for example, to determine eligibility for a specific service or for admission to a specific facility), which would significantly lessen the value of electronic eligibility checking. Accordingly, we recommend removing this criterion from Stage 1.

Submitting Claims Electronically: As was the case for recording patient demographics, we view this functionality as one that is often fulfilled by a physician practice's administrative systems rather than through EHR technology. We see no value in now requiring EPs to use an EHR rather than an administrative system for this purpose or in requiring such an administrative system to undergo an expensive certification process. Once again, the simplest approach would be to remove this criterion from Stage 1.

Providing Health Information to Patients: Three proposed criteria address the provision of information to patients. One would require EPs to provide at least 80 percent of all patients who request an electronic copy of their health information with such a copy within 48 hours. A second would require EPs to provide patients with timely electronic access to their health information (including lab results, problem list, medication list, and allergies) within 96 hours of the information being available to the EP. A third criterion would require EPs to provide clinical summaries to patients for at least 80 percent of all office visits, through a personal health record, patient portal on the web site, secure email, electronic media such as CD or USB fob, or printed copy.

We have a number of concerns with these requirements. First, the "48 hour" and "96 hour" time limits are arbitrary, fail to recognize that physician practices are not typically open 24-7, and fail to appreciate that some information should only be provided to patients during a face-to-face encounter. Thus, if CMS must adopt time limits, they should be specified in terms of business days rather than hours to account for weekends and holidays. However, even two (or four) business days significantly exceeds the 30 days allowed under Health Insurance Portability and Accountability Act (HIPAA) for

providing an electronic copy of health information, and would be an inappropriately short period of time for “new” test results and information that has not already been discussed with the patient. It is important that our members have more time to discuss certain results, especially if the results involve bad news, in person or possibly over the phone to allow for discussion and questions. Also, the rule should be clarified to recognize circumstances that allow providers to refuse to provide copies of health information under the HIPAA. Further, the proposed rule does not explicitly indicate whether a physician could charge a patient if requested or required information is provided via electronic media, such as a CD or USB fob. Finally, we question the requirement to automatically provide clinical summaries of most office visits, whether or not desired by the patient. This appears to be an overly burdensome requirement. In addition, we are concerned about potential liability if such clinical summaries are provided automatically (that is, without obtaining the patient’s authorization), yet contain sensitive information such as a patient’s HIV status.

Capability to Exchange Key Clinical Information: We do not support this criterion, which would require that each EP test his/her certified EHR’s capacity to electronically exchange key clinical information during Stage 1. CMS recognizes that most areas of the country do not have the infrastructure to support such exchange. As a result, we recommend removing this criterion from Stage 1.

Perform Medication Reconciliation at Relevant Encounters and each Transition of Care: Although we support medication reconciliation as a method of resolving conflicts between different sources of information to minimize harm and maximize therapeutic effects, we do not support the 80 percent threshold requirement for Stage 1. In addition, CMS should clearly define the terms, “relevant encounter,” and “transition of care.” We recommend that CMS remove the 80 threshold requirement and instead require that EPs attest that they perform medication reconciliation.

Provide Summary Care Record for each Transition of Care or Referral: We do not support the 80 percent threshold requirement for this criterion. Also, CMS should provide a clear definition for the summary of care for the ambulatory setting. Given the difficulty and burden of manually capturing numerators and denominators absent EHR automatic tracking and reporting capabilities, we recommend that for Stage 1, EPs should only be required to attest to providing summary care records for transitions of care and referrals when requested by patients, in lieu of the 80 percent threshold.

Immunization Registries: We question the appropriateness of this requirement in the case of physician specialties that rarely, if ever, provide immunizations to patients in their practices. Our concerns are further compounded by the fact that we remain uncertain about what would be required to satisfy the Stage 1 criterion, namely, at least one test of the EHR technology’s capacity to submit electronic data to immunization registries. As

we understand it, an interface to an immunization registry costs approximately \$6,000, and it would be unreasonable to expect a practice that does not provide immunizations to have and to test such an expensive capability.

Capability to Provide Electronic Syndromic Surveillance Data to Public Health Agencies and Actual Transmission According to Applicable Law and Practice: We do not support this criterion, which would require at least one test of an EHR's capacity to provide electronic syndromic surveillance data to public health agencies during Stage 1. Currently, interfaces with public health agencies do not readily exist, and this criterion is not relevant to all specialties. More time is needed to test this criterion and its readiness, so we recommend removing this criterion from Stage 1.

