June 17, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically at: www.regulations.gov

Re: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Proposed Policy Changes and Quality Reporting Requirements for Fiscal Year 2017 Rates

Dear Mr. Slavitt:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments regarding this Notice of Proposed Rulemaking (NPRM) on the Inpatient Prospective Payment System and Quality Reporting requirements for fiscal year 2017. This proposed rule was published by the Centers for Medicare & Medicaid Services (CMS) in the April, 27, 2016, issue of the *Federal Register*.

CHIME is an executive organization serving more than 1,900 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation. CHIME strongly supports efforts to reduce the reporting burdens that hospitals and doctors face in capturing and submitting quality data.

CHIME's comments focus on the requirements around electronic clinical quality measures (eCQMs). We appreciate CMS' recognition that further harmonization of measures across hospital quality reporting programs is needed. We generally support the efforts the

agency has taken to align Hospital Inpatient Quality Reporting (IQR) requirements and Medicare EHR Incentive Program quality measure reporting. However, we remain concerned that CMS significantly underestimates the complexity of generating valid, reliable and accurate eCQMs without human intervention. Below we offer our top recommendations, which are outlined in greater detail in our letter. **Specifically, CHIME recommends CMS:**

1. **Maintain voluntary electronic submission until both providers and policymakers agree on the maturity of eCQM specifications.**
2. **Continue the policy of four eCQMs for 2017 and do not increase the required number beyond what is in place for 2016.**
3. **Retain a reporting period of a quarter rather than a full year.**
4. **Prioritize adequate time for testing and deployment of eCQMs.**
5. **Provide greater transparency around the measure validation pilot.**

Growing Concerns

End to end electronic reporting is a worthy goal but at this time our members continue to rely heavily on manual abstraction, a costly and cumbersome process, for gathering and reporting the measures to supplement electronically generated quality data, and this is likely to be the norm for several years. CHIME members are increasingly concerned that the pace of adopting new eCQM reporting requirements is causing significant hardship. These concerns are not unfounded. A recent study published in *Health Affairs*[1] showed medical practices in just four specialties spend an estimated $15.4 billion each year reporting whether they are meeting their quality targets, which on average costs them $40,069 per physician, or 785 manpower hours.

Moreover, our members continue to spend vast resources trying to meet quality reporting mandates overall. Efforts have been underway since before passage of the Health Information Technology for Economic and Clinical Health Act in 2009 (HITECH) to devise quality indicators that can be electronically captured in clinical workflow, yet organizations still must expend significant resources – both human and financial – to manually abstract data since electronically-generated measures are still inaccurate and unreliable. We recognize future of value-based reimbursement is contingent on the ability to improve performance. The successful administration of value-based care will hinge on providers' and CMS' ability to accurately capture and meaningfully measure the quality of care delivered to the nation's patients. Efforts to reduce provider burden by streamlining reporting redundancies must be a priority and requiring data collection and submission on measures that do not advance patient care must be eliminated. The Institute of Medicine reflected this point in a 2015 report noting, "significant opportunity costs are entailed in devoting resources to inefficient, redundant, or poorly specified measurement activities, which can displace other valuable opportunities to improve health and healthcare."[2]

Additionally, we remain concerned with the current state of technology needed to support quality reporting. The Hospital Association of New York State (HANYS) recently published a white paper chronicling the challenges with quality measure reporting and had this to say about limitations around current technology: "Many measures continue to require meticulous reviews of medical records by trained professionals who otherwise would be directing their expertise to providing and improving patient care."[3] Policies that support enhanced capabilities of EHRs for quality measurement in this area and free vendors to pursue innovative solutions that best meet provider and patient needs would be helpful.

Finally, we would be remiss if we did not point out our concerns with the overall cost of vendor upgrades needed to meet regulatory requirements. We want to be sure CMS recognizes that the purchase price for a software upgrade is just the tip of the iceberg when it comes to provider costs; there may be additional hardware expenses, but most of all the cost to the organization for the additional training and required process change cannot be discounted.

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[1] Casalino, Lawrence P., David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong, and Todd B. Evenson. "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures." Health Affairs 401-406 35.3 (2016). Http://healthaffairs.org/. Mar. 2016. Web. 16 Mar. 2016.

[2] IOM (Institute of Medicine). 2015. Vital signs: Core metrics for health and health care progress. Washington, DC: The National Academies Press.

[3] Hospital Association of New York State, "Moving from Measure Madness to Measures that Matter." https://www.hanys.org/quality/clinical_operational_oversight/measures_that_matter/docs/mtm_report.pdf Accessed June 13, 2016.

Increased Number of eCQMs

Starting in calendar year 2016, hospitals are required to submit four eCQMs out of a total of 28. For calendar year 2017, CMS proposed that hospitals report on 15 eCQMs, a near-quadrupling of requirements. In the proposal, CMS considered requiring eight eCQMs, however, determined that hospitals have had many years to prepare and that 95 percent of hospitals are already submitting measures electronically.

CHIME members are deeply concerned with the proposal to increase eCQM submission from four to 15 measures and are worried CMS is overlooking some substantial barriers to meeting the current set of requirements. Importantly, several members report they do not feel the requirements being imposed are yielding better care. They are committed to improving patient outcomes, however, they do not believe the current process is getting us there. In fact, they report that these requirements are pulling resources away from patient care. Below are testimonials from two CHIME members:

> *This is very concerning as our organization's resources that are available to add additional CQMs and staff workflows in place will be quite limited. Some of the processes to capture the data require quite a few additional steps that require time away from patient care to train all providers/nursing staff. To begin this in 2017 would be extremely difficult for our organization, and we are not one of the largest hospitals, so I'm sure this would be even more difficult for those that would need to provide significant training to a large amount of employees.* (member testimonial #1)

> *The process for implementing eCQMS is labor intensive and requires alternate workflow. The biggest issue, however, is that they don't really improve care. The build with the Value Sets that are required to provide consistency in reporting are incomplete, and we have to end up creating workarounds which shifts the focus to providing the data and not providing care.* (member testimonial #2)

In addition to the above mentioned concerns, CIOs are also contending with an increasing number of application upgrades that require additional investments and are necessary to keep up with the regulatory mandates. CMS regulations frequently force our members to do major upgrades (that take 3-6 months each) at least every 18 months. Below are two additional testimonials which speak to this:

> *Many EHRs are just coming up to speed with the entire concept of ECQMs… While I believe this is the way to go, it will require software upgrades to complete which will detract from our ability to implement a new EHR to help improve overall patient care.* (member testimonial #3)

> *With every regulatory change…(upgrades) forces us to use a large portion of our annual IT operating budget towards solutions that do not impact patient care in the least.* (member testimonial #4)

> *(Upgrades are) resource dependent and frankly usually the first set of hospitals reveals enough needed fixes that we have to stop, load patches and then continue…then get forced into a fixed schedule and produce code that is NOT prime time ready. (member testimonial #5)*

More broadly, our members are increasingly concerned with the pace of regulatory change and its impact on their ability to adapt to new delivery and payment models, an issue we spoke to in our response to CMS' Request for Information on CEHRT and quality measure reporting. Providers are devoting an increasing number of staff to keep up with CMS' requirements. This pace of change is impacting not only providers, but vendors too. Our members report some vendors have not yet created the functionality to report all measures.

One member who is with a small community hospital reported they installed their EHR in 2005 and took all the functionality offered by their vendor at the time, which was well ahead of HITECH. They met Stage 1 in 2011 and Stage 2 twice. Nonetheless, the it is extremely difficult for them to keep up with the pace of regulatory change. Despite being live with the EHR for more than 10 years, the quality measure components in their emergency department (ED) system did not pull from clinical notes, therefore clinicians were required to document separately. Further, clinicians are still capturing patient information in an unstructured format. This makes measure reporting all the more daunting since data is not easily reported electronically and can be located in various areas of the EHR, making electronic abstraction extremely difficult, resource intensive, and prone to errors of omission. This member invested heavily in upgrades to facilitate more facile electronic reporting and used a third party to do so, however, this party was unable to use the QRDA file and was only able to do so using XML. Thus, the use of unstructured data remains a significant challenge for them. Moving from four to 15 eCQMs would increase the regulatory burden

on healthcare providers and further slow efforts to transform their operations. The challenges are great for hospitals, regardless of size and location.

Finally, while we continue to believe a more prudent approach for eCQMs is one where CMS makes reporting optional until measures are rigorously tested and validated, we recognize it is unlikely CMS will change this policy. **Therefore, we strongly urge CMS not to increase the number of eCQMs beyond four for the 2017 reporting / 2019 payment year.**

Full Year Reporting

For 2016, hospitals are required to report for one quarter (either Q3 or Q4). CHIME is very concerned that CMS has called for a full year reporting period for eCQMs for the 2017 reporting / 2019 payment year. Similar to our concerns with CMS' proposal to increase the number of eCQMs, the proposal for full year of reporting is premature and represents a significant leap from what is currently required today. **We strongly urge CMS to retain a single quarter reporting requirement for eCQMs.**

Decreasing Total Number of eCQMs

CMS has proposed reducing the number of overall of eCQMs available from 28 to 15 from both the IQR Program and the Meaningful Use Program, thereby reducing the overall number of eCQMs by 13. CMS notes the, "coordinated reduction in the overall number of eCQMs in both programs would reduce burden on hospitals and improve the quality of reported data by enabling hospitals to focus on a smaller, more specific subset of eCQMs." CMS furthermore notes that the burden of retaining topped out measures outweighs the benefits. **CHIME supports this proposal.** We appreciate CMS' efforts to reduce the burden on hospitals and also believe this will help provide some relief for vendors. CHIME also wants to note that while these changes are welcomed, once a measure has been deemed topped out a hospital must then adopt new workflows and processes to adopt a fresh measure in its place which again take time and resources.

