



**Rural Wisconsin Health Cooperative**  
**Comments on CMS Proposed HIT Incentive Rule**  
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Introduction

The Rural Wisconsin Health Cooperative (RWHC) is owned and operated by 35 rural Wisconsin hospitals. Among the many services and activities undertaken by RWHC include collaborative EHR adoption, quality indicators submission, and best practice facilitation through our numerous interdisciplinary roundtables and listserves. Our vision is for Wisconsin rural communities to be the healthiest in America.

Given our strong focus on EHRs and quality, we were excited to hear about an incentive program that was intended to provide aggressive yet reasonably achievable objectives for EHR adoption in pursuit of quality and efficiency improvement. We believe that such a program, if appropriately structured, could have a significant positive impact on healthcare outcomes in rural communities.

Unfortunately, the proposed rule does not provide such an appropriate structure. Indeed, we believe that the proposed rule is likely to have negative, rather than positive, effects on rural providers and the communities they serve.

The primary reason for this is that the proposed rule fails to take into account the relevant differences between early EHR stage providers and advanced EHR stage providers. Small rural providers tend to be at early stages of EHR adoption, and face various barriers to EHR system adoption specific to their size. While the proposed meaningful use standard may be reasonably achievable for advanced EHR providers, it is clearly unachievable for most early stage providers. The result of applying this standard will be to rush rural and other early stage providers through speedy vendor-driven implementations that are likely to increase medical errors, reduce quality, and decrease efficiency.

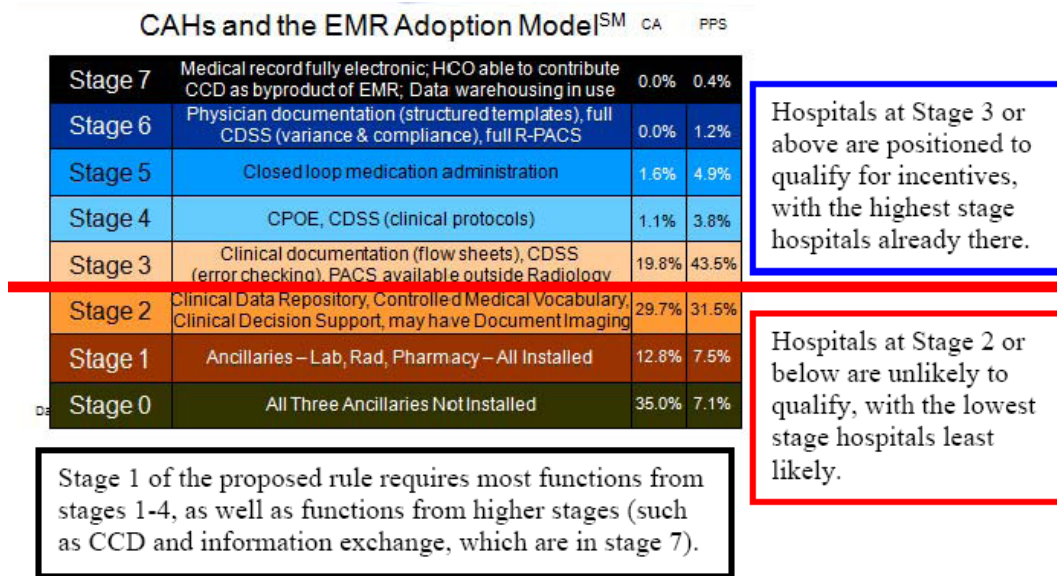
The above said, we believe that there is still an opportunity to avoid these unintended consequences. By affording rural providers reasonable time to perform the workflow analysis, quality and efficiency planning, and education activities that are universally-acknowledged to be prerequisites of EHR implementation success, CMS can include rural providers in the HIT incentive program and effectively improve the health of rural populations. Please consider the below recommendations toward that end.

Issue 1: The proposed meaningful use staging strategy will exclude the vast majority of rural providers and has the potential to reduce patient safety and efficiency in rural communities (pgs. 40-47)

According to the proposed rule, “While we believe that requiring satisfaction of all objectives is appropriate for the majority of providers, we are concerned that certain providers may have difficulty meeting one or more of the proposed objectives. We solicit comments on whether this may be the case, and invite commenters to identify the objectives and associated measures that may prove out of reach for certain provider types or specialties, and to suggest specific objective criteria we could use to determine whether an objective and associated measure is appropriate for different provider types.”

