College of Healthcare Information Management Executives

June 25, 2021

Administrator Chiquita Brooks LaSure
Centers for Medicare and Medicaid Service
500 Security Boulevard
Baltimore, MD 21244

Submitted Virtually Through Regulations.gov

Dear Administrator Brooks LaSure:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS') "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals" published in the *Federal Register* on May 10, 2021.

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders. With more than 5,000 members, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate for the effective use of information management to improve the health and healthcare in the communities they serve.

We appreciate the regular work the administration continues to do while simultaneously fighting the COVID-19 pandemic. Providers and the American healthcare system have faced a relentless number of threats this year from both COVID-19 and the constant threat of ransomware attacks. With this in mind, CHIME members are grateful to see efforts from CMS in the FY22 IPPS proposed rule to remove reporting duplicity, while also aiming to streamline pieces of the Promoting Interoperability (PI) program. It is also important to highlight that while many of the proposals were made in a spirit of burden reduction and automation, the proposals themselves may be too forward-looking, putting providers in the difficult situation of needing to respond to complex scoring areas geared towards future technology, with current technology unable to meet the expectations. Similarly, while CHIME membership supports the expansion of public health requirements in our health system, they are also concerned that doing too much too fast puts them in a position where they are unable to meet expectations due to circumstances out of their control.

CMS is often asked to accomplish the difficult task of moving healthcare forward, while not overburdening any single sector. CHIME is sympathetic to that challenge and note through much of its response, that the provider community has a deep interest in partnering with CMS to develop and implement common sense changes that benefit both CMS and providers. As the COVID-19 pandemic has shown, the nation's healthcare system is ripe for rapid progress and problem solving, and we as a representative of the provider community, look forward to providing direction and suggestions for how CMS and other federal agencies can use rapid iteration in order to create a more sustainable system for everyone involved.

CHIME's broad comments on the FY22 IPPS include:

1. **CMS should work with providers to determine the correct timing and manner to implement shifts in PI categories to ensure no provider communities are excluded from being able to take advantage of the optional or proposed required categories due to lack of access to technology, capital or connectivity.**
2. **CHIME supports CMS' efforts to reduce the reporting burden on the provider by eliminating duplicative requirements and encourages CMS to examine other programs to determine other duplicative reporting requirements.**
3. **CHIME is supportive of efforts to determine health equity gaps and close them, however, CMS must ensure providers who are unable to comply with any new reporting requirements are not inappropriately penalized, despite actively working to combat equity gaps in care.**
4. **Application programming interfaces (APIs) and the Fast Healthcare Interoperability Resource (FHIR) are two technological innovations CHIME is incredibly supportive of, but caution CMS and the broader HHS community from embracing them as the only interoperability or data exchange solution before the technology has reached proven maturity.**

Specific comments to the proposed rule are as follows:

Health Equity Requests for Information (RFI)

CHIME supports the federal government's efforts to identify and capture data related to health equity and the gaps that currently exist in care. Within the FY22 IPPS, CMS proposed multiple health equity RFIs asking for information on a variety of topics. CHIME has opted to respond to those RFIs collectively, instead of individually, as we believe our broader comments on health equity pertain to multiple RFIs. Comments include:

- CHIME encourages CMS to work with the Office of Management and Budget (OMB), the Office of the National Coordinator for Health Information Technology (ONC) and other relevant federal government agencies to refine and update the federal requirements for social determinants of health (SDOH) and sexual orientation and gender identity (SOGI) data collection. As it currently stands, the OMB dictated data collection standards are too limited and are often out of date compared to state level requirements. This limits the federal government in understanding how accurate its collected SDOH and SOGI data is and creates an environment where each state will set its own standards, requiring providers and technology developers to track and implement multiple different sets of data collection requirements. With this in mind, relevant SDOH and SOGI data experts and the public should be consulted to draft updated and accurate SDOH and SOGI data categories for implementation at the federal level.
- CMS should work to determine the best method of standardizing and ensuring accuracy for the collection of related data. One area CHIME recommends CMS explore, is utilizing and expanding the ONC United States Core Dataset for Interoperability (USCDI) to better target and determine how and what data should be collected during the care process.
- CHIME recommends CMS continue the process of harmonizing the data collection process and data standardization process across federal agencies and technologies prior to creating a hospital equity score. There are multiple standards and exchange requirements that must be designed and implemented prior to the federal government even being able to determine what needs to be measured. Similarly, CMS needs to better understand and determine how to account for the impacts of geography and economics on the providers who would be subject to this equity score to ensure no providers are penalized for issues outside of their control.

Proposed Reporting Periods

CHIME supports the proposed CMS reporting periods for CY 2023 and 2024 for 90-days and 180-days, respectively. CMS is urged to ensure the longer reporting periods do not impact the ability for providers who

need to have longer implementation times for EHR upgrades and deployment. This is especially key as it relates to the upgrade to 2015 Cures Update Edition certification that providers must implement in 2023.

Optional Query of Prescription Drug Monitoring Programs (PDMP) in CY2022

CHIME supports leaving the optional query of PDMPs as optional with an increase in bonus points from five to 10.

Permanent Query of PDMP

CHIME encourages CMS to keep the query of PDMP as an optional category. There are multiple issues that must be addressed within healthcare prior to shifting the query of PDMP from an optional category to a permanent one. Those challenges include:

- The readiness of FHIR for PDMP and the ability to report on the query requirements are not at a level of maturity that would allow for this requirement. The security restrictions placed on querying a PDMP does not allow for FHIR to access or report to PDMPs. With this in-mind, FHIR will also not lessen the burden of PDMP query activity, as the main constraint preventing providers from participating in PDMP query is with states having active PDMPs ready to receive FHIR based queries and the ability for providers to implement the query activity in their workflows.
- Larger health systems are currently able to meet this requirement, but smaller critical access hospitals (CAH) and smaller single practice facilities will struggle to meet this requirement.
- Additional funding will be required to help raise the technology floor for some providers in order to help them meet this requirement if it would be made permanent.

As it relates to inter/intra-state data exchange, there is not cross-state reporting and query activity currently taking place today. ONC and the USCDI should be utilized as a tool to bring cross-state standardization to fruition allowing for true cross-state reporting. If a nationwide PDMP exchange model is what CMS desires, CHIME encourages them to pursue a nationwide PDMP instead of a series of state-based PDMPs.

Proposed Changes to the Provider Electronic Access to Patients Requirements

CHIME strongly recommends CMS reconsider the proposal to require eligible hospitals and CAHs to ensure information remains available indefinitely and instead require eligible hospitals and CAHs to ensure information remains available for one year. As it exists today, the technology is not in-place to allow for this data exchange and access to remain in place and providers are largely unable to transfer this data from EHR-to-EHR if they were to choose to change EHR vendors. Additionally, other regulations at both the federal and state level already dictate records retention requirements for providers, making this requirement in direct conflict with requirements already in place. Similarly, keeping information available indefinitely presents an inherent risk to patient data compromise, as any unauthorized access to the available information would be of far greater consequence if a larger section of a patient's record is available as opposed to just a year's worth of information.

If CMS were to decline eliminating the proposed requirement, CHIME urges CMS to delay implementation to CY2023 to give the technology additional time to mature and allow for CMS to develop a concrete and expansive set of exceptions for when providers would not need to make the data available indefinitely and ensure all requirements align with other federal programs.

Proposed New Bi-Directional Exchange Through Health Information Exchange (HIE) Measure

CHIME supports the proposal of new bi-direction exchange through health information exchange measures and continued work by CMS to give providers optional and innovative ways to respond to PI categories. With that in-mind, CHIME encourages CMS to provide clarity on several items outlined within the proposal. They include:

- Clarifying that HIE means all forms of health information exchange, including state HIEs and health information networks such as CommonWell and CareQuality.
- Further defining “all patients” as that definition can differ between state and federal regulations.
- Providing additional context to how “workflows” will be used to demonstrate compliance, as in some cases workflows do not always mean utilization.

Additionally, in-order to attain the level of data exchange CMS is hoping to achieve, CHIME recommends CMS and the wider federal government continue to collaborate in the creation of a broader national interoperable healthcare network. With a more robust backed system, there would be increased incentives for providers to utilize this optional measure.

It is also important to note, that while these optional requirements may increase the availability of data, it may not increase the utilization of that data. For instance, one member suggested that this measure would open up such a firehose of data that it would be largely unusable for those unprepared to receive the data. It was suggested by another member that a larger set of data transmitted as discrete elements would better incentivize utilization.

