



AMERICA'S ESSENTIAL HOSPITALS

May 29, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

**Ref: CMS-3310-P: Medicare and Medicaid Programs; Electronic Health
Record Incentive Program—Stage 3**

Dear Mr. Slavitt,

America's Essential Hospitals appreciates the opportunity to submit these comments in response to the above-captioned proposed rule. We support the Centers for Medicare & Medicaid Services' (CMS') aim to encourage the use of electronic health records (EHRs) by eligible hospitals (EHs) and eligible professionals (EPs) through the Medicare and Medicaid EHR Incentive Programs (meaningful use program). EHRs should be used to help providers improve the care they deliver without overburdening their systems and infrastructures.

However, the requirements of the meaningful use program thus far have proven quite burdensome for providers, particularly essential hospitals with scarce resources and diverse patient populations. The great majority of essential hospitals have implemented EHR systems in their integrated health systems and become meaningful users of this technology. However, America's Essential Hospitals remains concerned that as CMS proposes requirements for stage 3 of the program, some essential providers are still experiencing difficulty with the current structure of the program, both in terms of their infrastructure and their diverse patient populations. Furthermore, substantial developments in the national health information technology infrastructure are necessary before providers can achieve objectives requiring advanced functionalities such as health information exchange. **To this end, we believe CMS should delay finalizing the stage 3 rule and in the meantime consider necessary changes to stage 3 that will reduce the**

burden on providers, offer them much-needed flexibility, and allow for public and private stakeholders to make improvements in interoperability.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our more than 250 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of patients at essential hospitals are racial and ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals are able to provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital industry— with an aggregate operating margin of -3.2 percent, compared to 5.7 percent for all hospitals nationwide.¹ Through their integrated health systems, members of America's Essential Hospitals offer the full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients.

Essential hospitals' mission to serve all regardless of socioeconomic circumstance and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges, such as poverty, homelessness, language barriers, and low health literacy, which affect their ability to access their electronic patient information. In addition to these challenges, half of our members operate at a loss. Many hospitals have already begun to receive penalties for not participating in the meaningful use program, and others are no longer receiving Medicare incentive payments. These circumstances compound essential hospitals' challenges and call for much-needed accommodations to ensure they are not unfairly disadvantaged for serving the most vulnerable among us, and so they may continue to provide vital services in their communities.

As CMS develops current and future requirements for the meaningful use program, we urge the agency to be cognizant of these circumstances and to consider the following comments.

1. CMS should change the all-or-nothing structure of the program and instead allow providers to meet a subset of meaningful use objectives.

To encourage providers to participate in the program but not penalize them for failing to meet only one of many objectives, CMS should change the all-or-nothing structure of the program. In its current form, the meaningful use

¹Reid K, Roberson B, Landry, C, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013. America's Essential Hospitals. March 2015. <http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf>. Accessed May 26, 2015.

program requires providers to meet and attest to all core objectives and select a subset of menu objectives. In stage 1, hospitals must meet 11 core measures and 5 of 10 menu objectives, and in stage 2, hospitals must meet the thresholds for and attest to 16 core objectives and 3 of 6 menu objectives. For stage 3, CMS proposes one set of objectives and associated measures and removes the menu-core distinction. Thus, eligible hospitals and eligible professionals would be required to meet all eight proposed objectives in stage 3. Most of these measures have higher thresholds than in stage 2 and thus would be more difficult for providers to meet.

Providers already struggle with difficult measures in the program, such as the measure requiring electronic exchange of a summary of care document or the measure requiring a certain percentage of patients to electronically access their health information.² Under the program's current structure, if a provider meets all of the objectives and measures, except for a single measure under a single objective, the provider is not deemed to be a meaningful user and will be penalized. Even if the provider fails to meet the measure by a single percentage point, the provider is not considered to have met meaningful use. Penalizing a provider that is willing and able to meet the thresholds for all of the objectives and measures, but cannot meet the thresholds for one or two measures, is a disincentive to participation in the program.

To alleviate this concern, giving providers the option to attest to seven out of eight objectives in stage 3, for example, would be a positive step. In the proposed rule, CMS does provide some limited flexibility within three specific objectives, but this does not go far enough. For the health information exchange and care coordination through patient engagement objectives, CMS is proposing to require providers to attest to all three measures under each objective, but they would only have to meet the thresholds for any two of the three measures under each objective. For the public health reporting objectives, EPs will have to report on three of five measures and EHs on four of six measures. This provides some flexibility, but because these measures have been historically difficult for providers—and the stage 3 thresholds are higher than in previous stages—this flexibility is not sufficient.