As indicated in the introduction, we agree that certain provider types will have difficulty meeting one or more of the proposed objectives. Figure 1, below, provides our analysis of which providers are poorly positioned to achieve the meaningful use standard as written.

**Figure 1**



The vast majority of rural and critical access hospitals are at HIMSS EMR adoption stages that we believe are unlikely to qualify for incentives if the meaningful use bar remains where it has been proposed. Consistent with American Hospital Association estimates, we believe that nearly 70% of critical access hospitals are unlikely to qualify for EHR incentives due to their early stage status. We also believe that close to 50% of PPS hospitals, including the majority of rural PPS hospitals, are unlikely to qualify.

**Recommendation 1: Adopt the AHA’s alternative framework of meaningful use objectives, including a separate glide path for hospitals with less than 100 beds.**

The AHA’s alternative framework for meaningful use is our preferred methodology for addressing the problems raised above. The AHA’s approach would give providers until 2017 to achieve all

components of EHR implementation and would provide flexibility for providers to adopt a certain % of a larger number of objectives over time. The AHA approach would also give due consideration to the fact that small hospitals are starting at earlier stages of EHR adoption by reducing the number of objectives required for hospitals with less than 100 beds.

**Recommendation 2: At the very least, incorporate a deferral mechanism (w/CPOE deferrable) into Stage 1**

If the AHA approach is not adopted, one way to at least enhance the likelihood that rural providers will be able to participate in the incentive program is to allow early stage providers to defer the most advanced EHR implementations to later years. The HIT Policy Committee's recommendation to create flexibility in the program through a deferral mechanism is therefore a second best alternative.

However, the Policy Committee's recommendation to make CPOE a mandatory requirement that cannot be deferred would defeat the purpose of such a deferral mechanism. CPOE is the one objective that absolutely should be deferrable for three reasons: (1) it is the most complicated EHR process to implement, (2) it is a capstone application that requires that most other elements of the EHR be in place before it can be successfully implemented, and (3) if implemented without the time required and attention paid to success factors, CPOE is the implementation most likely to produce numerous unintended consequences, such as increased medication errors, reduced care quality, and reduced efficiency.

Whether the threshold is 10% or 100%, providers at early stages of EHR adoption will not have the necessary infrastructure and applications implemented to even start a CPOE implementation by the end of the program. While we recognize that CPOE is one of the requirements in the statute, and that some consider CPOE to be the sacred cow of EHR implementations, there is evidence that CPOE is not always an effective implementation in small rural hospitals. We believe that Pharmacy systems, eMARs, and bedside medication verification are a much better formula for optimal medication safety in most small rural facilities.

Other requirements that are unreasonable to impose on small and rural providers include the requirements for electronic medication reconciliation, summary care document exchange, and information exchange, all of which are at stage 4 or higher in the HIMSS EMR adoption model.

The HIMSS EMR adoption model has been designed with consideration paid to the proven ways that providers incrementally advance to a complete electronic health record environment. As far as we know, the HIMSS adoption database is the most comprehensive dataset for provider EMR adoption statistics. Using this dataset in conjunction with estimates of the time it should take to successfully move from early to advanced stages of EHR adoption is one methodology for determining the appropriateness of the meaningful use objectives for different provider types. Requiring providers at stages 0-2 (nearly 70% of all critical access hospitals and likely a similar percentage of rural hospitals with less than 100 beds) to reach stages as high as 4-7 as part of Stage 1 meaningful use we believe objectively contradicts the principle of reasonable achievability.

Compounding the implementation challenges, rural providers will also face other barriers, such as workforce and vendor availability, as well as network infrastructure development challenges, which

we believe will dramatically increase the reasonable time required for rural providers to meet the meaningful use objectives. Does CMS recognize that small rural hospitals often have 0-1 IT FTEs compared to a large hospital's 100 or more? Rural hospitals will need to **multiply** their IT FTEs in order to achieve full EHR implementation, which will multiply costs (costs not reimbursed through the incentive program) and take significant time.

**Recommendation 3: Create a distinctive rural provider meaningful use bar for Stages 2 and 3**

While the deferral recommendation is a good start, it does not address the problem of how early-stage providers can possibly achieve Stage 3 at the same time (2015) as providers that are starting at advanced stages of EHR adoption.

