June 25, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1688-P
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted electronically at: http://www.regulations.gov

Re: Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information(CMS-1694-P)

Dear Administrator Verma:

On behalf of CHRISTUS Health, we appreciate the opportunity to comment on the Hospital Inpatient Prospective Payment System for Acute Care Hospitals (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Federal Fiscal Year (FY) 2019 Proposed Rule published by the Centers for Medicare and Medicaid Services (CMS) in the May 7, 2018 Federal Register. CHRISTUS Health ("CHRISTUS") is an international, faith-based, not-for-profit health system comprised of nearly 350 services and facilities, including more than 50 hospitals, primarily located in Texas, Louisiana, and New Mexico. We share the Administration's strong commitment to promoting health and wellness solutions that improve the lives of the individuals and communities we serve.

We appreciate the ongoing efforts by CMS to administer and improve the payment systems for acute inpatient hospital services. CHRISTUS offers the following comments on certain aspects of the proposed rule. CHRISTUS appreciates that CMS is working to allow flexibility in the Promoting Interoperability (PI) Program and Hospital Inpatient Quality Reporting (IQR) Program as organizations implement and adapt to new technology. However, we are concerned that the
new proposed scoring method, as well as the measure changes and additions, represent significant change to the PI program that will require review and development time by EHR vendors, as well as testing and implementation by hospitals. Beginning the new program changes in 2019 does not allow the necessary preparation time.

It is the recommendation of CHRISTUS Health that CMS consider the following:

- Allow an additional year of reporting Modified Stage 2 in 2019 as preparations for the scoring and measure changes and additions that are underway;

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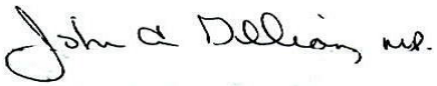
- Reduce the number of points needed to meet program requirements;
- Reduce the burden of the 2015 Edition CEHRT additions to the Common Clinical Data Set;
- Allow continued flexibility in selection of public health reporting options;
- Clarify measure specifications and exclusion allowances; and
- Mandate state Medicaid programs to adopt the PI proposal to support alignment between Medicare and Medicaid requirements.

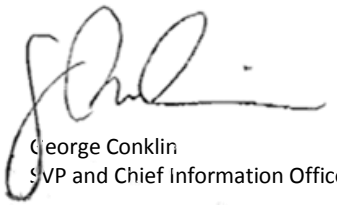
Further comments on specific aspects of the proposed rule are attached.

Thank you for your consideration.

Sincerely,



John Gillean
EVP Chief Clinical Officer



George Conklin
SVP and Chief Information Officer

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Proposal	Comments
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Certification Requirements Beginning in 2019** "Beginning with the EHR reporting period in CY 2019, the 2015 Edition of CEHRT is required pursuant to the definition of CEHRT under § 495.4. We are not proposing to change this policy, and, as discussed below, we continue to believe it is appropriate to require the use of 2015 Edition CEHRT beginning in CY 2019." (p 1333) **Current:** 2015 Edition CEHRT required in 2019. **Proposed:** 2015 Edition CEHRT required in 2019 (No change).	We support the continued requirement of 2015 Edition CEHRT in 2019. However, the extension of the Common Clinical Data Set in 2015 Edition CEHRT (p 1336) requires certain new elements that are challenging to include, such as implantable devices where the FDA Unique Device Identifier and device attributes are not always easily quantified and may be recorded in external systems. We recommend that the 2015 Edition CEHRT requirements be amended to remove this burden. We do not recommend that these amendments require re-certification as we are proposing a reduction rather than the addition of new requirements.
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Proposed Revisions to the EHR Reporting Period in 2019 and 2020** "For the reasons discussed earlier, we are proposing the EHR reporting periods in 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency would be a minimum of any continuous 90-day period within each of the calendar years 2019 and 2020." (p 1340) **Current**: Never finalized. **Proposed:** 90 day reporting periods in both CY 2019 and 2020.	We support the establishment of a minimum of any continuous 90-day period for reporting in both CY 2019 and 2020. This is consistent with previous years' reporting periodsand will provide much needed time to continue implementation of new 2015 Edition CEHRT in 2019 and to develop and adjust to the new proposed measures and scoring methodology.

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Proposal	Comments
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Proposed Measure Removals** "We are proposing to remove six measures. Two of the measures we are proposing to remove – Request/Accept Summary of Care and Clinical Information Reconciliation – would be replaced by the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, which combines the functionalities and goals of the two Stage 3 measures it is replacing. Four of the measures – Patient-Specific Education; Secure Messaging; View, Download or Transmit; and Patient Generated Health Data – would be removed because they have proven burdensome to health care providers in ways that were unintended and detract from health care providers' progress on current program priorities." (p 1366) **Current:** 11 required measures. **Proposed:** Elimination of measures Patient-Specific Education, View, Download, or Transmit, Secure Messaging, and Patient-Generated Health Data.	We support the reduction of measures required by the Promoting Interoperability Program. View, Download and Transmit, Secure Messaging, and Patient Generated Health Data were particularly challenging as they required action on the part of the patient. While clinicians and hospital staff can help encourage patient action to support engagement in their health care, ultimately it is a personal choice by the patient if and how they do so. Additionally, the adoption of these technologies outside of the hospital setting has been slow to take effect given the characteristics of the many rural environments that we serve.
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Proposed Performance-Based Scoring Methodology** "Each measure would be scored based on the eligible hospital or CAH's performance for that measure, except for the Public Health and Clinical Data Exchange objective, which requires a yes/no attestation. Each measure would contribute to the eligible hospital or CAH's total Promoting Interoperability (PI) score. The scores for each of the individual	We support establishing a new performance-based scoring methodology for the Promoting Interoperability program. However, we recommend that an additional year of Modified Stage 2 for 2019 be allowed followed by the implementation of the new scoring methodology in 2020. We also recommend reducing the number of points to avoid a penalty to a threshold of 40, rather than 50. The new scoring, in addition to new and adjusted measures, represents a significant change to the program that will require review and development time by EHR vendors. Newly developed workflows and reports will then need to be tested

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Proposal	Comments
measures would be added together to calculate the total Promoting Interoperability score of up to 100 possible points for each eligible hospital or CAH. A total score of 50 points or more would satisfy the requirement to report on the objectives and measures of meaningful use under § 495.24, which is one of the requirements for an eligible hospital or CAH to be considered a meaningful EHR user under § 495.4 and thus earn an incentive payment and/or avoid a Medicare payment reduction. Eligible hospitals and CAHs scoring below 50 points would not be considered meaningful EHR users." (p 1348-1349) **Current:** Threshold based scoring where all measure thresholds must be achieved. **Proposed:** Weighted scoring to achieve at least 50 of 100 points, all measures must be reported but not achieved at a specific threshold.	and implemented by hospitals. Our ability to measure whether the number of points to avoid a penalty is achievable requires this development and a period of data tracking. With the finalization of this rule not anticipated until the fall of 2018, beginning the new program changes in 2019 does not afford hospitals necessary preparation time.
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Proposed Performance-Based Scoring Methodology** "In the event that the eligible hospital or CAH receives a performance rate or measure score of less than 0.5, as long as the eligible hospital or CAH reported on at least one patient for a given measure, a score of 1 would be awarded for that measure…In order to meet statutory requirements and HHS priorities, the eligible hospital or CAH would need to report on all of the required measures across all objectives in order to earn any score at all. Failure to report any required measure, or reporting a "no" response on a yes/no response measure, unless an exclusion applies would result in a score of zero… We are seeking public comment on the proposed	We request clarification of whether the required reporting on at least one patient for each measure refers to one patient in the denominator or in the numerator. Additionally, we believe that reporting on a smaller subset of measures, namely those that we select to meet the point requirement, would be appropriate and in line with the goal of reduced reporting burden.

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Proposal	Comments
requirement to report on all required measures, or whether reporting on a smaller subset of optional measures would be appropriate." (p 1357-1358)	
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **ePrescribing – Measure Changes and Additions** "In our proposed scoring methodology, the e-Prescribing objective would contain three measures each weighted differently to reflect their potential availability and applicability to the hospital community. In addition to the existing e-Prescribing measure, we are proposing to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement. For more information about these two proposed measures, we refer readers to section VIII.D.6.b. of the preamble of this proposed rule. The e-Prescribing measure would be required for reporting and weighted at 10 points… The Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement measures would be optional for EHR reporting periods in 2019… although eligible hospitals and CAHs may choose to report them and earn up to 5 bonus points for each measure. We are proposing to require these measures beginning with the EHR reporting period in 2020, and we are seeking public comment on this proposal." (p 1350-1351) **Current**: Single ePrescribing measure which allows exclusion of controlled substances from reporting. **Proposed:** Two additional measures for tracking of opioids.	We request clarification on the ePrescribing measure calculation for 2019 and whether or not hospitals can choose to exclude controlled substances. In past years, an exclusion for controlled substances has been allowed in reporting. This is beneficial as the roll out of electronic prescribing of controlled substances (EPCS) requires substantial financial cost as well as technical resource time and physician training. Such an exclusion would provide more time to implement e-prescribing of controlled substances. The newly proposed measures, Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement, as described require the implementation of EPCS and costly integration with the EHR. This adds a significant annual financial burden to the hospital as 3rd party vendors must be engaged to support the integrated query to the PDMP. In addition, the vendors that host the state PDMPs have a pass through charge that is passed along to the hospital. This is again an added financial burden above the per user licensing cost for each physician utilizing EPCS. CHRISTUS currently provides a non-integrated link to the state PDMP websites which provides physicians with easy access to perform a search without added expense to the organization. In addition, the new measures also require workflow additions for clinicians and new report development, all of which require significant review and testing time. We recommend that less integrated options be allowed to achieve compliance with the new measures. We also request clarification on the components of an opioid treatment agreement.

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Proposal	Comments
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **HIE – Measure Changes** "For the Health Information Exchange objective, we are proposing to change the name of the existing Send a Summary of Care measure to Support Electronic Referral Loops by Sending Health Information, and proposing a new measure which combines the functionality of the existing Request/Accept Summary of Care and Clinical Information Reconciliation measures into a new measure, Support Electronic Referral Loops by Receiving and Incorporating Health Information." (p 1352) **Current:** Measures are Send Summary of Care, Request/Accept Summary of Care, Clinical Information Reconciliation. **Proposed:** Send Summary of Care would become Support Electronic Referral Loops by Sending Health Information. Request/Accept Summary of Care and Clinical Information Reconciliation would combine into Support Electronic Referral Loops by Receiving and Incorporating Health Information.	We do not support renaming the Health Information Exchange measures. Send Summary of Care is a short, clear description of what is being done and measured where Support Electronic Referral Loops by Sending Health Information is lengthy and somewhat ambiguous. Further, as this measure has been in place for the past two years, the current naming is well recognized. If information to be exchanged is being expanded from the Summary of Care only, we recommend replacing Summary of Care with Health Information (i.e., Send Health Information). We also do not support the combination of Request/Accept Summary of Care and Clinical Information Reconciliation measures into a new measure with new naming. The separation of these two measures helps us to know which piece of the workflow is not being met and allows the potential for us to meet one of two measures rather than failing a single measure. Additionally, we would appreciate further clarification on how the numerator and denominator would be calculated, as well as the particular circumstances in which an exclusion would be allowed. Clarification is also requested regarding the effort required to identify electronic summary of care records if none are received. HIE is a complex process and while technology may be available, implementation of acceptance and reconciliation into clinical workflow presents a number of challenges.

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Proposal	Comments
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Provide Patients Electronic Access to Their Health Information – Weighted Scoring** "We are proposing to weigh the one measure in the Provider to Patient Exchange objective, Provide Patients Electronic Access to Their Health Information, at 40 points toward the total Promoting Interoperability score in 2019 and 35 points beginning in 2020. We are proposing that this measure would be weighted at 35 points beginning in 2020 to account for the two new opioid measures, which would be worth 5 points each beginning in 2020 as proposed above." (p 1353-1354)	We agree that providing patients' electronic access to their health information is an important service and that it should be highly weighted. We request additional clarification on how this measure would be calculated in relation to Application Program Interface (API). We would also recommend additional explanation on whether API be required to generate a numerator because it is not clear how that be calculated. API is a new technology which would require substantial cost and time for implementation. It is also difficult to adequately test as it requires the development of apps that may not exist.
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Public Health and Clinical Data Exchange – Measure Changes and Weighted Scoring** "The measures under the Public Health and Clinical Data Exchange objective are reported using yes/no responses and thus cannot be scored based on performance. We are proposing that for this objective, the eligible hospital or CAH would be required to meet this objective in order to receive a score and be considered a meaningful user of EHR. We are proposing that the eligible hospital or CAH will be required to report the Syndromic Surveillance Reporting measure and one additional measure of the eligible hospital or CAH's choosing from the following: Immunization Registry Reporting, Electronic Case Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, Electronic Reportable Laboratory Result Reporting. We are proposing an eligible hospital or CAH would receive 10 points for the objective if they attest a "yes"	We agree that reporting public health information is an important function and that this aspect of the Promoting Interoperability Program should be retained and required. We support the reduction of the requirement for 3 points toward public health reporting to 2 to allow additional flexibility in selecting reporting appropriate to our patient population and supportable by our technology and resources. However, we recommend that continued flexibility in the choice of registries be allowed rather than the requirement of syndromic surveillance. For example, extra bonus points could be allotted for optional reporting to more than the required number of registries to incentivize further engagement in this measure. Additionally, we request clarity about whether this measure requires the 2015 CEHRT versions of interfaces, particularly bi-directional immunizations. Many states, including Texas, are not prepared for bi-directional immunizations and lack state health department resources needed to onboard new facilities or upgrade existing interfaces.

