Dear Acting Administrator Frizzera:

The Alliance of Specialty Medicine (Alliance) is pleased to submit written comments on the Department of Health and Human Services Notice of Proposed Rule Making (NPRM), entitled, Medicare and Medicaid Programs; Electronic Health Record Incentive Program [CMS – 0033—P; RIN 0938 – AP78] that was posted in the Federal Register on January 13, 2010. The Alliance is a coalition of 10 national medical specialty societies representing more than 200,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

The Alliance supports the availability of financial incentives for meaningful use of electronic health record technology. We further appreciate the extensive efforts of the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), and the Office of National Coordinator (ONC) in trying to address the complex issues involved in the implementing regulations.

The essence of our comments that follow will be that CMS should reduce the number of specific criteria that eligible providers must meet in the first two years of this program; reflect differences in what is meaningful across different specialties, and also build in some flexibility for providers to select criteria that specifically fit their practice environment.

In general, we are concerned that the collective requirements in the NPRM represent a substantial burden for all physicians, especially specialists. There are, of course, already hospitals and some providers groups that have adopted and are meaningfully using electronic health record technology. Others have been weighing the burdens, uncertainties, change in work flow and other issues against the potential benefits of electronic health record technology adoption and use. Presumably some portion of the Medicare and Medicaid incentives would help move such participation forward.

However, with participation come multiple changes in work flow and numerous adjustments for a practice. CMS must take care not to add new challenges during this period of time.

We are also concerned that under the NPRM, some specialists would have to spend an excessive amount of time inputting patient information into their EHR systems that may not be essential to diagnosis and treatment of conditions or injuries. A specialist who is asked to create or maintain information not relevant to his area not only has an unnecessary burden but potential liabilities for areas not relevant to his or her practice. Therefore, we
would recommend that CMS set a specific number of the most highly valued criteria in order to meet the meaningful use definition as opposed to all of the standards and revisit the adoption timeframes. This will provide greater ability for physicians in small practices and specialties to adopt electronic health record technology and take advantage of incentives payments from Medicare and Medicaid.

II. Framework and Context

Congress has authorized substantial additional power to HHS through the Medicare and Medicaid meaningful use incentives pursuant to the American Recovery and Reinvestment Act (ARRA). Indeed, Congress even limited the accountability of the Department by restricting judicial review of decisions on standards and regulations under this program.

It is very difficult to account for what is meaningful or appropriate in thousands of existing, new and future health care and health information settings. The meaningful use rules will separate those who can obtain an incentive from those who cannot, but also down the road those who will be penalized and those who will not. If criteria are applied unfairly, without proper clarity, in a way that imposes needless burden on health care providers, in ways that restrict innovation, or that interfere with the specific needs of providers including specialties, such rules will harm and distort an already stressed system for providers. Providers who are basically doing the right thing and stepping up to the plate should receive the incentive payments and avoid penalties. Regulations should not impose needless detail in the name of “change management.”

We are concerned that the current proposal does not properly tailor to the needs of specialty practices. CMS proposes reporting of dozens of quality measures before they have been properly tested. The certification regime may need to evaluate thousands of permutations in how technology and software may be connected together to meet the definition of a certified electronic health record. In a rapidly changing world it is a mistake to restrict innovation and also a mistake to presume any given business model is best. The phrase “use” will need to accommodate electronic health record technology that is web-based and not physically present in any give location. Health information exchanges may provide some of the necessary services. This means providers will need to rely on the status of technology that may belong to a different legal entity.

Specialty doctors are clearly within the ambit of the Medicare and Medicaid incentives. It is incumbent on HHS not to create rules that would unnaturally force a specialty to perform a test or accounting measure if certain functions are not part of the general practice in that specialty.

While Congress has provided HHS substantial flexibility, the minimum requirements of the statute are not substantial. Beyond these minimum statutory requirements, any additional requirements should be fair, doable, understandable, and have a basis for why that standard at this time is the right thing to do. It is not a sufficient approach for HHS to throw a large range of unworkable standards and ask the public to explain the problems. It is also incumbent on HHS to explain the basis for each standard and distinction it would purport to apply.

