May 26, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3310-P
Submitted electronically to: http://www.regulations.gov (tracking number: 1jz-8j2l-9ddq)

Dear Mr. Slavitt:

The College of Healthcare Information Management Executives (CHIME) appreciates the opportunity to submit comments regarding the regulation proposed by the Centers for Medicare & Medicaid Services (CMS) for Stage 3 of the electronic health record (EHR) meaningful use program.

CHIME has more than 1,400 members, composed of chief information officers (CIOs) and other top information technology executives at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business information technology (IT) systems that will facilitate healthcare transformation. CHIME shares the vision of an e-enabled healthcare system as described by the many efforts under way at the Department of Health and Human Services.

CHIME appreciates the numerous competing priorities CMS is trying to address with this proposed rule. We acknowledge that CMS has tried to streamline participation by reducing the number of objectives and harmonizing reporting periods for eligible professionals (EPs) eligible hospitals (EHs) and critical access hospitals (CAHs). However, we regretfully submit that the sum total of proposals for Stage 3 meaningful use is unworkable. Were all requirements finalized as proposed, we doubt many providers could participate in 2018 successfully. And with so few providers having demonstrated Stage 2 capabilities, we question the underlying feasibility of many requirements and we question the logic of building on deficient measures.

The EHR Incentive program has been instrumental towards increasing the adoption of EHRs among providers and it has encouraged organizations to redesign decades-old workflows meant to capitalize on the advantages of modern information technology. However, this program has demanded more of providers and their vendor partners than any comparable program managed by the federal government. And while CMS has attempted to make the program sustainable for the long-term, several important changes need to be adopted in the final version of this proposed rule. CHIME recommends CMS:

- Make available a 90-day reporting period for the first year of Stage 3 compliance, at least for payment adjustment purposes;

- Modify requirements for and retain the 90-day reporting period for providers attesting to meaningful use requirements for the first time, whether in a Medicare or Medicaid context;
- Eliminate patient action thresholds for the care coordination objective;
- Reduce the number of required measures in multi-measure objectives, health information exchange and care coordination;
- Create hardship exceptions for providers switching vendors;
- Allow providers to take a 90-day reprieve during any program year for upgrades, planned downtime, bug fixes related to new technology or optimizing the use of new technology within new workflows; and
- Allow, in limited circumstances, paper-based means to achieve measure thresholds.

Additionally, CMS needs to consider a single definition of meaningful use that relies simply on outcome quality measures, relies on participation in proxy programs – such as the Million Hearts campaign – or otherwise reduces compliance burdens for the long-term. We support the notion that full reimbursement should be contingent on use of modern technologies and techniques, but the year-over-year compliance costs of participating in the Medicare and Medicaid EHR Incentive program are simply unsustainable, especially in the context of other HHS regulatory requirements and Departmental goals.

Lastly, CHIME believes it would be prudent for CMS to finalize this proposed rule following completion of the 2016 program year. Much of the rule portends the widespread availability of new technologies, such as application program interfaces (APIs) to accomplish objectives. While we do not disagree that APIs and emerging standards architectures, such as FHIR, hold incredible promise, we believe it premature to rely so heavily on untested, unproven technology in healthcare. The additional time would also give policymakers a chance to understand how the private sector performs relative to modifications proposed for program years 2015 through 2017 (FR 80 20346-20399).

CHIME hopes our comments, attached below, are helpful. Should you have any questions about these comments or need more information, please contact Leslie Krigstein, Interim Vice President of Public Policy at lkrigstein@chimecentral.org. We look forward to continued partnership and dialogue.

Sincerely,

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CC: Dr. Karen DeSalvo, National Coordinator, Office of the National Coordinator for Health Information Technology, US Department of Health & Human Services

Enclosed Attachment

Stage 3 Required for All Providers in 2018

Under the CMS proposed rule, all providers—eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs)—would be required to meet Stage 3 EHR meaningful use (MU) requirements beginning in 2018 regardless of their prior participation.

CHIME sees the value of having all providers held to the same set of meaningful use and certified electronic health record (CEHRT) requirements, especially since this is likely to further the important goal of interoperability. On the other hand, since essentially the same requirements are being proposed for all providers, whether small or large, whether urban or rural, whether they serve a medically literate population with ready access to computers and other technology or not, we believe it is critical that these requirements strike a reasonable balance or allow for additional exceptions for those without adequate resources to meet the regulations. While we acknowledge policymakers' intention to make each Stage more difficult than the last, we are concerned with the strategy that envisions Stage 3 serving as both the apex of MU requirements and as a starting point for those providers with no experience at Stage 1 or Stage 2 of the EHR Incentive program. We worry some of the objectives, outlined in greater detail below, pose too great a stretch for seasoned meaningful users, let alone those who have never participated in the program.

