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February 5, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS-3323-NC, Request for Information (RFI): Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide input on the certification frequency and requirements for the reporting of quality measures under the Centers for Medicare & Medicaid Services' (CMS) programs, including the Electronic Health Record (EHR) Incentive Program and the Hospital Inpatient Quality Reporting (IQR) Program, among others.

Hospitals support the long-term goal of using certified EHRs to streamline and reduce the burden of quality measurement, while increasing access to real-time information to improve care, and support quality improvement. Our members have been working diligently to implement certified EHRs and new health information technology (IT) with an expectation to reach this goal. Since the start of electronic clinical quality measure (eCQM) reporting in the EHR Incentive Program in 2011, eligible hospitals (EHs) and critical access hospitals (CAHs) have shared their challenges with the implementation and use of certified EHRs for eCQM reporting with CMS. As a result of CMS's engagement with stakeholders, including EHs, CAHs and eligible professionals (EPs), the complexity of eCQM reporting requirements is more widely understood than at the beginning of the program.

The AHA is encouraged that CMS is requesting feedback on several areas of concern to providers, particularly the misalignment between the reporting requirements on providers and the number of eCQMs that certified EHRs are required to support. While CMS will undoubtedly receive numerous responses to its RFI, **the AHA recommends that CMS also consider the input received to date from EHs, CAHs and EPs about their eCQM experiences, including the evidence from CMS eCQM pilots and demonstrations, to inform future rulemaking**



regarding any requirements for the use of eQMs for quality reporting. This letter includes our comments on eQm reporting within the context of quality measure reporting and answers specific questions on the frequency of certification, eQm reporting requirements and health IT module testing and certification.

UTILIZE INFORMATION RECEIVED TO DATE TO INFORM EHR CERTIFICATION AND REPORTING REQUIREMENTS FOR eQMS

The requirement to report updated eQMs must build on the provider experience to date with eQm implementation. Since 2013, CMS has launched demonstrations and pilots to encourage electronic submission of eQMs. The 2013 Medicare EHR Incentive Program Electronic Reporting Pilot data was expected to inform the development and testing of the eQm data collection process, as well as monitoring process. Lessons learned from this two-year pilot were anticipated to inform the development of eQm policy. In 2015, CMS launched an eQm validation pilot. The pilot results were to support the development of a future eQm validation strategy. CMS also created in 2014 a voluntary electronic reporting option to encourage EHs to electronically report eQMs for the Hospital IQR Program and receive credit for the EHR Incentive Program quality reporting requirement.

To date, CMS has not shared insights from these efforts. We do not know the number and characteristics of the hospitals participating in the pilots and demonstrations, the number and variety of certified EHRs represented in each pilot or demonstration, and the number of successful or failed submissions. Additionally, the criteria used to define success and failure also are unclear. **In order to support successful electronic eQm submissions in calendar year (CY) 2016, the AHA recommends that CMS release the results of the previous eQm demonstrations and pilots before the release of future rulemaking governing eQm reporting.**

Hospitals are keenly interested in evaluating variations in chart-abstracted measures and eQMs, and some have initiated their own validation activity of eQMs to advance their knowledge. The AHA studied the experiences of four hospitals with eQm implementation. Throughout the implementation process, each hospital encountered significant challenges to meeting the goal of generating accurate and reliable quality data from their certified EHR and using this data to improve care.¹ The results of the CMS pilots, demonstrations and voluntary electronic reporting option will provide useful insight for hospitals that are continuing to work through eQm implementation challenges.

Revise CMS education and outreach activities on EHR certification and eQm reporting in 2016 to support a learning environment that benefits all stakeholders. CMS and the Office of the National Coordinator for Health IT (ONC) are to be commended for launching an ongoing series of small-scale meetings intended to identify challenges with eQm reporting and advance solutions to improve processes and increase successful submissions by providers. In select

¹ *A Study of the Impact of Meaningful Use Clinical Quality Measures.* American Hospital Association and iParsimony, LLC. July 2013. <http://www.aha.org/content/13/13ehrchallenges-report.pdf>

venues, CMS and ONC have offered some insights on the process improvements identified and implemented. Yet the challenges addressed and lessons learned have not been widely shared through national provider calls or other mechanisms targeted at the full breadth of providers now required to report eQMs.

The AHA recommends that CMS immediately expand and enhance eQm education and outreach efforts to support successful electronic reporting of eQMs in 2016 and beyond.

In addition, we recommend that CMS offer educational content in multiple formats and at different levels of complexity in order to reach the widest audience and address the greatest number of questions and concerns. The recently updated Electronic Clinical Quality Improvement (eCQI) Resource Center website is helpful, as it serves to identify and direct users to other educational resources about eQMs. However, additional outreach efforts to providers are needed. For example, CMS provided considerable education, outreach and support to providers in advance of the 2015 launch of ICD-10. While that level of effort may not always be possible, similar types of education, outreach and support should be available to facilitate successful electronic submission of eQMs. A collaborative learning environment that offers layers of educational content on the quality measures, the technology supporting data capture, calculation and reporting, and the submission methods will benefit CMS, providers and vendors in efforts to improve the entire eQm process.