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Proposal	Comments
response for both the Syndromic Surveillance Reporting measure and one additional measure of their choosing. If the eligible hospital or CAH fails to report either one of the two measures required for this objective, the eligible hospital or CAH would receive a score of zero for the objective, and a total score of zero for the Promoting Interoperability Program." (p 1354-1355) **Current:** 3 public health reporting points required. No specific registry required. **Proposed:** 2 public health reporting points required. Syndromic surveillance required to be one of the registries.	
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Public Health and Clinical Data Exchange – Removal in CY 2022** "we intend to propose in future rulemaking to remove the Public Health and Clinical Data Exchange objective and measures no later than CY 2022, and are seeking public comment on whether hospitals will continue to share such data with CMS-1694-P 1412 public health entities once the Public Health and Clinical Data Exchange objective and measures are removed, as well as other policy levers outside of the Promoting Interoperability Program that could be adopted for continued reporting to public health and clinical data registries, if necessary." (p 1411-1412)	Public health reporting represents a large effort in implementation and maintenance. Electronic reporting offers certain benefits in reducing manual workflows, such as faxing results, and produces easier analytics. However, these benefits are also offset by new costs in technology and resources. If not required by the Promoting Interoperability Program, our organization would utilize other criteria (regulatory requirements, program certification requirements, or selected performance improvement initiatives, etc.) to determine whether or not to share data with specific public health entities.

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Proposal	Comments
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **Security Risk Analysis – Inclusion and Scoring** "The Stage 3 objective, Protect Patient Health Information, and its associated measure, Security Risk Analysis, would remain part of the program, but would no longer be scored as part of the objectives and measures, and would not contribute to the hospital's total score for the objectives and measures. To earn any score in the Promoting Interoperability Program, we are proposing eligible hospitals and CAHs would have to attest that they completed the actions included in the Security Risk Analysis measure at some point during the calendar year in which the EHR reporting period occurs…We are seeking public comment on whether the Security Risk Analysis measure should remain part of the program as an attestation with no associated score, or whether there should be points associated with this measure." (p 1355-1356) **Current:** Security Risk Analysis required. **Proposed:** Security Risk Analysis required (No change).	We support the continued inclusion of the Security Risk Analysis as part of the Promoting Interoperability Program. Constant assessment and improvement of our systems is necessary to safeguard patient information in a digital world and requirement of this as a measure holds organizations to do so on a yearly basis. We do believe that this measure should be scored to reflect the work performed and ensure that the measure is not forgotten because it is not tied to a point value. As this would be a yes/no attestation similar to Public Health Exchange, we feel that 10 points would be appropriate weighting. We also advise that the Security Risk Analysis measure must remain on everyone's radar given the continuously evolving risk environment.
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **eCQMs – Measure Removal** "To align with the Hospital IQR Program, we are proposing to reduce the number of eCQMs in the Medicare and Medicaid Promoting Interoperability Programs eCQM measure set from which eligible hospitals and CAHs report, by proposing to remove eight eCQMs (from the 16 eCQMs currently in the measure set)	We appreciate the continued alignment of the Promoting Interoperability Program and Hospital IQR Program with relation to eCQM submission and support the removal of the following eCQM options: eAMI-8a, eED-1, eED-3, eEHDI-1a, eHMPC, ePC-01, eSTK-8, and eSTK-10. In some cases, this may mean hospitals with certain patient populations need to take zero denominator exclusions, but on the whole it will encourage better alignment of high priority measures nationally and within our own organization. Better alignment allows for less build, testing, and implementation time. It

