NOSORH
national organization of state offices of rural health

May 3, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

CMS-0044-P: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2

Dear Administrator Tavenner,

The National Organization of State Offices of Rural Health (NOSORH) is pleased to have the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding the American Recovery and Reinvestment Act's Electronic Health Record (EHR) incentive payment program (NPRM).

NOSORH is a national nonprofit membership organization of the fifty State Offices of Rural Health (SORH). Our mission is to promote the capacity of state offices of rural health to improve health care in rural America through leadership development, advocacy, education, and partnerships. The SORH are anchors of rural health activity and have responsibility for information dissemination, coordination, data collection and technical assistance to support rural communities. NOSORH supports the comments of the National Rural Health Association and its partners in the National Rural HIT Coalition.

We are concerned that a number of the planned policies set forth in this proposed rule may hinder small rural providers' ability to fully adopt integrated EHR systems with the same ease as their large urban counterparts. We are concerned that a system designed for a fully implemented EHR does not take into account the unique challenges and opportunities in rural areas, which will only serve to further handicap rural providers ability to deliver care.

Despite these difficulties and potential pitfalls, rural providers want to do everything in their power to become fully compliant with HIT guidelines set forth by CMS. They understand that a fully implemented EHR system will translate to a higher quality, cost efficient, and streamlined health care delivery system. NOSORH greatly looks forward to working with CMS to ensure our similar goal of expanding EHR to all providers is achieved and exceeded.

NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH
• 44648 Mound Road, #114 • Sterling Heights, MI 48314-1322 •
• Phone: 586-739-9940 • Fax: 586-739-9941 • Email: nosorhpd@comcast.net •
• www.nosorh.org •

The following letter analyzes the proposed rule's impact on rural hospitals and Eligible Professionals (EPs). NOSORH greatly appreciates the opportunity to offer our comments on this important regulation. We appreciate your continued commitment to the needs of the one-quarter of America's health care beneficiaries residing in rural and underserved areas, and look forward to continuing our collaboration to ensure improved health care access and quality.

The timing and increased metrics create a disproportionate burden on rural providers

The NPRM states that the proposed regulation will have a significant effect on a number of rural hospitals in that it will help in "the streamlining of care and the ease of sharing information with other EPs to avoid delays, duplication, or errors."[1] NOSORH agrees. Implementation of EHRs and other Health Information Technologies (HIT) such as telemedicine hold many positive possibilities for rural providers and patients. EHRs and other HIT can solve a number of problems in rural areas and make care safer, more accessible, and timelier.

There is, nonetheless, significant risk in pushing rural providers too far, too fast. Data from within CMS and from industry analysts show that rural providers are having a harder time adopting certified EHR technology and other Health Information Technologies than other providers. To date, only about 40 Critical Access Hospitals (about 3% of all CAH facilities) have received any incentive payments for full attestation of meaningful use. While NOSORH commends CMS for extending the attestation period for Stage 1, we continue to be concerned that many rural providers remain unable to accomplish meaningful use, even with this extension. The increased compliance metrics and reporting requirements proposed in this NPRM for Stage 2 are likely to put rural providers further behind their urban and suburban counterparts. Furthermore, these requirements risk excluding rural hospitals, CAHs and EPs from incentive payments and exposing them to increased risk of future penalties.

NOSORH recognizes the statutory restraints on further delaying requirements and does not believe that completely stopping implementation is reasonable or beneficial. In our comments to CMS on Stage 1, we recommended adoption of the alternative methodology developed by the American Hospital Association for rural hospitals under 100 beds. We renew our support for alternative metrics that better recognize the realities and challenges currently faced by rural providers.

To be sure, a change in course at this juncture creates its own set of challenges. Nonetheless, given the current number of rural facilities that have been unable to successfully attest to meaningful use and the significant gulf between rural and urban and suburban facilities, we believe that alternative, rural specific metrics create the best likelihood that rural facilities will be able to adopt certified EHR technology and become meaningful users. In the alternative, CMS and ONC should do everything in their power to address the gap in meaningful use compliance in the rural health care system and provide as much time as possible for these facilities to become compliant before imposing penalties.

If CMS and ONC are not willing to create new metrics for rural providers, we feel that there are a number of items in this NPRM that can be modified so as to avoid penalizing rural providers. These modifications will not solve all the problems faced by rural providers but will go far in addressing many rural concerns within the current framework.

Modify Stage 2 Reporting Period

[1] NPRM 352.

