The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the Healthcare Information and Management Systems Society (HIMSS), we are pleased to provide written comments to the Notice of Proposed Rule Making (NPRM) regarding Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Disclosures of Ownership Comment Solicitation (CMS-1785-P.) HIMSS appreciates the opportunity to leverage our members' expertise to share feedback on the adoption of digital quality measures and changes to the Inpatient Quality Reporting Program (IQR) and we look forward to continued dialogue with the Centers of Medicare & Medicaid Services (CMS) on these topics.

HIMSS is a global advisor and thought leader and member-based society committed to reforming the global health ecosystem through the power of information and technology. As a mission-driven non-profit, HIMSS offers a unique depth and breadth of expertise in health innovation, public policy, workforce development, research, and analytics to advise global leaders, stakeholders, and influencers on best practices in health information and technology driven by health equity. Through our innovation engine, HIMSS delivers key insights, education and engaging events to healthcare providers, governments, and market suppliers, ensuring they have the right information at the point of decision. HIMSS serves the global health information and technology communities with focused operations across North America, Europe, the United Kingdom, the Middle East, and Asia Pacific. Our members include more than 120,000 individuals, 480 provider organizations, 470 non-profit partners, and 650 health services organizations. Our global headquarters are in Rotterdam, Netherlands, and Americas headquarters are in Chicago, Illinois.

For our public comment, HIMSS offers the following thoughts and recommendations on this NPRM:

**The addition of new eCQMs to the Inpatient Quality Reporting Program**

Core to the HIMSS mission is promoting the use of health information and technology to improve the quality of healthcare delivery through effective performance measurement and decision support. HIMSS believes that the use of digital health information can be utilized to identify gaps in care, optimize clinical care delivery, and improve patient outcomes.

Historically, HIMSS has not offered recommendations on the clinical appropriateness of clinical quality measures proposed for inclusion in CMS programs. Instead, HIMSS cross references proposed measures against a series of criteria to ensure those measures are accurate, meaningful to improving clinical care and patient outcomes, not overly burdensome to collect and report, and are actionable to improve clinical care. At a high level, the framework calls for new measures to be:

A. **Meaningful measure of care quality:** Any new quality measure should utilize data to present a meaningful and actionable assessment of patient care. Emphasis should be placed on the development of measures which are clinician-driven to support care delivery meeting the standard of care, not meeting the data collection needs of payers only.
B. **Accurate measure of care quality:** Any new quality measure should be lab/simulation tested, field tested, and validated to produce comparable and consistent results against the measure's intent.
C. **Actionable measure of care quality:** Whenever possible, clinical quality measure data should be available in as close to real time as possible to drive needed changes in workflow to eliminate gaps in care. The latency of data for clinical quality measures should be driven by measure type. Performance data should be interoperable with data visualization tools that can easily identify gaps in care at the patient level.
D. **Not overly burdensome to collect and report:** Any new quality measure and associated policies should reduce the implementation and data collection burden on health systems, providers, and health information technology developers by using data already collected for care and without introduction of new inefficient workflows. We must ensure that data facilitates effective process change without overwhelming clinicians and resources.

Accuracy against the measure's intent and burden are often associated with rushed implementation deadlines. The healthcare industry can not initiate the implementation of new measures until the measure's full set of specifications and code sets are finalized and available to the public. In previous public comments in response to IPPS proposed rules, HIMSS indicated that, on average, the industry needs 18 months from the moment that a new measure's specifications and code sets are available to implement the measure within the workflow of a healthcare organization in a manner where the data can be collected to produce comparable and consistent results with the measure's intent. In this proposed rule, CMS established a 2025 reporting year/2027 payment determination date for including the three new proposed measures in the Inpatient Quality Reporting (IQR) Program measure set, aligning with HIMSS recommended glidepath for implementation. HIMSS commends CMS for listening to the industry's recommendations and strongly recommend that CMS continue to use the 18-month implementation timeline for future eCQMs.

