Tom Bell  
President and CEO

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

Re: CMS-3323-NC, Request for Information (RFI): Certification Frequency and Requirements for the Reporting of quality measures Under CMS Programs

Dear Mr. Slavitt:

On behalf of our 127 member hospitals, the Kansas Hospital Association (KHA) appreciates the opportunity to provide input on the certification frequency and requirements for the reporting of quality measures under the Centers for Medicare & Medicaid Services/ (CMS) programs, including the Electronic Health Record (EHR) Incentive Program and the Hospital Inpatients Quality Reporting (IQR) Program, among others.

Kansas hospitals support the long-term goal of using certified EHRs to streamline and reduce burden of quality measurement, while increasing access to real-time information to improve care, and support quality improvement. Our members have been working diligently to implement certified EHRs and new health information technology with an expectation to reach this goal. Since the start of electronic clinical quality measure (eCQM) reporting in the EHR Incentive Program in 2011, eligible hospitals (EHs) and critical access hospitals (CAHs) have shared their challenges with the implementation.

The KHA is encouraged that CMS is requesting feedback on several areas of concern to providers, particularly the misalignment between the reporting requirements on providers and the number of eCQMs that certified EHRs are required to support. The KHA recommends that CMS also consider the input received to date from
hospitals and physicians about their eCQM experiences, including the evidence from CMS eCQM pilots and demonstrations, to inform future rulemaking regarding any requirements for the use of eCQMs for quality reporting.

UTILIZE INFORMATION RECEIVED TO DATE TO INFORM EHR CERTIFICATION AND REPORTING REQUIREMENTS FOR eCQMS

The requirement to report updated eCQMs must build on the provider experience to date with eCQM implementation. In 2013, 2014 and 2015 CMS launched multiple demonstrations and pilots to encourage electronic submission of eCQMs. It was anticipated that the results of these pilots would support the development of a future eCQM validation strategy and to inform the development of eCQM policy. To date, CMS has not shared insights from these efforts. In order to support successful electronic eCQM submissions in calendar year 2016, the KHA recommends that CMS release the results of the previous eCQM demonstrations and pilots before the release of future rulemaking governing eCQM reporting.

Our Kansas hospitals have shared with us that they have encountered significant challenges to meeting the goal of generating accurate and reliable quality data from their certified EHR. Due to the unreliability of the data pulled from the EHR, hospitals are unable to use it to either measure quality or to improve patient care. Vendors are failing to develop tools that naturally incorporate data capture into clinician workflows. Some of the workflows created require specific documentation tools and are, in essence, a form of electronic abstraction. This leads to inefficiencies and inaccuracies as well. Hospital are concerned about how the data could be erroneously used to measure a hospital’s performance.

The KHA recommends that CMS immediately expand and enhance eCQM education and outreach efforts to support successful electronic reporting of eCQMs in 2016 and beyond. Revise CMS education and outreach activities on EHR certification and eCQM reporting in 2016 to support a learning environment that benefits all stakeholders. A collaborative learning environment that offers layers of educational content on the quality measures, the technology supporting data capture, calculation and reporting, and the submission methods would benefit CMS, providers and vendors in efforts to improve the entire eCQM process.

The KHA urges CMS, as part of its national quality strategy, to work collaboratively with stakeholders to improve quality by harmonizing measures to focus on what really matters and not just creating another reporting system. The KHA recommends that CMS clearly state its plans for the transition from chart-based reporting to electronic reporting across CMS programs and to communicate how its plans will align with requirements for electronic submission of eCQMs to other organizations such as the Joint Commission.

The KHA recommends that CMS accelerate its work to identify the data elements and the definitions of those data elements necessary for eCQM reporting and submission. Our hospitals express concern that the Quality Reporting Data Architecture Category I (QRDA-1) format is the only format available for eCQM submission. The QRDA-1 format has not been proven to be effective and requires the submission of patient level data
elements not necessary for quality measure calculation. By better identifying the necessary data elements, other
data captured can be eliminated, thus, simplifying reporting for providers. QRDA-1 files are not easily
transferrable or moveable. Vendors tend to pick or drop the eCQMs solely on the basis of the regulatory
environment. This can eliminate the opportunity for hospitals to choose quality measures that align with their
institutional goals and drive quality improvement. This represents vulnerability where pulled data may create an
operational vacuum.