Finally, we continue to believe that provisions which hold providers accountable for the actions of patients and other providers, relative to their use of technology, are ill-conceived. We fully appreciate the intentions of policymakers to distribute responsibility across providers to engage patients, or to encourage wider adoption of EHRs and exchange of patient data. However, we believe the specific patient engagement measures chosen for meaningful use have, in many instances, distracted users from the true objectives proposed. Rather than choose arbitrary percentages, we believe that simply demonstrating that these capabilities are implemented should be sufficient.

Below we provide comments regarding specific objectives, their related measures, and other matters. As noted in more detail below, we believe that some of the elements of the proposed rule are overly ambitious and could easily result in an anti-EHR-meaningful-use backlash by providers. In short, unless the proposed Stage 3 requirements are modified in important ways, along the lines of what we recommend below, we believe that a requirement that all providers meet Stage 3 requirements in 2018 would not be feasible.

CHIME also wishes to emphasize our strong belief that providers should have the flexibility to use a 90-day reporting period for the first year in which they choose to adopt the 2015 Edition of EHR technology and attempt to meet Stage 3 meaningful use requirements (whether that is 2017 or 2018). It is simply unreasonable to expect providers to adopt a new version of EHR technology, complete all the related testing and training, and make all the workflow and other adjustments needed to meet Stage 3 requirements on the timeline proposed in this rule. We note that CHIME and other stakeholders previously warned CMS regarding this problem for purposes of the 2015 reporting period and CMS has belatedly proposed a 90-day reporting period for 2015, even though the final rule on this will not be published until we are well into 2015. To avoid this kind of chaos, we urge

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CMS to provide for a 90-day reporting period for the first year of Stage 3 compliance and to do so in the first Stage 3 final rule that is published.

Objective 1: Protect Patient Health Information

Objective 1 focuses on protecting patient health information through technical, administrative and physical safeguards. The related measure would require providers to conduct or review a security risk analysis and implement security updates as necessary, with the timing or review of such analysis required to occur upon installation of CEHRT or upon upgrade to a new Edition of CEHRT, and subsequently at least once per EHR reporting period.

CHIME continues to believe that this objective is superfluous, given the fact that the Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements already apply to providers and we see no need to impose any additional requirements through the EHR meaningful use program. However, we understand and agree with the need to protect electronic personal health information (ePHI). As such, our concern is that providers may be confused over the timing of required assessments / reviews. Given the measure's wording, we suggest finalizing the proposal in the following way:

The timing or review of the security risk analysis to satisfy this proposed measure must be as follows:

- EPs, eligible hospitals, and CAHs must conduct the security risk analysis upon initial installation of CEHRT or upon upgrade to a new Edition of certified EHR Technology. The initial security risk analysis and testing may occur prior to the beginning of the first EHR reporting period using that certified EHR technology.
- In subsequent years, a provider must review the security risk analysis of the CEHRT and the administrative, physical, and technical safeguards implemented, and review the security analysis as necessary, but at least once per EHR reporting period.

This clarification will help providers understand their responsibilities vis-à-vis this objective and avoid any possible misunderstanding that reviews be required every time a provider receives a patch or other update to their CEHRT from a vendor.

Objective 2: Electronic Prescribing

Objective 2 focuses on electronic prescribing. One related measure applies to EPs while the other applies to hospitals. More specifically, the proposed hospital measure would require that more than 25 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) be queried for a drug formulary and transmitted electronically using CEHRT.

CHIME believes the proposed hospital measure should be modified to require 10 percent of discharge medication orders be queried for a drug formulary and transmitted electronically, not 25

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percent. We also recommend CMS continue to allow refill prescriptions to count, not only new and changed prescriptions. This would greatly simplify compliance efforts.

With respect to Objective 2, CMS encourages public comment on whether over-the-counter (OTC) medicines should be included for purposes of Stage 3. CHIME agrees with the CMS proposal to continue to exclude OTC medicines from the definition of a prescription.

