AMIA

29 May 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-3310-P
Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3
Proposed Rule

On behalf of the American Medical Informatics Association (AMIA), I am pleased to submit these comments in response to the above-referenced proposed rule. AMIA is the professional home for biomedical and health informatics and is dedicated to the development and application of informatics in support of patient care, public health, teaching, research, administration and related policy. AMIA seeks to enhance health and healthcare delivery through the transformative use of health information technology (health IT).

AMIA's 5,000+ members advance the use of health information and communications technology in clinical care and clinical research, personal health management, public and population health, and translational science with the ultimate objective of improving health. Our members work throughout the health system in various clinical care, research, academic, government, and commercial organizations.

AMIA thanks the Department of Health and Human Services (the Department) and the Centers for Medicare and Medicaid Services (CMS) for issuing this proposed rule, which implements stage 3 of incentive funding for meaningful use (MU) of certified electronic health record (EHR) technology as called for by the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5). In providing input, we will provide general comments about the approach to MU Stage 3, respond to the requests for specific comment included in the Federal Register, and discuss other selected provisions of the proposed rule.

General Comments

AMIA strongly believes that the following underlying principles are essential to achieving the meaningful use of certified electronic health record technology: (1) we must invest in people, as well as technology; (2) users need EHR systems that are built on well-established functionalities that have been tested in real-world settings; and (3) adoption of EHR systems requires a balancing of benefits and burdens that users will accept.

Investing in people. The investment in people - especially individuals who are trained in both clinical and technical aspects of health care delivery - is beyond the scope of the meaningful use program. But we believe that CMS must be cognizant of the demand they are creating for qualified informatics professionals and should make every effort to support the funding of informatics training programs to ensure the growth of a robust pipeline of trained and skilled informatics professionals. For example, to accelerate informatics training, CMS should promote changes in GME funding of clinical informatics subspecialty training programs that would allow for billing in the fellows primary specialty while they complete a subspecialty in clinical informatics. Please see the recently published article in *Applied Clinical Informatics* on the need for a viable financial model for clinical informatics fellowships.[1]

Thoughtful testing. For more than 30 years, AMIA members have been leading efforts to advance health IT and have been advocating for accelerated adoption of EHRs and advanced tools for facilitating meaningful health information exchange and interoperable systems. We are grateful for the heightened interest among policymakers, regulators and federal payers in leveraging their positions to accelerate the adoption and optimization of health IT. But we must take care that our push to accelerate is conducted in the context of a well-defined framework and a thoughtful set of processes that include thorough, real-world testing. In general, we would like to continue to see a more staged approach to the creation of methods for measuring the effective and meaningful use of EHRs that focuses on outcomes over process.

Balancing benefits and burdens. The HITECH Act was passed during a time of intense uncertainty about the future of the global economy. As a result, some of the timelines and stages created to transform healthcare through the adoption and meaningful use of EHRs were driven by the need to stimulate the economy -- at times sacrificing sound principles of system change and process improvement in favor of expedited infusion of capital into various HITECH-mandated programs. As ONC staff were sometimes fond of saying, they were "building the plane while they were flying it" -- an approach that is comforting to neither pilots nor passengers. We are no longer in a state of imminent economic collapse and much of our current status has changed. The Affordable Care Act is now law; EHR adoption among EPs, EHs and CAHs is significant; and there is now a plan to roll the EHR incentive program into the Merit-based Incentive Payment System (MIPS), as was signed into law on April 16, 2015 as part of the "doc fix" legislation. Additionally, the House Energy and Commerce Committee has been advancing a 21st-Century Cures legislative package that includes significant changes to our approach to interoperability and EHR adoption. The Senate Health, Education, Labor and Pensions (HELP) Committee is also drafting legislation on interoperability. We, of course, cannot base regulation on the possibility of new legislation being signed into law, but the landscape is quickly changing and the meaningful use program needs to adapt to an environment that is significantly different from when the HITECH Act was signed into law in 2009.

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[1] Lehmann CU, Longhurst C, Hersh W, Mohan V, Levy BP, Embi PJ, Finnell JT, Turner AM, Martin R, Williamson J, Munger B. Clinical informatics fellowship programs: In search of a viable financial model – an open letter to the Centers for Medicare and Medicaid Services. Appl Clin Inf 2015; 6: 267–270 http://dx.doi.org/10.4338/ACI-2015-03-IE-0030.

