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Department of Health and Human Services
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Re: Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition

Dear Ms. Tavenner and Dr. DeSalvo;

On behalf of our 135 member hospitals, health systems and other health care organizations, the Kansas Hospital Association appreciates the opportunity to comment on the recent proposed changes to the requirement for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2014.

We reviewed the proposed changes with our members individually, in small groups and technical advisory discussions. The initial hopes that the proposal would provide some much needed relief has given way to concerns that the proposed changes, while well intended, will have limited benefit.

Upgrades to 2014 Certified Edition software and changes in Meaningful Use Stage 1 have slowed attestations. Patient electronic access and changes in quality reporting left hospitals struggling to purchase and install the necessary upgrades, then implement and redesign workflows to comply. Members report previously functional workflows have been replaced with duplicative processes to insure capture of data in accordance with vendor specifications. Facilities have postponed or eliminated local quality efforts in order to focus on meeting the specific federal mandates. There is confusion and frustration with the lack of available time, financial, vendor and educational resources to meet the new changes.
We appreciate the intent of the proposal to provide flexibility to use a variety of CEHRT to meet the Meaningful Use Stage measures, but unfortunately the timing of the proposal is too late. Hospitals planning to meet any stage of Meaningful Use in 2014 have already made plans, purchased and implemented their 2014 Certified Electronic Health Record Technology (CEHRT). Upgrades, training and plans were required to be in place before July 1 to begin the last available 2014 reporting period.

It would have been a welcome relief had the announcement been made sooner. For example, a small Kansas PPS hospital met Stage 1 Meaningful Use in 2013. They invested a large amount of human and financial resources selecting and implementing additional software systems to meet the 2014 quality and electronic access requirements. This significant time and investment is for an average daily inpatient census of only 2. The added flexibility and additional time for vendor selection and implementation offered by the proposal would have been invaluable.

Hospitals preparing to meet Stage 2 requirements have invested considerable time and effort into redesigning workflows and mapping quality measures to meet the Stage 2 objectives and are unable to change their course. Those preparing for Stage 2 expressed that attesting to Stage 1 is not a viable option due to the software and complex workflow redesign already in place. Those that could use a combination of 2011 and 2014 CEHRT are unclear how the two editions would calculate the 2013 objectives and express concerns about the data validity.

Under the proposed rule, hospitals were unclear how they would attest to being unable to fully implement the 2014 Edition CEHRT. This includes the process to accurately generate the EHR certification ID. As noted by the American Hospital Association, much uncertainty remains about the level of documentation that will be required at attestation time. More clarification on the attestation process is necessary. We would further request specific instructions to address audit requirements.

There’s Still Time and Hope for 2015

Provide an initial 90 day reporting period for Stage 2. Additional time is required to continue to iron out clinical workflows and determine the most effective use of resources. It has been virtually impossible for hospitals to meet MU2 in 2014, so expecting them to meet it beginning Oct 1 of 2014 for a full year is a recipe for failure. We strongly urge CMS to provide a 90 day initial reporting period for Stage 2 Meaningful Use and all other initial reporting periods of Meaningful Use. A 90-day reporting period gives all providers time to understand the many workflow and other changes required for Stage 2 and avoids the immediate rush at the beginning of the fiscal year.

Transitions of Care measures rely on expectations of systems that are in development within our state, such as the use of DIRECT secure messaging and health information exchange. Providers and health care entities are only beginning to participate in the secure messaging service, and a centralized directory does not yet exist. The lack of an organized infrastructure and differing timelines for implementation between EPs and EHs contribute to the difficulties in meeting this objective for a full year reporting period. We need the additional flexibility of the 90-day reporting period to develop our exchange systems and implement this measure.
Public Health Measures: Regardless of size, eligible hospitals that order any reportable labs must electronically report them to the state. There is no exclusion. A small CAH that may order less than 10 reportable labs per year must still pay for and maintain electronic EHR interfaces to meet MU 2. The same requirements apply to immunizations and syndromic surveillance. We request the addition of exclusions for low volume hospitals for all three public health measures: electronic lab, immunizations, and syndromic surveillance.

Learn from Stage 1 to build value in future stages. This is an example shared by one of our facilities. “In stage 1, we used an acetaminophen alert that was focused on preventing liver damage to patients due to acetaminophen overuse. The alert was programmed to pop up when a patient’s dose approached 80% of the maximum dose of 4000 mg. With the help of this alert and the report that can be generated, we are making strides in addressing overuse of acetaminophen-containing medications, while using it as a platform for discussing pain control in patients. Since many of our alerts came from the use of post-op pain combination meds, we were able to address with nurses and physicians patient perception of pain and improve pain control and outcomes. Now, in Stage 2, the CDS alerts increased in number, and due to certification requirements we cannot use the above listed alert to meet the CDS objective. We plan to leave the acetaminophen alert in place, but the point is that the MU2 criteria did not continue the good work that was performed in stage 1 to enable us to improve patient quality of care and outcomes. We are trying to do this in spite of the stage 2 changes.”

Slow down the Pace and Requirements. Poor design, incomplete and rushed implementations, coupled with a lack of planning and understanding defeats the program intent. We urge both ONC and CMS to allow eligible hospitals and professionals the opportunity to achieve mastery of electronic health records before adding changes. We need adequate time to achieve a common set of competencies before incurring additional requirements. Only then will we be able to advance interoperability and patient engagement with improved health outcomes.

Thank you for the opportunity to provide input on the proposal. We have made great progress and continue to succeed, but believe this is a journey that requires planning, preparation and adequate time to implement.

If you have any questions, please contact me or Melissa Hungerford at mhungerford@kha-net.org.

Sincerely,

Thomas L. Bell
President