CLINICAL QUALITY MEASURES

In the proposed rule, CMS states that it does not anticipate having the capacity to electronically accept data on clinical quality measures from EHRs for the 2011 payment year. As a result, EPs and eligible hospitals will be expected to use an attestation methodology to submit summary information to CMS on clinical quality measures as a condition of demonstrating meaningful use of certified EHR technology. This means that EPs and eligible hospitals must attest that they used certified EHR technology to capture the data elements and calculate the results for the applicable clinical quality measures, they must attest to the accuracy and completeness of the numerators and denominators for each of the applicable measures, and they must report the results for all applicable patients to CMS. For the 2012 payment year, CMS does expect to be capable of receiving clinical quality measure data from EHRs electronically, and thus EPs and eligible hospitals will be expected to submit such data electronically at that time (unless CMS advises otherwise in a future notice in the *Federal Register*). In the proposed rule, CMS asks whether it may be more appropriate to defer some or all clinical quality reporting until the 2012 payment year, rather than requiring reporting through attestation in 2011, or whether reporting on some "key" measures rather than all measures should be required for 2011.

The undersigned organizations strongly urge CMS to postpone quality data reporting until Stage 2. Although quality data reporting is required by statute, flexibility exists as to what stage the reporting can be introduced. We believe that 2011 is far too early for EPs, CMS, EHR vendors, measure developers, and others to comply with this requirement. Our reasons for urging the deferral are described in detail below:

- EPs should not be required to submit such data until CMS is fully prepared to receive such data electronically, including from registries where EPs elect to submit quality data from their EHR to such registries. An interim attestation requirement would be unnecessarily burdensome.

- Before quality data reporting is required, CMS should identify appropriate quality measures with e-specifications and allow for public comment on such e-specifications.
- We agree with the HIT Policy Committee's recommendation described in its February 17, 2010, letter to Dr. David Blumenthal that the proposed core measures are not appropriate and should be dropped.
- More time is needed for physician specialties to identify appropriate quality measures for reporting from EHRs, including measures that are relevant to as many physician practices as possible. The currently proposed measures would not be relevant to entire specialties and subspecialties. For example, the proposed measures for ophthalmology would not be relevant for ophthalmologists who specialize in the management of glaucoma or cataracts, and no measures are proposed for anesthesiology even though some anesthesiologists might not meet the proposed definition of hospital-based physicians (see below for additional discussion of this issue), and thus be subject to meaningful use requirements. Further, we seriously doubt that EHR vendors would be prepared in the near term to accommodate the customization that we anticipate will be required to meet the diverse quality data reporting needs of various specialties.
- When CMS ultimately does require quality data submission, the Agency should limit this requirement to Medicare patients (for Medicare EHR incentives) or Medicaid patients (for Medicaid EHR incentives), and not require data submission for all patients. After sufficient experience with data submission for Medicare and Medicaid patients, CMS and other stakeholders would then be in a better position to determine the appropriateness and value of requiring data submission for a broader patient population.

In terms of the specific measures being proposed, CMS lists six measures for the "Proceduralists/Surgery" measure group but also says that it expects that each measure group would be narrowed down to a required subset of three to five measures. Having noted above our strong view that quality reporting should be deferred as a meaningful use criterion for the time being, we offer these additional thoughts regarding the six proposed surgery measures. First, the proposed measures would not accommodate all surgical specialists and, as noted earlier, no measures are specified for anesthesiology even though there is no iron-clad guarantee that all anesthesiologists will be considered hospital-based and thus not subject to EHR meaningful use requirements. Second, some measures might not easily be captured in an ambulatory EHR (for example, 30-day readmission rate).

In terms of the ophthalmology measures group, the three proposed measures do not represent the full spectrum of ophthalmology and its various subspecialties. Ophthalmology has created a robust set of eye care measures that are included in CMS' Physician Quality Reporting Initiative (PQRI) program and are National Quality Forum (NQF) approved. However, more work is needed in regards to the creation of e-specifications and testing of EHR compatibility for all of the eye care measures.

Similarly, in terms of the obstetrics and gynecology measures group, CMS lists nine measures that may be appropriate for general obstetrician-gynecologists, but that are not appropriate for certain obstetrician-gynecologist specialists, including maternal fetal medicine specialists, reproductive endocrinology and infertility specialists, and uro-gynecologists. Such specialists would not report on any of these nine measures identified in the proposed obstetrics and gynecology measures group, and we believe that more work is required to identify suitable measures and related e-specifications for this measures group.

HOSPITAL-BASED MDS

CMS proposes to define hospital-based EPs as those furnishing at least 90 percent of allowed services in a hospital setting, either inpatient, outpatient or an emergency department. We appreciate the fact that the proposed threshold was likely selected to permit as many physicians and other relevant professionals as possible to be potentially eligible for Medicare or Medicaid EHR incentive payments, but we offer the following comments. The 90 percent threshold would generally appear to be workable in the context of voluntary eligibility for incentive payments. However, we are concerned that this threshold will be too high when the time comes to determine which EPs should be subject to penalties for failure to become meaningful users of certified EHR technology.

