



CHiME
College of Healthcare
Information Management Executives

June 22, 2020

Administrator Seema Verma
Centers for Medicare and Medicaid Service
500 Security Boulevard
Baltimore, MD 21244

Submitted Virtually Through [Regulations.gov](https://www.regulations.gov)

Dear Administrator Verma:

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') "FY 2021 Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS)," proposed rule published in the *Federal Register* on May 11, 2020.

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 3,200 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 Administration's efforts to continue advancing the requirements outlined in the 21st Century Cures Act (Cures Act) and moving to implement the information blocking provisions contained within the Act. Within the IPPS rule, CMS requests comment on how Medicare can best support areas of overlap with the Cures Act, explicitly recognizing the interoperability and information blocking final rules published by CMS and the Office of the National Coordinator (ONC). The healthcare world looks very different today than when the Cures Act was first signed into law in 2016. The Coronavirus Public Health Emergency (PHE) has also completely changed the way medicine is delivered, and many experts believe this state of new normal could last as long as two years¹. With that in mind, it is crucial for CMS to carefully and thoughtfully examine when the best time is to align requirements contained within the CMS and ONC interoperability and information blocking final rules with future iterations of the IPPS rules. CHIME previously submitted comments² to both agencies' rules and has reviewed the text within the final rules published earlier this year.

Related to this request, CHIME has the following recommendations:

- 1. In the context of fighting the COVID-19 Public Health Emergency, CHIME requests CMS refrain from any in-depth planning or implementation of activities to penalize actors unable to implement lengthy and complicated information blocking and interoperability**

1 https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part1_0.pdf

2 <https://chimecentral.org/wp-content/uploads/2019/06/CHIME-letter-on-IPPS-FY20-FINAL.pdf>

requirements until at least calendar year 2023 or until the public health emergency ends, whichever comes later;

2. **CMS refrain from finalizing any disincentive or penalty requirements until the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and ONC provide additional details on how complaints related to the Cures Act requirements will be investigated and what documentation is required of the actor; and**
3. **CMS ensures whatever requirements to penalize actors for failure to meet the requirements contained within the Cures Act final rules are fair and take into consideration that not all violations of these requirements are malicious in intent and that whatever disincentive activity CMS proposes to engage in is considered proportional relative to a violation of the Cures Act requirements.**

Allowing providers to have enough time to ensure they can implement the information blocking and interoperability requirements is crucial to ensuring the success of the provisions now contained as part of the Promoting Interoperability Program. CHIME's recommendation of waiting until at least plan year 2023 allows for all of the requirements within both of the previously mentioned ONC and CMS final rules to arrive at their compliance dates³. All actors should have enough time to work together within the program to support each other as they work to implement these needed information blocking provisions. The final major compliance deadline within the ONC and CMS rules is May 1, 2022, when provider application programming interface (API) implementation is required, and the definition for electronic health information (EHI) is updated to include all electronic protected health information (ePHI). By waiting until plan year 2023, these requirements have time to be put into place and for each actor to ensure they function to meet the true intent of the requirement. Rushing providers, and other actors, to implement complicated essential requirements only creates an opportunity for work to be incomplete and may not truly solve the information and interoperability problems within the health system.

As part of the alignment activities proposed within the IPPS proposed rule related to the Cures Act, CMS acknowledges it is working to reduce provider burden. Continuing to push forward with these requirements and forcing providers to understand and implement – at times – costly new requirements will only further hinder the health system's ability to respond to the COVID-19 PHE. Provider organizations will not only need to implement new or upgraded systems potentially, but they will also all be required to dedicate critical staff time to fully understanding the information blocking and interoperability requirements, to review their own internal policies, and then rewrite internal requirements to ensure they will not be penalized in a time when they are already at a financial disadvantage.

Provider organizations are going to be coping with the massive loss of internal revenue for years to come as they continue to fight COVID-19. The PHE requires providers to limit the amount of elective procedures and bear the burden of substantial upfront costs needed to implement care delivery models, such as virtual care, without new revenue models in place. With this in mind, requiring providers to now dedicate additional staff to these interoperability and information blocking requirements will put patients and providers at risk as they work to juggle multiple critical tasks at the same time. This is further complicated by the fact many providers needed to layoff key staff in response to the economic impacts of the PHE.

Additional comments related to the promoting interoperability program include:

- **Maintain an electronic health record (EHR) reporting period of a minimum of any continuous 90-day period in CY 2022 for new and returning participants (eligible hospitals and critical access hospitals [CAHs]);**
 - **Comment:** CHIME supports CMS in maintaining the status quo related to the EHR reporting period. It is crucially essential for providers to be able to continue to focus on treating

³ <https://chimecentral.org/wp-content/uploads/2020/04/ONC-CMS-Timelines-Chart.pdf>

COVID-19 patients. Ensuring that the logistics and paperwork required to remain eligible under Promoting Interoperability remain unchanged will play a critical role in allowing that.

- **Maintaining the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional worth five bonus points for CY 2021;**
 - **Comment:** CHIME supports CMS in continuing to allow the PDMP query to remain optional for CY 2021. While fighting the opioid epidemic and ensuring that needed information related to the prescribing of opioids and controlled substances are crucially important, the ability for providers to query PDMPs remains imperfect. Additionally, as providers continue to fight the COVID-19 PHE, they will be limited in their ability to implement new technical requirements that are not related to either public health reporting or disease management. While CHIME would support making this a requirement of providers in the future – perhaps after the Cures Act work is fully implemented – we do not feel that this year is the correct time to make this measure permanent.
- **Increasing the number of quarters of electronic clinical quality measure (eCQM) data reported, from one self-selected quarter of data to four quarters of data, over three years, and to begin public reporting of eCQM data for eligible hospitals and CAHs as early as the fall of 2022 using CY 2021 data.**
 - **Comment:** CHIME asks for CMS to continue to monitor the timing and method for this reporting going forward. While eCQMs are crucial for measuring the quality of care provided within a provider facility, it is important to also recognize the burden placed on physicians by increasing the amount of reporting that is required as part of this program. As part of fighting the COVID-19 PHE, providers already have numerous, timely and costly additional reporting requirements placed on them by the federal government. As the PHE continues for, as previously stated, potentially two years, it is imperative CMS continues monitoring the reporting burden being placed on providers. While under normal operations, an increase in reporting frequency is already a significant additional burden for providers, increasing reporting requirements while also implementing new information blocking and interoperability requirements during a PHE has the potential to push providers down an unsustainable path. If it becomes clear to CMS, through rulemaking public comment processes and from communications from providers and the general public, that increasing the eCQM reporting frequency is burdensome, then we encourage CMS to update this proposal to lengthen the timeline for increasing reporting.

We appreciate the opportunity to comment and welcome the chance to help inform the critical work being done by CMS. We look forward to continuing to be a trusted stakeholder on addressing healthcare as this PHE continues to evolve and as new information blocking and interoperability compliance deadlines continue to pass. Should you have any questions about our letter, please contact Andrew Tomlinson, Director of Federal Affairs, at atomlinson@chimecentral.org.

Sincerely,



Russell P. Branzell, CHCIO, LCHIME
President and CEO CHIME



John Kravitz
Chair, CHIME Board of Trustees
CIO, Geisinger