The burdens of the rules should also be considered in the face of substantial cuts in Medicare reimbursement for providers, new requirements for 5010 and ICD-10 coding, new privacy and security rules, and existing reporting and other requirements. Health care professionals are first and foremost delivering care. There is a certain amount of energy that a practice can devote to government regulations, practice transformation, work flow changes, changes in medicine, changes from insurers, etc. HHS needs to ensure that they are not needlessly
adding to these burdens. Distraction from delivering care and more costs and distractions in an already stressed system would not be helpful.

III. Statutory Flexibility and Discretion

While Congress provided a great deal of flexibility to the Secretary to implement the meaningful use provisions such authority must be exercised in a credible and rational way. There are many known downsides to excessively regulatory programs and requirements that take time and resources from professionals and staff who need to provide care. Accordingly, HHS must justify requirements above the required statutory minimum with a record supporting that requirements advance quality, are reasonable, do not distract from care delivery, and are relevant to given professionals.

An appropriate place to start would be the statutory requirement to use EHR technology in a meaningful manner. This does not have to be a demanding standard. There are many activities listed in the NPRM and outside the NPRM that could constitute “use in a meaningful manner.” The statutory standard does not require eligible professionals to engage in activities or uses that are not relevant in the context of their practice. Congress included specialists in the list of eligible professionals. We contend that these regulations should not burden such specialty professionals with requirements that do not fit. HHS should not, as a practical matter, weed out specialties from the incentives because their specific uses are not as robust as primary care doctors or other specialists.

The statute requires an eligible professional or hospital to have certified EHR technology that is connected in a manner that provides for the electronic recording of health information. The statute does not require that any particular amounts, percentages, or other features be included in requirements.

The statute provides authority for the Secretary to select clinical quality measures, but does not require this on any particular date. There is no requirement that there be any particular core set. Nothing requires or suggests the Secretary should make such a requirement where the quality measures have not been tested or where HHS or others are not in a position to make relevant use of such measures.

From what we have read and through communications with many provider and other groups, we are not alone in suggesting that the sweep of the provisions in the NPRM is a significant problem; the provisions are not properly tailored, create ambiguity and uncertainty, fail to allow time for a reasonable certification process, and fail to provide time for proper adoption and planning for changes in work flow. None of these adverse outcomes are required by the statute and should be avoided as a matter of policy.

We believe it is incumbent on the CMS to have a record and reason supporting extensive requirements which may or may not be meaningful in a given context. CMS must be prepared to articulate a clear process and implement that process. If the agency cannot do this, it should not proceed with such an ambitious agenda. Specialists and all professional have every incentive to pursue meaningful activities.

IV. Comments and Recommendations

A. Meeting All Objectives and Associated Measures (Section 495.4 Definition of Meaningful EHR user)(Section 495.6(a))(Section 495.8(a))
In their draft letter from their February 17, 2010 meeting, the HIT Policy Committee stated among other recommendations:

“We believe it is important to exhibit some flexibility in the "all-or-nothing" approach to earning meaningful use incentives, while preserving a floor of important mandatory functional use requirements. We wish to move the nation forward quickly towards meaningful use by applying the front-loaded meaningful use incentives, yet we recognize that providers and vendors must have sufficient time to achieve an extensive array of objectives and measures. Unfortunately is it difficult to predict which objectives and measures will be most difficult to achieve for a given provider in the local environment. Therefore, we believe that the incentive program should contain some inherent flexibility, and that it should recognize providers who make good progress toward Stage 1 meaningful use.”

Under the committee's recommendation, providers would be permitted to select up to five meaningful use measures (up to three measures in the "improving quality, safety, efficiency, and reducing health disparities" category, up to one measure in the "improving care coordination" category, and up to one measure under the "improving population and public health" category) to defer to Stage 2 of their HIT implementation. Six of CMS's proposed meaningful use requirements would be mandatory and would not be deferrable beyond Stage 1.

The Alliance also believes that requiring the adoption of ALL criteria in order to be eligible for incentive payments will impose a significant burden in both time and effort from physicians and their staff. We support the general concept of the HIT Policy Committee on this point but, even there, we believe that the remaining numbers may not be realistic or appropriate without further flexibility. Specialty practices can vary. There are many ways that specialty doctors use electronic health record technology and it would be appropriate to allow such variation to satisfy the meaningful use requirements.

Our experience in Physician Quality Reporting Initiative (PQRI) reporting tells us that such an extensive number of measures (about 25 functionality measures and more quality reporting measures) are more than the average practice is capable of achieving. As proposed, the extensive requirements proposed in the first year are daunting for even experienced EHR users, let alone a practice struggling with the adoption and training involved with a new EHR installation. Therefore, we urge CMS to allow practices to report on a limited measure set of five functionality meaningful use measures. Note this is greater than what is required in the context of PQRI reporting. Upgrades to electronic health records can take months to achieve and participants should have the most flexibility during these transitions to phase in uses.

B. **High Thresholds** (Section 495.6)

The Alliance is concerned about the large number of measures with very high thresholds. In most cases, 80% compliance is a difficult level to achieve when eligible providers are relearning workflow and the other challenges associated with implementing certified EHR technology. In addition, there are substantial measurement challenges for many of these measures, especially those that require denominators to be calculated with non-EHR data (e.g. managing patient interactions). Therefore we urge CMS to eliminate the 80% reporting rate in all measures adopted in the Final Rule.

Stage I should focus on having eligible providers begin using the electronic health record technology and reporting on baseline measures, with much less focus on specific percentages. The combination of all of the
requirements that creates implementation challenges contains too much complexity to be managed in such short timeframes.

C. Flexibility Regarding the Term “Use” for Health Information Systems (Section 495.4 Definition of Meaningful EHR user)(Section 495.6(a))(Section 495.8(a))

It is clear from the many comments from sophisticated users of health information technology that HHS cannot describe the many reasonable permutations of technology, model of ownership, means of exchange, and relationships among parties related to a health information system. As a general matter, the Alliance supports flexibility in how providers and exchanges accomplish health information system functions. The Alliance supports the proposition that compliance with the meaningful use requirements might be achieved through a collection of EHR technology modules in the context of a system that may also involve non-certified technology to accomplish various functions. The Alliance believes this flexibility is important and realistic. HHS should not:

- penalize best of breed systems
- create location requirements for technology
- create requirements that dictate how information flows through health information technology in any given setting
- force such a overwhelming certification system and burden that currently functioning electronic health records and systems could not reasonably achieve certification
- slow upgrades because of certification requirements
- force changes simply because of regulations when system architects have a different approach to optimizing information flow in a given setting
- prevent web-based or other use of services that themselves may use certified technology

Among other items, CMS should make clear that hospitals or eligible providers may use non-certified technology along with using certified technology to accomplish functions and objectives. As we have seen with recent innovative technologies, users will find "meaningful use" in various ways that enable the most productive use in their local environment beyond the very specific expected value of any given component or application. CMS must leave technical discretion among ways of putting together systems that meet real needs in real settings and not specific regulations that purport to dictate specific means of accomplishing objectives.

D. Reporting Levels and Percentages

Although we applaud CMS’s decision to allow attestation for Year 1 of the reporting schedule, we are very concerned that the unfamiliarity with calculating denominators and numerators may reduce the confidence of many eligible providers from signing an attestation. As would be consistent with the objectives of an incentive program, many providers will be obtaining or upgrading to systems with certified EHR technology. These providers must also make steady progress toward meaningful use. Such providers have no reason to move backwards or use a system inadequately, other than the difficulty of adopting and changing work flow. Regulations should not seek to rush this process. Such haste is unrealistic, may create medical errors, and force work flow changes in ways that diminish care.
We recommend that, to the extent possible, the measures prescribe an option of a relatively low hard count achieved for the selected measures or a low percentage for providers to select from. Similar to the 2010 requirements for electronic prescribing, if a provider uses a system feature sufficiently to inform him or her about the ease of use, it is likely that the provider will continue to use the feature and actually increase the rate of use. Therefore, in the list of specific functionality measures, we propose a number of incidences to replace the percentages proposed. In the alternative, the Alliance suggests a simple attestation that a use is above a relatively low percentage. A provider should not be penalized for lack of specificity or perceived accuracy as long as that provider is reasonably above a threshold.