Modifications to the Public Health and Clinical Data Exchange Objective

CHIME continues to support the federal government’s efforts to advance the availability and exchange of available public health data. It was made clear because of the COVID-19 pandemic, that the health system as a whole must work together to better increase its ability to capture, share and utilize this important data. This is especially true during emergent events such as pandemics and other widespread crises.

As CMS works to encourage the exchange and utilization of public health data, CHIME proposes several recommendations to ensure all providers are able to participate, and burden is not increased on the provider. Those recommendations include:

- CHIME recommends CMS implement an on-ramp to mandatory public health reporting, similar to other past CMS programs, allowing for a provider organization to prove two-to-three measures to meet the first year of the program, and then increasing the number of required categories year-over-year.
- CMS should ensure there are exclusions available if there is not a state immunization registry available for a provider to report to.
- Additionally, CMS should survey the state immunization registries to determine if there is readiness at the state level to conduct this level of exchange.
- CMS needs to determine if states are willing to also move towards electronic data exchange. Many state agencies continue to mandate manual reporting; if they continued to do this and CMS mandates online reporting, it will increase the burden on providers, as they will need to report in two different formats.
- Similarly, CMS needs to ensure FHIR APIs and electronic case reporting is in place prior to mandating this requirement. As a result, CHIME recommends delaying making this requirement mandatory until CY2023.

SAFER Guides

CHIME supports the inclusion of the SAFER guides as part of the PI program. With that in-mind, CHIME urges CMS to determine the burden level placed on providers to complete the SAFER guides every year. And, if CMS does determine completion of the full SAFER guides is too burdensome, CMS should require a hospital to complete all nine SAFER guides over a three-year period, with three of the provider organization’s choosing completed each year. Every three years, all nine SAFER guides would be completed, and providers would then remain in compliance. If CMS is unable to determine burden placed on the provider by this requirement, then it should undertake a pilot program before mandating this requirement for everyone.

CHIME also recommends CMS work with ONC to update the SAFER guides prior to implementation, as they will be over five years old by the time they are mandated.

Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Removal of Attestation Statements

CHIME supports the work CMS is doing to eliminate duplicative reporting burden and encourages CMS and HHS to engage in further activity to remove administration reporting burden through duplicity.

FHIR API RFIs

CHIME continues to support the use and adoption of FHIR APIs across the health system. However, prior to further requiring or implementing FHIR based APIs for reporting, the federal government must wait for the FHIR-based API requirements to take effect and be implemented on the provider level. FHIR can be a piece of all reporting and burden reduction solutions, however, it cannot be treated as a cure-all for every problem until it is implemented and proven at the provider action level.

Patient Access Outcomes Measures RFIs

CHIME encourages CMS to refrain from measuring and tracking third-party app utilization and connection at the provider level. Doing so would prove burdensome for providers, as once the FHIR APIs are implemented in 2023, patients will be able to access their record with no action required on the provider side. Tracking the potentially infinite number of apps connecting to an API would be challenging, given how the open API format does not necessitate a tracking requirement. Similarly, there is no clear way for a provider to measure a patient's access to their EHI at this time, or the utilization of that data, in order to determine benefit of access.

Clinical Notes RFIs

CHIME encourages CMS to refrain from implementing a requirement that would assign a star rating for EHR excellence. There are several third-party awards given to providers who utilize and exchange health information, including CHIME's Digital Health Most Wired award that is given yearly. With that in-mind, in the FY23 IPPS, CHIME would welcome an RFI from CMS seeking further information on how best to evaluate health IT interoperability based on outcomes, as opposed to utilizing a star rating system.

We appreciate the opportunity to comment and welcome the chance to help inform the important work being done by CMS. We look forward to continuing to be a trusted stakeholder throughout your tenure as CMS Administrator and continuing to deepen the long-standing relationship CHIME and CMS have shared. Together we can work together to envision and achieve the 21st century health system of the future we have long dreamed of implementing. Working together through the rulemaking process, such as with the IPPS, is just one way we can do that together. Should you have any questions about our letter, please contact Andrew Tomlinson, Director of Federal Affairs, at atomlinson@chimecentral.org.

Sincerely,

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