If the AHA alternative framework is not adopted, we recommend that CMS develop Stage 2 and 3 meaningful use criteria that are different (i.e. more appropriate) for providers starting at early EHR stages than for providers starting at advanced EHR stages. If this needs to be done by provider type, the provider types qualifying for the lower stage bar should include small hospitals with 100 or fewer beds, including critical access hospitals, as well as disproportionate share hospitals. Multiple data sources clearly show that these hospital types are starting at significantly lower EHR adoption rates than other categories of hospitals. The exempted objectives should include those mentioned in Recommendation 2, since they are objectively unattainable by most of these providers by 2015.

**Recommendation 4: Fix proposed meaningful use objective ambiguities and inconsistencies and require that measure calculations be incorporated into EHR products through the certification process.**

Additionally, we support AHA and CHIME comments on the many practical impediments and ambiguities associated with some of the meaningful use objectives, and we recommend revising the objectives based on their input. We also believe that in order for CMS administrative burden estimates to be anywhere near accurate, requirements for meaningful use objective measure calculations need to be incorporated into EHR products through the EHR certification process.

Issue 2: Many of the proposed clinical quality measures are not suitable for electronic abstraction in Stage 1 environments, and not rurally relevant (pgs. 110-139)

According to the proposed rule, "We welcome comments on the inclusion or exclusion of any given clinical quality measure or measures proposed herein in the EHR incentive programs clinical quality measure set for EPs or eligible hospitals for the 2011 and 2012 payment years, and to our approach in selecting clinical quality measures ... As part of the public comment process, we welcome comment on not only the clinical utility of the measures we have proposed, but also their state of readiness for use in the EHR incentive programs."

We believe that the quality measures have been designed without attention paid to the measures' relevance to small rural providers. Many of the quality metrics in the proposed rule are for conditions that will not have denominators for small rural providers, and metrics that are especially relevant, such as the hospital Outpatient Core Measure Set (which was built with rural and critical

access hospitals specifically in mind), have not been included. It seems to us that the hospital Outpatient Core Measure Set, which includes AMI (Heart Attack), Chest Pain, and Surgical metrics for outpatients that come through EDs and Day Surgery settings, is a more appropriate measure than the proposed ER throughput measure, and it is data that is already accessible by CMS through the Quality Net Warehouse.

Additionally, we question whether Stage 1 EHRs will have the required data elements in discrete fields to be automatically abstractable without the need for manual abstraction by 2012 and after. Unless abstraction specifications are significantly revised, many of the selected measures will not be electronically abstractable even after providers achieve Stage 1 meaningful use. Take for example the inpatient AMI core measure AMI-5 “Beta-blocker Prescribed at Discharge.” When a physician decides not to prescribe a beta-blocker for a specific clinical reason, the data identifying that clinical decision-making process (currently abstractable from 11 data sources identified in 5 pages of CMS abstraction specifications) will be in a transcription or a physician’s note that is not extractable without human intervention. The current specifications for abstracting that one aspect of the beta-blocker measure require complex logic as well as in-depth combing of a patient’s medical record, including parts of the medical record that will not be electronically abstractable.

Finally, there is the issue of the administrative burden. Even if the same questions will not have to be answered under separate programs, the fact that CMS is creating a new program with distinctive rules will create significant duplicate work for rural providers already stretched with reporting requirements. Why can’t we develop one comprehensive reporting program from which all quality stakeholders (whether RHQDAPU, HIT Incentive, or State programs such as Checkpoint in Wisconsin) can access data from the CMS warehouse? Rural providers that must prioritize dedication of quality expertise hours between reporting requirements to an ever-growing list of stakeholders jeopardize patient safety and quality at the point of care.

**Recommendation 5: Delay implementation of any measures that have not been tested and proven to be suitable for electronic abstraction in Stage 1 environments, and include rurally relevant measure sets.**

We recommend that CMS focus on a starter-set of metrics that are relevant to both large and small providers (including an exportable version of the hospital Outpatient Core Measure Set), that are NQF and HQA endorsed, and that are tested for electronic exportability in Stage 1 meaningful use environments before they are imposed. CMS needs to take care to design incentive program quality reporting measures and abstraction specifications with an understanding of what will be electronically abstractable in Stage 1 meaningful use environments.