E. **Specific Objectives and Measures** (Section 495.6)

**Stage 1 criteria for EPs and eligible hospitals or CAHs**

- **Section 495.6(c)(1)—Implement drug-drug, drug-allergy and drug formulary checks** – We would encourage HHS to add language to acknowledge the potential for what is referred to as “alert fatigue” and re-frame this requirement to say that eligible providers attest that they have implemented and obtained some experience with these functions to determine their appropriateness in improving patient safety for the drugs they routinely prescribe. The final rule should specifically allow providers to switch off warnings that interfere with their ability to provide adequate pharmaceutical treatments for specific patients.

- **Section 495.6 (c)(2)—Maintain an up-to-date problem list of current and active diagnoses** – The Alliance strongly believes that physicians should have a correct and timely list of issues occurring with their patients as relevant to their practice. We appreciate that a problem list is described in the preamble as “a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.” We recommend the inclusion of the terms “relevant to the current care of the patient” to be in the regulatory language. Remove 80% from Stage 1 and replace with attestation requirement that problem lists are up-to-date.

- **The rule references ICD-9 but we will soon be in transition to ICD-10.** We recommend that the regulation state that diagnoses should match ICD-9 or coding systems approved by CMS.

- **Section 495.6 (c)(3)—Maintain active medication list** – Remove 80% from Stage 1 and replace with attestation requirement that medication lists are up-to-date.

- **Section 495.6(c)(4)—Maintain active medication allergy list**— Remove 80% from Stage 1 and replace with attestation requirement that medication allergy lists are up-to-date.

- **Section 495.6(c)(5)—Record demographics** –Demographic data is not clearly defined. Demographic data is often supplied to the electronic medical record database from a separate practice management system. A more appropriate measure is attestation that the electronic health record system being used has a pre-determined process to update demographic data when reported by the patient. This process may include direct input by either the eligible provider, the employees of an eligible provider or the patient themselves. It may also include automated transfer of existing data upon system implementation. Remove 80% from Stage 1 and replace with attestation requirement that demographic data is updated using a pre-determined process.
Section 495.6(c)(6)--Record and chart changes in vital signs, BMI, and growth chart – As detailed in the comments below on Section 495.6 (d) (3), the Alliance contends that the requirement of reporting of quality measurements in Stage 1 is premature. We see the recording of changes in vital signs, BMI and growth chart as a quality measure which should be deferred in the initial program year along with all others.

- Section 495.6(c)(7)--Record smoking status in patients 13 years or older – As detailed in the comments below on Section 495.6 (d) (3), the Alliance contends that the requirement of reporting of quality measurements in Stage 1 is premature. We see the recording of smoking status as a quality measure which should be deferred in the initial program year along with all others.

- Section 495.6(c)(8)--Incorporate clinical lab test results as structured data – The volume of clinical lab test results varies widely from provider to provider and patient to patient. For example, in urology practice, urinalysis tests are often ordered but not billed due to negative results that do not assist in diagnosis and treatment. In fact, in many commercial insurance plans, the urinalysis is bundled by contract into the office encounter. Requiring that as many as half of these negative results for unbilled tests be entered seems excessive. We recommend eliminating this requirement. However, if this remains a requirement for 2011, we recommend that the eligible provider be allowed to attest that clinical lab results pertinent to the diagnosis and treatment of the patient’s problem are routinely entered in the record as structured data without a specific count or percentage.

As currently written, we believe this standard creates a disadvantage for small practices, particularly those in rural areas. The time and expense involved with developing electronic interfaces is not insignificant, and relies on the cooperation of lab vendors. We would recommend the standard read “incorporate clinical lab tests results into EHR as structured data, where practical”

We are further concerned that this requirement seems more like something in the control of labs. Currently, many labs do not today and will not create interfaces to/from smaller provider offices. It is not clear how this will be accomplished since there is no incentive for labs to cooperate and so the cost will need to be borne by the practices. Where a provider is receiving lab values from a different entity, is the obligation on the provider or the lab? Applying the requirement to those who do not enter or send laboratory information would not seem appropriate. The Alliance would support having laboratories use standards-based submissions.

