November 23, 2020

Administrator Seema Verma
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013
March 6, 2020

Submitted electronically to Sherrette.Funn@hhs.gov

Re: 0990-New-60D Agency Information Collection Request; 60-Day Public Comment Request HHS Teletracking COVID-19 Portal (U.S. Healthcare COVID-19 Portal).

Dear Administrator Verma:

On behalf of the 4,100 U.S. hospitals and health systems and more than 200,000 other providers and organizations in the Premier healthcare alliance, we are pleased to submit these comments in response to 0990-New-60D Agency Information Collection Request; 60-Day Public Comment Request HHS Teletracking COVID-19 Portal (U.S. Healthcare COVID-19 Portal). Premier has more than 20 years of experience offering clinical, financial and supply chain technologies to health systems and physician practices, retail pharmacies and life-sciences companies across the country.

Housing the nation's largest and most comprehensive comparable dataset on clinical, financial, supply and operational outcomes data, Premier also provides a one-stop shop for information on medical supplies, inventory, staffing, resource allocation, clinical surveillance, syndromic surveillance, clinical decision support, and medical utilization at the local, state and national levels. Premier has deployed technology and tools at provider sites across the US to manage real-time data extraction and transmission from clinical, financial and supply chain systems used by our health systems.

With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide.

Premier appreciates CMS' efforts to reduce regulatory burden on hospitals during the public health emergency (PHE) by providing regulatory flexibilities. These flexibilities have allowed providers and their clinicians to meet the needs of their patients and communities during the PHE and many of these flexibilities have led to improved care delivery. However, we have ongoing concerns that the Administration has mandated extensive hospital data collection and imposed severe and unnecessary penalties for reporting failures given the vast amount of data hospitals are required to report each day, while continuing to treat rising cases of COVID-19. Our recommendations and comments below on CMS/HHS's mandatory hospital data collection are based on our solid, robust, and longstanding experience collaborating with providers on data collection and governance, reporting and analytics.

Comment Areas and Focus

As requested in the information collection request (ICR), our comments focus on the following areas:

- The necessity and utility of the proposed information collection for the proper performance of the agency's functions
- The accuracy of the estimated burden
- Ways to enhance the quality, utility, and clarity of the information to be collected

- The use of the automated collection techniques or other forms of information technology to minimize the information collection burden

Necessity and Utility of the Hospital COVID Reporting Requirements

As the number of infected patients and deaths continue to rise globally, clinicians, scientists and researchers worldwide are struggling to understand all facets of COVID-19. Having robust and timely data is critical to tracking, monitoring, and evaluating the impact of COVID-19 and designing adequate local and national public health responses for the management and containment of this pandemic.

The interim final rule with comment (IFC) released by CMS on August 25, 2020 mandated that hospitals report daily COVID-19 cases and related data to HHS as a condition of participating in Medicare and Medicaid. Hospitals and critical access hospitals (CAHs) are required to report daily data that CMS says is critical to support the fight against COVID-19. HHS has issued and updated several guidances on hospital data submissions and established that the penalty for not reporting the data is withdrawal from the Medicare and Medicaid programs.

We appreciate HHS's efforts to collect data to help address COVID-19 but **oppose using the Conditions of Participation (CoP) as a lever because CoPs are not the appropriate vehicle**. HHS/CMS' approach is cumbersome and duplicative with other existing reporting requirements. A multitude of data reporting requests from numerous federal, state, local, and private entities **continue to place a significant burden on hospitals and CAHs whose resources are already stressed** during the COVID-19 PHE. Failure to report the enormous amount of data at the required frequency may be due to inadvertent or unintentional technical or logistical errors.

