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August 8, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5059-P
P.O. Box 8012
Baltimore, MD 21244-1850

Dear Dr. Berwick,

The American Health Information Management Association (AHIMA) would like to submit to you comments and recommendations in response to the notice of proposed rulemaking published in the *Federal Register* Wednesday, June 8, 2011 to implement new statutory requirements regarding the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers [76FR33566].

AHIMA is a not-for-profit professional association representing more than 61,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most. We respectfully submit our comments as our members are and will continue to be active participants in the implementation, maintenance, and compliance of this program.

If AHIMA can provide further information or if there are any questions regarding our recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or Dan Rode, vice president, policy and government relations, at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations
Crystal Kallem, RHIA, CPHQ, Director, Practice Leadership

General

The proposed regulation does not provide a description regarding the manner in which the performance measurement information will be published. AHIMA encourages CMS to provide some detail on the manner in which this information will be published.

§401.703 Eligibility criteria for qualified entities

A listing of tasks is presented on page 76FR33567 in order for potential qualified entities to perform. Regarding the task of successfully combining claims data from different payers to calculate performance reports, AHIMA recommends this claims data be representative consistently across healthcare setting to ensure the database represents information that is comparable.

Regarding the consideration by CMS on limiting the number of qualified entities [76FR33580], AHIMA suggests taking a phased approach or a slow approach on the number of qualified entities that are approved for this program. We believe it would be prudent to allow for the healthcare industry some time to filter information that is being publicly reported in light of all the other quality reporting programs that are currently in existence today.

§401.704 Operating and governance requirements for qualified entities

The proposed rule states CMS does not have the statutory authority to require qualified entities [76FR33578] “*to share not only Medicare data but also their claims data from other sources with providers of services and suppliers, if they ask to correct an error or appeal their results on specific measures.*” AHIMA appreciates CMS’ encouragement of qualified entities to share claims data from provider sources other than Medicare in order to correct an error or conduct an appeal. We believe this approach provides a consistent and fair methodology for both sets of data and will also ensure the opportunity for comparability among the Medicare and non-Medicare data sources.

We believe the proposed process stated above is in direct conflict with the statement made within the background section of the proposed rule whereby it states [76FR33566] “*Congress also required that qualified entities combine claims data from sources other than Medicare with the Medicare data when evaluating the performance of providers of services and suppliers.*” This demonstrates CMS’ ability to access and combine non-Medicare data but later in the proposed rule the qualified entities’ have the ability to not allow providers the ability to correct or appeal the data that is published. AHIMA strongly encourages CMS to revisit this section of the proposed rule and consider ways in which both sets of data will be provided for correction or appeal. We suggest allowing providers of non-Medicare data the opportunity to correct and appeal be added to the list of requirements in order to ensure there is equal opportunity.

§401.705 The application process and requirements

Regarding CMS’ proposal to encourage the development of a voluntary knowledge sharing mechanism for qualified entities to communicate with each other, AHIMA believes this would

be a challenge to succeed without stronger language or incentive for these entities to share information about best practices. We encourage CMS to evaluate the model that has been created by the Office of the National Coordinator Health Information Technology Research Center (HITRC) program that was established under the electronic health record incentive regulation. According to the HITECH Act, the HITRC is to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize health information technology. We understand that this regulation does not address the adoption and implementation of HIT, however there may be opportunities to leverage knowledge from the existing program.

AHIMA believes the best technical support that CMS can provide in the development and implementation of the Medicare data for performance measurement program is ensure there is a good understanding of the measure specifications. We encourage CMS to require the qualified entities have an experienced coder or someone that has a background in coding in support of the measures reporting.

AHIMA strongly encourages CMS to ensure this program accommodates the transition to ICD-10-CM/PCS.

§401.707 Ensuring the privacy and security of data

The proposed regulation outlines a list of actions that CMS may take if a qualified entity does not observe. After reviewing the preliminary list, AHIMA strongly encourages CMS to treat qualified entities on par with covered entities under the HIPAA regulations. It is stated earlier in the regulation [7FR33575], *“While qualified entities would not legally be a contractor of CMS and therefore would not be subject to these laws and policies, we believe that these protections should not cease merely because CMS is making these data available to another entity for other purposes that are perceived to have a public benefit.”*

We agree that the qualified entities are not considered a legal contractor and would not be subject to the laws and policies outlined in HIPAA, we do strongly believe that CMS should make every effort to ensure the use of data is treated in the same manner and that penalties align with those outlined in the HIPAA statute. AHIMA believes the penalties outlined in the regulation are not sufficient enough to foster beneficiary trust and support of this program.

On page [76FR33579], the proposed regulation outlines a list of information requirements necessary for the application process. AHIMA encourages the regulation to update #6 *“Documentation of its proposed data privacy and security policies and enforcement mechanisms.”* We recommend the regulation reflect the need to provide a copy of the qualified entities’ proposed data privacy and security policies and enforcement mechanisms to successfully complete the application process.

§401.708 Selection and use of performance measures

AHIMA is pleased to see that CMS is supporting the development of new measures within the healthcare industry. If CMS accepts a customized measure specification, we strongly encourage CMS verifies these measures go through a rigorous vetting process. We believe the entity seeking an alternative/customized measure should be required to request the Secretary's consideration of a candidate measure. Once an alternative measure has been approved by the Secretary, the alternative measure would be available for use by all.

In the proposed rule CMS states [76FR33570] "*We recognize that some measure specifications may require additional customization to implement in specific contexts, but such customization should not change the defined numerator, denominator, and exclusion criteria for the measure.*" AHIMA believes this is in direct conflict with using standard measures that have been through a rigorous vetting process such as the National Quality Forum's (NQF) consensus endorsement process. By modifying the measure specifications, it may alter the intent or the value of the measure itself.

AHIMA understands the HITECH Act EHR provisions are subject to separate rulemaking activities from the provisions outlined in the VBP rule. We also appreciate CMS' acknowledgement of there being important areas of overlap and synergy with the EHR incentive program and other HHS quality measurement programs. We believe maintaining a level of awareness will help to reduce duplication of programs and foster alignment among the quality measurement programs to improve patient care. However, we strongly encourage CMS to leverage the EHR incentive program as a focal point or source of insight when developing future quality initiatives. The adoption of EHRs and health information exchange will continue to increase and these systems will serve as a valuable source of data for quality measurement initiatives. We also encourage CMS to align planning efforts with the integration of ICD-10-CM/PCS as well.

AHIMA supports CMS' proposed validation process for the Value Based Purchasing (VBP) program as it will reflect the same process established for the Hospital IQR program. We agree this approach will prevent additional burden for hospitals. To further reduce burden we continue to encourage CMS to leverage the electronic health record as a source for quality measurement data.