Because the NPRM proposes increased metrics that will put a large burden on a number of rural facilities, NOSORH recommends that the first reporting period for Stage 2 meaningful use be 90 days. CMS has clarified in the NPRM that, regardless of payment year, "providers who are demonstrating meaningful use for the first time (Stage 1), their EHR reporting period is 90 days regardless of payment year."[2] The rationale used to arrive at this decision is also applicable for providers who are attempting to move from Stage 1 to Stage 2.

Many providers face a number of challenges in advancing from Stage 1 to Stage 2: lack of capital needed to invest in the necessary technology, lack of available certified EHR technology in rural markets, lack of adequate workforce to implement and maintain technology, etc. These challenges, coupled with the short deadlines included in the rule, increase the risk that they will not be able to meet all the required EHR use metrics and quality measures for an entire year before the applicable deadlines. Allowing these facilities to demonstrate meaningful use for 90 days increases the likelihood of timely adoption, incentive payment realization and penalty avoidance. It also offers providers an incentive to begin the process immediately, knowing that they have not already missed the window for avoiding meaningful use adoption penalties.

This modification will be particularly necessary for small, rural hospitals participating in the PPS system. Known as "tweeners", these facilities face many of the same challenges that CAH facilities face. Nonetheless these "tweener" facilities will be required to be meaningful users two years before their CAH counterparts. Because of the structure of the PPS system and CMS's desire to avoid large-scale payment reconciliation with large hospital repayments these facilities will have to attest to meaningful use two years before the applicable penalty period.[3] This short timeline creates an enormous burden and incredible uncertainty for these "tweener" facilities.

Because CMS will be looking at meaningful use compliance long in advance of actual payment or penalty, these vulnerable facilities will benefit greatly from a reduced, 90 day reporting period. Given CMS's desire to avoid these large-scale reconciliation situations and the short compliance timeframe outlined in the NPRM, NOSORH believes that a 90 day demonstration for each stage is the most equitable and reasonable method for beginning Stage 2 and, ultimately, Stage 3 attestation.

Computerized Physician Order Entry (CPOE) as First Record of Order should be modified

The NPRM attempts to clarify when, in the ordering process, the CPOE function must be utilized. The proposed rule indicates that there has been some confusion about when an order or document becomes part of the patients' medical record and, therefore, at what point an order must be entered into an EHR system using CPOE to qualify as first order of record. The proposed rule seeks to clarify this point by stating that "we propose that to be considered CPOE, the CPOE function must be utilized to create the first record of any type for the order". This requirement would mandate that if a prior, written note about the order was made at the time of consultation such note would have to be destroyed upon CPOE into the certified EHR technology.

NOSORH is concerned about this definition and the destruction of such notes to satisfy the CPOE first order of record measures. Though fully integrated CPOE has the potential to streamline and increase the overall effectiveness of EHR,

[2] NPRM Pg. 22
[3] NPRM 269

implying strict standards before a provider is able to comply could result in reduced quality, reduced efficiency, and medication errors. This is especially true in the early months of adoption while providers are familiarizing themselves with the CPOE and EHR systems. Allowing providers to maintain written notes while counting the applicable entry in their numerator for purposes of CPOE calculation will guarantee safety and efficiency during the transition periods.

The NPRM stated that the experience with Stage 1 indicated that a denominator with all orders (rather than only orders entered in an EHR) is not "unduly burdensome" and that many providers were using the EHR as the only medical record of any kind. If that were true, the burden may be smaller. However, a number of rural facilities, especially during transitional periods, continue to use both electronic and paper orders and records. The requirement that a hospital provide proof that 60 percent of their orders are computerized places a huge administrative burden on rural hospitals and EPs whose administrative staffs are comparatively small and are already stretched thin in the transitional period. As currently defined, CMS plans to require providers to compute this percentage using a denominator that combines both paper and electronic processes. The very calculation of these CPOE measurements would require many extra staff hours to merely sift through electronic and paper records. This added administrative burden could add to the current workforce shortage problems experienced by rural hospital or EP, thus affecting their ability to serve patients.

The NPRM solicits comments about whether the stipulation that the CPOE function be used only by licensed healthcare professionals remains necessary or if administrative staff, such as a scribe, should be allowed to enter the order using CPOE. As NOSORH has mentioned in comments on other rules, the small size of rural facilities offers a unique opportunity to implement new processes at a more rapid pace than some larger facilities. There are, however, a number of challenges that rural facilities face because of their small size.