While AMIA supports some of the added provisions (e.g., public health case reporting) in stage 3, we are concerned that the transition to a consolidated MIPS program makes the one-year transition to stage 3 highly burdensome while offering only modest gains. The continuation of process measures with thresholds means that prescriptive definitions will control EHR software design as well as vendor build decisions, testing, and certification and will perpetuate the problems with EHR usability made worse by the current regulatory process. This final and open-ended stage of meaningful use could become a fundamental part of the post-SGR Medicare world for the foreseeable future. The drivers for the meaningful use of EHRs should instead be based on patient outcome measures (as they are developed and improved) that are relevant to each specialty to which they are applied, specific to each scope of practice of clinical care providers and are actually meaningful to providers, which the current process measures are not.

As the process stands now, Stage 3 of MU will only exist as a stand-alone program for a single year for at least Medicare Eligible Providers before being consolidated into the MIPS program. Rather than create all of the new requirements and program changes for a single year, it would be better for all if CMS simply extended its modified plan for 2015-2017 to cover 2018. This approach will save everyone from the heavy lift of a new program for 2018 and the expected heavy lift for a new program that will begin in 2019 to meet the requirements of the MIPS program. We emphasize that AMIA is strongly in favor of making progress and advancing greater interoperability and data flow -- especially for public health and for improving patient access to their own data. But we want these advances to be done in a thoughtful manner.

We appreciate the effort CMS has made to have a glide path to a single stage of meaningful use, which includes one set of rules or measures, as this will ease the transition to MIPS. We do not believe that the measures and rules proposed here are the right sets. CMS has chosen measures that can be counted easily rather than measures that would demonstrate the results of improvements in care through the use of health IT.

We appreciate the flexibility within meaningful use objectives and measures that CMS has proposed for some measures by focusing on those that are most relevant to unique practice settings and that allow providers to have some flexibility in choosing which objectives best apply to their settings within the context of an associated measure. We believe that this type of flexibility will provide adequate pressure for providers to advance their use of EHRs while focusing on the measures that have the best fit for their settings.

As we have commented in our response to the ONC rule on certification, we encourage HHS to make deeper investments in the total lifecycle of standards development -- giving special attention to real-world testing of these standards and proposed certification criteria through the development of an early adoption incentive program. While such a program would seem to slow the pace of our progress toward the shared goals of improved outcomes, lower costs and improved population health, we will ultimately be more successful as we thoughtfully and methodically make iterative and incremental progress through needs-based and patient-focused use case development and refinement,

responsive standards development, rigorous testing and evaluation, market-directing certification, well-planned implementation, and post-deployment evaluation, resulting in continuous process improvement and a more functional health care system.

AMIA is generally supportive of the approach CMS and ONC have taken in developing further separation of the ONC-managed EHR/HIT certification program for Health IT Modules from the specific criteria and measures required of eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) by CMS to qualify for Medicare and Medicaid EHR incentive payments and avoid downward payment adjustments (penalties) under Medicare.

With respect to attestation and reporting, given our recent history and experience, it should be obvious to all that no EP will have fully implemented a system capable of Stage 3 reporting by January 1, 2017. Further, even if a vendor is capable of delivering a certified system to a practice in 2017, the practice will be unable to attest in 2017 due to the downtime required to implement the new system and all of the new measures. We believe that a 90-day reporting period is a best practice that should be maintained in the program. Continuous reporting does not allow proper time for provider organizations to implement and refine their implementations. In contrast a flexible 90-day reporting period yields the same information about objective achievement will allowing implementers to optimize the timing of those implementations with respect to other priorities. We therefore implore CMS to maintain a 90-day reporting period for each reporting year to allow EPs, EHs and CAHs the opportunity to upgrade, implement, and report successfully.

We appreciate that CMS acknowledges the use of health information technology provides overall "positive effects . . . on key aspects of care, including quality and efficiency of health care." We agree, although making such a statement glosses over the well-described socio-technical complexities of EHRs, their potential to contribute to harm and create new types of hazards, and the lack of understanding about what makes for successful, safe EHR implementations and maintenance. CMS should continue to work with ONC and other federal agencies to monitor and respond to the unintended consequences of health IT adoption in creating these new hazards.

Our comments on the specific objectives and meaningful use measures below presume that CMS will continue with some version of stage 3, though our preference is that stage 2.1 be extended through 2017 and stage 3 be implemented as part of a consolidated MIPS program in 2018. Alternatively, CMS could consider making small modifications to stage 2.1 that include a limited number of new measures such as public health case reporting. Most of our detailed comments are focused on the ONC 2015 Edition proposed rule. We encourage CMS to work closely with ONC to balance the tradeoffs incumbent in driving market change through technology certification and provider incentives and penalties. As you weigh those priorities, we believe that the EHR incentive programs should ultimately focus on interoperability, public health, patient and caregiver engagement, system integrity, and other measures that don't have strong incentive or reimbursement drivers outside of these programs.

On the same day these comments are due, AMIA has published a report that summarizes many months of work on recommendations for improving our collective experiences with electronic health records over the next five years. This report, called EHR 2020, has been published in *JAMIA*[2] and a summary is available on AMIA's blog.[3] We implore you to take advantage of the vision and priorities that have been presented in this work.

Below we provide specific comments on the eight objectives. These should be reviewed within the context of the general comments we have provided above.

Specific Comments Related to Proposed Stage 3 Meaningful Use Requirements

Objective 1: Protect Patient Health Information
Within the context of our general comments, we support this objective and approach.

Objective 2: E-Prescribing
Within the context of our general comments:

We agree that over-the-counter medications should continue to be excluded from the electronic prescribing measurement and that providers be given the option of whether they include controlled substances in the numerator and denominator -- *including prescribers in states where the electronic prescribing of controlled substances (EPCS) is now permissible*. We believe that the mechanisms for complying with the DEA rule are manageable but still difficult in certain settings. We also believe that, for practices where EPCS is a predominant feature, the desire to have a consistent process for both non-controlled and controlled substances will drive these practices to include EPCS in their prescribing process.

We also agree that these thresholds should not rise above 80 percent (for transmission) to account for patient preference and other circumstances where a printed prescription is preferred. Ultimately, CMS and ONC should work with providers and retail pharmacies to determine effective methods and related standards for creating a prescription and having it made available for patients to determine the best options for fulfilment. Especially as patients carry a direct burden for the costs of their medications, price sensitivity and price (as well as convenience) variation among pharmacies should drive the patient/caregiver choice of pharmacy. Selecting the pharmacy at the time of prescribing is not reflective of what happens in the paper world; pharmacy selection by the patient/caregiver with full information should be better accommodated.

We do have some concerns about the thresholds for EHs and CAHs as these settings have different workflows than ambulatory settings -- especially with respect to establishing the pharmacy to which a discharge medication should be sent. The ONC certification rule has proposed expanding the number of SCRIPT message types that are certified (adding RXCHG / CHGRES, CANRX / CANRES, REFREQ / REFRES, RXFILL, and RXHREQ /

[2] http://jamia.oxfordjournals.org/content/early/2015/05/22/jamia.ocv066
[3] http://fridsma.amia.org/ehr-2020-charting-the-course-to-a-better-future/

RXHRES). We believe that these additional messages are particularly important for the emergency department and hospital discharge settings, where medications are frequently adjusted before discharge, the final pharmacy for fulfillment is uncertain, and medication reconciliation is an essential part of the discharge prescribing process. These additional messages, though clinically important, are not in widespread use. The workflows needed to manage their use will be especially challenging in an EH/CAH setting.

We agree that formulary checking is an important part of the prescribing process, but express concern that this can represent an expensive proposition for EHs and CAHs who currently focus on inpatient prescribing and in-house pharmacies for their pharmacy fulfilment. Our members have indicated that formulary clearinghouses are charging inpatient facilities significant amounts for formulary access. If CMS has not accounted for these charges into their burden assessments, this additional cost and requirement would represent an "unfunded mandate" for these providers. We would ask that formularies for which an access fee is required be considered "unavailable" in defining the numerator and not counted toward fulfilment of this goal.

With these caveats, we agree that the proposed thresholds are acceptable for the settings as described. If providers in EHs and CAHs voice significant concerns about the 25% threshold for electronic prescribing, we believe CMS should consider lowering this threshold. Similarly, CMS should listen carefully to any well-reasoned objections to the threshold for sub-populations of EPs who may be challenged to achieve the 80% threshold.

We also encourage CMS to continue to work with the DEA and ONC to create a common framework for strong authentication within not just prescribing but all electronic records management to reduce the tactical burdens of multi-factor authentication while improving the integrity and veracity of all electronic records, not just those for EPCS.

Objective 3: Clinical Decision Support
AMIA has been on the forefront of clinical decision support (CDS) for many years; our members have been pioneers of the original concepts of CDS. We are therefore very supportive of the concept of CDS within the context of care delivery. We also understand that this is a complex domain where good CDS interventions may be difficult to measure consistently across provider settings. We therefore support the notion of providing flexibility in implementation here and allow providers to develop approaches to CDS that best fit their clinical settings and outcomes improvement goals. CMS should be clear that providers can use methodologies other than the use of certified technologies for fulfilling this requirement.

We urge CMS to provide additional options in its current and proposed requirement that CDS interventions align with a current CQM, enabling providers the flexibility to choose CDS interventions that align with their own clinical priorities. We believe that this change to the proposed rule will improve patient safety and clinical quality by allow providers to focus their efforts on more targeted CDS interventions.

Objective 4: Use of CPOE
Within the context of our general comments, we support this objective and approach.

Objective 5: Patient Electronic Access to Health Information

We are encouraged that CMS is giving serious attention to the role of patients and caregivers in accessing their own health information and increasing their engagement in their health. The "view, download and transmit" provisions in the proposed rule provide an essential but not sufficient component for realizing this goal.

A critical component of patient engagement is the management of the data that patients receive. Though we have seen a strong movement of engaged patients and caregivers and support this movement, relatively few individuals with complex medical conditions that span time or multiple health care delivery settings will be able to successfully consolidate and organize on their own the information that would be delivered through a VDT paradigm as envisioned in this proposed rule. It will be insufficient to establish a marketplace for apps to receive this information; at some level, "view, download and transmit" will need to be expanded to "view, download, transmit and manage."

We also express concern that VDT will create silos of information rather than true interoperability of health information. We believe it will be important that both certified EHRs and more patient-centric, person-controlled personal health record systems that include person-generated health information (PGHI) will ultimately be certified with these capabilities and that certified EHRs will need to be able to receive consolidated data from these data aggregators just as they will be able to receive transition of care summary records. We also anticipate that many patients will choose to have these services performed by their primary care providers or other health care providers, who will serve as consolidators of their longitudinal health records. We would encourage CMS to use the rights afforded patients under HIPAA to empower patients get a copy of their complete medical record in an electronic, computable format rather than just a summary of care record. This complete record should include both structured and unstructured information, and should be in a computable format (like free text) rather than a PDF or scanned image.

We acknowledge that this view represents a next step in the evolution of health information management and interoperability and will be out of scope with Stage 3 implementation. We encourage HHS to invest in standards development and piloting to support the deeper inclusion of patients and caregivers in their own health information.

Some of our provider members have expressed concern about the 24-hour timing requirement. At a minimum, CMS needs to provide clarity about the definition of 24 hours. Does this include weekends? Business days only? Does the concept of provider availability mean that the information needs to be released within 24 hours of the information's availability to the practice setting or to the individual provider who needs to sign off on the information's release?

Evidence thus far from the Meaningful Use program, because of how it defines "access," is only helpful for determining a lowered barrier to patient engagement, but not an affirmation

of patient engagement. Access is defined as a patient being offered access, declining access, or having signed up at least once for an electronic system of access. Companion data on how frequently patients make use of such access to electronic information shows that actual access is far less. This alone suggests a change in label of the objective to "availability" rather than "access". Further, as the definition of "access" is structured (offered, using, or declined) such that it could or should be a consistent practice operation, in much the same way that name, date of birth, and insurance information is expected 100% of the time. We could see this information being incorporated into a future "notice of privacy rights, electronic information security practices, and electronic access to PHI" – which is then an annual YES/NO attestation.

There is a high risk of further fragmentation of patient information with reliance on APIs and third-party apps. How can portability of health information be assured between third-party apps and any EHRs into which the patient may want his information imported? Without defining standards for APIs, it is likely that each vendor will implement an API differently. This will result in little if any gain over requiring patients to enroll in different portals for different EPs.