Differences in the data definitions between HHS and some state-level data reporting requirements are significant, which adds significantly to the burden of data collection on the front line. Here are some examples:

- HHS COVID+ ICU metric is based on patient location and requires reporting of adults only; State is based on level of care and includes pediatrics
- HHS positive patient count includes patients no longer on isolation precautions; State is active only
- HHS patient under investigation (PUI) count does not include emergency type patients on site at the time of the report; State PUI count does include emergency type patients
- HHS metrics include Newborns; State excludes
- HHS COVID-related deaths include PUIs; State Deaths are COVID+ only

The evolving reporting requirements and expansion of data points associated with each question has become increasingly time consuming for hospitals to gather and report. Hospitals must now report on 38 data points that contain multiple sub-elements without a clear reason for the need for reporting. Complying with the daily reporting elements has required hospitals to redirect staff to source the data, format it, accommodate changes in reporting requirements and, finally, develop a report suitable for submission.

Accuracy of CMS Burden Estimates

HHS/CMS underestimates the burdens on reporting facilities. **Premier urges CMS to recognize the true financial impacts and administrative burdens incurred by hospitals and health systems in complying with these reporting requirements.** Since the beginning of the data reporting process, the administration has required quick turnaround times for hospital reporting without properly considering the time hospitals need to implement changes. Health systems and their associated clinicians face ongoing and increasing challenges providing high-quality, safe, and efficient care for their COVID and non-COVID

patients. These data reporting requirements increase provider administrative and reporting burdens during an unprecedented, challenging time.

The HHS/CMS notice for comment oversimplifies the data collection and reporting requirements and greatly underestimates the complexities involved and thus has underestimated the additional burdens and impacts on providers. The current HHS reporting requirements necessitates data collection from at least three major data domains and sources (supply, inventory, and bed data; clinical, patient level data; and laboratory data).

HHS must keep in mind that these federal reporting requirements are in addition to reporting hospitals are required to do at the state and local levels. Increased reporting combined with inconsistent requirements data definitions, reporting timeframes (frequency and cycles), variation in underlying data sources, and desired data granularity adds to the confusion on what and to whom to report. These reporting obligations are further complicated for health systems that span more than one state. The objective should be to automate this process to the extent possible.

Ways to Enhance the Quality, Utility, and Clarity of Collected Information.

The Administration should immediately address the inherent shortcomings and challenges of the HHS/CMS data collection process and requirements. HHS/CMS should ensure that any additional or revised data elements, template changes, and other requirements tied to data collection and reporting efforts are clearly explained and directly connected to mitigating COVID-19. **HHS/CMS should validate the absolute need for any potential changes against the level of investment of effort and resources on the part of hospitals**.

HHS/CMS should communicate how it is using the data to guide the federal government's response to the pandemic. Further, data was no longer made public after reporting was redirected from the CDC in July.

We offer the following **additional recommendations to enhance quality, utility, usability, understandability, and clarity of collected information**:

- Implement a more automated and seamless reporting approach that is consistent with the internal operations and processes of reporting organizations to help alleviate provider reporting burdens (this is discussed in more detail in the following section).
- Provide feedback to and share information with healthcare facilities to inform them about their data (insights and trends) and national, regional, and local data. Ideally data used for public reporting should also be useful inside the facility for management of patients and quality of care. This can be accomplished through real-time alerting tools that notify on positive cases.
- Implement greater transparency on the reasons for collecting the information and how the data is currently being used as well as consideration and plans for additional or different uses of the data.
- Allow for reporting at the health system (not institution) level to avoid redundant data collection efforts and artificially imposed metrics.
- Provide more comprehensive and robust technical guidances and clarifications, including a data dictionary with clear definitions for each data element. Minimize opportunity for mis-interpretation, reduce ambiguity of the data collection effort, and help improve data validity.

