McKesson Corporation
One Post Street
San Francisco, CA 94104-5296

Ann Richardson Berkey
Senior Vice President, Public Affairs

MCKESSON
Empowering Healthcare

March 15, 2010

The Honorable Charlene Frizzera
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-0033-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: **Comments on CMS-0033-P Medicare and Medicaid Programs; Electronic Health Record Incentive Program**

Dear Administrator Frizzera:

On behalf of McKesson Corporation (hereinafter "McKesson"), I am pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the initial criteria required by eligible providers to qualify for the electronic health record (EHR) incentive program.

For 177 years, McKesson has led the industry in the delivery of medicines and healthcare products. As the largest health information technology (IT) company in the world, we are actively engaged in the transformation of healthcare from a system burdened by paper to one empowered by interoperable electronic solutions that improve patient safety, reduce the cost and variability of care, and improve healthcare efficiency.

McKesson has decades of experience serving the health IT needs of the largest and most diverse provider customer base in the industry, including 50 percent of all health systems, 77 percent of health systems with more than 200 beds, 20 percent of all physician practices and 25 percent of home care agencies, supporting more than 50,000 home care visits annually. Our perspective on these recommendations is based on our extensive experience with health IT and the quality, safety and efficiency improvements that can be realized by the hospitals, health systems, physicians and pharmacies that adopt such technology.

General Comments

McKesson strongly supports the overarching goal of the HITECH provisions in the American Reinvestment and Recovery Act of 2009 (ARRA) to encourage providers to adopt EHR systems and other health IT solutions to improve the quality and efficiency of patient care. McKesson supports the key goals adapted from the National Priorities Partnership as an effective template for defining the criteria and the progression needed to measure meaningful use over the implementation timeframe for ARRA. We are pleased that the proposed rules for meaningful use and interim final rule for certification are closely aligned; however, we offer recommendations to improve the applicability and relevance to both physicians and hospitals.

We see significant gaps between the proposed rules for meaningful use and certification and today's real-world infrastructure and the readiness of eligible providers and eligible hospitals. The proposed rule for meaningful use establishes an application model that requires all applicants to qualify at Stage 3 by 2015, thereby creating an aggressive path for providers unable to start during the first qualification year. This formula for compliance is inconsistent with accepted practice and the evolution of successful EHR system implementations, and subsequently will impede the ultimate goal of encouraging greater adoption and use of health IT. Therefore, we recommend rewards for incremental progress, flexibility in achieving adoption milestones, and less emphasis on the attainment of any one criterion. We believe this approach will achieve the broadest possible participation in health IT adoption.

Modify Staging for Successful Participation

Through McKesson's experience in successfully deploying technology in hundreds of hospitals, health systems and thousands of physician practices, we have learned that success hinges not only on the technology, but on thoughtful roadmaps and governance models that include the necessary policy and process changes that drive adoption.

McKesson recognizes that the proposed staging model attempts to create equality among all qualifying providers by requiring that providers who deploy EHR systems later than 2011 meet the same goals as early adopters. In order to minimize the "digital divide" between hospitals and physician practices that have EHR technology and those that do not, we recommend that every provider have at least two years to adapt to the new technology before being required to move to the next stage. Our concern is that the proposed staging model will discourage many small and rural providers from attempting to qualify for ARRA incentives.

Broaden the Definition of Eligible Provider

Since one of the key goals of the HITECH Act is to promote health IT adoption to better coordinate care across providers and settings, it is important to incentivize as many physicians as possible to realize this objective. The proposed rule excludes physicians who practice in outpatient centers and clinics owned by a hospital from receiving incentive payments, despite clear Congressional intent to include them. To achieve widespread and meaningful use of EHRs, hospitals must be able to electronically coordinate patient care across the continuum with their employed physicians as well as those who are independent. McKesson recommends that CMS modify the eligibility criteria to include physicians who practice in an office or clinic that is owned by the hospital.

Narrow the Definition of an EHR

McKesson agrees with comments submitted by the American Hospital Association (AHA), the College of Healthcare Information Management Executives (CHIME), Health Level 7 (HL7), the Healthcare Leadership Council (HLC) and others, which call for the elimination of proposed meaningful use and certification criteria requiring the inclusion of administrative data for "complete EHRs." By including administrative information such as insurance verification, eligibility checking and electronic claims submission, the definition for a certified EHR system extends well beyond core patient care functions. As a result, both complete and modular EHR systems would need to be certified, along with any financial hospital information systems (HIS), practice management system (PMS) and any health information exchanges (HIEs) that provide for the transport, routing and packaging of this data.

Consistent with the goals of the HITECH Act, McKesson recommends that the definition of a certified EHR be limited to core patient care functions, such as clinical documentation, medication management, CPOE, clinical decision support, care coordination and quality management. Insurance eligibility verification and automated claims submission requirements should not be included.

Couple Flexibility with Progression in Stages

McKesson believes greater flexibility and a more gradual approach toward full EHR adoption is necessary to ensure steady progress in encouraging adoption. By front-loading workflow requirements in Stage 1, the proposed rules risk overwhelming healthcare providers and may, in fact, slow adoption of EHR technology as providers seek to delay such dramatic changes to their operations.

We urge greater flexibility for eligible providers and hospitals to enable them to qualify for the meaningful use incentives. For eligible providers, we recommend aligning the Stage 1 incentive threshold with the targets established in the Medicare Improvements for Patients and Providers Act (MIPPA). We also recommend that hospitals have the flexibility to substitute the medication administration goal now proposed in Stage 2 for the proposed Stage 1 goal of computerized provider order entry (CPOE) adoption, so long as these hospitals are required to meet all Stage 1 goals by the conclusion of the Stage 2 time period.

Moreover, we also support a lower meaningful use threshold rather than the proposed "all or nothing" approach. McKesson supports a tiered approach that was recommended by the Health IT Policy Committee. Specifically, McKesson recommends the following objectives for each stage:

- Stage 1: 50% achievement of the objectives
- Stage 2: 75% achievement of the objectives
- Stage 3: 90% achievement of the objectives

Hospitals and CPOE

Through our experience, we have learned that the majority of hospitals do not typically implement CPOE as a first step toward clinical automation. Rather, most hospitals focus initially on automating ancillary departments and then proceed to automating the clinical functions of nursing documentation, medication administration and clinical monitoring. These other vital systems build the required infrastructure and the clinical progression that is so critical to the successful implementation of CPOE. Our customers have found that this progression enables them to create the needed governance model for managing physician relationships and workflow change that ultimately drive adoption. This has been the conventional health IT adoption model in the industry since the 1999 Institute of Medicine (IOM) report revealed the magnitude of the patient safety problem. Requiring CPOE as a Stage 1 requirement inverts these priorities for hospitals, forcing them to rush to CPOE without the necessary pre-requisite systems for successful implementation.

The HIMSS (Health Information Management Systems Society) Analytics study points out that only 13.5 percent of U.S. hospitals have reached Stage 4 in its EMR Adoption Model with CPOE/CDS deployed. In contrast, 85.5 percent of U.S. hospitals have reached Stage 3 in its EMR Adoption Model and deployed nursing documentation and other ancillary solutions that create the building blocks for CPOE success. The HIMSS Analytics study also recommends that nursing applications, such as flow sheets, care plans, and eMAR, should be implemented before

CPOE in hospitals. In addition, the AHA has surveyed overall industry readiness and found that not a single U.S. hospital can currently meet 12 out of the 23 proposed meaningful use objectives. The AHA also concludes that very few hospitals will be able to meet the proposed requirements, even though they are considered among the leaders in adoption of EHRs.