Chart and eCQM Abstraction

CMS clarifies its plan on requiring providers to report in 2017 for 2019 payment on some measures both electronically and through chart abstraction. CMS states, "for three measures (ED-1, ED-2, and PC-01), our previously finalized policy that hospitals must submit a full year of chart-abstracted data regardless of whether data also are submitted electronically continues to apply." This proposal, on top of the proposal to require reporting of 15 eCQMs adds tremendous burdens to providers. We would further add that providers are not only reporting to Medicare, but to Medicaid and private payers as well. Many our members submit over 20 reports across federal, state and private sector programs each month. Duplicate reporting adds an unnecessary layer of complexity and burden which we simply do not support.

Additionally, it appears that CMS believes that clinician documentation is easily queried for the generation of clinical quality measures; unfortunately, that's not the standard today. Going back to our earlier comments about the complexity of measure calculation, we are very concerned that there is significant risk to a provider who is being asked to rely upon their vendors to calculate this correctly. Given that data still is often located in different areas of the EHR, this makes it very challenging for vendors to ensure they have correctly captured what is needed to substantiate a measure, which is why the manual abstraction is still so heavily relied upon. **Rather than requiring dual measure reporting, we urge CMS instead to slow the pace of eCQM reporting and focus on testing and validation measures instead.**

Form, Manner and Timing of Quality Data Submission

CMS states it plans on continuing to use the process previously established for eCQM data certification for 2016 reporting / 2018 payment. That is, it would require hospitals to report using either 2014 or 2015 certified technology for 2017 reporting / 2019 payment. For 2018 reporting / 2020 payment, CMS proposes to require the use of Version 2015 CEHRT. CMS also states it plans on aligning the IQR and the MU reporting deadlines such that 2017 reporting data would need to be reported two months after the close of the reporting period. **CHIME supports CMS' efforts to align reporting.**

Data Validation

CMS currently validates data submitted through manual chart abstraction. CMS states it plans on updating the data validation process for in 2018 to include eCQM data for the 2020 payment year. CMS furthermore states it plans on randomly picking 200 hospitals for eCQM validation. CMS would exclude any hospital picked for chart-abstracted

measure validation and those who have been given an extraordinary circumstances exception. The agency states that it is important to validate data; under a validation pilot CMS found matching rates between the data reported via manual abstraction and the QRDA I file to vary as much as 50 percent. The variation was mostly due to missing data. CMS offers very little detail in the rule on pilot they conducted. **CHIME urges CMS to be more transparent and provide greater details on the outcome of the pilot, so that we can better understand the results and their general applicability to the greater hospital community.**

Certification

CMS says it plans on continuing to use the process previously established for eCQM data certification for 2016 reporting / 2018 payment. That is, it would require hospitals to report using either 2014 or 2015 certified technology for 2017 reporting / 2019 payment. For 2018 reporting / 2020 payment, CMS proposes to require the use of Version 2015 CEHRT. If a hospital / CAH is using Version 2014 CEHRT in 2017 and it does not have all the 15 CQMs available for 2017 reporting, they would need to get the EHR certified such that it could handle the reporting for 2017. For electronic reporters in 2017, this would require using the spring 2016 version of CQMs. CMS notes that an EHR does not need to be recertified every time it is updated to a more recent version of CQMs. CHIME appreciates that CMS is allowing providers to continue using Version 2014 CEHRT in 2017. **We are however very concerned that the vendor community will not have adequate time to deliver the updated products to the market place in time for all providers to meet the 2018 reporting, which would require use of Version 2015 CEHRT.** This combined with a year reporting makes CMS' proposal very worrisome for providers. **Providers should be allowed to continue using Version 2014 in 2018.**

We continue to be concerned with providing a sufficient amount of time to vendors and providers to test and deploy CEHRT needed to support eCQM reporting. As we have commented in the past, it usually takes a minimum of 24 months for a vendor to make updates to a product and for a provider to deploy the new version. During this period, it takes roughly 18 months for the vendor to create/update the product and then at least six more months for a provider to test and deploy it. While we recognize that measures need to evolve, a balance needs to be reached such that the churn around development and deployment is not endless. It is unrealistic to expect that providers can change their systems every time a change is made to an eCQM or if the reporting standards change. We appreciate CMS recognizing that this is a burden. We strongly support a "predictable" cycle from measure development to provider data submission. As we have outlined in the past, we recommend that rather than setting specific deadlines for such a cycle, a timetable is created so when certain pieces of the timeline slide that the remaining pieces can be shifted to the right rather than adhering to an unrealistic deadline.

Conclusion

CHIME appreciates the opportunity to comment on the proposed rule and the impact reporting eCQMs has on our members and their ability to help transform the delivery system. We remain steadfast in our commitment to improving patient care through the use of health IT, but this must be done in a manner that removes, rather than adds, complexity for providers and should not pull resources away from patient care. Please feel free to follow-up with any questions you may have with Mari Savickis, vice president, federal affairs at msavickis@chimecentral.org.

Sincerely,

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