Physicians should not be penalized as a result of services received from external sources like independent laboratories. The documentation of clinical lab results into EHR as structured data is dependent on the EMR vendor and the laboratory, not the physician’s use of the EMR.

- Section 495.6(c)(9)--Generate lists of patients by specific conditions – The Alliance has no specific comment on this requirement.

- Section 495.6(c)(10)--Implement five clinical decision support rules relevant to specialty – Appropriate clinical decision support rules must be derived from scientific evidence. We do not believe that the process to gather peer-reviewed evidence, translate it into programmable code, test it in a clinical environment and evaluate it for medical liability risks has been adequately developed to make this a requirement in the early years of adoption. Our position here is consistent with our position that quality measure reporting is not ready as a requirement. Moreover, we note that clinical decisions support takes development by vendors. Clinical decision support for specialties is not always first in line for vendors.
• **Section 495.6(c)(11)—Check insurance eligibility electronically from public and private payers** – Verifying insurance eligibility is a business function and has nothing to do with clinical record keeping. The Alliance recommends this requirement be eliminated as a requirement for 2011 under the meaningful use provisions. We would note that this type of requirement is not particularly relevant to EHR technology and constitutes more of a practice management issue. We further note that HIPAA regulations addressing the X-12 and 5010 standards are underway. These will directly affect such electronic submissions. Those requirements should govern. There should not be additional, and possibly inconsistent, approaches under the meaningful use regulations. We recommend this requirement be eliminated under the meaningful use regulations, at least for 2011.

• **Section 495.6(c)(12)—Submit claims electronically to public and private payers** – The Alliance notes that the basic substance of this provision is already a requirement for participating Medicare providers. As described in our comments for 495.6(c) (11) this requirement is a business function and not clinical record keeping. Based on the same rationale we recommend this requirement be eliminated under the meaningful use regulations, at least for 2011.

• **Section 495.6(c)(13)—Perform medication reconciliation at relevant encounters**. We recommend that the 80% requirement be removed for Stage 1 and that the eligible provider be asked to attest that a test of this capability be conducted during the reporting period. Requiring an 80% success rate is unreasonable when such reconciliation would depend on the capability of the other party involved in a transition of care. Moreover, there are several specialties where this provision is not relevant.

• **Section 495.6 (c)(14)—Provide a summary of care record** – The Alliance does not have specific comments on this provision.

• **Section 495.6 (c)(15) Capability to submit electronic data to immunization registries** – This capability is not universally applicable to specialty practices. While the Alliance recognizes that patient immunization data is an important component of their medical history, it is not nearly as important for quality of care for some specialties and subspecialties. For example, this information may be vital for pediatric orthopedists, but not as relevant for an orthopedic surgeon with a practice focus in adult sports medicine. We would also note that there does not appear to be an easy way to test this capability as there are many different immunization registries. HHS needs to have clear standards and testing connected to the registries themselves. Moreover, there may be many registries – compliance will be difficult to gauge if CMS means all registries. Placing this obligation on providers is very difficult for specialty doctors. We recommend this requirement be eliminated for 2011 and not imposed until there is a clear system to allow a simple test of the capability. In the alternative, we recommend this standard be changed to read “Capability to submit electronic data to immunization registries, when relevant.”

• **Section 495.6(c)(16)—Capability to provide electronic syndromic surveillance data to public health agencies** - This capability is not universally applicable to specialty practices. Accordingly, there is again an issue of relevance. Moreover, there are significant issues on the scope of this requirement. There are hundreds of public health agencies. They have different systems and capabilities. Providers should not be penalized where such agencies are not in a position to receive information. Moreover, interoperability issues cannot simply be solved by the providers. Indeed, it is difficult to see how vendors can assure
• **Section 495.6(c)(17)—Protect electronic health information created or maintained by certified EHR technology** – Eligible providers are already required to carry this out in accordance with HIPAA Security standards. Adding these requirements in under the ambit of the meaningful use requirements probably causes needless duplication and confusion. First, we want to make sure that relatively minor violations would not be a cause for denial or even efforts to seek reimbursements from incentive payments. Second, the Alliance believes it may be difficult to avoid ambiguous or inconsistent interpretations between enforcement of the HIPAA regulations and the meaningful use regulations.

**Additional Stage 1 criteria for EPs.**

• **Section 495.6 (d)(1)—Use CPOE** – The proposed rule points out that this objective “relies solely on a capability included as part of certified EHR technology”. We contend that the proposed specifications for the denominator (all orders) and numerator (80% using CPOE) is unreasonable. The proposed rule acknowledges in the hospital portion that CPOE is often one of the last functions adopted and we believe this is true in a small specialty practice where the physician includes tests to be ordered in the recorded plan and instructs an office employee to order the tests using a prescription form, a printed requisition or a phone call. Often tests such as a urinalysis are conducted right in the provider’s office and the extra work required to order such a test by CPOE is not efficient. We propose that the provider attest that they (or an employee directly supervised) have conducted at least one test of the certified technology’s CPOE function during the reporting period.

• **Section 495.6 (d)(2)—Generate and transmit permissible prescriptions electronically.** Because the state laws vary as to what is “permissible prescriptions”, the denominator of the measure is not clearly defined. We recommend following the same guidelines as the current E-Rx measure. The user must attest that 25 electronic prescriptions are generated and transmitted within the reporting period or attest to a lower percentage, in the alternative.

The Alliance applauds the intent of this provision and believes this is a vital component to a comprehensive Electronic Health Record (EHR). In many areas of the country there still exist “independent, single store” pharmacies not affiliated with large chains. These local pharmacies may not have the resources necessary to invest in electronic prescribing or the capacity to receive electronic prescriptions. In addition, the expense of setting up electronic communication between an office-based EHR and a local pharmacy or national chain may be substantial for some practices. Until all pharmacies are equipped to be equal players in the transmission of prescriptions, we would suggest adding “where possible” to this criteria. This would allow practices in small or rural towns to still qualify even if their local small pharmacy has not adopted the appropriate technology. We would recommend using the reporting options from the current e-prescribing program as a template. In later years, CMS could revise this standard if/when the vast majority of pharmacies are able to electronically receive prescriptions.

• **Section 495.6(d)(3)—Report ambulatory quality measures to CMS or the States** – The Alliance contends that it is premature to require any quality reporting under the first year of meaningful use because: (a) only a few of the hundreds of EHR vendors have engaged in CMS-approved testing of direct reporting PQRI measures from their software and (b) the electronic reporting specifications for the vast majority of measures have not even been developed.
We recommend that the reporting of quality measures criteria in the proposed meaningful use rules be deferred until such time as most certified EHR systems have the ability to transmit such data and CMS has the capability of receiving clinical quality data directly from EHRs. It is also critically important that this process is tested in a variety of situations before any specific reporting requirements take effect. When CMS ultimately does require quality data submission, we recommend that such requirements be limited to Medicare beneficiaries for Medicare EHR incentives or Medicaid recipients for Medicaid EHR incentives. It is not appropriate to require data submission for all patients when the measure sets may vary so widely among the various commercial payers.

- **Section 495.6(d)(4)--Send reminders to patient per patient preference for preventive/follow up care**
  - As specialty-specific certified EHR systems are still emerging, the Alliance has concerns as to the ability of most systems to meet patient preferences. While we understand this will be a certification requirement, some users may have systems that have text message, email, or telephone capabilities while others may not. Until all systems have a variety of communication methods, we feel it is important to include “with respect to system capability” after patient preferences. Some patients’ preferences may exceed an individual system’s current capabilities, which would be beyond the individual physician’s control. Once certified specialty-specific EHR systems have uniform communication capabilities, CMS could revise this standard. We recommend attestation that the eligible provider attests that a patient reminder process using EHR has been activated in the system and at least one defined reminder protocol has been tested.