In the proposed rule, CMS mentions that stakeholder associations have been asking for more flexibility since the inception of the program but declines to provide such flexibility. CMS notes that the statute covering the requirements of the meaningful use program discourages such an approach. However, the language that CMS cites in support of its all-or-nothing approach, while mandating increasingly stringent requirements, the reporting of clinical quality measures (CQMs), and a measure pertaining to electronic information exchange, does not require that a provider meet all objectives in the program. In fact, the

²Levinthal N, Panjamapirom A. The Latest Stage 2 Meaningful Use Attestation Data: Shocking Yet Anticipated. July 29, 2014. <http://www.ihealthbeat.org/perspectives/2014/the-latest-stage-2-meaningful-use-attestation-data-shocking-yet-anticipated>. Accessed May 26, 2015.

statute provides the agency with broad authority to determine the requirements of information exchange and meaningful use of certified EHR technology (CEHRT).³ **Therefore, using this discretion, the agency should allow providers to waive one objective and all associated measures under that objective. Furthermore, for the care coordination through patient engagement and the health information exchange measures, CMS should only require providers (EPs and EHs) to meet one (instead of two of three) measure thresholds. As we also recommend below, CMS should remove two of the three measures under the care coordination through patient engagement objective for hospitals, effectively requiring EHs to only attest to and meet one measure under this objective.**

Members of America's Essential Hospitals are ready to adopt and meaningfully use EHR technology. In fact, many essential hospitals were among the earliest adopters of health information technology, having attested to the program in its first year in 2011. All members have indicated their intent to participate in the program.⁴ More than 80 percent of essential hospitals scheduled to move on to stage 2 of the program did so in 2014, while others benefited from flexibility provided in the certification rule.⁵ Yet, some essential hospitals initially participated but did not follow through in subsequent years because of difficulty with particular measures. Others have not yet begun to participate in the program. Notwithstanding their intention to participate, essential hospitals face tangible barriers in meeting the requirements of the program, whether due to financial constraints, infrastructure challenges, or for reasons outside of their control (e.g., vendor issues or their unique patient population). **To this end, CMS should provide hospitals the flexibility mentioned above in stage 3 objectives.**

2. CMS should maintain the phased stage structure of the program and allow hospitals three years at each stage as a way to gain experience before transitioning to the next stage.

CMS should maintain the current stage structure of the program but allow providers to meet the requirements of a stage for three years before moving on to the next stage. The agency should not finalize its proposal to place all hospitals in stage 3 in 2018 irrespective of the provider's stage in 2017. CMS proposes to allow providers to remain at their current stage in 2017 or to move to the next stage. Under this proposal, providers who attested to stage 1 in 2016 may stay in stage 1 in 2017 or attest to stage 2 or 3. Providers who were in stage 2 in 2016 may either stay in stage 2 in 2017 or attest to stage 3. The option to

³Social Security Act § 1886(n)(3)(A)(i)-(iii)(2010).

⁴National Association of Public Hospitals and Health Systems. Health Information Technology and the Safety Net [Issue Brief]. May 2012. <http://essentialhospitals.org/wp-content/uploads/pdfs/HIT-and-the-Safety-Net-Issue-Brief.pdf>. Accessed May 26, 2015

⁵America's Essential Hospitals. Analysis of fiscal year 2014 CMS stage 1 and stage 2 attestation data. May 2015.

attest to stage 3 objectives and measures would be completely voluntarily. **We support this flexibility for providers to continue at their current stage or progress to a higher stage in 2017 if they are prepared for the requirements of the next stage.**

CMS proposes that in 2018 and subsequent years, however, all providers will be in stage 3, which will be the only stage of the program at that point. Providers will have to meet stage 3 requirements without regard for which stage they attested to in 2017 or how long they were at that stage. A hospital that attested for the first time at stage 1 in 2017 will be in stage 3 in 2018 according to this proposal. America's Essential Hospitals is strongly opposed to this approach, which eliminates the current phased structure of the program.