Issue 3: Excluding Provider-Based Clinics will impede the incentive program’s goals of promoting integrated care (pgs. 179-189)

According to the proposed rule, “Because, by definition of the requirements for provider-based departments and entities, EPs who furnish substantially all of their covered professional services to hospital outpatients use the hospital’s facility and equipment, including the integrated medical record system, for which payment is made by Medicare to the hospital, we believe these EPs should be

considered hospital-based EPs, and thus excluded from the Medicare EP EHR incentive payments. This is fully consistent with the definition of hospital-based EPs in section 1848(o)(1)(C)(ii) of the Act ... We seek comment on whether we should use another method for defining hospital-based EPs than what we have proposed here. Any comments should address implementation based on the specific POS codes identified, and/or any complexities that would result from not including all outpatient settings owned and operated by and integrated with the hospital in the determination of whether an EP is hospital-based.”

We believe that CMS has made an error in interpreting the Congressional intent of the hospital-based EP ARRA language. By indicating that the determination of whether an EP is “hospital-based” should be based on “site of service” rather than “employment or billing arrangement,” and by using pathologists, anesthesiologists, and ER physicians, rather than outpatient clinic physicians, as examples of hospital-based EPs, we believe Congress intended to include provider-based physicians as eligible professionals.

The practical reason they should be eligible is that the hospital EHR environment is a separate project from an ambulatory clinic EHR (whether provider-based or not), and failing to incentivize this separate project will likely lead to reduced integration between the two settings of care that have by far the most patient transfers and referrals. How can the incentive program meet its goals if only one of these sites of service can exchange information or produce summary care records?

Our position on this matter is supported by numerous other organizations, as well as 16 Senators that voted for ARRA under the impression that the language in fact included provider-based clinics. According to their letter to Secretary Sebelius, “we hope you will instruct CMS to follow clear congressional intent in the final rule.”

#### **Recommendation 6: Include Provider-Based Clinics (as Congress intended)**

We recommend CMS revise the proposed rule to create a distinction between physicians that practice in a hospital setting (i.e. physicians that predominantly use a hospital EHR, such as pathologists, anesthesiologists, and ER physicians) and physicians that practice in an ambulatory clinic setting (i.e. physicians that predominantly use a physician clinic EHR). The latter physicians should all be eligible for incentives, whether or not they are provider based.

Provider-based physicians use place of service code 22 (outpatient hospital) to designate place of service on their 1500s. We recommend that CMS consider what data elements within the RBRVS structure can best be used to distinguish between ambulatory clinics using POS 22 and other outpatient departments using POS 22, in order to make provider-based ambulatory clinics eligible.

#### Issue 4: What qualifies for the critical access hospital incentive remains ambiguous and overly contingent on future certification activities (pgs. 229-235)

According to the proposed rule, “for the purposes of computing the CAH incentive payment, we are proposing that the reasonable costs for the purchase of certified EHR technology mean the reasonable acquisition costs, excluding any depreciation and interest expenses associated with the

acquisition, incurred for the purchase of depreciable assets as described at part 413 subpart G, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in §495.4 of this proposed rule.”

In developing their ARRA compliance strategies, CAHs (unlike PPS hospitals) depend on rule-makers to appropriately articulate exactly what costs are eligible. By inadequately defining what constitutes an eligible EHR expense, rule-makers place CAHs in the situation of not having the information they need to make appropriate strategic decisions. This confusion will inevitably lead to fewer CAHs (the majority of which are already at a disadvantage, being at lower stages of EHR adoption) becoming eligible for incentives.

The proposed rule defines reasonable cost as “reasonable acquisition costs incurred for the purchase of depreciable assets, such as computers and associated hardware and software, necessary to administer certified EHR technology.” This definition seems to be an acknowledgment that there is a category of technology costs not only for the certified EHR technology itself, but also for the underlying technologies needed to support certified EHRs, such as networks, wireless systems, security devices, and computers and software without which certified EHRs cannot operate.

We support this important acknowledgement. However, we are concerned that there remains significant ambiguity as to what constitutes an eligible depreciable expense. Without additional guidance, different CAHs and different Medicare contractors will be able to interpret the definition in many different ways. And CAHs need to make their implementation plans right now, not after they have purchased technologies that may or may not be eligible depending on later interpretation.

Additionally, it is unreasonable for CAHs that are meaningful users to have to wait for future Stage 2 and 3 meaningful use objectives to be published before they can begin advanced implementations that are reimbursed through the CAH incentive. Examples of advanced technologies that are an important part of the EHR and provide various patient safety benefits include PACS, telemedicine, and automated medication dispensing systems. We believe these and various other systems should be funded, since they are critical components of the EHR environment. Yet PACS, for example, cannot be said to be necessary for the “administration” of the EHR; it is rather a component of the EHR. If ONC fails to create certification programs for PACS and other types of EHR-related systems, it is unclear to us whether they will be eligible under the CAH incentive.

The AHA alternative framework will partially mitigate this problem, as it identifies a complete list of objectives through 2017. But the issue of the timely establishment of certification programs remains a concern.

**Recommendation 7: Better define what constitutes a CAH eligible expense to clearly include the broad range of costs “necessary to administer” certified EHR.**

We recommend that CMS provide additional clarity to the concept “depreciable assets, such as computers and associated hardware and software, necessary to administer certified EHR technology” by identifying a list of examples of what would qualify as “assets necessary to administer certified EHR.” There are many examples of assets without which certified EHRs cannot be administered, such as (but not limited to):

- Servers, Storage Area Networks (SANs), Network Area Storage (NASs), and other hardware and software necessary to administer certified EHRs.
- Datacenter infrastructure, without which the servers and storage systems cannot be safely maintained.
- Network infrastructure, including switches, wiring, wireless systems and other hardware and software without which certified EHRs cannot be accessed by clinicians
- Network management systems, such as domain controllers and network monitoring software, without which certified EHRs cannot be securely accessed by clinicians
- Security devices, such as firewalls, intrusion detection systems, and patch management systems, without which EHRs cannot be appropriately secured and compliance with HIPAA and ARRA requirements cannot be achieved.
- Disaster recovery and backup systems, without which EHR availability cannot be assured.
- Computers and other peripheral equipment, without which certified EHRs cannot be accessed or administered.
- Telecommunications-related infrastructure and equipment, without which certified EHR data cannot be exchanged.
- Other assets necessary to administer certified EHRs.

**Recommendation 8: Ensure that EHR systems that are necessary for the implementation of full EHRs are eligible for the CAH incentive. For these types of systems, require certification only if certification programs exist.**

We believe it will be impossible and not cost effective for ONC to create certification programs for all of the systems required to implement a full EHR hospital environment. PACS, CR, medication dispensing systems, vital sign integration systems, discharge instruction systems, OB, ICU, Rehab, and ED specific systems, among many other EHR systems, are required to achieve a complete hospital EHR. CAHs should be reimbursed, per their incentive, for all systems that provide demographic and clinical patient information into the EHR repository, even if ONC fails to establish certification programs for those EHR components.

**Recommendation 9: Consider the issue of how to incent ASP models, which have been shown to reduce costs in CAHs**

ARRA and the proposed rule, by focusing on depreciable assets, prohibits CAHs from receiving incentives for costs associated with Application Service Provider (ASP) and/or cloud computing models (generally leasing arrangements), which can reduce the total cost of maintaining HIT applications, since they reduce the FTEs required to support the EHR systems. Due to the structure of the CAH incentive, those hospitals that can most benefit from ASP models are not being incented to utilize them to reduce their total cost of ownership (PPS hospitals can use ASP models without jeopardizing their incentives). We believe it is in the interest of CMS, CAHs, and the entire healthcare system, for CMS to develop a mechanism that allows ASP model utilization to be reimbursed through the CAH incentive structure. One way to approach this is to allow ASP vendors to provide CAHs with a depreciable asset % of their annual fee that could be applied to the CAH incentive.

Issue 5: Excluding critical access hospitals from the Medicaid incentive is contrary to congressional intent and will negatively impact the CAHs most in need (pgs. 279-282)

According to the proposed rule, “we are proposing to define acute care hospitals for purposes of this Medicaid EHR incentive program as those with an average patient length of stay of 25 days or fewer and with a CCN that has the last four digits in the series 0001 through 0879 (that is, short-term general hospitals and the 11 cancer hospitals in the United States).”

Even though the Social Security Act and MedPAC consider CAHs to be acute care hospitals, the proposed rule has excluded CAHs without comment simply by excluding CAH CCN #s from the eligible range.

