June 25, 2013

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
[Submitted electronically]

RE: CMS-1599-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; Proposed Rule (Vol. 78, No. 91), May 10, 2013

Dear Ms. Tavenner:

On behalf of our 126 member hospitals, the Kansas Hospital Association (KHA) appreciates the opportunity to respond to the request for comments on the Centers for Medicare & Medicaid Services’ (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2014. This comment letter is in response to the Quality Reporting Requirements for Specific Providers, specifically the reporting of Clinical Quality Measures, CQM, through electronic health records.

Electronic Clinical Quality Measures. With a stated goal of enhancing the alignment of the IQR with the Medicare Electronic Health Record (EHR) Incentive Program, CMS proposes to allow hospitals to report one quarter of data for 16 IQR quality measures using EHRs certified in the meaningful use program. The electronic reporting option would allow hospitals to meet both their FY 2016 IQR reporting requirement for those 16 measures, as well as fulfill the electronic quality measure reporting requirements in the meaningful use program in calendar year (CY) 2014. The agency strongly encourages participation in the voluntary election as a precursor to a required electronic reporting requirement of measures in the future.

The Kansas Hospital Association supports the long-term goal of using EHRs to streamline and reduce the burden of quality reporting while increasing access to real-time information to improve care. However, we believe the current proposal by CMS would undermine the intent of the IQR Program and provide little insight into whether EHRs can be used to effectively report comparable data for purposes of public reporting in the future. Our hospitals are very concerned about the implications of retrospective versus real time reporting of quality measures and the use of trend data by CMS given the reporting changes. We agree with the AHA recommendation that CMS allow hospitals to electronically report data gathered according to the IQR specifications, and thereby receive credit for both the IQR and Medicare EHR Incentive Program.
Limiting choice in meaningful use. As proposed, the electronic reporting option would limit hospitals’ choice in fulfilling meaningful use requirements. Most obviously, by naming a specific set of 16 eCQMs, CMS has taken away the choice hospitals currently have of reporting any 16 of 29 eCQMs. Vendors will be permitted to select which eCQMs they will support under the “modular certification” construct in the EHR Incentive Program. They will not be required to support all eCQMs. Because vendors are not required to support all 29 measures, they may not, in fact, support these specific 16 measures.

In addition, the Stage 2 meaningful use rules require hospitals to implement at least five clinical decision support (CDS) tools in their EHRs that are related to the eCQMs that they report for meaningful use. Thus, by limiting the eCQMs reported, CMS would also constrain the choice of CDS tools to only three clinical domains (stroke, VTE, and delivery). The KHA recommends that CMS rectify this problem by eliminating the requirement that CDS tools be related to eCQMs. Hospitals should be free to choose the CDS tools that best help them achieve their individual quality improvement strategies and goals.

The KHA does not support requiring the electronic submission of IQR measures in 2015. Instead, we recommend that CMS continue a voluntary electronic reporting option in IQR in order to fully inform future decision-making about the timetable for required electronic reporting of measures in the IQR. We do not believe that CMS will have a sufficient amount of evidence from the voluntary reporting option in 2014 to specify a date certain for the start of required eCQM reporting in IQR. In general, IQR requirements are set forth in each year’s inpatient PPS rule. With respect to 2015, both electronic submission deadlines for the proposed voluntary reporting option would come after CMS generally issues the Notice of Proposed Rulemaking for the inpatient PPS. The rule would also be finalized before the second submission deadline of Nov. 30, 2014. CMS would, in short, propose required reporting without the benefit of experience from the field. Additionally, there is a lack of alignment between the timeframes of electronic reporting option, and established timelines for rulemaking. We urge the agency to align these timeframes in the future.

Moreover, the experience of Stage 1 of the EHR Incentive Program indicates that a rushed timeline and insufficient testing of certified EHRs led to an inability to generate useable, accurate clinical quality data out of EHRs certified to meet the Stage 1 requirements. Stage 1 of the EHR Incentive Program includes 15 of the 16 measures in CMS’s proposal. Hospitals participating in that program are best positioned to assess their readiness to generate accurate CQMs, and the challenges they have faced are numerous. For example, electronic specifications (e-specifications) are meant to provide guidance on how measures can be generated from the EHR. However, there are known errors in e-specifications of the measures. Additionally, vendor products supporting Stage 1 met very light testing requirements before receiving certification that they could report eCQMs. Rigorous testing before certification occurs is essential to ensuring needed data are routinely captured by the EHR.

In practice, Stage 1 hospitals found that much of the needed data was not captured without extensive additional effort, counter to the idea that electronic reporting would reduce measure burden. In recognition of these issues, CMS in the fall of 2011 provided sub-regulatory guidance stating that the EHR Incentive Program requires providers only to attest that eCQMs were generated as output from the certified EHR in order to successfully demonstrate for meaningful use. The program does not currently require data accuracy for eCQMs because hospitals have found that their certified EHRs generally cannot generate accurate data. Therefore, hospitals in the EHR Incentive Program have had very limited experience with generating and attesting to the accuracy of electronic quality measures in the Medicare EHR incentive program.

As outlined in the final rule for Stage 2 of the EHRs Incentive program, electronic CQM requirements will move from simply attesting to obtaining the results from a certified EHR, to reporting of the actual results. Hospitals will need to restructure work flow processes to insure physician and provider compliance with standardized concurrent data collection. The collection of quality metrics electronically may require added manual validation and duplication of efforts to insure accuracy. New nomenclature and standards are not well understood and require further training and support.
Most CAH and rural hospitals have a limited number of eligible cases relative to the increased expense and resource burden.

Measures endorsed for manual abstraction have not been reviewed and specifically endorsed for EHR automated reporting. This step is needed to provide assurance that the data is valid, reliable and feasible to collect. It is important to note that though the measures look similar for both Meaningful Use and IQR (the measures have the same title, etc.), the measure specifications and calculation are actually quite different. The IQR measures are all manually collected and have different specifications. The federal process for managing updates to e-specifications needs improvement before additional measures are reported via EHRs.

Vendor readiness issues continue to be of concern for our hospitals. Our hospitals express that some of the components of their EHRs are immature in relation to electronic reporting of quality measure data.

Certification for EHRs should include testing the accuracy of the embedded measure calculations. Some systems were implemented prior to the unveiling of the complexity of data exchange that CMS is requesting. As a result vendors attempt to modify existing systems or create new products that hospitals feel pressured to purchase.

The majority of our hospitals will have to contract with an additional vendor, outside of their EHR vendor, to report the eCQMs. Kansas hospitals report implementation and ongoing subscription costs of up to $400,000. Because of the expense involved in implementation of EHRs, hospitals often introduce individual modules in phases and progress toward a complete system in the future. This delays implementation for critical access and small rural hospitals due to limited resources.

Thank you for the opportunity to share our concerns and comments. Kansas hospitals seek to move toward an e-enabled health care system where all hospitals meaningfully use EHRs to improve patient care and safety and achieve national goals for improved health. The Kansas Hospital Association applauds the efforts of the CMS to align quality initiatives in various programs, to reduce the manual process currently required, and to allow for consistent data generated from the programs. Our hospitals are still on the journey toward the electronic collection of quality data and have much more to do to reach this goal. We encourage CMS to consider stakeholder participation to make the automated quality measure reporting successful. The value of quality measurement and reporting requirements should be balanced with recognition of the significant burden of reporting.

Sincerely,

Thomas L. Bell
President