Beginning in 2019, physician requirements under the Medicare EHR Incentive Program will be folded into the
new Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs). The KHA urges
CMS to adopt a system that measures providers fairly, minimizes unnecessary data collection and reporting
burden, focuses on important quality issues and promotes collaboration across the health care delivery system.

The alignment of any modifications to the definitions, structure and reporting requirements of the EHR
Incentive program for eligible providers should be aligned with requirements for eligible hospitals. This
is critical to ensuring the ability to share information and improve care coordination among providers across the
continuum of care.

The following comments respond to specific questions posed by CMS in the Request for Information:

Frequency of Certification. The KHA supports a requirement for certified health IT to be recertified when a
new version of the eCQM specification is available.

The provider timeline for implementation of eCQM updates must be considered as a separate but related issue
in the consideration of the frequency of EHR certification. The certified health IT vendor timeline to revise their
software to support eCQM specification updates is different than the hospital timeline to implement the new
eCQM specification and new software. Gathering the data necessary for eCQM reporting has proven to be time
intensive for hospitals due to the complexities involved in data integration across many separate information
systems within hospitals. Hospitals also must map necessary data elements from their source to the EHR and to
the QRDA format required for submission to CMS. Time must also be allotted for the validation of the
measures.

Annual updates to eCQM specifications launch internal reviews that determine if quality measure logic or
changes in standards also necessitate workflow revisions to support accurate information capture. These
revisions to other clinical systems may involve working with other vendors to support new queries. As a result,
the timeline for hospitals to implement updates to eCQM specifications can be lengthy. Our members indicate
that a 24-month timeline is require or hospitals to successfully take on a measure update, from the initial release
of a new eCQM specification until providers can successfully report on the measure. A 19-month timeline is the
average time required for a hospitals to successfully take on an updated eCQM specification.

As a result of the different timelines, the KHA recommends that CMS establish a policy in which the
effective date for provider use of recertified health IT allows sufficient time for provider implementation
of the certified health IT in their setting, mapping of the data required for reporting, updating other information systems and instituting necessary workflow adjustments.

Changes to Minimum CQM Certification Requirements. Currently, EHRs are not required to support the reporting of all the eCQMs available for reporting. CMS seeks feedback on two options for minimum eCQM certification requirements; certify health IT modules to all eCQMs, certify IT modules to a specific number of eCQMs and increase the number to include all eCQMs. CMS also requests comment on an option to certify health IT products to more than the current minimum number of eCQMs but not to all available eCQMs. The KHA recommends that CMS require developers to certify health IT modules to all eCQMs available for EHs and CAHs. The current mismatch in vendor and provider requirements results in providers identifying the eCQMs that their certified EHR supports and then confirming the availability of the data required to meet the measure reporting requirements, rather than selecting measures that reflect their patient populations and the areas they have prioritized for quality improvement. This is particularly challenging for our small rural hospitals, with small populations.

CQM Testing and Certification. The KHA recommends that CMS prioritize increased and more robust testing opportunities to improve the quality of eCQMs. The Cypress testing tool is available to test EHRs ability to accurately calculate eCQMs. It uses a standardized set of simplified patient test data to evaluate the EHR performance for eCQM implementation. Testing of eCQM specifications in a complex environment will provide a valuable insight on the validity of updated specifications, and insight on whether the specification change is a minor or substantive change. In the absence of robust testing, providers bear the weight of testing and validation.

Also, the KHA recommends that eCQM certification include conformance to the data submission method required by CMS programs. The QRDA version required for eCQM submission to CMS should be supported by the recertification of EHRs when the version is updated. A distinction between the data format providers are required to submit and the format that certified EHRs are required to support will result in confusion and unnecessary compliance burden for providers.

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. We appreciate the opportunity to share our concerns and comments.

Sincerely,

Tom Bell
President and CEO