Among these challenges is the relatively small provider (MD, DO, PA, and NP) workforce. It is not uncommon at many clinics or hospitals to have only one or two providers present at a time. The requirement that the attending physician be the one who enters the order directly into the certified EHR using CPOE presents an increased burden and time constraint on these providers. Allowing a scribe or other administrative assistant to participate in the CPOE would go far in helping alleviate the administrative burden experienced by providers in small clinics, practices and hospitals. We believe that any time **computerized physician order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed, <u>certified or appropriately credentialed</u> healthcare professional who can enter orders into the medical record per state, local, and professional guidelines**. We urge CMS to adopt this alternative entry allowance.

We are encouraged by the possibility of allowing administrators to assist in CPOE. Nonetheless, NOSORH feels that this allowance further exemplifies the need to allow retention of written notes that do not negate the CPOE metric as a first order of record. The written notes may serve as a quality check, again, during the transition period to guarantee that administrative staff and providers are in sync and that patients are receiving the appropriate lab work, radiation procedures and medications as proscribed.

<u>The Patient Portal requirements produce high burden for rural providers</u>

In Meaningful Use Stage 1, CMS mandated that EPs provide patients with an electronic copy of their health information upon request and offered a menu item of providing patients with electronic copies of health information such as lab results and allergies within 4 business days. This rule seeks to modify this requirement by stipulating that each patient

must have the ability to view online, download and transmit their full record within 4 business days of the same information becoming available to the provider. This modification will produce a high financial and administrative burden on all rural providers as the EHR equipment required will be different. Rural providers will also experience difficulties as their ability to obtain necessary EHR technology from vendors in the short timetable allowed in the rule will be limited.

Rural providers face a number of difficulties in obtaining any EHR technology. As in other areas, their small size creates challenges. In the case of obtaining certified EHR technology, their small scope and limited purchasing power has led to complications in obtaining necessary technology. On many occasions, Critical Access Hospitals, rurally located eligible hospitals and rural-based EPs have waited months to receive needed hardware and software after the actual contracts to purchase the items have been processed. Limited supply, especially in emerging product areas, means that the "little fish" receive their product last. The EPs and hospitals will then still have to install the products and workout internal kinks before the systems can go live. Only once these steps are taken can the actual attestation begin. Given the short attestation timetable for Stage 2, especially for early Stage 1 adopters, this modification puts rural providers at a significant disadvantage.

NOSORH encourages CMS to modify this requirement to more closely mirror the measures included in Stage 1. If CMS is unwilling to revert to a Stage 1 type measure, NOSORH encourages modifications to the current requirements associated with posting and viewing the full health record and the record of the most recent visit.

Patient portal requirements are unworkable and should be modified

NOSORH is concerned with CMS's announcement that part of the portal objective will include actual patient use and transmittal from the online portal. NOSORH is concerned that basing incentive payments and, ultimately, financial penalties on actions that are outside the control of the individual provider is not appropriate and that CMS should rescind the requirement that 10% of unique patients view, download and transmit their electronic health information.

The NPRM notes that "this new measure does not focus solely on access and instead requires action by patients or their authorized representatives in or for the EP (hospital) to meet it." This "departure" from the norm established in Stage 1 and in other measures is intended to "ensure" that EPs and hospitals "promote the availability and active use of electronic health information".

While NOSORH agrees that the promotion of such information is a laudable goal, this proposal creates significant risk for providers who may do all in their power to promote interaction with, and use of, electronic health information. It is entirely possible that a provider place significant effort and resources behind this objective only to have their patients fail to visit the portal or transmit their information. This is especially concerning because the objective and accompanying measurement metric are made core, rather than menu-set, objectives and measurements. This means that it is possible for an EP or hospital to be completely denied meaningful use status and subjected to a penalty in spite of their best efforts and for actions not taken by people entirely outside of their control. Like other associations and provider groups we affirm our belief that this metric is unfair and should be rescinded in the final regulation.

If CMS chooses not to rescind this requirement, there are some calculations that do not accurately reflect the stated goals in the patient portal discussion sections as they relate to rural patients and providers. This is true of both the

posting requirements and the view, download and transmit requirement. There are some challenges that are unique to the rural environments and that make this objective particularly concerning to rural providers. These include access to broadband, the local population's ability to navigate the portals and the transient nature of some rural populations.