We believe that this exclusion is contrary to the intent of Congress. Why would Congress use specific designations (“CAHs” and “subsection d hospitals”) in the Medicare portion of ARRA, and then a term “*not currently defined in the Medicaid regulations*” in the Medicaid portion, if Congress did not intend for the term “acute care hospital” to cover all hospitals that provide short-term (acute) inpatient care? Additionally, why would Congress provide a much larger incentive to high-Medicare utilization CAHs, than to the lowest reimbursed and most needy (high-Medicaid utilization) CAHs? We do not believe there is a reasonable justification for this arbitrary determination.

**Recommendation 10: Include CAH CCN ranges (1300-1399) into the definition of “acute care hospital” and provide these most needy of hospitals (that provide acute care) with the full benefit of the Medicaid “acute care hospital” incentive.**

Issue 6: The Regulatory Flexibility Analysis is not supported by source material and fails to address the EHR implementation challenges of small rural providers (pgs. 414-415)

According to the proposed rule, “any impacts that would arise from the implementation of certified EHR technology in a rural eligible hospital would be positive, with respect to the streamlining of care and the ease of sharing information with other EPs to avoid delays, duplication, or errors.”

In supporting its case for the benefits of HIT for “all” eligible healthcare providers, the proposed rule states: “there are benefits that can be obtained by eligible hospitals and EPs, including: *reductions in medical record-keeping costs, reductions in repeat tests, decreases in length of stay, and reduced errors.*” The proposed rule goes on to reference a 2008 Congressional Budget Office (CBO) study, [\*Evidence on the Costs and Benefits of Health Information Technology\*](#), to support this position, and then makes the claim that: “Certified EHR technology has the potential to help reduce medical costs through efficiency improvements, such as prompter treatments, avoidance of duplicate or ... unnecessary services, and reduced administrative costs (once systems are in place), with most of these *savings being realized by providers rather than by Medicare or Medicaid.*”

We believe that this analysis is both false and dangerous. If one reads the referenced CBO study, it becomes clear that the proposed rule has misstated the conclusions drawn by federal researchers. According to the study:

*Reductions in Medical Record-Keeping Costs:* “Research has shown that physicians’ offices can realize savings from reducing the pulling of paper charts and the use of transcription services (Wang and others, 2003). Those savings might not apply in very small practices, however, because such offices typically have low but relatively fixed costs related to medical records and the physicians who work there are much more likely than those in larger practices to write notes manually in the charts. Savings from less pulling of charts is typically accomplished by reducing the number of staff required to do so. But that type of staff reduction may be impossible in a small practice if the employee who pulls charts also performs other tasks (such as scheduling and billing), as is usually the case.”

This is a key point that is also true of small rural hospitals. Financial benefits that may be achievable in large provider environments are very unlikely to be achievable in small provider environments.

*Reductions in Repeat Tests:* “For the most part, any savings from avoiding duplicate or inappropriate diagnostic tests would be realized primarily by a health insurance plan, not a health care provider. Thus, the extent to which savings in this area would actually benefit providers is unclear.”

*Decreases in Length of Hospital Stays:* “Reducing the length of time required to process a lab test or diagnostic image from the time it is ordered to the moment the results are delivered only speeds up the delivery of care; it does not necessarily reduce the amount of care provided or its associated cost. Moreover, the promise of shortening the average length of time that a patient stays in the hospital might not be very compelling to a typical institution because it already faces a sizable financial incentive to pare its costs per admission.”

*Reduced Errors:* “Because medical errors can lead to the use of additional health care services, health IT systems that successfully reduce such errors may also diminish expenditures on health care. The effectiveness of health IT in reducing errors, however, depends largely on the type, setting, and quality of the systems.”

We would add to this that reducing errors requires that appropriate time be given for providers to perform culture change, workflow redesign, and education activities. If these activities are not performed, it is likely that errors will increase rather than decrease, which is why we believe that the assertion that “EHRs can only be positive” is dangerous and should be retracted.

Additionally, we believe that a reasonable analysis of how the proposed rule will impact small rural hospitals under 100 beds should call attention to the fact that every research study that has been published on this topic indicates that small rural hospitals are at lower stages of EHR adoption and have various additional EHR adoption challenges, many of which are a function of their size.

Once these facts are acknowledged, we recommend that CMS consider their implications (including those we have drawn throughout this commentary) to the appropriateness of the proposed rule for small rural providers.

**Recommendation 11: Revise the Regulatory Flexibility Analysis to be consistent with source material and other research. Use the conclusions from a valid RFA to drive revisions in the proposed rule that will accommodate the needs of rural providers and rural communities.**