May 28, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201 1

[Submitted electronically]

Re: CMS-3310-P, Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 Proposed Rule

Dear Mr. Slavitt:

On behalf of our 126 member hospitals, the Kansas Hospital Association (KHA) appreciates the opportunity to respond to the Request for Comments on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 published on March 30 (Federal Register, DOC #: 2015-06685).

Kansas hospitals seek to move toward an e-enabled healthcare system where all hospitals meaningfully use EHRs to improve patient care and safety and achieve national goals for improved health. We appreciate the focus on interoperability, but we caution that there is not yet sufficient experience at Stage 2 to consider Stage 3 proposals to be achievable. It is important for CMS to work closely with ONC to build out the infrastructure on information exchange and to move from standard development to standard implementation.

The KHA is very concerned that the proposed Stage 3 requirements raise expectations too high without first addressing the challenges with meeting the existing program thresholds, particularly related to the patient portal, transitions of care and electronic quality reporting. Further, objectives moved from menu to core should not have the threshold increased.

Patient Engagement. The KHA supports the proposal to continue the use of the patient portals to facilitate patients' access to their health information, but we are concerned about increased thresholds for actions required by patients for engagement from 5% in Stage 2 to 25% in Stage 3. Our hospitals report that this is an unrealistic goal. Despite extensive investment in patient engagement strategies, even one of our larger systems is barely meeting the 5% threshold. It is important that the patient have the opportunity to convey their preferred method of engagement. Holding providers responsible for getting patients to a particular threshold of use of technology is the wrong path. The KHA believes the measures are structured inappropriately and recommends that demonstrating proof of functionality with one patient would be a more appropriate measure than increasing the threshold.
Health Information Exchange. CMS is asking for comments relative to application program interfaces (APIs), patient electronic access to health information and coordination of care through patient engagement. The idea of APIs shows potential, but we believe we need to learn more. However, the standards to support the use of APIs are still under development and are not yet mature enough to be included in regulation. The KHA opposes the acceleration of the timeframe – from 36 hours to 24 hours – for the provider to give access to a patient to view, download or transmit, or access the information through an API as it would present operational challenges to hospitals. The KHA recognizes the potential future use of APIs to facilitate information exchange but recommends that the API reference in the patient access measure be modified or removed. Relative to patient access to health information, our members suggest that patient education should not be defined only by materials posted electronically to the portal, and that the method of communication should be determined by the provider and patient. Forcing all patient education delivery through the portal is misleading and does not drive quality of patient engagement.

Patient Electronic Access to Health Information. CMS proposes to increase the requirement for electronic creation and exchange of a summary of care record that includes actively seeking and incorporating the summary of care document for 40% of new patients and the inclusion of non-clinical (API) data. Our member hospitals report that this does not fit into a hospital workflow, and to incorporate available data is extremely burdensome. Currently, data does not match perfectly in the transfer of care documents. API data has not yet been studied, nor is there evidence that such incorporation would improve care. Successfully meeting the new threshold (50% from 10%) is contingent on partners that use the appropriate technology and that have invested in the infrastructure required. These are variables outside of an individual provider’s control.

Quality Reporting. The KHA strongly 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, required electronic submission of electronic clinical quality measures (eCQMs) for a full year in 2018, as proposed in the rule, is too ambitious a goal. Experience to date indicates that eCQMs have required hospitals to expend considerable financial and workforce resources to modify how data are captured and the locations in the EHR where data is captured, but they have not yet resulted in measurement data that are comparable across measurement methodologies. eCQMs must be valid, reliable and feasible to report. Additionally, the EHR vendors should be required to modify their products to support the annually updated eCQM specifications.

Clinical Decision Support (CDS). For Stage 3, the rule proposes to continue the Stage 2 objective that CDS interventions be implemented focused on high-priority conditions. CMS proposes two measures to meet the objective. The first measure requires five CDS interventions related to five or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. The second measure requires implementation of the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. The KHA recommends removing the tie between clinical decision support and eCQMs and instead use CDS to support high priority safety and quality improvement objectives. eCQMs will continue to evolve, and removing the tie provides an opportunity for hospitals to better use their EHRs to reduce reporting burdens and to achieve goals.

Public Health Registry Reporting. The KHA supports the proposed change in the requirement that providers are in “active engagement” with a public health registry or clinical registry rather than the Stage 2 requirement for an “ongoing submission” of data to meet the public health objective. The proposed six measures in support of the public health registry reporting requirement give an appearance of flexibility but will require hospitals to exhaust multiple reporting options in order to claim an exemption for a given measure. This represents a significant increase in the reporting burden. The KHA encourages CMS to work with public health to receive data in a standardized format. And, as registry options are added, there be greater assurance that the registry can receive the data.
Reporting period. The KHA supports the move from fiscal year to calendar year reporting for hospitals beginning in 2017. However, a full year of reporting for the first year of Stage 3, as proposed in the rule, is unrealistic. The KHA strongly recommends a reporting period of any 90 days in the first year of a new stage, including Stage 3. The first year of Stage 1 and Stage 2 offered a 90-day reporting period, which proved to be essential to supporting a safe and orderly transition to use of new technology. In addition, new entrants to the program should continue to have a 90-day reporting period in their first year of participation. Providers new to the program need time to install and learn to use technology before beginning their first reporting period.

Relative to first time attesting. twenty-five of our eighty-four critical access hospitals have not yet met Stage 1 Meaningful Use but expect to in 2015. These facilities are unable to “attest” because the Center for Medicare and Medicaid Services EHR attestation site has been inaccessible for submitting Stage 1 2015 meaningful use data since January of this year. These hospitals have invested significant resources both financial and workforce over the past several years to adopt, implement and upgrade their information systems and electronic records to enable all of their facilities to meet meaningful use by 2015. The inability of our Kansas hospitals to attest is unfair, particularly as they face potential penalties beginning in October 2015 for failing to attest. No explanation was provided on the site for its unavailability; however, reasons for the closure became clear in the recent proposed CMS modifications to Meaningful Use in 2015-2017 published in April. The KHA encourages CMS to reopen the opportunity for hospitals to attest in 2015.

Kansas hospitals are committed to moving toward an e-enabled health care system to improve patient care and safety and achieve national goals for improved health. Thank you for the opportunity to share our concerns and comments.

Sincerely,

Tom Bell
President and CEO