For example, we would argue that a physician, such as a surgeon or anesthesiologist furnishing 75 to 90 percent of his or her allowed services in a hospital setting should not be subject to penalties because it would not be reasonable to expect them to acquire a certified EHR in the first place. Instead, such physicians would likely be using technology acquired by the hospital(s) in which they furnish a very large proportion of their services. And if such hospital(s) chose not to acquire and implement certified EHR technology, the affected physicians should not be penalized for this failure. Perhaps this situation could be addressed as CMS undertakes rulemaking relating to the significant hardship exceptions authorized under ARRA.

Second, the 90 percent threshold, which is based on allowed services and the setting(s) in which they are performed, risks placing surgeons paid primarily on a global fee basis at some disadvantage. This is because the typical allowed service for surgeons is a global service (with a 10 or 90-day global period) comprised of a procedure furnished in one

setting and pre-operative and post-operative services that may be furnished, in whole or in part, in other settings. For example, while a major procedure might be performed in a hospital inpatient or outpatient setting, other elements of the global service might be furnished in the office of the physician who performed the procedure. Nevertheless, as we understand CMS' proposed method for determining which physicians are hospital-based, a physician performing a procedure subject to global payment would receive no credit for services included in the global fee that are actually furnished in his or her own office. At the very least, this suggests that CMS should consider making some accommodation in its definition of hospital-based physicians for physicians primarily paid on a global fee basis. Such an accommodation would acknowledge the fact that physicians furnishing large numbers of global surgical services in a hospital setting might nonetheless maintain an active office practice for which an ambulatory EHR would be of benefit and for which EHR incentive payments should be possible.

Third, we believe that CMS should establish a mechanism for informing EPs about whether they are or are not considered "hospital-based." Otherwise, a given EP might have no way of knowing whether he or she is eligible for financial incentives beginning in 2011, or whether he or she is subject to penalties beginning in 2015. In this regard, as noted above, we are concerned about the potential implications for EPs considered "hospital-based" in some years but not others, especially if they are just above or just below the 90 percent threshold. In any event, we believe that there should be some means for EPs to determine their "hospital-based" status in a timely manner.

Finally, with respect to the definition of hospital-based physician and eligibility for EHR incentive payments, we remain concerned that any definition will result in denying access to EHR incentive payments to some health professionals who have personally incurred the costs associated with the acquisition, implementation, and meaningful use of certified EHR technology. In our view, any physician or other entity that incurs such costs and can demonstrate meaningful use of such technology should also qualify for EHR incentive payments. Simply assuming that such physicians are using EHR technology acquired and paid for by others does not appear fair or reasonable. The underlying premise of the statutory language relating to hospital-based physicians (in the context of EHR incentive payments) is that the hospital-based physician would be using the EHR "of the hospital." However, where this is not the case, we believe that EHR incentive payments should be available to physicians meaningfully using EHR technology that they themselves have acquired and paid for.

OTHER ISSUES

We believe that it will be critical for CMS or the Office of the National Coordinator for Health Information Technology (ONC) to create a mechanism for evaluating the progression of meaningful use objectives and measures, as well as the costs of adoption,

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prior to moving from Stage 1 to Stage 2. With respect to planning for Stages 2 and 3, we support the HIT Policy Committee recommendation described in its February 17, 2010, letter to Dr. David Blumenthal that to the extent possible, CMS should consider publishing the Stage 2 meaningful use notice of proposed rulemaking well before the anticipated December 2011 timeframe because vendors need more time to develop the appropriate functionality and providers need more time to integrate it into the clinical workflow.

Finally, we note that the Medicaid incentive program qualifying threshold for pediatricians would be a minimum of 20 percent of all patient encounters attributable to Medicaid over any continuous 90-day period within the most recent calendar year prior to reporting (rather than the 30 percent threshold for other EPs). We believe that the lower threshold should apply to EPs in various pediatric specialties and subspecialties, such as pediatric surgery, pediatric orthopedics, and others that focus on a pediatric patient population. Not providing pediatric specialists and subspecialists with the same opportunity to qualify for Medicaid EHR financial incentives as general pediatricians runs counter to the intent of ARRA and the overarching goal of encouraging interoperability (e.g., electronic exchanges between general pediatricians and pediatric specialists and subspecialists.)

We hope the preceding comments are helpful. If you have any questions about these comments or need more information, please contact Vinita Ollapally, Senior Regulatory Associate, American College of Surgeons, at (202) 672-1510 or via e-mail at vollapally@facs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology- Head and Neck Surgery
American Association for the Surgery of Trauma
American Association of Neurological Surgeons
American Association of Orthopedic Surgeons
American College of Osteopathic Surgeons
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Osteopathic Academy of Orthopedics
American Society for Cataract and Refractive Surgery
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Plastic Surgeons
American Urogynecologic Society

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American Urological Association
Congress of Neurological Surgeons
Eastern Association for the Surgery of Trauma
Society for Vascular Surgery
Society of Gynecological Oncologists
Society of Thoracic Surgeons