This proposal does not afford providers the time and resources they need to become up to speed with the latest requirements of the program. The purpose of the phased stage structure is to allow providers to become familiar with the requirements of the program and gain experience with measures and objectives before having to meet higher thresholds and requirements in the next stage. Forcing providers to attest to measures with higher standards without allowing them to gain some experience first is setting them up for failure. A hospital that was an early adopter of CEHRT and has been demonstrating meaningful use since 2011 may have the systems, staff, and processes in place to transition to stage 3, while a hospital that first attests in 2015 or later will not benefit from this same experience. CMS should allow these latecomers to the program to build their way up to stage 3 instead of forcing them to enter the final stage without the requisite preparation. Expecting all providers to be prepared for stage 3 in 2018 is unrealistic and inconsistent with the history of the program.

To account for providers on different timelines of EHR adoption, CMS should not require all hospitals to attest to stage 3 meaningful use requirements in 2018. CMS should allow hospitals to attest for three years at a stage before moving to the next stage.

3. CMS should allow a 90-day reporting period for hospitals attesting to the program for the first time and for all providers in 2018.

CMS should allow providers a 90-day reporting period in their first year of the program and should allow a 90-day reporting period for all providers in 2018, which will be the first year of stage 3. CMS proposes a full calendar year reporting period for all providers beginning in 2017, except for those providers that are first-time participants in the Medicaid EHR Incentive Program. All other providers, including providers in their first year of the Medicare EHR Incentive Program, will be required to be on a full calendar year reporting period. America's Essential Hospitals strongly opposes the removal of the 90-day reporting period option.

If CMS finalizes its proposal to require all providers to be in stage 3 in 2018, a 90-day reporting period will be crucial to ensuring successful participation in the program. Additionally, because CMS is proposing to require providers to implement a new edition of CEHRT in 2018, a 90-day reporting period will be vital to ensure providers are able to make the necessary upgrades to their systems and take other associated steps, such as staff training and preparation for new measures and objectives. In 2014, providers were unable to adopt the 2014 version of CEHRT in time to meet the program's deadlines because of vendor delays in making this software available. This prompted CMS and the Office of the National Coordinator for Health Information Technology (ONC) to issue a regulation giving providers flexibility on the version of CEHRT they used and on meeting the objectives and measures.⁶ This experience shows that providers need time to prepare for using a new version of CEHRT for reasons that can be beyond their control. And a 90-day reporting period would allow for that. The shorter reporting period is also crucial for hospitals who are participating in their first year of the program, so that they may use the additional time to implement the necessary technological and workflow changes in preparation for reporting on meaningful use objectives. **As such, CMS should finalize a 90-day reporting period for hospitals in their first year of the program as well as for all hospitals in 2018.**

We also have serious concerns with CMS' proposal to change the timeline for avoiding penalties under the program. Under current policy, the reporting period for hospitals that are already meaningful users to avoid a penalty is two years before the payment adjustment year. For example, to avoid a penalty in 2016, a hospital must have attested in 2014. For hospitals in their first year of the program, the reporting period to avoid a penalty is 90 days within the year before the payment adjustment year. Hence, a hospital in its first year of the program in 2015 can report for 90 days in 2015 and avoid a penalty in 2016. However, CMS is proposing to change this beginning in 2017 and require even first-time providers to fulfill a reporting period two years in advance of the payment adjustment year. Under this proposal, a hospital that attests for the first time in 2017 will avoid a penalty in 2019 but still receive a penalty in 2018. This policy change is unnecessarily confusing for providers and also departs from existing policy on payment adjustments. It will also unfairly penalize first-time participants and those who are late to enter the program. **CMS should therefore retain its current policy to allow first-time attestors to avoid a penalty in the subsequent year.**

4. CMS should revise certain measures to provide additional flexibility for providers.

CMS should not finalize the significantly higher proposed thresholds for key measures, particularly measures relating to health information exchange,

⁶Modifications to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for 2014 and Other Changes to the EHR Incentive Program, 79 Fed. Reg. 52,910 (Sept. 4, 2014).

patient electronic access, and patient engagement. Until it is clear that providers are prepared to meet more stringent thresholds, CMS should postpone any increases in measure thresholds. As CMS notes in the proposed rule, it reserves the option of “addressing [] changes in future rulemaking” when “circumstances warrant.”⁷ Accordingly, CMS should reduce measure thresholds in the final rule and only increase thresholds if it determines later that this is warranted by successful provider participation on these measures. Of particular concern to America’s Essential Hospitals are the following proposed stage 3 objectives and associated measures:

- Objective 5—Patient electronic access to health information
- Objective 6—Coordination of care through patient engagement
- Objective 7—Health information exchange

In 2014, the majority of providers in the program attested to stage 1 measures and objectives, which do not include more advanced stage 2 measures requiring patients to view, download, or transmit their data and requiring providers to electronically exchange a summary of care record for transitions of care. By virtue of being in stage 1, these providers have not been exposed to these measures’ reporting requirements and have not undertaken the necessary system upgrades, workflow adjustments, and staff training to report on them. Given that the majority of providers as of 2014 had not even experienced reporting on these measures, there is no evidence pointing to provider readiness to attest to these measures and meet significantly higher proposed thresholds.

With regard to those providers that did attest to similar stage 2 measures, attestation data points to difficulties with measure thresholds. CMS acknowledges in the proposed rule that in 2014, median hospital performance on the view, download, or transmit measure was 11 percent, yet proposes to increase the threshold to 25 percent. Median hospital performance for the measure requiring electronic exchange of a summary of care document for transitions of care or referrals was higher, but still significantly low at 29 percent, yet CMS is proposing to increase the threshold to 50 percent. This information on hospital performance in 2014 demonstrates that CMS’ proposal to increase the thresholds for these measures is premature. To allow providers to concentrate their resources on utilizing their EHRs in a way that improves the provision of care and health outcomes, CMS should revise these measures as follows.

- a. CMS should revise the patient access measure of objective 5 to make it more attainable for providers and should encourage the use of application-program interfaces (APIs).

⁷Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3, 80 Fed. Reg. 16,732, 16,738 (proposed Mar. 30, 2015) (to be codified at 42 C.F.R. pt. 495).

CMS should maintain the 50 percent threshold for measure 1 of the patient electronic access to health information objective. CMS should also encourage the use of APIs to enable patients to use third-party applications to access their health information as a positive step in increasing patient engagement.

The proposed objective 5 includes the following measure (measure 1) requiring an EH or EP to give 80 percent of patients access to their health information electronically:

- For more than 80 percent of all unique patients seen by the EP or discharged from the eligible hospital or [critical-access hospital (CAH)] inpatient or emergency department (POS 21 or 23):
 - (1) The patient (or patient-authorized representative) is provided access to view online, download, and transmit their health information within 24 hours of its availability to the provider; or
 - (2) The patient (or patient-authorized representative) is provided access to an ONC-certified API that can be used by third-party applications or devices to provide patients (or patient-authorized representatives) access to their health information, within 24 hours of its availability to the provider.

The proposed threshold of 80 percent is 30 percentage points higher than the 50 percent threshold for stage 2. In stage 1, providers are required to provide access for 50 percent of patients who actually request their health information, as opposed to 50 percent of all discharged patients in stage 2. **Because of providers' difficulty attesting to this measure with lower thresholds, CMS should keep the requirement at 50 percent.** Doing so would allow providers to focus on using patient health information meaningfully and to work with their patients to ensure they are viewing and sharing their health information in a way that improves their health. Requiring hospitals to meet the steep percentage increases shifts staff time and resources away from meaningful quality and patient experience improvement activities to solely focusing on calculating and meeting numerator and denominator counts for measures. By keeping the stage 3 requirement the same as stage 2, this measure will be more attainable for providers and will free up resources that can be used in truly engaging patients to access their health information to improve health outcomes.

The proposed measure also includes an option for providers to give patients access to their health information through an API that is certified by ONC. As CMS explains in the proposed rule, providers can use APIs to allow patients to access their health information through third-party applications—such as smart phone applications—instead of being limited to a vendor's patient portal. The introduction of APIs in stage 3 is promising because it offers the potential for providers and patients to have a range of choices of applications through which to access their health information instead of limiting them to a single portal. The

prospect of using APIs in the health care context will also spur competition among application developers and foster more tailored applications that better meet the needs of different patient populations. For hospitals that have not implemented a patient portal because it is financially prohibitive or because the portal does not meet the organization's needs, the availability of the API functionality will provide an alternative option to meet this measure.

For these reasons, America's Essential Hospitals supports the concept of leveraging APIs to satisfy the patient access requirement, in addition to allowing for the current method of meeting this objective. However, much work remains to be done by ONC to develop certification criteria to ensure these APIs are tailored to meet the requirements of the meaningful use program and have mature standards. There are also privacy and security concerns surrounding the use of APIs and third-party applications. These unresolved questions will need to be thoroughly addressed by CMS and ONC before APIs are ready for use in stage 3 of the program. **Provided that these issues are resolved, America's Essential Hospitals supports APIs as an additional mechanism to engage patients in their health care.**

- b. CMS should ease the requirements of the measures under objective 6 because of difficulties providers face with measures that rely on patient action.