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Proposal	Comments
beginning with the reporting period in CY 2020." (p 1424) **Current:** Submission of 4 eCQMs from 16 available options. **Proposed:** Submission of 4 eCQMs from 8 available options.	also allows for more consistent data collection which can be used for future benchmarking and goal thresholds for measures. We recommend that CMS continue to align government quality measures across programs, as well as with outside regulatory bodies such as The Joint Commission. We also recommend that the yearly eCQM specification changes be reduced to every other year. Yearly changes to specifications require that we use significant resources for rebuild and retest which could be used to better purpose analyzing the data and remediating fall out areas in order to provide better quality of care to our patients rather than simply measuring.
[Promoting Interoperability - Meaningful Use (EHR Incentive Program)] **eCQMs – Request for Comment** "We are seeking stakeholder feedback on ways that we could address these and other challenges related to eCQM use. Specifically, we are inviting comment on the following:" (p 1432)	**1. What aspects of the use of eCQMs are most costly to hospitals and health IT vendors?** Our highest cost is the amount of time and resources necessary for selection, build, testing, implementation, validation, submission, and analysis of measures. We manually submit our measures but many organizations have additional financial costs for external vendors to support and submit their data. **2. What program and policy changes, such as improved regulatory alignment, would have the greatest impact on addressing eCQM costs?** Continued improved regulatory alignment greatly reduces eCQM cost. Not changing the measure specifications every year would also greatly reduce time and resource costs. **3. What are the most significant barriers to the availability and use of new eCQMs today?** Barriers include: • What measures CMS accepts as eCQMs. There are only 16 eCQMs available and that is proposed to reduce to 8 which helps alignment but not

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Proposal	Comments
	availability. • The eCQMs the EHR vendor is coding and how long it takes for them to release the reports. • Need for expertise on eCQMs from clinical and technical resources. • Need for new system build and discrete data capture and mapping. • Need for education of staff on new build and why discrete fields are required. Additional documentation time and burden for staff. • Difficult cultural shift from chart abstraction to eCQMs. • Measures not being relevant to our patient population (i.e., some facilities may not have newborns, so therefore cannot report newborn hearing screening measure). **4. What specifically would stakeholders like to see us do to reduce costs and maximize the benefits of eCQMs?** Aligning chart abstracted measure specifications with eCQM specifications and allowing the eCQM to be submitted in place of abstraction would be beneficial and reduce duplication of work. As noted above, we recommend not changing the specifications each year, and would supportcontining one quarter per year reporting. **5. How could we encourage hospitals and health IT vendors to engage in improvements to existing eCQMs?** Allow a gap year between submissions and/or specification changes to be used for measure analysis and improvement. Provide incentive for improvement or meeting a threshold goal (i.e., program bonus points or financial incentive dollars). **6. How could we encourage hospitals and health IT vendors to engage in testing new eCQMs?** See question 5 response. **7. Would EHs and HIT vendors be willing to**

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Proposal	Comments
	participate in pilots of alternative approaches to quality measurement that would explore less burdensome ways of measuring quality, such as sharing data with third parties that use machine learning and natural language processing to classify quality of care? Yes. We are very interested in making the measures less burdensome. NLP in place of discrete fields has great potential. However, participation in pilots would require resources and we would recommend some type of incentive to offset this cost to organizations. **8. What ways could we incentivize or reward innovative uses of health IT that could reduce costs for hospitals?** Incentives could include: • Funding for resources and technology necessary for these special projects • Program bonus points • Public recognition of innovative work **9. What additional resources or tools would hospitals and health IT vendors like to have publicly available to support testing, implementation, and reporting of eCQMs?** We appreciate the eCQI Resource Center and outreach webinars provided by CMS and would like to see these continue. We would also like a venue through which to share best practices and lessons learned with other organizations as well as any national recommendations. For example, case studies, FAQs, and expert resources we could query would be useful. We would like QNet to open earlier in the year for testing. We also would like a web-based submission option like The Joint Commission has in place of the Pre-Submission Validation Application (PSVA) tool which must be downloaded and updated and has

Comment [1]: Spell out?

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Proposal	Comments
	Java requirements that many computers do not easily support. Additionally, we would like easy organizational level administration and submission for organizations with multiple facilities.

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