Objective 4: Computerized Provider Order Entry

Proposed Objective 4 focuses on computerized provider order entry (CPOE) with separate measures for medication, laboratory and diagnostic imaging orders. The proposed rule emphasizes that laypersons are not qualified to perform the clinical decision support-related functions associated with order entry. It also notes that a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant could qualify to enter orders for purposes of Objective 4 but only if a credentialing body other than the medical staff member's employer performed the credentialing function. The proposed rule does not specifically address the implications of the proposed policies with respect to the use of scribes. We note that a recent article published in the Journal of the American Medical Association states that "the Joint Commission prohibition on use of scribes for order entry is unequivocal" and adds that "some physicians still advocate use of medical scribes for CPOE."[1] This same article also notes that a number of organizations currently train and certify scribes. CHIME urges CMS to address the issue of scribes in the final rule and to indicate whether and when such individuals might satisfy the requirements related to Objective 4 for EPs and/or hospitals. For example, we wonder whether a third party that certifies scribes could qualify as a credentialing body if it were not the scribes' employer. We also understand that some scribes now enter orders only when the physician is present in the same room, in part to facilitate communication regarding clinical decision support alerts and other matters, and wonder whether such physician presence might be an important factor to consider.

Measure 1 would increase the percentage threshold related to CPOE use for medication orders from 60 percent for Stage 2 to 80 percent. CHIME is concerned that this proposed increase would be too great for some providers and believes that it would be better to maintain the current threshold. In addition, since we support the proposed 60 percent thresholds for laboratory and diagnostic imaging orders, we strongly believe there would be great value in having the same percentage threshold apply to all three types of orders.

Objective 5: Patient Electronic Access to Health Information

Objective 5 addresses patient electronic access to their health information and the use of clinically relevant information from CEHRT to identify patient-specific educational resources and provide

[1] George A. Gellert, Ricardo Ramirez, and S. Luke Webster, "The Rise of the Medical Scribe Industry: Implications for the Advancement of Electronic Health Records," Journal of the American Medical Association 313 (13):1315-1316, April 7, 2015

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electronic access to them. Measure 1 focuses on the first issue and Measure 2 focuses on the second.

CHIME does not have any major concerns with the proposed access threshold for Measure 1, especially since there are two means to satisfy the requirement. Patients may either be provided access to view online, download, and transmit their health information (e.g., through a portal) **or** provided access to an application-program interface (API) certified by the Office of the National Coordinator for HIT (ONC) that can be used by third-party applications or devices to provide patients access to their health information. However, we would note that there is tremendous uncertainty regarding APIs, including potential security and authentication issues, and even whether they will be readily available in vendor products by 2018. Thus, CHIME opposes the alternate proposals discussed in the proposed rule, all of which would in some way require EPs and hospitals to make the API function available to patients. In addition, CHIME takes this opportunity to again bemoan the lack of patient safety identifiers that we believe are essential to safe and efficient accessibility to, and exchange of, electronic health information.

The above comments notwithstanding, CHIME believes the current policy relative to timely access is appropriate. We note that comparable Stage 2 measures give EPs 4 business days and require hospitals to make information accessible within 36 hours of patient discharge. The 24 hour timeframe does not, for example, provide time for a hospital to give the patient's attending physician time to review the information to be made accessible or account for possible system downtime or other technical impediments to information posting. Additionally, we wish to underscore the importance of having relevant context joining health information when it is presented; we see no reason to reduce the applicable timeframe. Further, given CMS' decision to adopt the same Measure 1 for both EPs and hospitals, we believe that the final rule must clarify whether the specified timeframe would apply no earlier than after the patient has been discharged from the hospital. For example, for a patient who is hospitalized for several days or held in observation status for a lengthy period, we presume that CMS is not intending to imply that they must be given electronic access to "available" health information prior to discharge. The comparable Stage 2 measure makes this clear but not the proposed Stage 3 measure.

CHIME has very strong reservations regarding Measure 2, which not only increases the percentage threshold from 10 percent for the somewhat comparable core measure under Stage 2 to 35 percent, but also precludes counting in the numerator those instances where the patients have been furnished (given access to) educational materials in a non-electronic format. CHIME agrees that electronic access to such educational materials may have important advantages, but we believe it is premature to require such electronic access for a specified percentage of unique patients, especially a percentage considerably higher than the current one under Stage 2 (where the provision of educational resources in non-electronic formats can be counted in the measure numerator, thus facilitating compliance). We believe such an electronic access requirement would impose significant additional costs on providers stemming from content vendor-related charges, and would also necessitate workflow changes. In light of the above, CHIME recommends that the percentage threshold for Measure 2 not be increased or that this Measure be considered optional until there is more experience with electronic access to educational resources.

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Objective 5 is the first objective for which an exclusion is provided based on broadband availability. More specifically, this exclusion is available to an EP who conducts 50 percent of more of his or her patient encounters in a county or any hospital in a county that does not have 50 percent or more of its housing units with 4MBps broadband availability according to the latest information available from the Federal Communications Commission (FCC) at the start of the EHR reporting period. The same exclusion is available for Objectives 6 and 7. CHIME notes, however, that the FCC recently changed its definition of broadband from 4 Mbps to 25 Mbps, which has the effect of significantly reducing the percentage of the United States population considered to have high-speed Internet access. The proposed rule ignores this important policy change. However, CHIME believes that, in doing so, CMS is proposing to retain an outdated and inadequate exclusion policy. This will become more problematic given CMS' evident intent to increase EHR meaningful use requirements for which broadband access is a critical factor. We, therefore, urge CMS to re-examine this issue in light of the decision made earlier this year by the FCC.

Objective 6: Coordination of Care through Patient Engagement

Objective 6 focuses on the use of the communication functions of CEHRT to engage patients or their authorized representatives about patients' care. Measure 1 addresses patients actively taking advantage of available options for accessing their health information. Measure 2 addresses the sending of secure messages containing health information to patients or their representatives by providers. Measure 3 requires the incorporation into CEHRT of patient-generated health data or data from what the proposed rule labels "non-clinical settings." Under the proposed rule, providers would need to attest to the numerator and denominator for all three Measures and successfully meet the threshold for two of the three measures.

The Measure 1 percentage threshold of more than 25 percent of unique patients actively accessing their health information is far too ambitious, especially given CMS' recent release of a separate proposed rule that would require only a single patient do so for the years 2015 through 2017. Thus, while the Stage 3 proposed rule notes that the measure threshold for Measure 1 would increase from 5 percent for Stage 2 (for a related measure) to 25 percent, this point has now been overtaken by CMS' more recent regulatory proposal. We note, too, that the Stage 3 proposed rule justified the proposed increase to 25 percent by pointing to Stage 2 median performance for hospitals of 11 percent, which is considerably below the proposed 25 percent threshold. Under the circumstances, we believe it would be more reasonable to adopt a 5 percent threshold for Stage 3, as this would be a more logical and potentially more feasible progression from the "single patient" threshold under the proposed rule for 2015 through 2017. As it is, our members tell us that many of their patients are not even willing to sign up for their portals, a necessary step to gaining access to their health information. In other cases, it is simply unreasonable to expect patients being treated by multiple providers to access the portals of all of these providers. Also, as noted earlier, we are deeply concerned about objectives and measures that leave providers vulnerable for patient unwillingness or inability to complete certain actions. Further, to the extent that policy makers wish patients to take specific actions, they need to provide sufficient incentives for them to do so, and not simply hold providers accountable for behavior over which they have essentially no control. In sum,

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CHIME has significant concerns regarding Measure 1 and recommend adoption of a significantly lower threshold.

As far as Measure 2 is concerned, CHIME does not believe that secure messaging should be considered relevant for most patients discharged from the inpatient or emergency department settings. Once again, a secure messaging measure strikes us as much more relevant to the EP setting, especially where there is an ongoing relationship between the EP and the patient. However, even for EPs, we believe the proposed threshold of 35 percent of unique patients having been sent a secure message is much too high. We note that CMS has just recently proposed that a comparable EP measure for 2015 through 2017 would be satisfied if the capability for patients to send and receive a secure electronic message with the EP was fully enabled. Going from this standard to the proposed 35 percent threshold would be unreasonable even in the EP context.

In the proposed rule, CMS asks whether Measure 3 should be proposed for hospitals or remain an option only for EPs. CHIME does not believe that Measure 3 is appropriate for patients discharged from hospital inpatient or emergency departments. Once these patients have left the hospital, their primary point of contact for incorporating patient-generated data or data from "non-clinical settings" should be an EP practice. While we understand CMS' desire to adopt a set of meaningful use objectives and measures involving minimal differences between EPs and hospitals, we do not consider Measure 3 to be appropriate for hospitals, even as an option.

Given the preceding comments, CHIME recommends that hospitals be required to meet only Measure 1, assuming a more reasonable threshold is adopted. We also believe it would be more reasonable to require EPs to meet only one of the three measures associated with this objective, provided that the requirements are amended to our recommendations.

Objective 7: Health Information Exchange

Objective 7 focuses on health information exchange. CMS proposes three measures, one focusing on the creation and electronic exchange of summary of care records, one on the incorporation of summary of care records by providers on the receiving end of a transition of care or referral, and one on clinical information reconciliation by a receiving provider. CMS proposes that providers would need to attest to the numerator and denominator for all three measures and successfully meet the threshold for two of the three.

CHIME's fundamental problem with proposed Objective 7 relates to the thresholds proposed for the three associated Measures. We believe they are unrealistic. In the case of Measure 1, many receiving providers are not able to accept electronic summary of care records today and many are unlikely to be capable of doing so even in 2018, such as post-acute care providers, who have not been eligible for EHR incentive payments. Further, in terms of Measures 2 and 3, we believe it would be unreasonable to focus not only on transitions of care and referrals, but also on patients never before seen by the provider. For example, emergency department workflows are simply incompatible with requirements to try to identify outside sources of summary of care records for

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walk-in patients. The infrastructure for doing this does not exist in most areas and is not likely to exist for several years to come.

In sum, CHIME recommends that the thresholds for all three Measures for Objective 7 be significantly reduced. For Measure 1, we would suggest a 20 percent threshold instead of the proposed 50 percent threshold. This would be double the threshold CMS recently proposed for 2015 through 2017 for the comparable measure. For Measure 2, a brand new measure, we would recommend a threshold of 10 percent. With respect to Measure 3, clinical information reconciliation, we recognize that the comparable Stage 2 medication reconciliation measure has a 50 percent threshold and that CMS recently proposed to retain this threshold for 2015 through 2017. However, given the very limited experience with medication reconciliation and given the expanded requirement to reconcile medication allergies and problems (not just medications), we would recommend against raising the clinical information reconciliation threshold for Measure 3. We note, too, lingering provider uncertainty about what actions can be counted in the reconciliation measure numerator (e.g., where it is not immediately possible to fully reconcile the information in question or where the clinician has doubts regarding some of the external/incoming information).

CHIME also questions the need to require providers to attest to all three Measures, even though they are not required to meet all three Measures. We would prefer that providers be required to attest only to the numerators and denominators of the measures they actively attempt to meet.

CMS poses several questions regarding the clinical information reconciliation measure. One question asks whether the reconciliation should be automated or manual. Some have been confused by this terminology, wondering whether CMS was envisioning the possibility that the external/incoming information might come in a non-electronic (paper) format, be "manually" reconciled and then incorporated into an EHR. We do not believe this is what CMS has in mind nor do we believe this measure should count instances in which external/incoming information arrives in a non-electronic format. On the other hand, we agree that the clinical information reconciliation should not be automatic (that is, it should not involve decisions made automatically by CEHRT rather than providers).

Objective 8: Public Health and Clinical Data Registry Reporting

Objective 8 focuses on public health (PHA) and clinical data registry (CDR) reporting. EPs would be required to choose from among 5 measures and successfully attest to any combination of three measures. Hospitals would be required to choose from among 6 measures and successfully attest to any combination of four measures.

CHIME believes this objective fails to recognize the limited capabilities of many PHAs and CDRs. Even in the arena of immunization reporting, bidirectional communication is far from an established capability. At this time, we are uncertain about the industry's ability to support full bidirectionality. We recognize that available exclusions for Objective 8 measures include those relating to PHA and CDR capacity to accept the specific standards required to meet the CEHRT definition and their readiness to receive data, but we also note that an exclusion for a measure would not count toward

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the total of 3 or 4 measures that must be met by an EP or hospital, respectively. In light of the current state of readiness of PHAs and CDRs, we believe that EPs and hospitals should be expected to meet a combination of 2 or 3 measures in Stage 3, respectively, not the proposed 3 or 4. We recognize that this is what CMS recently proposed for 2015 through 2017. However, we believe that our recommended measure requirements would be more reasonable for Stage 3 purposes and we will have more to say about the CMS proposed rule for 2015-2017 in the comments we intend to submit in response to that regulation. In addition, given all the increased requirements being proposed for Stage 3, we believe CMS should show restraint with respect to Objective 8.

EHR Technology Certification Requirements for Reporting of CQMs

In the proposed rule, CMS argues that EHRs should be certified to more than the minimum number of clinical quality measures (CQMs). CMS invites comment on a possible future rulemaking that would adopt a phased approach for requiring certification to a growing number of CQMs over time.

CHIME appreciates CMS' desire to give providers more options for reporting CQMs. However, we believe this must be balanced against the burdens that would be imposed on EHR vendors and acknowledge that any requirement to certify against all CQMs would involve a great deal of waste, especially when the CQM menu is large. In general, CHIME believes that the marketplace has been responsive to provider demands with respect to CQM reporting. While we see potential value in requiring that EHR products be certified against more than the minimum number of CQMs, we do not believe it would ever be necessary to require certification against all of them. What would be far more helpful to providers would be having all public and private payers and other quality data requesters agree on the same set of CQMs (and specifications) that need to be reported, whether such reporting is for monitoring, public disclosure, payment or other purposes.

Demonstration of Meaningful Use

CMS seeks comment on alternative policies that would reduce provider flexibility in 2017. For example, CMS asks whether providers should not have the option to attest to Stage 3 in 2017, and whether some providers should be required to attest to Stage 3 in 2017.

CHIME urges CMS to retain as much flexibility as possible in the final rule. In particular, we do not believe that any providers should be required to meet Stage 3 requirements in 2017, nor do we believe it would make sense to prohibit providers from meeting Stage 3 requirements if they chose to do so.

Payment Adjustments and Hardship Exceptions

Beginning with the EHR reporting period in 2017, CMS proposes to eliminate the option under which EPs and eligible hospitals that have never successfully attested to meaningful use would have an EHR reporting period for a payment adjustment year that is any continuous 90-day period, with a

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limited exception for Medicaid eligible providers demonstrating meaningful use for the first time. CMS also proposes no changes to the types of hardship exceptions available to EPs and hospitals for purposes of avoiding payment adjustments for failure to demonstrate meaningful use of CEHRT.

CHIME remains concerned about the decision to eliminate the 90-day reporting period option under Medicare for providers meeting meaningful use for the first time, especially with respect to payment adjustments. We note, too, that there are other circumstances besides first-time meaningful use demonstration that present significant challenges to providers forced to comply with a full calendar year reporting period. These include major CEHRT upgrades, and other major changes, such as the relocation of a data center. In light of this, we recommend that CMS give further consideration to its reporting period and hardship exception policies. More specifically, we urge CMS to adopt a 90-day reporting period for the first year of Stage 3 compliance, at least for payment adjustment purposes. We also urge CMS to retain the 90-day reporting period for providers attesting to meaningful use requirements for the first time, whether in a Medicare or Medicaid context. Finally, we ask CMS to consider new hardship exception policies that would allow providers to more easily switch vendors without fear of penalties. We recommend CMS adopt a hardship exception for providers switching EHR vendors, especially if CMS moves forward with full-year reporting periods in perpetuity. Our members express concern with their inability to transition to new products during any given 365-day period due to the overwhelming complexity of the task and the increasing thresholds of program participation. Many members recall an adoption cycle that last, at minimum, 8 to 14 months. For safety and competition concerns, CMS should adopt a new hardship for providers switching vendors. As noted much earlier, we believe it is simply unreasonable to give all providers only one option: they must plan for, test and fully implement a new CEHRT edition in time to "flip the switch" on January 1 or face a future payment adjustment. We believe this will not work and will end up penalizing a large number of providers.

Collection of Information Requirements

The proposed rule provides estimates of the amount of time required to attest to various meaningful use objectives and associated measures. These estimates assume that 1 to 10 minutes would be required per objective. While we presume these estimates comply with the requirements of the Paperwork Reduction Act, we cannot help but note that providers find these time estimates grossly misleading. Suffice it to say that meeting EHR meaningful use requirements requires a huge investment of staff time, and the focus of the Paperwork Reduction Act on mere attestation times ignores all the staff time required to plan for, and implement, CEHRT and accomplish the many demanding tasks required to demonstrate meaningful use, including adjustments to workflow. Focusing on attestation minutes strikes us as an insulting distraction. We recognize, of course, that the regulatory impact analysis accompanying the proposed rule attempts to estimate the financial resources required to purchase and implement CEHRT and for ongoing maintenance, upgrades and training (repeating estimates provided during past rulemaking) but we are not confident these financial estimates come close to capturing the required level of resources.

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