- Review and assess the existing data points to minimize the rework that is required in reporting processes when HHS deploys revisions. [1]
- Clearly demarcate changes to an existing FAQ.
- Review and alleviate ambiguous and/or conflicting guidances and/or directions[2].
- Improve communication from vendors (TeleTracking), who have provided inconsistent guidance or incompatible service on various issues[3]

Use of Automated Collection Techniques or Other Forms of Information Technology to Minimize the Information Collection Burden

We recommend building an on-call, nimble automated data collection infrastructure that the nation can call upon in any future crises similar in magnitude to COVID-19. This system does not need to be on except when needed. When operationalized, it would be automated and behind the scenes. It would be tested to assure that it works at least annually. It would provide visibility of supplies in hospital inventories with detailed information that would enable accurate and intelligent decisions about supply allocation and needs at the local, state, regional and national levels. Moreover, it can used to provide visibility to providers so as to minimize hoarding. Specific attributes include:

- **Automate collection of data elements consistent with the HHS COVID data collection form**
    - Automating the collection and reporting of data minimizes additional hospital burdens; increases consistency and data quality from manual reporting; and provides greater opportunity for meaningful and robust analytics
    - Leverage existing multiple data sources, digital health technologies, and health information technology infrastructure to automate data collection and reporting
        - Implement real-time data feeds from clinical care systems, including EHRs, infection prevention, and clinical surveillance applications
        - Provide nimbleness and adaptability beyond today's COVID-19 pandemic to ensure preparedness for future disasters, attacks, or other unforeseen events
    - Develop and deploy an electronic, ready to go supply chain system by automating the collection and reporting of a minimum viable dataset of supply item inventory
        - Collect and share supply chain data to inform intelligent decisions on what products are available and needed from manufacturer to distributor to hospital inventory (allocation and resourcing).
        - Expand the scope of data collected to better understand and predict demand and burn rates at the local, state, regional and national levels and to leverage inventory data to inform and justify dynamic supply allocation to facilities based upon the priority of needs.
        - Provide real-time insights into device supply, demand, and utilization
    - Develop and implement data governance, oversight, and management (i.e., data access; use case; quality standards/expectations; provenance).
        - Clearly articulate permitted government data access and uses
        - Address privacy and security considerations

[1] Examples: Data points required on July 15, 2020 were different from guidance provided; Data points required on July 22, 2020 were redefined; Data points required on October 19, 2020 were reconfigured (102 of 104 fields were renamed, most changes were cosmetic and unnecessary); Harmonize definitions of isolated and non-isolated patients in accordance with CDC guidelines and allow for alignment with metrics collected by the state.

[2] Examples: Except for the revision on October 19, 2020, hospitals were not given advance notice when fields became required; discrepancies related to data on total bed capacity versus only areas used for treatment of COVID patients; and as of November 19, 2020, the FAQs continue to provide conflicting information about the definition/calculation of COVID-19 Confirmed Patients.

[3] How to report COVID positive patients in the ED without a bed request; If/how to report PPE at the system level; How to provide corrected information (file upload vs email); and Effective date of when backdated corrections can be submitted for the prior seven days instead of the prior four days

- Ensure that Federal data collection is for monitoring and effective allocation; not to remove inventory from organizations
- Applicability and deployment only during national emergencies
- Provide meaningful and actionable data for both external and internal stakeholders
- Minimize additional or redundant provider data collection and reporting

Address and remedy current shortcomings, challenges, and gaps with the Teletracking system

- Enable feedback loops so that data will inform decision-making by the reporting healthcare providers and the greater health care and public health eco-system
- Provide feedback and share actionable data to reporting entities so that they can:
- Leverage insights from the data
    - Monitor the clinical spectrum of illness and responses to treatment, and inform mitigation strategies
    - Determine institution and local community spread and impact
    - Leverage predictive modeling to make actionable forecasts
    - Forecast surges, disease rates and subsequent clinical and supply/logistic needs

CONCLUSION

The Premier healthcare alliance appreciates the opportunity to submit comments to this request for information. We urge HHS and CMS to consider our recommendations as soon as practicable. Ongoing and future improvement to public health infrastructure and data systems is critical to ensuring robust public health practice and infrastructure.

If you have any questions regarding our comments or need more information, please contact me or Meryl Bloomrosen, Senior Director, Federal Affairs, at meryl_bloomrosen@premierinc.com or 202.879.8012. We look forward to continued dialogue. Thank you again for providing us the opportunity to offer comments.

Sincerely,

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance