March 9, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-0033-P, Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule (Vol. 75, No. 98), January 13, 2010

Dear Ms. Frizzera:

The National Organization of State Offices of Rural Health (NOSORH) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services Proposed Rule for Electronic Health Record incentives made possible by the American Recovery and Reinvestment Act.

NOSORH is a national nonprofit membership organization that represents the fifty State Offices of Rural Health around the nation. NOSORH and its members work together to improve health care in rural America. State Offices of Rural Health are expert conveners of rural stakeholders, provide technical assistance to improve health information technology and serve as conduits of information to rural communities and providers on key rural health issues.

As independent observers of the central role of the Medicare program in rural America's health care system, NOSORH and its member Offices of Rural Health are convinced that an effective use of Electronic Health Record System will facilitate improved quality of care for rural populations and greater efficiencies for the providers that serve them. Six key areas of concern and recommendations are outlined below.

Meaningful use – Like other interested parties we too are concerned that certain providers will have difficulty meeting one or more of the proposed objectives. The effort to build a comprehensive system must include consideration for how interoperable EHRs are implemented in a variety of settings including solo private practices, rural health clinics, critical access hospitals and allow for integration with hospice, long term care, laboratories, oral health, behavioral health and EMS providers. These rural providers are uniquely challenged by limited capital resources and little or no qualified technical staff to support the long term effort required to properly plan, develop and implement interoperable effective EHR systems. To make matters worse opportunities to expand HIT systems to rural communities can be limited as the result of the current "digital divide" plaguing some

isolated rural providers who do not have broadband access or the ability to send and receive data at volumes and speeds.

Recommendation: NOSORH recommends that CMS establish benchmarks that are not "one size fits all" and allow for benchmarking meaningful use based upon capacity of the provider and type of providers; those standards proposed by AHA for small hospitals under 100 beds may be an example as a first step to establishing these types of benchmarks.

Specifically, NOSORH supports the recommendation of the HIT Policy Committee workgroup to allow eligible professionals (EP) and eligible hospitals (EH) limited flexibility in achieving stage 1 meaningful use. We support their recommendation of allowing deferment of up to three Stage 1 objectives from the first Health Outcomes Policy Priority area and up to one objective from the second, third and fourth. This is recommendation "12.0" (referenced as the "3-1-1-1-0 proposal) in the draft February 17, 2010, letter to Dr. David Blumenthal.

Computerized Physician Order Entry (CPOE) Deferral - In February, the HIT Policy Committee met and discussed flexibility within the EHR incentive program. The Committee ultimately adopted a new set of recommendations that loosened the MU objective standards that would allow providers to defer a portion of the objectives set forth in the rule without affecting their incentives. This decision would represent a welcome change in rural America, where providers demonstrating their dedication to do everything in their power to meet MU guidelines may still have difficulties doing so.

Therefore, while NOSORH greatly appreciates the Committee's recommendations to award providers doing everything they can to meet MU requirements by allowing limited deferral of certain objectives, we urge CMS to recognize the importance of a properly integrated CPOE system and therefore adopt similar deferral guidelines for CPOE objectives. We believe this would reward providers doing their due diligence to become meaningful users, while at the same time recognizing the unique challenges many rural and underserved providers face.

Recommendation: CMS should recognize that providers with a CPOE system in place, have demonstrated their intent to move toward a fully integrated computerized order entry system, and allow them to qualify for Stage One Meaningful Use guidelines without requiring specific percentage thresholds for order entry. NOSORH adds it voice on this recommendation to that of the National Rural Health Association.

Hospital-Based Professionals and Provider Based Clinic Exclusion -

NOSORH supports the ability of EPs working in provider-based RHCs and provider-based FQHCs to obtain EHR incentive payments for the meaningful use of the EHR, as provided for in the proposed rule. However, we believe that other provider-based physicians should also be eligible for incentive payments. Specifically, we believe there should be a distinction between physicians practicing in a hospital setting, such as ER doctors, pathologists and anesthesiologists; and physicians practicing in ambulatory settings. All ambulatory physicians should be eligible for the incentive payments, regardless of whether they are provider based or not.

Recommendation: NOSORH supports the National Rural Health Association recommendation that in order to calculate this, CMS should factor in a provider's place of service code. Ambulatory physicians, for instance, who use POS Code 22 should qualify, whereas inpatient physicians (POS Code 21) and ER doctors (POS Code 23) should not.

Critical Access Hospital Medicaid Exclusion - The HITECH Act did not provide a definition of "acute care hospital," likely because this has long served as a generally accepted term. Because no CAH's CMS Certification Number (CCN) falls within the range contemplated in the proposed rule, CMS has effectively prevented CAHs from Medicaid incentive eligibility, despite CAHs qualifying for the average length of stay requirement in the proposed rule.

CAHs have long been considered acute care hospitals, notably by the Medicare Payment and Advisory Committee (MedPAC), Congress and the Social Security Act. Therefore excluding them from the ARRA Medicaid incentives was not consistent with Congressional intent.

Recommendation: We support the National Rural Health Association recommendation that CMS should include CCN ranges (1300-1399) into its definition of "Acute Care Hospital."

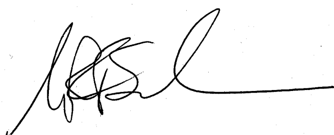
Health Information Exchange at the U.S.-Mexico Border. A wide range of Americans and foreign nationals cross the border to obtain a variety of health care services. Americans obtain prescriptions from Mexican physicians and have them filled in Mexican pharmacies; and CAHs, CHCs and Rural Health clinics provide emergency room and other charity care to Mexican residents whose medical records are located across the border in Mexico. These patients will also have medical and pharmaceutical histories on the Mexico side of the border. Mexican residents with private U.S. health insurance coverage frequently use American hospitals for in-patient care, but their primary care physicians are located in Mexico. Canadian citizens also receive health care in the U.S.

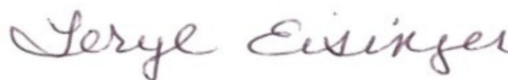
Recommendation: CMS should exclude patients using pharmacy services in Mexico or Canada from the denominator used to determine if the provider has met the required E-prescribing threshold.

NOSORH is dedicated to working with CMS, policy makers, partners and rural providers to build capacity for implementing initiatives which improve the quality of health care services for rural Americans. NOSORH joins with the National Rural Health Association and the National Rural Health Information Technology Coalition who voice similar concerns on behalf of rural patients and providers across the nation.

If you have questions or require further information please contact us directly or our Health Information Technology Committee Co-Chairs Alison Hughes (Arizona Rural Health Office) ahughes@u.arizona.edu or John Hanson (Washington Statewide Office of Rural Health) john.hanson@doh.wa.gov. Thank you for the opportunity to comment on these important regulations.

Sincerely,





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