March 2010 Letter on the CMS Electronic Health Record Incentive Program

March 4, 2010

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Sebelius,

Thank you for the opportunity to comment on the proposed Centers for Medicare and Medicaid Services (CMS) regulation “Medicare and Medicaid Programs: Electronic Health Record Incentive Program” as it pertains to rural providers. The National Advisory Committee on Rural Health and Human Services (NACRHHS) provides recommendations on rural health and human services issues to the Secretary of the Department of Health and Human Services (HHS). We appreciate the work CMS and the Office of the National Coordinator (ONC) for Health Information Technology (HIT) have done on the implementation of HIT and agree with the ultimate goals of meaningful use to create standards for comprehensive systems within health care organizations to track and improve quality of care. However, the Committee believes there needs to be specific attention devoted to plan components that address low volume and rural-specific issues. In particular we are concerned about the feasibility of the timeline for implementation for rural providers.

It is evident that HIT presents a number of opportunities for improving the health of rural America. HIT can help disparate rural providers from across the spectrum of care better coordinate services for their patients. However, there are challenges in implementing HIT in rural areas. As you may already know, rural hospitals are smaller and less specialized, operating with thinner margins and treating a higher proportion of Medicare patients than their urban/suburban counterparts. In fact, for many of the approximately 2,000 rural hospitals (including approximately 1,300 Critical Access Hospitals (CAH)) throughout the country, Medicare dollars account for over 60 percent of their case mix. The Committee understands the benefits of HIT to facilitate patient coordination as the rural patient population tends to be older, have a lower socioeconomic status, and suffer from more debilitating chronic illness. However, in regards to quality improvement (QI) and HIT activities, rural hospitals tend to have less sophisticated data collection systems and have fewer staff to devote to these activities.

The Committee agrees with HHS's ultimate objective to have a functioning Electronic Health Record (EHR) system adopted by all necessary parties to document the care of beneficiaries by 2015. However, the Committee recommends a less aggressive approach on the front end of the EHR adoption scale for small and rural providers. One of the Committee's primary concerns is the starting point of adoption of EHRs by rural prospective payment system (PPS) and CAH hospitals compared to the national levels. According to Healthcare Information and Management Systems Society (HIMSS) analytics data, approximately 35.0% of all CAHs are at Stage 0 adoption level, while 7.1% of PPS hospitals are at Stage 0. Comparing to the median adoption levels, 43.5% of PPS hospitals are at a Stage 3 while only 19.8% of CAHs have reached Stage 3. This information indicates that on average rural hospitals have lower levels of EHR adoption rates and will have more to put into practice in order to meet the proposed implementation stages. Rural PPS and CAH hospitals have lower levels of cash flow and cash reserves to invest in EHR systems as demonstrated by their cash flow margin which measures their ability to generate cash flow from providing patient care services. According to 2008 cost report data, CAHs have a cash flow margin of 5.6% compared to 6.2% for their urban PPS counterparts.

The Committee's understanding is that implementation of EHR systems can be difficult to achieve on a strict time schedule. Ensuring the ultimate system works for beneficiaries requires that they be part of the process. The concern with artificial time frames is that significant rework may be necessary later to modify the system to meet the users' needs not properly identified prior to implementation. The chance of this occurring in rural areas, either in physician offices or hospitals, is greater because of the lack of skilled HIT personnel with clinical backgrounds available to smaller organizations. Poor implementation can ultimately increase the cost of these systems significantly, which is particularly problematic for rural providers that may struggle financially and have limited cash reserves. The proposed implementation timeline for stages of meaningful use runs the risk of a two-tiered system penalizing small and rural providers for circumstances beyond control, furthering the digital divide.

Due to lower EHR adoption rates in rural areas, the Committee requests flexibility for small and rural providers to progress along the EHR continuum and a gradual approach towards the implementation process. Given the lower starting point of rural hospitals, the Committee would recommend measuring "meaningful use" by measuring improvement along a continuum rather than attainment of specific benchmarks. This approach would create a baseline starting point of all hospitals and then measure specific advancements to further EMR adoption. For example, if a CAH is HIMSS Stage 0 then it needs to be a Stage 2 by 2013, if it's a Stage 1.5 then it needs to be Stage 3 by 2013, and so forth. We understand the CMS has proposed utilization of adoption years for attaining meaningful use in Stages 1, 2, and 3. While that approach gives

flexibility for implementation of Stage 1 in years 2011, 2012, or 2013, the Committee believes that achievement of Stage 2 and 3 criteria may be beyond the scope of rural providers within a two year period of time. For that reason, we recommend the improvement approach as an alternate method to measure a rural provider's progress along the HIT continuum.

Additionally, the Committee is concerned about the exclusion of CAHs from participation in Medicaid incentive program. The American Recovery and Reinvestment Act of 2009 legislation says that "acute care hospitals," are eligible for Medicaid incentive payments. In one section of the proposed regulation CMS describes acute care hospitals with a definition that includes both PPS and CAH hospitals. Later, the definition used for acute care hospitals eligible for the Medicaid incentives is those whose CMS Certification Number (CCN) falls only in the range that is used for PPS hospitals. The Committee does not understand the rational for excluding CAHs from this part of the program. Like many rural providers, these hospitals have limited access to capital and cash flow. Approximately half of States pay CAHs at the same rate as PPS hospitals for inpatient services under the Medicaid program, as opposed to cost-based reimbursement. Inclusion in the Medicaid program would be an important resource in CAH ability to advance stages of adoption. The Committee is deeply concerned that CMS would make the decision to exclude CAHs from the Medicaid incentives without understanding the possible ramifications.

Finally, the Committee encourages CMS to consider the relevance of measures to rural hospital operations and the ability for measures to be applied to all facilities, regardless of volume or size. When considering additional measures the Committee urges CMS to include rural relevant measures that are focused more on primary care and outpatient procedures such as pneumonia care, chronic disease management, triage and transfer of patients, discharge instructions, and patient satisfaction. Many small rural hospitals will not perform specialty or advanced procedures at their facility. In addition, many rural hospitals may have fluctuation in their measures due to a lower volume of services and should not be penalized for services which they do not perform or perform at low rates.

Thank you again for the opportunity to share our insights and recommendations. I am also sending an identical copy of this letter to Dr. David Blumenthal, National Coordinator for Health Information Technology and Charlene Frizzera, CMS' Acting Administrator. The Committee appreciates the difficulty of developing this regulation and the need for an aggressive implementation schedule. The challenge is to not make it insurmountable, as the current proposal will be for a cohort of rural providers based on the collective experience of this committee. In this unique situation HHS cannot afford to leave a significant segment of providers and beneficiaries at a disadvantage. We would welcome further dialog on how to best meet the goal of providing high quality care to beneficiaries in rural America through the implementation of HIT.

Sincerely,

David M. Beasley
Chair