CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 1, 2013

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare &Medicaid Services
Department of Health and Human Services
Mailstop C4-26-05
7500 Security BLVD
Baltimore, MD 21244-1850

Transmitted electronically via www.regulations.gov

Subject: Request for Information on Hospital and Vendor Readiness for Electronic Health Records Hospital Inpatient Quality Reporting (CMS-3278-NC)

Dear Acting Administrator Tavenner:

On behalf of more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for information from hospitals and vendors regarding their readiness to electronically report certain patient-level data under the Hospital Inpatient Quality Reporting Program beginning with calendar year 2014 discharges. The request for information focuses on a narrow set of very specific operational questions but does not address the broader more strategic questions that both the Office of the National Coordinator (ONC) and CMS must wrestle with in the coming year. **CHA urges CMS and ONC to work collaboratively to and continue to convene and engage stakeholders in this important discussion so that we can meet our shared goals**

CHA shares Congress' and the Administration's vision of a health care system where high-quality and efficient patient care is supported by EHR systems. Many believe that in the long term data collection of clinical quality measures will decrease the burden of data collection and improve the accuracy of reporting. **However, evidence suggests that at the present time, this is not the case and, in fact, hospitals report the burden associated with reporting using certified EHRs has increased and that we are far from achieving the level of accuracy needed for public reporting.**

The National Quality Forum, in cooperation with ONC and CMS, convened several forums in 2012 where hospitals and physicians shared their experiences in implementing the clinical quality measures for meaningful use. A common theme of those discussions was that the level of effort needed to implement the clinical quality measures into the appropriate screens and work flow has been grossly underestimated. Even with significant modifications to the EHRs, several hospitals must go back to paper medical records in order to have all the data necessary to report on a quality measure. Further, as you know, several stand-alone systems that are used in the operating room or for obstetrical services are not yet considered certified electronic technology

and they cannot be directly linked to other EHR systems due to interoperability issues. This creates the need for workarounds and adds more time to the process of collecting and reporting data, which can lead to inaccurate data. Many hospitals have reported that the "off the shelf" vendor products are not sufficient and have expended additional human and capitol resources to customize their products to more accurately capture the necessary data for reporting clinical quality measures.

Finally, hospitals report that the data that they pulled from their EHRs was not comparable to the nurse abstracted data that was being reported for the inpatient quality reporting program. **Until such time as each of these issues can be addressed and or mitigated, it would be inappropriate to move forward in collecting and reporting measures from certified EHR technology for use in the IQR program.**

The IQR is the cornerstone of CMS' pay for reporting program. It is important to keep in mind that changes in this program will have a rippling effect across other programs. For example, any measure used for the hospital value-based purchasing (VBP) program must first be included in IQR and made available on *Hospital Compare* for one year prior to inclusion in the program. Any changes to the platforms for data collection will not only have data reliability and validity issues for public reporting, but those issues would be magnified in the redistribution of dollars in the VBP program.

The vast majority of hospitals have not met the meaningful use requirements for Stage 1, and we anticipate it will be many years before we can make a full transition. As of December 31, 2012, only 9 percent of California's hospitals had received incentive payments. CMS and ONC should proceed in evaluating the feasibility of a phased approach to implementation and fully investigate the impact on hospital payment.

The experiences of California's hospitals have informed our comments on several of the specific questions articulated in the request for information and are noted below.

How do hospitals and vendors perceive the alignment of EHR based reporting and hospital quality reporting programs? What are the foreseen benefits and challenges?

CHA is very concerned about what we believe are two separate tracks for quality reporting through EHRs. The first track is largely driven by the Health Information Technology (HIT) Policy Committee and the ONC under the umbrella of the meaningful use program. The second track is the process CMS undertakes as it considers measures for inclusion in the Inpatient Quality Reporting Program. While many measures overlap by name, the measurement specifications are not aligned. **Instead of a process that is jointly undertaken where CMS and ONC request information on an agreed upon approach, we have agencies working independently, on differing timelines and with different priorities.**

Alignment is beginning to occur at the Measures Application Partnership (MAP) table. CHA appreciates the progress the MAP has made in improving the alignment of quality reporting efforts across programs this year. **One important area where the MAP can bring additional value is at the intersection of the clinical quality measure reporting required for**

meaningful use and the traditional hospital and physician quality reporting program requirements. CHA is disappointed with the level of discussion regarding this critically important intersection and urges the MAP to take on this charge in 2013. More specifically, we would urge MAP to lay out guiding principles for meaningful use clinical quality measurement and to strategically align them with both the MAP measure selection criteria and the newly created principles. The MAP can play a critically important role in working with CMS and ONC on a shared vision and pathway to meeting our broad goals of alignment across ***ALL*** programs so that the objectives of reducing data collection burden and measurement parsimony can be fully realized in the years to come. We urge CMS and ONC to use the MAP process to more actively engage in these alignment activities.

In addition, this work should also be informed by the findings of the CMS pilot. CMS has not shared any findings from the pilot, and we anticipate that the work being undertaken would more fully inform the comments of stakeholders and the process more broadly.

Do hospitals and vendors envision being able to meet the criteria for reporting clinical quality measures electronically for the EHR Incentive Program as set forth in the EHR Incentive Program – Stage 2 final rule (77 FR. 53968) and any related guidance issued? If not, what are the issues in meeting the requirements and what additional information is needed?

The measure specifications for Stage 2 have just recently been released and even more recently been revised. The timeline is so accelerated that it is unclear if the vendors will be able to provide products that meet the hospital's needs. **CHA remains concerned that these measure specifications have not been fully vetted and will continue to undergo revisions resulting in meaningless and burdensome data collection.**

Is the hospital planning to adopt EHR technology that has been certified to the 2014 Edition EHR certification criteria during or before calendar year (CY) 2014?

CHA suggests CMS work with ONC on reviewing the most recent data and proposing any necessary revisions to the American Hospital Association HIT survey to help glean insights into the anticipated timing of adoption as this varies across the hospital field. In California, many of our large systems are moving forward, but the readiness of our independent, small and rural hospitals remains uncertain due to mounting financial constraints at both the federal and state levels.

Is the hospital aware of the payment adjustments authorized under the HITECH Act beginning in FY 2015 for failing to demonstrate meaningful use under the Medicare EHR Incentive Program?

Hospitals are struggling to balance the ever increasing resources, both capitol and financial that meaningful use will demand and while striving to meet the goals set forth, are faced with the reality that they may have no choice but to incur a payment penalty going forward.

We appreciate CMS efforts in engaging stakeholders on this important topic. Thank you for the opportunity to weigh in on these important issues. If you have any questions or wish for additional clarification, please do not hesitate to contact me at akeefe@calhospital.org or 202-488-4688.

Sincerely,
/s/
Alyssa Keefe
Vice President Federal Regulatory Affairs