February 1, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3323-NC
P.O. Box 8013
Baltimore, MD 21244–8013


Submitted electronically via www.regulations.gov

Dear Mr. Slavitt:

UnityPoint Health (“UPH”) is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services’ (“CMS”) Request for Information on certification frequency and requirements for reporting of quality measures under CMS Programs. UPH is one of the nation’s most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 280 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 4.5 million patient visits. In addition, UPH is actively working to engage patients and improve patient outcomes using our Certified Electronic Health Record Technology (“CEHRT”). UPH has invested substantial time and thoughtful consideration to our efforts to build a secure, efficient information technology (“IT”) system that can accommodate the needs of our providers, our patients, and those who care for our patients, and meaningfully improve coordination and quality of care. UPH’s IT system houses and analyzes the records of over 5.5 million unique patients, and provides Certified EHR Technology to over 500 eligible professionals and more than 30 hospitals.

As an integrated healthcare system, we believe that an integrated electronic health record system with robust quality measure reporting tools will enable healthcare providers to focus on population health and care coordination instead of episodic care. As a major provider of health care services in markets that include rural health populations, we were an early adopter of Certified EHR Technology and have seen the benefits of the quality reporting programs, including both the Hospital Inpatient Quality Reporting (“IQR”) Program and the Physician Quality Reporting System (“PQRS”), to the quality of care provided to our patients. We respectfully offer the following comments in response to the CMS Request for Information on certification frequency and requirements for reporting of quality measures under CMS Programs.
Frequency of Certification

As an integrated healthcare system comprising hospitals, clinics, and specialty providers, we have faced significant challenges in selecting tools that are both interoperable and provide the right kinds of quality data for all of our providers’ varied practices. These tools, as CMS has acknowledged, issue regular updates to ensure they meet the standards of the most current CQM rules. Updates like this require significant resources to test and validate each updated CQM, as well as to educate and train providers on new workflows when necessary. We believe that if these updates were delayed due to a requirement that the CEHRT also be re-certified annually, it would impose a significant cost on UPH due to the time required in the re-certification process. Under the current process, the CEHRT is updated and released shortly thereafter, giving health systems the time to review, test, validate, and implement the upgrades in order to begin reporting for the following year. If CMS required re-certification, it would almost certainly eat into the time that both the Certified EHR Technology vendor has to test and develop the software and the time that the healthcare customer has to implement the updated technology. The impact of this is two-fold: (1) vendors may rush their CEHRT updates to pass initial certification testing without properly validating how it will operate in a live environment or how it will impact customer workflows; and (2) healthcare customers will similarly need to rush their implementation of upgrades in order to meet reporting timeframes, and may not have time to appropriately train providers on the new processes for each updated CQM.

While we agree that the current process for updating CQMs without re-certification or testing is imperfect and may result in some issues with accuracy, we believe that under this process both health IT developers and their healthcare customers have strong incentives and time to test and validate the implementations to prevent potential patient safety concerns. Additionally, we believe there are significant benefits to establishing and maintaining a predictable cycle from measure development to provider data submission. If this cycle could be established while also extending timeframes so as to provide additional time for both health IT developers and healthcare customers to perform their necessary testing, then a predictable cycle would certainly enable a healthcare system like UPH to better allocate its own IT resources in preparation for an upcoming update or certification process. The benefits here would, of course, hinge on the actual predictability of the cycle, which can be variable due to multiple agencies interacting in establishing new standards and due to the various development schedules of health IT developers. Without extending the time allotted for upgrades, UPH believes it is unlikely that adding additional steps in the process would in fact introduce predictability.

Changes to Minimum CQM Requirements

We agree and support CMS’s position that EHRs should be certified to more than the minimum number of CQMs as required by the ONC Base EHR definition. The current requirement that EHRs certify to only the minimum number disproportionately impacts specialty providers who do not collect the broad array of data a primary care physician or large hospital might. For example, UPH has seen this challenge in its use of behavioral health-focused CEHRT, which frequently certifies only to the minimum number of CQMs, as very few apply directly to behavioral health practice. This means that behavioral health providers who may be collecting other types of data are limited in their reporting to the nine CQMs the health IT developer has selected as relevant to the behavioral health practice. This limits the data that could be available to both CMS and to the providers.

However, in evaluating the three overarching options proposed by CMS in its Request for Information, UPH does not believe that every EHR should be certified to every CQM as suggested in Option 1, even if
it were phased in over time as suggested in Option 2. As noted in the discussion on frequency of
certification, the work and resources required to update CQMs annually is significant. The inclusion of all
available CQMs would demand that both health IT developers and their healthcare customers devote
significant time to the build and maintenance of additional CQMs. With regard to the phasing-in
approach suggested in Option 2, if the number of certified CQMs increased each year, this would
certainly require that the CEHRT be re-certified each year for the additional set of CQMs required. For
both Options 1 and 2, UPH is concerned that requiring vendors to be certified in all CQMs will reduce the
number of vendors that are certified at all, making it more difficult for organizations to contract with a
vendor and meet reporting requirements. As a consequence, organizations that have implemented EHRs
that are not certified will be forced to seek out another vendor that is certified and endure additional
financial burden.

UPH recommends that CMS adopt the approach suggested in Option 3, which would require some
number of CQMs in addition the minimum number required for reporting, but would not require CEHRT
to certify to all available CQMs. This would permit health IT developers to work toward a consistent goal
and to ensure the CQM reporting capabilities are robust in the areas they focus on. Of the three sub-
options proposed under Option 3, we believe that the best approach is to adopt a new minimum
number of CQMs for the Base EHR definition, but not include all CQMs. We would recommend this
approach because of the realistic constraints of present health IT development. Currently, the best way
to ensure that all CEHRT in a large integrated healthcare system like UPH can communicate back and
forth between various settings of care is to use a broad-based CEHRT which has applications for various
specialties as well as primary care providers. Focusing CQM certification requirements on the specific
population served by the CEHRT could discourage such broad-based CEHRT and instead encouraging
health IT developers to focus on distinct tools for different specialties, to avoid the burden of certifying
all of the CEHRT they develop to all available CQMs and updating those CQMs annually. This may make
interoperability of health IT systems less likely, even while potentially making more individual healthcare
provider data available to CMS, which would mean providers would have less opportunity to draw from
that broad base of data available through interoperable health IT and ensure they are providing high
quality, coordinated care for their patients.

CQM Testing and Certification

As a healthcare system, UPH does not have significant interaction the Cypress Testing and Certification
Tool, but would note two things overall with regard to CQM testing and certification: (1) We believe that
the testing is currently robust and would stand to benefit from additional information being available in
the ONC certification companion guidelines and test procedures, including any issues or concerns that
were observed during initial testing that may assist healthcare organizations in implementing the CEHRT
and developing personalized workflows; and (2) we believe that the number of test cases for adequate
test coverage should vary with the average patient load for each health IT developer, ensuring that
health IT developers with larger customer pools will submit sufficient data to ensure CEHRT is properly
tested for a large variety of use cases.

As a final note, UPH wishes to reiterate its support for CMS’s stated goal of aligning the quality reporting
systems. We believe that alignment of the measures and processes for reporting under these systems
will simplify and reduce the burden of CQM testing, certification, and updates for both healthcare
providers and health IT developers, and may enable significantly more data to be collected and reported
in a meaningful way to CMS, as well as used in the delivery of patient care.
We appreciate the opportunity to provide this response to the CMS Request for Information relating to quality measure reporting and technology certification, and the impact of those requirements on our integrated healthcare system. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Public Policy and Government Payors at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

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