McKesson believes eligible hospitals that have invested in some of the meaningful use technologies currently identified as Stage 2 objectives, such as medication administration and nursing documentation, should be allowed to utilize those technologies in Stage 1. Therefore, we recommend allowing hospitals to substitute the Stage 2 goal for medication administration for the goal of CPOE use, provided they meet both goals by Stage 2.

Eligible Providers and CPOE

The requirement for 80 percent CPOE use in Stage 1 by eligible providers is not consistent with the goal of broad health IT adoption. A 2008 *New England Journal of Medicine* study showed that only four percent of U.S. physicians use a fully-functional EHR. In the ambulatory setting, our experience indicates that physicians typically deploy e-prescribing first and enter only a small portion of other clinical orders electronically. After the implementation of e-prescribing, physician practices will typically automate medications and allergy lists, and then clinical documentation. After achieving adoption in these areas, physicians will then incorporate other ancillary data, such as laboratory results and treatment orders, into the patient record. McKesson recommends reinforcing the e-prescribing targets included in MIPPA as a requirement for Stage 1 and ensuring that the CPOE objective is fully achieved by Stage 3.

In summary, McKesson recommends that there be flexibility in the progression of Stage 1 and Stage 2 requirements, which will allow eligible physicians and hospitals to build their clinical automation and patient safety initiatives in the order that has been proven successful over the last 11 years. Since industry practice is clearly further along with medication administration, nursing documentation and other clinical automation, McKesson recommends an adoption model that enables providers to utilize work already completed and then build upon it. For those that have not deployed these foundational technologies, the incentives can effectively drive adoption more systematically.

Provide Greater Specificity for Vendor and Provider Roadmaps

To foster provider participation and reduce healthcare costs, we believe that both healthcare providers and vendors of EHR platforms will be able to make better investment decisions if ONC provides a roadmap to address all of the major standards and functionality for each of the three stages. Vendors need time to develop the appropriate functionality for EHR systems, and hospitals and eligible providers need time to integrate the new standards into their clinical workflow. As such, clear communication regarding forthcoming meaningful use requirements is critical to ensure that providers are given predictable expectations. The financial impact of changing direction every few years to meet new or adjusted requirements has the potential to drive healthcare expenses exponentially higher in the form of administrative and development costs.

We recommend the creation of a roadmap for adoption of clinical automation standards that includes all major measures and IT functionality through Stage 3. The roadmap should provide clear expectations for providers and vendors over at least a four to five year time period.

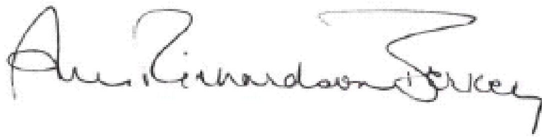
Conclusion

McKesson applauds the efforts of CMS to establish comprehensive requirements for the adoption and meaningful use of EHRs and strongly supports incentives for eligible providers. In summary, we recommend that the following changes be incorporated in the final rule for the successful implementation of incentives for eligible providers to adopt and use EHRs:

- Modify the staging model relative to the industry's current adoption experience to encourage greater participation and success among healthcare providers;
- Re-examine the definition of and eligibility for a hospital-based provider to enable hospitals to electronically coordinate patient care across the continuum;
- Narrow the definition of an EHR to core patient care functions;
- Allow greater flexibility in measuring and attaining the meaningful use objectives;
- Provide a detailed roadmap, including guidance for Stages 2 and 3, to support provider and vendor success; and
- Reward incremental progress to encourage broad participation over a defined timeline.

Thank you for the opportunity to provide our comments on the proposed rule to establish the initial criteria required by eligible providers to qualify for the electronic health record (EHR) incentive program. We hope these comments provide constructive insights as CMS finalizes the requirements for incentive payments for the adoption and use of EHRs. Should you have questions or need further information, please contact me at (415) 983-8494 or ann.berkey@mckesson.com.

Sincerely,



Ann Richardson Berkey