Access to broadband should be determinative for all rural providers

We are pleased that CMS has recognized that there are barriers to patient use in many rural areas. NOSORH has commented on the lack of broadband in rural areas on a number of occasions and the concern that creates for many rural healthcare providers in multiple contexts. We commend CMS for proposing metrics that take into account these realities and provide exclusions for providers practicing in many of these areas.

While the full exclusion for many of these providers is a positive step, NOSORH believes that calculation of the denominator for many other providers should be modified based on their location. The same rationale that led CMS to conclude that a certain threshold of broadband is necessary to require compliance with this metric should lead CMS to modify how the denominator is calculated for purposes of view, download and transmit compliance.

A provider in an area with barely more than 50% of the applicable broadband availability is at a large disadvantage compared to someone with 95% broadband saturation in that it will require a larger proportional share of use by those patients with broadband access to meet the 10% compliance requirement as outlined in the rule. As currently constituted, a provider situated in a locale where 60% of the residents have broadband is not measured on how many of that 60% view, download and transmit their record. Rather, under the current methodology, the provider is measured on how many out of 100% of the whole (his or her entire patient population), view, download and transmit. This is not an equitable outcome where only 60% can reasonably access the record. NOSORH recommends that CMS modify their denominator calculation to capture only those patients who reside in areas with 4Mbps broadband availability. If that population with 4Mbps broadband is 60% of the whole patient population for a specific provider, then only 6% of the whole population would be required. If 75% of the residents in the county have access to broadband, then 7.5% of all patients must view, download and transmit. While we recognize that this modification may add to the complexity of verification of attestation for CMS, we believe that this more accurately and equitably accomplishes the goals set out under this metric in the NPRM.

Transient populations should be excluded from patient calculation for purposes of portal usage

Rural areas are unique in that they may have a large population of people that visit an area and use the local healthcare facilities but that do not remain in the locale on a permanent basis. This is especially true in rural areas where agriculture is prevalent. Agricultural work is, by nature, seasonal and can result in a great influx and exit of people at a particular community. This is also true of rural tourist locations. Because these rural areas tend to have a relatively small permanent population, these patients may cause an artificial increase in the denominator of this calculation without the ability to offset these cases by higher compliance of the permanent population base. This is concerning to rural providers because these transient patients do not necessarily have the same incentive to monitor their records and may be less likely to take time to view them online.

This problem may be addressed, again, by limiting the calculation only to those patients whose records indicate that they are permanent residents of the area where they receive care or by limiting the denominator to include only those

patients who have one or more encounter with the provider in question. Both of these methodologies would serve to limit the denominator to those patients who are local and have an ongoing interest in the care that they are receiving from a particular provider.

Clarification

Some NOSORH member facilities seek clarification as to the transmit requirement. These facilities currently participate in Health Information Exchanges and would like clarification as to whether or not participation in such an exchange would satisfy the patient requirement to transmit their health information to another provider. NOSORH requests that information about these arrangements and their ability to satisfy the transmission requirement within this NPRM.

Summary of Care transition calculation should be modified

The NPRM stipulates that the EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provide a summary of care record for more than 65 percent of those transitions. Furthermore, 10 percent of the transitions of care summary documents must be sent using certified EHR technology to a "recipient with no organizational affiliation and using a different Certified EHR Technology vendor".[4] Both of these calculations present concern for rural providers.

First, because of the aforementioned difficulties that rural providers have had in becoming meaningful users, there are limited partners with whom the originating provider can transfer records to. The 3% of CAHs who have achieved meaningful use Stage 1 are likely to encounter a number of barriers in finding another provider who has the capability of receiving a summary of care document via certified EHR technology. This inability of a third party to act, as with the portal usage issue discussed above, should not inhibit a provider from becoming a meaningful user.

Furthermore, due to the nature of rural care, the 10 percent threshold for extra-system transfer presents problems for many rural providers. Many rural economies do not have the economic forces or buying power to support competing systems of care. Undoubtedly, many areas would likely be left entirely without access to care if it were not for special programs that incentivize doctors and hospitals in rural environments. Congress and CMS have recognized this need through special designations while many rural facilities act as de facto sole providers for their communities even if they are not designated as such. For these reasons many rural areas and facilities *naturally* belong to the same system. It is, therefore, likely that many rural providers, who are otherwise compliant with the meaningful use guidelines, will not be able to meet the qualification mandating 10% transition transmittal to providers outside of their system or those using certified EHR technology from other vendors.

NOSORH suggests two modifications that will help solve the two problems inherent to a rural delivery system.

