

National Indian Health Board



Submitted via <http://www.regulations.gov>

February 1, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3323-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare and Medicaid Programs; Certification Frequency and Requirements for the Reporting of Quality Measures, CMS-3323-NC

To Whom It May Concern:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the Centers for Medicare and Medicaid Services [CMS-3323-NC] Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/AN). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

Thank you for the opportunity to respond to the certification frequency and requirements for reporting quality measures. As we have recently commented regarding CMS's proposed rule on stage 3 of the Electronic Health Record (EHR) Incentive Program, NIHB is appreciative and supportive of CMS efforts to streamline reporting requirements and reduce reporting burdens on eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). We are also supportive of measures to ensure that health information technology (IT) products are effectively certified, robustly tested, and include sufficient clinical quality measures (CQMs).

The Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the American Recovery and Reinvestment Act of 2009 ARRA) and Title XIII of Division A of the ARRA) authorizes incentive payments under Medicare and Medicaid for the adoption of and

meaningful use of certified EHR technology (CEHRT) and downward payment adjustments under Medicare for failure to demonstrate meaningful use. In order to qualify for incentive payments or avoid negative payment adjustments, eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) are required to use CEHRT for reporting certain CMS quality reporting programs. CMS quality reporting programs include, but are not limited to the Hospital Inpatient Quality Reporting (IQR) Program, and the Physician Quality Reporting System (PQRS) to report quality data.

The Office of the National Coordinator for Health Information Technology's (ONC's) "2015 Edition Health Information Technology Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications Final Rule" (80 FR 62601). The ONC Health IT Certification Program provides a certification process with specifications for Health IT Module(s) and establishes the standards and implementation criteria that CEHRT needs to include to support the achievement of meaningful use by eligible professionals (EPs), eligible hospitals, and Critical Access Hospitals (CAHs). CEHRT is defined for the Medicare and Medicaid EHR Incentive Programs in 42 C.F.R. § 495.42. The CEHRT definition creates EHR technology prerequisites that must be used by providers to meet the MU objectives or allows providers to qualify for an incentive program by updating, implementing, or upgrading CEHRT.

The NIHB supports the proposal that Electronic Health Records (EHRs) should be certified to more than the minimum number of CQMs as required by the Office of the National Coordinator for Health Information Technology (ONC) 2014 Edition Base EHR definition in 45 C.F.R. § 170.102. Using only the minimum number of CQMs for health IT developers leads to limited CQMs available and potential inability to report CQMs applicable to the patient populations or practices at EPs, eligible hospitals, and critical access hospitals (CAHs). The increased frequency of certification, number of CQMs, and robustness of testing may impose additional burdens on health IT developers, however there would be an increase of effective certification and reporting of CQMs for health care providers. The desired outcome is for EPs, eligible hospitals, and CAHs to have a choice of which CQMs are most applicable to their patient population or scope of practice to report. Flexibility for health IT developers should be a factor to produce CQMs for their targeted consumers.

NIHB advocates for the changes to minimum CQM certification requirements in Policy Option 3. Option 3 will require EP health IT developers to certify health IT products to more than the current minimum number of CQMs required for reporting, but not to all available CQMs. Option A consists of an approach that would set a minimum number of measures, which health IT developers must certify to for the EP settings or eligible hospital/CAH settings that are a greater than the minimum number required for provider reporting. The feasibility is substantial for vendors complying with the requirements of each option in the first year if the vendor can select the measures it will develop. NIHB recommends a minimum number of EP measures to be 15 and eligible hospital measures to be 20. The impact of Option A provides a benefit to both the providers and health IT vendor by meeting the needs of the consumer, while allowing the vendor flexibility to provide a product to meet their targeted consumer population.

NIHB does not recommend Policy Option 1, which requires EP health IT developers to certify Health IT Modules to all CQMs in the EP selection list; and eligible hospital/CAH health IT developers to certify to all CQMs in the selection list for eligible hospitals and CAHs. Option 1 would not be practical because not all measures are applicable to EPs and eligible hospitals in Indian Country. Therefore, the cost of development and maintenance of measures that the EPs and eligible hospitals in Indian Country would be ineffective. Option 1 would lead to an increase in development, testing, and certification time. This option would not be feasible

unless health IT funding is approved for new development requirements because CQMs apply to various applications to calculate measure logic.

NIHB does not support Policy Option 2, which will incrementally increase the number of CQMs required to be certified each year until Health IT Modules are certified for all CQMs available for reporting by EPs, eligible hospitals, and CAHs to meet their CQM reporting requirements. Option 2 provides more time to develop all the measures in which the requirements would become effective beyond the first year. However, CQM measures that do not apply to the provider population would need to be maintained by health IT developers.

Thank you for providing the opportunity to comment on the certification frequency and requirements for the reporting of quality measures under CMS programs. If there are any questions or comments regarding my/our comments, please contact our Director of Federal Relations, Devin Delrow, at ddelrow@nihb.org.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Lester Secretaro', with a long horizontal flourish extending to the right.

Lester Secretaro, Chair
National Indian Health Board

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs