**National Rural HIT Conference Call**
**MINUTES**
**February 4, 2010**

**Participants**

*Craig Baarson – Minnesota State Office of Rural Health and Primary Care*
*John Barnas – Michigan Center for Rural Health, National Organization of State Offices of Rural Health (NOSORH)*
*Nicole Clement – Rural Health Resource Center*
*Lynette Dickson – North Dakota Center for Rural Health, NOSORH*
*John Hanson – Washington Office of Community Health Systems/Rural Health, NOSORH*
*Terry Hill – Rural Health Resource Center*
*Alison Hughes – NOSORH*
*John Lily – SISU Medical Systems*
*Mike McNeely – Office of Rural Health Policy (ORHP)*
*Tracy Morton – Rural Health Resource Center*
*Mark Sandvick – SISU Medical Systems*
*Mark Schmidt – SISU Medical Systems*
*Mark Schoenbaum – Minnesota State Office of Rural Health and Primary Care, NOSORH*
*Louis Wenzlow – Rural Wisconsin Health Cooperative*

**Call to Order** Terry Hill called the meeting to order at 2:30p.m.

**Purpose of the Meeting**

To discuss the pending Meaningful Use definition as proposed by the Centers for Medicare and Medicaid (CMS) and its impact on critical access hospitals (CAHs).

**Scope of the Issue**

Louis Wenzlow has been posting current issues and commentary on the CMS proposed rule for the definition of Meaningful Use on a blog via the Wisconsin Office of Rural Health: http://www.worh.org/hit/

The CMS proposed definition for Meaningful Use (MU) includes 3 Stages of MU with Stage 1 including more than 20 objectives and over 30 quality reporting measures. Stage 2 and 3 are anticipated to be even more rigorous. Louis is concerned that there is not adequate time to achieve Stage 1 of MU within the proposed timeline and that small providers who are currently farther behind in HIT adoption have much farther to go in an unlikely timeframe. He also stated that funding has been crafted towards those practices that are farthest along in HIT adoption and inadvertently withheld from those who need it the most, small rural providers and facilities. It is possible that the outcome of the proposed MU definition may be that quality of care will deteriorate (rather than improve) due to the short timeframe to meet MU and the cost of care may increase as small providers pass on HIT costs to consumers. According to Louis, this is the exact opposite intent of the HITECH Act legislation. The focus of the concern is not that rural providers should not strive to implement HIT and become meaningful users, but that it needs to be done consciously to achieve a meaningful result.

According to the latest CMS interpretation, provider-based clinics are excluded from incentives. Hospitals with clinics need to purchase clinic systems, whereas a hospital without a clinic would not need to purchase this clinic system. Moreover, CAHs appear to be excluded from Medicaid incentives due to CMS definition of acute care hospitals.

**Suggested Solutions**

Louis provided suggestions on how to address the above issues. Similar to the American Hospital Association recommendations, Louis suggests increasing the timeframe for MU from 2015 to 2017 with flexibility in MU so that it is not the current "all or nothing" model. With that, create an option to choose a percentage of the MU standards to implement that make sense in the facilities' environments. Another suggestion is to allow physicians in provider-based clinics to be eligible for incentives as well as including CAHs in the Medicaid incentives. HIT Regional Extension Centers will be able to support physicians in provider-based clinics of a certain size, but only those with prescriptive privileges. Regional Extension Centers (RECs) will not achieve their full payment from the government until the provider they are working with achieves MU. If physicians in provider-based clinics are not eligible for HIT incentives, then the current REC model may not encourage RECs to work with provider-based clinics, as they are not financially incentivized to reach MU.

**Other Suggested Solutions by the Call Participants**

Mark Schoenbaum stated that 2015 as an end date for MU incentives is in Federal law and that any suggested change would not occur through comments on the CMS proposed definition of MU but rather through Congress.

Terry Hill noted that there is still a great lack of awareness of what needs to happen at many rural hospitals and clinics throughout the country to even approach HIT and MU.

Mark Schoenbaum and Louis Wenzlow agreed that any recommendation to CMS needs to be supportive of the end goal of MU and incorporates setting a more realistic goal line for MU, but be coupled with allowing the Regional Extension Centers time to do their work.

Alison Hughes suggested adding to comments real life examples, quotes, and stories from places around the country working on, or beginning to work on, HIT adoption and MU.

Alison Hughes also noted the rural long term care facilities have the highest number of patient transfers, yet there is no support for long term care facilities in HIT and health information exchange incentives.

Mark Sandvick stated that through SISU's experience, the bar may be set too high for Stage 1 of MU as proposed by CMS unless a facility is already along the path for MU. He stated that some of the hospitals SISU is working with that are currently at Stage 0 would struggle to meet Stage 1 of MU by 2015, even with extensive support. This is also coupled with vendors being overwhelmed and not being able to keep up with the demand, plus the fact that certification standards have not yet been finalized.

**Next Steps**

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Terry Hill noted that TASC is developing an HIT Key Informant Group, chaired by Louis Wenzlow, who will be available to TASC, the states, and ORHP for their technical expertise. This group will also include a financial representative as well, who can access the financial impact.

The Rural Wisconsin Health Cooperative is working with the National Rural Health Association (NRHA) on a comprehensive list of the issues and recommendations. Louis will share this list with the National Rural HIT Coalition and other organizations. It is important that the issues and recommendations are shared with rural legislators.

Participants on the call agreed that messages sent in the comment letters need to be proactive and suggest constructive strategies for change so there is both time and funding to support the rural HIT work that needs to be accomplished.
TASC will organize the issues and recommendations from this call and share them with NRHA. TASC cannot advocate, but can help to acquire information and help educate. Comment letters will need to be shared with State Offices of Rural Health, Flex Programs, and State Rural Health Associations. These activities can be coordinated with NOSORH and NRHA, who can work on the advocacy piece.