CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 28, 2019

Alex M. Azar II
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Sixth Floor
Washington, D.C. 20201

Donald W. Rucker, MD
National Coordinator
Office of the National Coordinator for Health Information Technology
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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 20201

SUBJECT: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Secretary Azar, Dr. Rucker and Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, as well as their related post-acute care providers, the California Hospital Association (CHA) appreciates the opportunity to comment on the Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology's (ONC) draft "Strategy on Reducing Burden Relating to the Use of Health IT and EHRs."

The 21st Century Cures Act requires HHS to establish a goal for burden reduction relating to the use of electronic health records (EHRs), and develop both a strategy and recommendations for meeting that goal. CHA is pleased to see ONC recognize many of the significant burdens hospitals have faced while advancing the use of health information technology (HIT) and adopting electronic health records (EHRs). Hospitals have been — and continue to be — committed to harnessing the power of HIT to improve care quality and efficiency for our patients. However, it is essential that the use of technology does not increase administrative burden or, most importantly, divert precious time from direct patient care.

CHA supports many of the recommendations outlined in the draft strategy, and we appreciate the articulation of the agencies' vision for the future. **However, the most effective strategies often identify**

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specific measures of success, outline timelines for implementation, and prioritize and sequence tactics to ensure the vision is achieved. This draft is an excellent first step, but we urge the agency to go further. We urge ONC and the Centers for Medicare & Medicaid Services (CMS), in collaboration with stakeholders, to address the gaps noted below and begin to prioritize specific strategies and recommendations. CMS and ONC should also set clear, measurable objectives and corresponding timelines so that, together, we can better gauge progress toward our shared goals and vision.

CHA urges CMS and ONC to consider California hospitals' and health systems' feedback and priorities as the agencies move forward. The agencies should focus immediately on the current, unnecessary burdens related to clinical documentation, EHR and electronic clinical quality measure (eCQM) reporting, and public health reporting. In addition, CHA respectfully requests that the draft strategy articulate in greater detail specific methods that will reduce barriers to interoperable exchange of health information in order to accelerate its adoption nationally.

CMS has taken steps to increase flexibility and reduce burden on providers under the Medicare and Medicaid Promoting Interoperability Program. However, notably absent from ONC's draft strategy are recommendations to reduce burdens associated with increasing interoperability through current EHR technology. Hospitals and health systems share the administration's goal of focusing on interoperability to ensure meaningful exchange of health information that supports improved quality of care for our patients. However, despite extensive efforts in our state, we are still plagued by disparate health information exchange efforts that are not coordinated. Further, though these efforts benefit all providers, their costs are often fully borne by hospitals and health systems. A recent report — *Sharing Data, Saving Lives: The Hospital Agenda for Interoperability* — discusses the benefits of fully interoperable data for patients and providers, outlines current challenges, and provides suggestions for how all stakeholders can work together to achieve the goal of the best possible health for each individual. CHA urges ONC and CMS to work together in prioritizing methods to address the challenges and burdens outlined in this report.

Our detailed comments on ONC's specific draft strategies and recommendations are below.

Clinical Documentation Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.

CHA appreciates CMS' significant efforts to engage stakeholders to help the agency understand the challenges that providers face in clinical documentation. As noted in the draft, many existing documentation requirements were crafted with paper-based systems developed to meet billing requirements that reflect a prior clinical era. They have not been updated to account for the current integration of HIT systems, greater clinical complexity of patients and available treatment options, or the increased need for longitudinal, coordinated care.

Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.
As ONC and CMS take steps to implement the draft strategy's recommendations to reduce overall regulatory burden related to documenting patient encounters — and leverage data already present in the EHR to reduce re-documentation — it is extremely important that a wide range of stakeholders, including hospitals and health systems, be convened to ensure that revised documentation guidelines successfully reduce burden while maintaining high-quality patient care. We urge CMS to bring together multiple perspectives that operate as a team within hospitals, including clinicians, nurses and health care IT leaders to understand issues specific to the inpatient setting.

Recommendation 4: Waive documentation requirements as necessary for purposes of testing or administering APMs.
As hospitals have advanced to provide seamless, coordinated, value-based care to patients, a critical component has been the integration of hospital billing systems with the clinical documentation of medical records within EHR systems. However, as acknowledged in ONC's draft strategy, clinical documentation standards required for payment have not been updated to reflect these increased levels of integration. CHA members report that, under certain payment arrangements — such as capitated agreements with commercial payers — there is far less need for "fee-for-service like" documentation in order to be paid appropriately. Unfortunately, at the federal level, alternative payment models (APMs) are based on Medicare fee-for-service rules; this creates extensive documentation burden. CHA urges CMS to review its APMs for opportunities to reduce documentation requirements, traditionally required for Medicare-fee-for-service, that no longer apply.

