June 12, 2015

The Honorable Andy Slavitt,
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1637–P
Submitted electronically at: http://www.regulations.gov

Re: Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2016 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 Inpatient Quality Reporting (IQR) and EHR Incentive program quality measurement requirements for Fiscal Year 2016. This proposed rule was published by the Centers for Medicare & Medicaid Services (CMS) in the April 30, 2015, issue of the *Federal Register*.

CHIME has more than 1,400 members, composed of chief information officers (CIOs) and other senior information technology executives at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business information technology (IT) systems that will facilitate healthcare transformation. Our organization shares the vision of an e-enabled healthcare system as described by the many efforts under way at the Department of Health and Human Services.

We appreciate your recognition of the need to further harmonize measures across hospital quality reporting programs and we generally support the efforts your agency has taken to align Hospital IQR and Medicare EHR Incentive Program quality measure reporting. However, we remain concerned that CMS underestimates the complexity of generating valid, reliable and accurate electronic clinical quality measures (eCQMs) without human intervention. 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 some time to come.

In keeping with previous recommendations to CMS, CHIME believes it prudent to require electronic submission of eCQM data after such time when federal regulators rigorously test and

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validate the accuracy/completeness of CQMs required by Medicare and Medicaid. **CHIME recommends CMS maintain its current policy of voluntary electronic submission until both providers and policymakers agree on the maturity of eCQM specifications.** While we understand that less than an ideal number of providers have taken advantage of a voluntary electronic submission option to-date, we believe it a far preferable challenge than having all hospitals participating in IQR "practice" electronic submission when there is little demonstrable clinical value of undertaking such an effort. Further, we encourage CMS to consider what factors might be contributing to the voluntary program's low participation rate and address the most likely causes.

The above recommendation notwithstanding, **CMS should move forward with stated plans to allow dual submission of EHR Incentive Payment Program and a subset of IQR Program CQMs on a voluntary basis.** And we support CMS plans to issue the Request for Information (RFI), mentioned in this proposed rule, so that technical and workflow barriers can be identified and addressed over the next two yearly cycles. We do not discount the value of the work done so far, or the value of the direction; however, question the timing and recommend that CMS target FY 2020 as a more appropriate timeframe for required electronic submission of CQM data for IQR and other purposes. CHIME recommends that CMS work in tandem with the Office of the National Coordinator for Health IT (ONC) and qualified measure developers/stewards to extensively test and validate eCQMs so that measuring quality is the byproduct of delivering care, not an end unto itself.

Section VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers

CMS proposes a number of changes to the Hospital IQR Program, including a measure set for the FY 2018 payment determination that includes 47 measures which are specifically required, plus a requirement for electronic reporting of 16 out of 28 electronically specified measures.

Section VIII. A. 5. Hospital Survey on Patient Safety Culture.
This proposed structural measure would be reported annually by hospitals through a web-based survey tool on the QualityNet website. Questions would cover whether (and how frequently) the facility administers a detailed assessment of patient safety culture using a standardized collection protocol and structured instrument; the name of the survey; whether results are reported to a central location; the number of staff who were requested to complete the survey and response rates. CMS discusses the benefits of patient safety culture survey tools, the various surveys currently used in the healthcare industry and the value to CMS assessing the feasibility of developing a measure targeting the culture of patient safety using a specific survey. The MAP supports inclusion of this measure in the IQR Program. The initial data collection period is proposed to be CY 2016, with data submission occurring in CY 2017.

RECOMMENDATION: Some members expressed support for inclusion of this survey measure, as they currently use a similar instrument to help identify issues internally and better understand barriers to quality improvement. We recommend CMS use the information generated by this proposed measure for future policymaking while refraining from immediately making such information publicly available.

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Section VIII. A. 7. Required Reporting of Electronic Clinical Quality Measures for FY 2018
Beginning with the FY 2018 payment determination, CMS proposes that reporting of electronic clinical quality measures be required as part of the IQR Program, rather than voluntary. Specifically, hospitals would be required to select and submit 16 electronic clinical quality measures covering three NQS domains from 28 available electronic clinical quality measures; data would be reported for calendar quarters Q3 and Q4.

RECOMMENDATION: CHIME does not support this as a requirement for hospitals participating in IQR during FY 2016. We understand policymakers' wishes to accelerate the use and submission of electronically specified CQMs. However, CHIME does not believe providers' limited time and resources should be devoted to submitting incomplete, inaccurate and otherwise meaningless quality data. Our view is that CMS should require submission of eCQMs after rigorous testing and validation of those measures is undergone.

Electronically submitted measures would not be publicly reported; CMS plans to evaluate the effectiveness of electronically reported clinical quality measure data. In the interim, measures reported via electronic clinical quality measure would be footnoted on Hospital Compare stating that: (1) the hospital submitted data via EHR; (2) data are being processed and analyzed; and (3) CMS will eventually publicly report this data once CMS determines the data to be reliable and accurate.

RECOMMENDATION: Again, we do not agree with the proposal to require IQR data – even a subset of measures – to be submitted electronically in FY 2016. Relative to this proposal, we do not believe that footnoting data on Hospital Compare will add value or improve accomplishment of CMS policy goals. Rather, we suggest CMS simply take no action and post such data on Hospital Compare after both parties determine they are reliable and accurate.

Section VIII. D. Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals Participating in EHR Incentive Programs in 2016

Reporting period and data submission deadlines for CY 2016. Noting that the EHR Incentive Program Stage 3 proposed rule would shift the EHR reporting period to a calendar year basis, CMS proposes to adopt a calendar-year based reporting for CQMs in 2016. In addition, reporting and data submission dates are proposed that would serve to align the EHR Incentive Program with the Hospital IQR Program electronic quality measure data submission requirements proposed in this rule for the FY 2018 payment determination (2016 data submission).

Specifically, for participating hospitals and CAHs that are reporting electronically, CMS proposes that for 2016, two full quarters of data (Q3 and Q4 of CY 2016) be submitted within two months after the end of the quarter (i.e., November 30, 2016 for Q3 and February 28, 2017 for Q4). For eligible hospitals and CAHs reporting CQMs by attestation, reporting for CY 2016 would be required by February 28, 2017, except that for those demonstrating meaningful use for the first time in 2016, attestation could alternatively be made for any continuous 90-day reporting period within

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2016. These reporting periods would apply for Medicaid, but states determine data submission methods and deadlines.

RECOMMENDATION: We support the options set forth in this NPRM allowing simultaneous submission of electronic CQMs for IQR and MU during Q3 and Q4 of CY 2016 should providers wish to do so. CHIME appreciates CMS' efforts to harmonize reporting and submission periods between IQR and the EHR Incentive Program.

CMS intends to publish a request for information on the establishment of an ongoing cycle for the introduction and certification of new measures, testing of updated measures, and testing and certification of submission capabilities.

RECOMMENDATION: CHIME fully supports CMS plans to issue an RFI to establish an ongoing cycle for introduction and certification of new measures, testing of updated measures and test and certification of submission capabilities. We believe that such work is exactly where the public and private sector can collaborate and leverage their respective strengths.

We look forward to a continuing dialogue with your office on how to improve the landscape of electronic quality measurement. We urge officials to contact Leslie Krigstein, Interim Vice President of Public Policy, at lkrigstein@chimecentral.org or (202) 507-6158, with any questions, comments or concerns.

Sincerely,

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