- **Section 495.6(d)(5)--Provide patients with an electronic copy of their health information upon request**
  - Although we support the rights of patients to obtain copies of the private health information, the measure specifications in the proposed rule are inconsistent with the HIPAA requirements that already exist. Patients have a right under HIPAA §164.524 to request and receive their health information, but that right is limited in certain ways. The scope of the disclosure is limited to a designated record set, a defined term that includes medical records or health information used to make decisions about the patient. There are many questions those regulations must address such has who pays, whether requests are reasonable, how they may be sent, and what are the security issues. In addition, there is insufficient guidance about the parameters of providing electronic information to protect eligible providers from malware or the extra time and expense to explain to patients what their rights are in this regard. We recommend this requirement be eliminated for 2011.

- **Section 495.6(d)(6)--Provide patients with timely access**
  - The rule needs to make clear that providing access is not the same as patients checking or accessing this information. Moreover, the broad statement that covers “their health information” is an overly broad and ambiguous statement. CMS should note that if access means that patients actually have the means to get electronic information, this imposes a requirement that is out of the control of the provider. This may further penalize providers who have patients in poorer areas. This provision shares many of the same problems that are set out in our comments to Section 495.6(d)(5). Accordingly, we recommend this requirement be eliminated for 2011.

- **Section 495.6(d)(7)--Provide clinical summaries to patients for each office visit**
  - The Alliance does not have specific comments on this provision.
• **Section 495.6(d)(8)—Capability to exchange key clinical information among providers of care electronically.** The Alliance does not have specific comments on this provision.

**F. Demonstration of Meaningful Use Criteria (Section 495.8)**

- **Attestation on Use** (Section 495.8(a)(1)(i) and (b)(1)(i)) In order to receive incentives, the proposed regulations require hospitals and eligible professionals to attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State) that during the EHR reporting period, the hospital or EP used certified EHR technology and specify the technology used. The Alliance notes that specialties may be relying on other organizations regarding what is and what is not certified EHR technology and how that technology is used in the context of a system. Accordingly, the Alliance supports a good faith standard incorporated into the attestation. Specifically, the attestation should be that a hospital or EP:

  > Attests, based on good faith belief, that the hospital or EP used, or used a service that used, certified EHR technology, along with a general description of the technology used.

- **Meeting Objectives and Measures** (Section 495.8 (a)(1)(ii) and (b)(1)(ii)) Under the proposed rule Hospitals and providers must also show that they satisfy each of the applicable objectives and associated measures under section 495.6. It is confusing to require satisfaction of the objectives. From all appearances it is only measurable to satisfy the measures. The measures may implicitly or explicitly refer to an objective, but the objectives are much broader and more ambiguous.

**V. Closing**

Again, thank you for the opportunity to provide comments on the meaningful use criteria. We believe that health information technology is a fundamental component to improving our nation’s health care system. While we are encouraged by the direction of the proposed rule, we have significant concerns about practicality. As specialty physicians, we face unique technology and operational challenges. The proposed criteria make it very difficult to become meaningful users of HIT, despite our desire to adopt new technology.

The amount of time specialty doctors would spend trying to meet the proposed criteria would ultimately result in less time treating patients, thereby reducing patients’ access to care. We support the common goals of improving quality and providing appropriate documentation of patients’ medical care, but we are concerned the complete set of standards is overly onerous and more relevant to primary care physicians, while disadvantaging specialty care physicians.

As such, we encourage CMS, in conjunction with the Office of the National Coordinator and the HIT Policy and Standards Committee, to create specialty specific meaningful use standards for specialists. We look for other opportunities to discuss and provide specific comment on such issues as they apply to specialties. It is vital that meaningful use criteria increase the adoption of the electronic health record technology and are not seen as impediments to adoption. We will not gain the benefits of this technology if additional tasks outlined in meaningful use criteria are not seen as valuable to excellent patient care.

Thank you for your attention to our concerns and to the unique needs and contributions of specialty medicine. We would be happy to discuss the issues raised in further detail. Please contact Rick Rutherford at
rrutherford@auanet.org or (410) 689-3713 or Lauren Bates at bates@aaos.org or 202-546-4430 for questions or further discussion.

Sincerely,
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
National Association of Spine Specialists
Society for Cardiovascular Angiography and Interventions