CMS should lower the threshold of measure 1 under the coordination of care through patient engagement objective for all providers and remove measures 2 and 3 for EHs. The three measures under this objective are as follows:

- During the EHR reporting period, more than 25 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department actively engage with the electronic health record made accessible by the provider (through a portal or API).
- For more than 35 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient's authorized representatives), or in response to a secure message sent by the patient (or the patient's authorized representative).
- Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15 percent of all unique patients seen by the EP or discharged by the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

The measures in this objective are dependent on patient action, and providers should not be penalized for failing to meet thresholds when performance on a measure is outside of their control. This principle is especially important for

providers who disproportionately treat vulnerable populations. Members of America's Essential Hospitals predominantly serve low-income, minority patients who are uninsured or covered by public programs. Many of these patients are homeless, and they seek care at homeless health care programs and benefit from respite programs at essential hospitals. In addition to homelessness, patients' ability to access the technology necessary to meet these measures is affected by a range of other sociodemographic factors, including income, education, and primary language. Many of these patients do not have electronic access to their health information outside of the hospital. While Internet service may be readily available in most urban areas, many families do not have a computer at home or cannot afford the monthly cost of Internet access. These unique circumstances that faced by patients of essential hospitals render these measures even more difficult to meet. **Thus, CMS should lower the proposed threshold for measure 1 to 5 percent so that instead of penalizing providers for factors over which they have little control, CMS can encourage essential providers to use their limited resources to engage their patients in other innovative ways.**

CMS should also remove the secure messaging measure (measure 2) for EHs. This measure is new to the program for hospitals, so hospitals do not have any familiarity with the requirements, and there is no record of how they will perform on this measure. Additionally, this measure involves the same patient-related challenges described above. Finally, the need to communicate directly with a patient is more relevant in the context of EPs, with whom patients have direct and recurring encounters. **For these reasons, CMS should remove the secure messaging measure for hospitals.**

Finally, CMS should not require EHs to attest to the third measure requiring the submission of patient-generated data. Similar to measure 1, this measure will be very onerous, especially for those hospitals that disproportionately serve vulnerable populations. In addition, a patient discharged from a hospital setting for a single episode of treatment may have less of a need to transmit information back to the provider than would a patient who regularly visits a primary care physician or specialist and needs to provide updates on personal health information. **Therefore, CMS should remove the patient-generated health data and secure messaging measures for EHs and only require that a hospital meet measure 1 with a lower threshold as recommended above.**

- c. CMS should address existing issues with objective 7, including addressing barriers to exchanging information, before raising measure thresholds.

Some of the challenges with the health information exchange objective, such as those around exchanging information using the Direct Project standard (Direct exchange), can only be ameliorated through actions by CMS and ONC. Until these barriers and others are addressed, CMS should maintain

the 10 percent threshold for the electronic exchange of a summary of care record instead of increasing it to 50 percent as proposed.

Members of America's Essential Hospitals have come across various obstacles to meeting the measure requiring electronic exchange of a summary of care record for transitions or referrals. As large, integrated health systems, essential hospitals have the ability to provide a range of services within their system without referring a patient to a provider outside of the system. Because of this, many essential hospitals lack a sufficient number of transitions or referrals outside of the system to meet the required threshold for this measure. Even in cases where an outside referral is necessary, the providers receiving the referral often do not have the capability to receive an electronic summary of care. Essential hospitals may choose to refer patients to providers who are able to offer linguistically and culturally competent care to their diverse patients, and these providers may not have EHRs that have the capability to receive a document for this measure. Providers in settings that do not take part in the meaningful use program, such as post-acute care providers, are also frequently not equipped with the technology to electronically accept a summary of care document. As a result, providers are either forced to change existing referral patterns solely to meet the measure or suffer the risk of not meeting the measure threshold due to factors unrelated to their own ability to exchange data.

CMS and ONC should also work on lifting barriers to exchanging information through the Direct Project standard. Direct exchange is a standard for secure transmission between providers and is one method through which providers can exchange information for the purposes of the electronic exchange measure. In stage 2, vendor EHRs must be certified to enable the use of Direct exchange. However, while vendor software is required to be Direct certified, many vendors have specific requirements for sending and receiving Direct messages that are incompatible with other vendor EHRs. Additionally, each provider has a Direct address to be used for transmitting data, but there is no centralized directory of Direct addresses that providers can use to locate a receiving provider's Direct address. **ONC should create standards necessary for the development of a centralized, accurate Direct directory that would enable providers to easily locate other providers' Direct addresses before sending a document.** This is one step that CMS and ONC can—and should—take in facilitating interoperability and information exchange.