Objective 6: Coordination of Care through Patient Engagement
We would like to see the thresholds for these measures aligned with the measuring methods and benchmarks found in the literature (e.g., messages per 100 patients per month). As noted in the paper "Personal Health Records: Meaningful Use, But for Whom?" a 25% threshold clearly exceeds the peer reviewed literature in terms of what is possible with the exception of a few industry leaders. Many sites determine patient engagement rates or use of PHR adoption numbers ranging from 25-75%. But as noted in "Organizational strategies for promoting patient and provider uptake of personal health records," the methods vary wildly. It would be better to introduce the concept of "threshold" and "stretch goal" here. Meeting a stretch goal would mean the EP, EH or CAH would get credit for 2 measures (extra credit, so to speak). For example, CMS could require a threshold of 10% and give credit for those exceeding 25% perhaps exempting from another measure.

Some AMIA members have expressed concern about how these measures are to be applied to the inpatient (EH and CAH) setting. Moving to a 25% threshold for patients to view, download, or transmit their electronic records is a big leap. What is the goal of this form of engagement? Requiring patients to perform one or more of these steps (and in fact, putting hospitals at risk if patients do not) is different from assuring that patients have the capability to perform these tasks should they choose to do so. Patients being discharged from an inpatient setting are focused on feeling better and understanding their discharge instructions, filling medications, getting to follow-up appointments, and moving on with their lives. Accessing their records online and receiving secure messages (with a 35% threshold) in that context seems a much lower priority. We understand that patient engagement is a high priority, but the context is very important. We are concerned that compliance with this threshold could result in the unintended consequence of providers sending automated boilerplate messages that add no value to patient care.

We appreciate CMS recognizing (and conveying in their proposed rule) that patients often consult with and rely on trusted family members and other caregivers to help coordinate care, understand health information, and make health care decisions. We believe there is a need for more structure in the articulation of how one designates a patient-authorized representative and make these relationships explicit within the context of the medical record. We ask that HHS invest more resources in establishing these methods so that providers can quickly determine who has been authorized to receive (and provide) electronic information on behalf of the patient.

Objective 7: Health Information Exchange
As we have outlined in our response to ONC on the 2015 Edition proposed rule, we are generally supportive of UDI inclusion. We do not think this should be expanded beyond non-UDI items. Implanted devices represent the most critical use case as, once implanted, these devices cannot be examined directly. Once the mechanisms for effectively exchanging this information is established, the use case could be expanded to include other devices, biologics, etc.

For proposed measure 3, more work needs to occur on clinical reconciliation -- including where and when it adds clarity and safety, and where it is just forcing check-box checking -- before making clinical reconciliation mandatory. While standards such as CCDs exist and are used, the wildly varying implementations of these standards makes such reconciliation painful and an excessive burden on providers and hospitals. This measure also creates a significant burden on top-tier specialists who see mostly new patients and have little follow-up obligations, i.e., the opinions of these providers is sought without continuing follow up with the referring providers. In these situations, his or her patients will be new and the practice setting will have to do reconciliation that will never be used.

We have also observed confusion as to denominator counts for this measure; having clinical information reconciliation as a process measure with a threshold will remain problematic. Note that the measure for medication reconciliation was most problematic not because of what it asked for, but because creating the denominator was a manual process or was often not done, resulting in a reported achievement that was often greater than 100%.

In our experience, EHR medication reconciliation technology remains fairly primitive and can contribute to medication errors as much as it can serve to avoid them. There are system constraints that lead clinicians to create best-fit workarounds to accomplish the medication reconciliation task. Medication reconciliation is especially difficult in the absence of widely adopted structured and codified sig in the electronic prescribing process. There needs to be more investigation into the capabilities and limitations of medication reconciliation tools in their current state and to ensure that minimum standards are met across vendor products. Given the current state of these tools, we believe that medication reconciliation should still be a manual process overseen by a licensed clinician. Tools can be helpful in aiding this process, but cannot replace clinical acumen at this time.

With respect to the number of relevant data sets to employ, two of three is reasonable. To our knowledge, no standards exist for how best to curate the problem list in a shared EHR, where primary care physicians, specialists, hospital providers, and others may all contribute. Some specialists may not feel comfortable reconciling problems outside their specialty (example: a cardiologist may not wish to reconcile the actinic keratoses placed on the list by the dermatologist). In other cases, there are often similar entries that mean more or less the same thing, where it is not clear whose responsibility it is to consolidate problems with more or less precision. For example: a PCP enters "cough" as a problem and pulmonologist sees the patient and after evaluation adds a form of interstitial lung disease (ILD) to the problem list. Now both terms are on the problem list referring to the same problem, adding to the length of the problem list. Whose role is it to streamline the problem list? Do current EHRs have the capability to recognize that any documentation entered under "cough" should now be included under the more precise problem list entry "interstitial lung disease"?