Calculation of summary of care transitions in general should be modified and limited to require 65 percent compliance when the patient in question is transferred to another provider who is capable of receiving the summary of care documents using certified EHR technology. This modification will ensure that providers who are attempting to comply with law and regulation are not punished by third parties who have not arrived at this stage of implementation as of yet.

[4] Pg. 107-113

Furthermore, CMS should review vendor saturation into various markets and market-share of various systems before imposing a cross-system requirement for transition documentation. Again, this will ensure that providers are not punished because of the location of their practice or their participation in a larger system.

Medication reconciliation metrics should be modified

Many rural facilities have expressed concern with the availability of certified EHR technology that would adequately comply with the proposed measure. As mentioned above, rural facilities small size and relatively low purchasing power means that they have limited access to some necessary technologies to become compliant. While NOSORH remains committed to making sure that all safety precautions are taken, we believe that postponing the measure as currently constructed would allow rural facilities the opportunity to become compliant as vendors develop and distribute the applicable technologies.

Quality Measurement:

NOSORH appreciates the efforts that CMS has undertaken in the proposed rule to highlight quality measurement. Many NOSORH members are at the forefront of quality improvement and quality measurement initiatives throughout the nation. We believe strongly that rural can and should lead the nation in quality improvement efforts and results. Rural hospitals, clinics and group practices are smaller and often have the opportunity to implement system changes that improve patient safety much more easily than larger, more bureaucratic institutions. Often, financial incentives and regulatory changes can make these changes improvements happen.

CMS should be applauded for steps taken to make quality improvement and patient care a priority. Furthermore, the announcement in this rule that CMS will try to align future quality measures from the EHR program with other programs, such as ACOs and Value-Based Purchasing, is an important, positive step. Aligning these quality reporting requirements will help rural providers develop systems to fully participate in reporting programs and train their staffs in these functions. We look forward to continuing our efforts to work with the agency to provide the best care possible to all rural Americans.

We are concerned, however, because CAH facilities are not currently required to report on many of the metrics identified in the rule. While NOSORH is supportive of appropriate quality monitoring and reporting, CAHs are at a distinct disadvantage because they will have to invest significant time and money into quality measurement capture that other facilities have already done. We suggest a delay or phase in of this quality reporting so as to avoid increasing another burden on these facilities when they are already working feverishly to become meaningful use compliant.

We are also concerned, that continually modifying the number of quality improvement measures simply adds to the administrative burden of rural hospitals, including those PPS facilities who are already tracking many of the quality metrics. While rural providers' smaller sizes may allow them to implement change more quickly than their larger counterparts, it also puts a much heavier burden on the small administrative staffs at clinics, hospitals and independent practices. We encourage CMS to evaluate the need for these modifications before imposing what could be overly burdensome requirements on rural providers. While NOSORH appreciates the efforts to align quality measures across

CMS programs, it is imperative that these measures be consistent and applicable to a wide variety of practice types and settings.

Many rural facilities have also expressed concern and dissatisfaction with the current vendor market, specifically with user-ability in data entry for tracking many of these quality measurements. As we have discussed in other sections of this letter, the lack of timely availability of new and updated EHR technology makes these modifications difficult to administer in many rural facilities. The short window for compliance inherent in this rule exacerbates the administrative burden due to a lack of modified EHR technology. Increased flexibility for the deadlines associated with quality reporting is imperative for all rural facilities.

NOSORH also encourages CMS to develop rural relevant quality metrics when putting menu sets together. Because of the nature of the rural delivery system, metrics that are appropriate for large, urban facilities may not be applicable to rural providers. Similarly, metrics that might prove invaluable to understanding the quality of care in rural areas might not be appropriate for other settings. Rural providers want to be held accountable and they want to report the quality of their care. Nonetheless, the metrics used to measure quality in rural environments and the manner in which that data is collected must reflect the realities of rural health care. Again, NOSORH looks forward to collaborative efforts to ensure high quality health care in rural settings while guaranteeing appropriate data collection and measurement.

Conclusion

The NOSORH greatly appreciates the opportunity to respond to this proposed rule, and looks forward to working to ensure accessible, quality health care for rural America. We look forward to continuing our work together to the mutual goals of improving access and quality care for all rural Americans. If you would like additional information, please contact me directly.

Sincerely,

Teryl Eisinger, MA
Director

NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH
• 44648 Mound Road, #114 • Sterling Heights, MI 48314-1322 •
• Phone: 586-739-9940 • Fax: 586-739-9941 • Email: nosorhpd@comcast.net •
• www.nosorh.org •