EHR Reporting Strategy 3: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.
CMS' Meaningful Measures Initiative has been a good first step in addressing the overwhelming burden of quality reporting across CMS' quality reporting programs. CHA appreciates ONC's acknowledgement of this important issue by including a specific strategy to reduce the burden of reporting eCQMs.

Recommendation 1: Consider the feasibility of adopting a first-year test reporting approach for newly developed eCQMs.
CHA strongly supports a first-year testing approach for newly adopted eCQMs and urges the agencies to immediately move to formally adopt this recommendation. CHA urges CMS to include such a policy recommendation in its federal fiscal year 2020 inpatient prospective payment system proposed rule.

The typical federal fiscal year rulemaking process — through which measures are proposed in spring, finalized in late summer, and implemented with the new fiscal year on October 1 — does not provide adequate time for vendors or providers to implement new eCQMs. Similar constrained timelines are also challenging for the calendar year rulemaking cycle. Once a measure has been finalized, vendors often require 12 to 18 months to make changes to technology and perform adequate testing. Hospitals must separately train staff and implement new procedures, which requires additional lead time. As eCQMs currently remain largely untested prior to implementation, these condensed timelines pose significant concern. We believe that a test-year approach — under which a hospital would have the option to report on newly adopted eCQMs — would be most valuable, as it would provide HHS an opportunity to use the reported measure data to refine the eCQMs, ensuring their accuracy and reliability. Further, CMS should be transparent in releasing the results of its analysis of all reported data and any steps taken to improve the measures prior to mandatory reporting deadlines.

Recommendation 2: Continue to evaluate the current landscape and future direction of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project.
CHA is also pleased that CMS is working to reduce eCQM development and implementation burdens by adding workflow considerations in the development process, with a commitment to obtaining more stakeholder feedback under the eCQM Strategy Project. We urge CMS and ONC to work closely with measure developers, hospital stakeholders and others in taking on this important work so that a wide range of clinical workflow scenarios is considered. This is important to ensure that electronic data

collection for quality measures does not contribute extra or unnecessary steps to the use of HIT in patient care.

Further, CMS must take immediate steps to improve its IT infrastructure to readily accept eCQM reporting from hospitals. Hospitals continue to share with us the challenges they experience each year while submitting Quality Reporting Document Architecture (QRDA) files to satisfy eCQM reporting requirements. At the time of submission, these systems are overloaded and repeatedly reject the files submitted, adding to an already time-intensive and burdensome process. Hospitals report that, even during early testing attempts, the CMS systems are unable to accept their files. This is unacceptable. Until CMS significantly improves its ability to receive data and make it transparent, we strongly urge the agency to maintain current eCQM reporting requirements of four self-selected measures for one self-selected quarter of data.

Public Health Reporting Strategy 1: Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.

California hospitals are required to report to various state and federal programs that are not electronically standardized or harmonized. More specifically, ONC acknowledges that, while integration of prescription drug monitoring programs (PDMPs) into EHRs is a priority, each state has varying rules governing the use of PDMP data. This results in variation in technical architecture and the electronic interfaces that enable integration. California's PDMP — the Controlled Substances Utilization Review and Evaluation System (CURES) database — recently implemented the CURES Information Exchange Web Services, as required by state law. While this represents an important step toward integrating the CURES database with health information systems, the state has not, to date, developed or implemented an application programing interface (API) that would make it possible for hospitals to query the PDMP without manually entering data into the EHR. While the state is working toward this goal, there is no clear timeline for API integration. Therefore, CMS' strategy should be accompanied by a realistic timeline based on the current status of state reporting infrastructures.

As CMS considers the implementation of mandatory measures under the Promoting Interoperability programs, such as the recently finalized voluntary Query of PDMP measure, it must not proceed until there is adequate infrastructure that would allow seamless reporting without creating tremendous burdens on hospitals. It is critical that CMS maintain the Query of PDMP measure as voluntary until there is widespread, national integration of PDMPs with EHRs that do not require additional manual data entry.

CHA appreciates the opportunity to share our comments on the draft strategy. If you have any questions, please do not hesitate to contact me at (202) 488-4688 or akeefe@calhospital.org, or my colleague Megan Howard, senior policy analyst, at (202) 488-3742 or mhoward@calhospital.org.

Sincerely,

/s/
Alyssa Keefe
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