Objective 8: Public Health and Clinical Data Registry Reporting
Within the context of our general comments about the timing of Stage 3 and MIPS, AMIA is strongly supportive of adding public health case reporting into the third and final stage of the MU program. Reporting cases of certain "reportable" conditions to state and local health departments, which is required by law in every jurisdiction in the United States, is a critical public health need. Without timely and reliable information on diagnosis and treatment of disease from providers and hospitals, health agencies would not be able to perform their core function of surveillance.

CMS's MU Stage 3 criterion for case reporting is a critical and logical next step in supporting the public health objectives of the MU program. Although laboratory reports support timely identification of disease trends and public health surveillance program needs, additional information on cases available only from clinicians (not laboratories) is necessary to identify patients who are receiving treatment and follow up care beyond diagnosis. The CMS NPRM correctly cites the case for electronic case reporting from the perspective of improved yield, burden-reduction, increased timeliness, and improved completeness for reports; it also identifies the need for EHRs to send initial case reporting data as well as support subsequent requests for supplemental data from public health authorities.

We also note the importance of public health authorities notifying clinical care providers of reportable conditions in patients they are treating and to which they have been exposed. Closing the information loop and providing useful, contextualized, population health information to clinical care through 'bidirectional communication channels' has been long sought by providers. Case reporting criteria are a first step towards creating the necessary public health infrastructure that can create bidirectional information exchange and communication that will one day also facilitate the delivery of public health lab results (e.g., serotyping), emerging population trends, and other contextual data to providers of care.

While we appreciate and support the goal of allowing providers and hospitals flexibility in achievement of Objective 8, AMIA is concerned that the regulations as proposed may

reverse progress on the exchange of crucial health information between clinical and public health. As proposed, EPs are required to choose from measures 1 through 5 and attest to any combination of three measures; whereas EHs and CAHs are required to choose from measures 1 through 6 and attest to any combination of four measures. Yet EPs, EHs, and CAHs can attest to Measures 4 and 5 multiple times in fulfilling their Objective 8 requirements. This opens the door for savvy providers and hospitals to completely fulfill Objective 8 requirements by reporting data to three (EPs) or four (EHs and CAHs) clinical data registries which, as defined in the regulations, are non-public health agency entities. While non-public health agency data registries contribute to better understanding of disease and treatment of disease, allowing providers to attest only to Measure 5 may inadvertently undermine the broader goal of supporting population health activities in public health agencies.

Therefore we encourage CMS to continue to make certain Objective 8 measures "core" or required (e.g., immunization reporting, syndromic surveillance and now case reporting).

AMIA makes these recommendations with the acknowledgement that many public health agencies have either a) struggled to efficiently onboard providers seeking to achieve current "core" requirements or b) asked providers and vendors to comply with technical specifications that may not be in alignment with national standards for transactions such as syndromic surveillance or electronic laboratory reporting. While this heterogeneity in requirements is in part due to the fact that public health authority is largely a function of state government with coordination from federal agencies, we acknowledge that public health agencies could do a better job collaborating and adopting consensus-based implementation guides from groups such as the International Society for Disease Surveillance as well as the American Immunization Registry Association. Evidence from several public health services research efforts has documented the need for greater investment in state-level public health agencies to improve our national health information infrastructure to enable collaboration and adoption of standards-based approaches. AMIA therefore encourages CMS, other federal agencies, and the Congress to identify new sources of funding to support public health authorities' capacity to onboard providers as well as collectively implement more homogenous approaches to the receipt of data. Strategic investment in the public health workforce and information infrastructure in public health authorities will be necessary to transform the overall American health system into a learning health system.

Conclusion

AMIA appreciates the opportunity to submit these comments. Again, we thank CMS for issuing this proposed rule, which we anticipate will be revised in timely fashion so that eligible providers and hospitals and technology vendors can prepare their systems to demonstrate meaningful use of EHRs and continue to participate in the Medicare and Medicaid EHR Incentive Program. Please feel free to contact me or Dr. Ross Martin, AMIA's Vice President of Policy and Development at ross@amia.org at any time for further discussion of the issues raised here.

Sincerely,

Douglas B. Fridsma, MD, PhD, FACP, FACMI
AMIA President and CEO