



June 25, 2018

Ms. Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244-1850

[Submitted online at: <https://www.regulations.gov/docket?D=CMS-2018-0046>]

Re: CMS-1694-P – Medicare Programs: 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Ms. Verma:

The undersigned members of the Physician Clinical Registry Coalition (the Coalition) appreciate the opportunity to comment on the proposed rule on changes to the Medicare Hospital Inpatient Prospective Payment System (IPPS) for FY 2019, specifically the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) (the Proposed Rule).¹ The Coalition is a group of medical society-sponsored clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care. We are committed to advocating for policies that encourage and enable the development of clinical data registries and enhance their ability to improve quality of care through the analysis and reporting of clinical outcomes. Most of the members of the Coalition have been approved as qualified clinical data registries (QCDRs) or are working towards achieving QCDR status.

Clinical data registries play an essential role in promoting quality of care. QCDRs and other clinical outcomes data registries provide timely and actionable feedback to providers on their performance, speeding and enhancing quality improvement opportunities. In addition, QCDRs and other clinical outcomes data registries allow for patient-centered, statistically valid and timely inter-practice and national benchmarking and comparisons. The measures developed by

¹ 83 Fed. Reg. 20,164 (May 7, 2018).

QCDRs and other clinical outcomes data registries are meaningful and relevant to participating providers and their patient populations.

The Coalition appreciates CMS's previous efforts to encourage the use of QCDRs for electronically reporting data across quality improvement activities. The Coalition is concerned, however, about CMS's proposal to remove the Public Health and Clinical Data Exchange objective and measures from the Promoting Interoperability Program no later than CY 2022. We strongly urge CMS to retain this objective and these measures as a necessary incentive for hospitals and, perhaps more urgently, EHR vendors, to share data electronically with public health entities and clinical data registries. While many hospitals may continue to share data with clinical data registries even if this objective were removed from the Promoting Interoperability Program, this program provides a necessary incentive for EHR vendors to communicate data seamlessly with registries.

As CMS explained in the Proposed Rule, "the Public Health and Clinical Data Exchange objective supports the ongoing systematic collection, analysis, and interpretation of data that may be used in the prevention and controlling of disease through the estimation of health status and behavior."² We agree with CMS's recognition of the essential role that electronic data reporting to public health entities and clinical data registries plays in improving "the efficiency, timeliness, and effectiveness of public health surveillance," as well as "safer" and "more coordinated care."³ Particularly in light of continued electronic reporting issues, this incentive is necessary to, in CMS's own words, "extend the use of electronic reporting solutions to additional events and care processes, increase timeliness and efficiency of reporting and replace manual data entry." CMS should retain this measure to achieve these important goals, particularly given the lack of evidence that this measure imposes any substantial burden on hospitals. At the very least, it would be premature to remove this measure without evidence of such a burden.

The Coalition also wishes to express its support for comments submitted by the Society of Thoracic Surgeons (STS) regarding how CMS can further facilitate price transparency. We agree with STS that clinical data registries could play an even greater role in price and value transparency if CMS provided QCDRs with the access to Medicare claims data required by Section 105(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10).⁴ The Coalition has raised its concerns about CMS' failure to properly implement Section 105(b) on several occasions, including in our attached August 31, 2016 letter to CMS regarding the Final Qualified Entity Rule and our attached December 19, 2016 comment letter on the final rule on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10) provisions related to MIPS and APMs. We reiterate and incorporate those strong concerns by reference here.

² *Id.* at 20,520.

³ *Id.*

⁴ Section 105(b) explicitly directs CMS to provide QCDRs access to Medicare claims data "for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety." MACRA, Pub. L. No. 114-10, § 105(b)(1)(A), 129 Stat. 136 (2015).

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The Coalition appreciates the opportunity to comment on the Proposed Rule. We urge CMS to adopt the Coalition's suggestions to facilitate and promote the use of QCDRs and other clinical outcomes data registries. The goal is to allow the use of registries to grow and ultimately result in even greater improvements in the quality of patient care. We encourage CMS to adopt policies across the board to further incentivize electronic exchange of data between providers and clinical data registries, in light of the critical role that registries play in improving patient outcomes and quality of care.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Rob Portman at Powers Pyles Sutter & Verville PC (rob.portman@powerslaw.com or 202-872-6756).

Respectfully submitted,

AMERICAN ACADEMY OF OPHTHALMOLOGY
AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
AMERICAN SOCIETY OF PLASTIC SURGEONS
AMERICAN UROLOGICAL ASSOCIATION
SOCIETY OF INTERVENTIONAL RADIOLOGY
SOCIETY OF NEUROINTERVENTIONAL SURGERY
THE SOCIETY OF THORACIC SURGEONS

Additional Sign-On Organizations:

AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION
AMERICAN ACADEMY OF NEUROLOGY
AMERICAN SOCIETY FOR RADIATION ONCOLOGY
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Attachments