Good afternoon. My name is Rick Reeves. I am Director of Government Relations for CPSI. Since 1979, CPSI has been dedicated to being a leader in healthcare IT for community and critical access hospitals across the nation. We appreciate the opportunity to participate and share our observations.

We offer the CPSI System 2014 Edition as a Complete EHR, certified July 3, 2013. The majority of our hospitals rely totally on us as a single source integrated solution. Many are in rural America and serve as the sole hospital in their communities. The typical IT Department is one to three people. CPSI also supports approximately 20% of CAHs nationwide where many leaders in these hospitals have a wide range of responsibilities and work diligently to achieve unprecedented levels of success, with more than 80% of our CAHs attaining meaningful use. Our 2014 Edition process includes HISP deployment. Currently, 91% of our hospitals are in various phases of implementation. Many hospitals have expressed needing a minimum of six months; therefore, only about 50% of our previous hospital MUs have committed to a reporting period for 2014.

CPSI System uses the Direct protocol for secure health transport. We also certified SOAP with XDR transport for HISP connectivity. Delayed availability for testing, testing tool performance issues and unexpected upgrades which modified the strictness of tool validation requirements resulted in the optional transport requiring much more time than expected and delayed implementation.

We partnered with Inpriva, a fully accredited ENHAC/DTAAP HISP in efforts to reduce the complexity associated with electronic transmission and to expand our interoperability capabilities. There are no transactional level fees; however, the HISP service is associated with ongoing support service agreements. We sought this solution because many disparate edge systems/HISPs were not EHNAC/DTAAP accredited and resulted in one-off connectivity being established between HISPs as one or both parties were not included in the nationwide trust bundle provided by Direct Trust. Additionally, we encountered reluctance from EHNAC/DTAAP accredited HISPs to compromise their accreditation status by connecting to non-accredited HISPs. Our current TOC onboarding and education process requires an average of 30 days. No hospitals have requested connectivity

with eHealth Exchange at this time. Hospitals using our system as described are able to produce both numerators and denominators for TOC measure 1 and measure 2 statistics.

Our hospitals have implemented TOC Measure 1 effectively. Measure 2 has presented significant challenge. For the majority of these hospitals, the primary recipients of care are long term care facilities and rehabilitation services not eligible for incentives in the meaningful use program. Our hospitals are usually the anchors in their community, and often the only healthcare facilities capable of satisfying the electronic exchange requirements. Many have actively engaged with referral providers in order to establish Direct messaging services. These efforts require cooperation and resources both physically and financially from non-stakeholders in the MU program. Our providers have had varying degrees of success negotiating such agreements.

Measure 3, has unfortunately created a roadblock for our early adopters engaged in the first quarter reporting period 2014. Measure 3 requires meeting either criteria (A) "conducts one or more successful electronic exchanges… which is counted in "measure 2"…with a recipient who has EHR technology that was developed designed by different EHR technology" or (B) "Conducts one or more successful tests with the CMS designated test EHR during the reporting period." We realized many of the rural hospitals were unable to satisfy Measure 3 with criteria (A), and communicated the urgent need for criteria (B) to CMS and ONC. Criteria (B) was not available during first quarter 2014; therefore, the early adopters who successfully completed all other objectives were prevented from attesting. The EHR Randomizer was launched January 16, 2014; however, there have been many issues voiced to us by hospitals attempting to utilize the website. We believe the situation will improve and offer this information on behalf of those trying to be successful. Once the issues with criteria (B) are solved, we anticipate many rural providers will continue to encounter difficulties with electronic exchange in their settings with criteria (A).

We have seen significant progress in implementing the 2014 Edition. As developers, we encountered many challenges in achieving certification, but

implementation has proven to be a far greater challenge. TOC and VDT have been the most troubling objectives for our hospitals. We partnered with a fully accredited HISP to help simplify the TOC process for the majority of our hospitals. The rate-limiting step remains the availability of exchange partners with the necessary technology in rural locations. We appreciate the opportunity to provide input on behalf of CPSI and our hospital partners.