Communicate CMS's strategy to transition from quality reporting based primarily on manual abstraction to quality reporting that utilizes eQMs. While the EHR Incentive Program will not require the electronic submission of eQMs by EHRs and CAHs until CY 2018, the Hospital IQR Program accelerates the timeline for mandatory electronic submission of eQMs by requiring the electronic submission of four eQMs in either Q3 or Q4 of the 2016 reporting year. CMS has recognized that measure rates may not be comparable between measures reported via chart-abstraction and measures that are electronically specified, and will not publicly report the eQm results submitted for the Hospital IQR Program. Also, we are aware that the standards included in the measures are not identical, even for the same measure title. For example, certain data such as date of birth or height are required to be collected in one way when using a certified EHR but are collected differently when chart-abstracted measures are submitted for CMS quality reporting programs.

The AHA recommends that CMS clearly state its plans for the transition from chart-based reporting to electronic reporting across CMS programs. We urge CMS, as part of its national quality strategy, to work collaboratively with stakeholders to improve quality by harmonizing measures to focus on what really matters and not just creating another reporting system.

Additionally, we recommend that CMS communicate how its plans will align with or diverge from requirements for electronic submission of eQMs to other organizations, such as The Joint Commission (TJC). Many hospitals report the same measures to CMS, TJC and state organizations. The alignment of measure specifications and submission requirements will help to reduce the reporting burden.

Also, the AHA recommends that CMS accelerate its work to identify the data elements, and the definitions of those data elements, necessary for eQm reporting and submission. We

remain concerned that the Quality Reporting Data Architecture Category I (QRDA-I) format is the only format available for eCQM submission by EHs and CAHs and requires the submission of individual-level patient data. Yet, we believe QRDA-I files may contain more information than is needed to calculate clinical quality measures. By better identifying the necessary data elements, other data captured can be eliminated, thus, simplifying reporting for providers.

Address future eCQM reporting in the new physician payment models. Beginning in 2019, physician requirements under the Medicare EHR Incentive Program will be folded into the new Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs). In our response to a request for information on how to implement these new physician payment models, we urged CMS to adopt a system that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on important quality issues and promotes collaboration across the silos of the health care delivery system. **We also recommended that any modifications to the definitions, structure and reporting requirements of the EHR Incentive Program for EPs be aligned with requirements for EHs and CAHs.** This alignment is critical to ensuring the ability to share information and improve care coordination among providers across the continuum.

The following comments respond to specific questions asked in the RFI:

Frequency of Certification. **The AHA supports a requirement for certified health IT to be recertified when a new version of the eCQM specification is available.**

The provider timeline for the implementation of eCQM updates must be considered as a separate but related issue in the consideration of the frequency of EHR certification. The certified health IT vendor timeline to revise their software to support eCQM specification updates is different than the hospital timeline to implement the new eCQM specification and new software. Gathering the data necessary for eCQM reporting has proven to be time intensive for hospitals due to the complexities involved in data integration across many separate information systems within hospitals. Hospitals also must map necessary data elements from their source to the EHR and to the QRDA format required for submission to CMS.

Annual updates to eCQM specifications launch internal reviews that determine if quality measure logic or changes in standards also necessitate workflow revisions to support accurate information capture. These revisions to other clinical systems may involve working with other vendors to support new queries. As a result, the timeline for hospitals to implement updates to eCQM specifications can be lengthy. Our members indicate that a 24-month timeline is required for hospitals to successfully take on a measure update, from the initial release of a new eCQM specification until providers can successfully report on the measure. A 19-month timeline is the average time required for hospitals to successfully take on an updated eCQM specification.

As a result of the different timelines, the AHA recommends that CMS establish a policy in which the effective date for provider use of recertified health IT allows sufficient time for provider implementation of the recertified health IT in their setting, mapping of the data

required for reporting, updating other information systems and instituting necessary workflow adjustments.

Changes to Minimum CQM Certification Requirements. Currently, EHRs are not required to support the reporting of all the eCQMs available for reporting. CMS seeks feedback on two options for minimum eCQM certification requirements: certify health IT modules to all eCQMs, certify health IT modules to a specific number of eCQMs and increase the number to include all eCQMs. CMS also requests comment on an option to certify health IT products to more than the current minimum number of eCQMs but not to all available eCQMs.

The AHA recommends that CMS require developers to certify health IT modules to all eCQMs available for EHs and CAHs. The current mismatch in vendor and provider requirements results in providers identifying the eCQMs that their certified EHR supports and then confirming the availability of the data required to meet the measure reporting requirements, rather than selecting measures that reflect their patient populations and the areas they have prioritized for quality improvement.

CQM Testing and Certification. **The AHA recommends that CMS prioritize increased and more robust testing opportunities to improve the quality of eCQMs.** The Cypress testing tool is available to test EHRs' ability to accurately calculate eCQMs. It uses a standardized set of simplified patient test data to evaluate the EHR performance for eCQM implementation. Testing of eCQM specifications in a complex environment will provide valuable insight on the validity of updated specifications, and insight on whether the specification change is a minor or substantive change. In the absence of robust testing, providers bearing the weight of testing and validation.

Also, the AHA recommends that eCQM certification include conformance to the data submission method required by CMS programs. The QRDA version required for eCQM submission to CMS should be supported by the recertification of EHRs when the version is updated. A distinction between the data format providers are required to submit and the format that certified EHRs are required to support will result in confusion and unnecessary compliance burden for providers.

Thank you again for the opportunity to comment. If you have any questions, please contact me or Diane Jones, senior associate director of policy, at (202) 626-2305 or djones@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development