Therefore, before increasing measure thresholds, CMS should take critical steps to facilitate information exchange and interoperability.

5. CMS should adopt criteria for identifying topped out measures that are consistent with other Medicare quality reporting programs.

CMS' proposed criteria for identifying topped out measures in the meaningful use program are different than the criteria it has finalized for other Medicare quality reporting programs. To ease the reporting burden on participants, CMS should instead adopt criteria that are the same as the criteria for other programs.

For the Hospital Outpatient and Inpatient Quality Reporting programs, CMS adopted the following criteria to determine which measures have consistently high performance without variation across hospitals such that meaningful distinctions and improvements are no longer feasible:

- statistically indistinguishable performance at the 75th and 90th percentiles
- a truncated coefficient of variation less than or equal to 0.10.

CMS also uses nearly identical criteria for the Hospital Value-Based Purchasing Program. America's Essential Hospitals appreciates any efforts by CMS to reduce the reporting burden on hospitals. By removing measures that no longer show improvements in quality, CMS will enable hospitals to use their limited resources for quality improvement. In the same way, by finalizing identical criteria for determining topped out status across the various quality reporting programs, CMS can add to these efforts and ensure consistency and alignment across programs.

In addition, once CMS settles on a new set of criteria, the agency should ensure all measures meeting the new criteria have done so for at least two years before removing them from a reporting program. This way, hospitals can continue to institute clinically effective processes to improve patient care for the wide array of measures included in the various programs. **For the meaningful use program, CMS should adopt the same criteria as other quality reporting programs with the modification that measures be deemed topped out for at least two years before being removed.**

6. CMS should not require electronic reporting of CQMs until these measures are reliable, valid, and have accurate specifications.

CMS should not require providers to electronically report CQMs and should continue to allow providers to report these measures through attestation. America's Essential Hospitals remains concerned about outstanding issues with the reliability of data produced from CEHRT, as well as issues with data validation of electronically reported measures. The data extracted from EHRs differs from the data that are obtained from chart-abstracted measures and have not yet proven to be reliable for display in a public reporting program. These issues have also been highlighted by the Government Accountability Office, which notes that "HHS has not yet developed a comprehensive strategy to address concerns with

the reliability of CQMs collected using certified EHRs.”⁸ Due to the differences between data extracted from CQMs and chart-abstracted quality measures, CMS should adopt a validation process that would ensure data being extracted from CQMs are accurate and comparable to chart-abstracted data.

Further, for CMS to finalize this requirement before all measures are fully electronically specified and field tested would be premature. In general, electronic measures have specific requirements about what type of information should be documented; they require more standardization than non-electronic measures. Without detailed electronic specifications far enough in advance, many providers will not have enough time to bring their reporting systems up to date to report these measures when required. In addition, it is unwise to finalize any electronic measure until there is enough evidence of its validity in the field to justify its inclusion as a truly meaningful electronic measure.

In addition, to secure sufficient vendor participation, CMS must be more flexible with patient-level data transfer standards—e.g., by adopting data transmission standards EHR vendors are already using. Without vendor support, most hospitals find it impossible to report measures electronically. If these challenges remain unaddressed, they will continue to plague hospitals as they electronically report measures. Differences in electronic measures and chart-abstracted measures can also have adverse implications for patient safety if the data from electronic measures is not accurate and reliable. Therefore, CMS should continue to work with EHR vendors to make electronic reporting a viable option for all hospitals.

Finally, CMS should clearly lay out the circumstances that would make electronic reporting unfeasible and thus qualify a hospital for an exception to electronic reporting. CMS provides examples such as a natural disaster, data submission system failure, and a certification issue outside of the provider’s control, but the agency should clearly delineate the circumstances that would warrant an exception. In addition, CMS should clearly state the process that a provider would use to demonstrate that electronic reporting is unfeasible and to qualify for an exception. To be consistent with other parts of the meaningful use program and other Medicare hospital quality reporting programs, CMS should adopt a process similar to the hardship exception process to avoid meaningful use payment adjustments.

For these reasons, CMS should not finalize mandatory electronic reporting.

⁸ Government Accountability Office. Electronic Health Record Programs: Participation has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care. March 2014. 37. <http://www.gao.gov/assets/670/661399.pdf>. Accessed May 26, 2015.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Beth Feldpush at 202-585-0111.