**New IQR Measures as a Microcosm for Testing and Measure Alignment Challenges**

HIMSS also would like to thank CMS for publishing the number of test sites and the testing data for each proposed new eCQM. However, this testing information highlights

a larger challenge, the lack of enough participation in testing to ensure eCQMs will generate comparable and consistent results once implemented nationwide. Each proposed measure was testing using two electronic health records at most, at less than 25 hospitals. While there are only a handful of electronic health record market suppliers dominate the market in the acute care ecosystem, hospitals and health systems often have unique configurations despite using the same electronic health record. As result, there is significant variation in clinical documentation workflows from one EHR to another and from one healthcare organization to another. Field testing a more diverse and larger cohort of hospitals is critical to ensure accurate and valid data collection when the measure is implemented nation-wide.

This presents a challenge. End to end testing of eCQM measure specifications is a multifaceted process requiring significant resources with complementary skill sets including CQL, data and terminology standards, Clinical/EHR workflows, data capture, mapping to local codes and data quality. Participation in testing by health systems is costly, labor intensive, and have very little return on investment for the participating health system outside of an early opportunity to implement the measure. Particularly for safety-net, rural, and critical access hospitals, there isn't a clear business case to offset the use of resources and costs associated with participating in testing. As result, most hospital participation in the testing program comes from large, well-resourced organizations that may not reflect the configurations and support capabilities for a large portion of the healthcare ecosystem.

As CMS works towards transitioning from eCQMs to digital quality measures (dQMs), addressing the need for more robust and diverse testing will be critical to successful adoption. In order to facilitate increased participation, HIMSS strongly recommend CMS consider two potential approaches:

1) Ensure that the testing cohort for new and/or substantively updated eCQMs and dQMs include a significant sample size, including large and small hospitals across a wide geographic and patient demographic spectrum.
2) Provide a significant scoring bonus for hospitals participating in testing in the Inpatient Quality Reporting program and other value-based care models. This heightens critical access, rural, and community hospitals opportunities to receive incentive program dollars.
3) A requirement for CMS-funded measure development and testing contracts to allocate sufficient funding to facilitate testing, mapping, and implementation work for field testing at testing sites.

In addition, HIMSS members cited concerns regarding the inclusion of the pressure injury eCQM and the Acute Kidney Injury (AKI) eCQMs to the IQR measure set. HIMSS members who represent organizations that participated in the testing process for the measure indicated varying interpretations of labs and other clinical data created problems having consistent documentation for both measures, negatively impacting the accuracy and actionability of the measure. Both measures proved to be challenging to capture data. HIMSS recommends CMS consult with testing partners, hospitalists, and nephrology subject matter experts regarding these challenges, and consider delaying the implementation of the AKI and pressure injury measures until these challenges can be resolved. HIMSS would be happy to facilitate conversations with our members to discuss these challenges in more detail.

**New IQR Measures and the Opportunity to improve Quality Measure Alignment**

The proposed Pressure Injury eCQM also provides a microcosm of a larger issue challenging HIMSS members; the burden of reporting similar quality measures with different combinations of numerators, denominators, and specifications to meet reporting requirements for disparate programs. Pressure injury quality measures are already captured through claims data populating Patient Safety Indicator 03 (PSI 03) for the Hospital Acquired Conditions program. In addition, hospitals must capture pressure injury quality performance for the National Database for Nursing Quality Indicators (NDNQI) operated by Press Gainey. NDNQI is critical for hospitals looking to retain magnet status. Quality teams at hospitals will be forced to capture the same ultimate outcome through three different measures and methods. Capturing data requires data segmentation, creating an incredible amount of avoidable burden for health systems and their hospital IT and quality teams. If the intent is to retire the PSI 03 measure when the eCQM is added to the IQR measure set, that intent is not clear in the rulemaking.

Similar comments were made about the Acute Kidney Injury measure. The AKI measure would need to be captured for CMS reporting compliance; however, the measure is captured in different ways to meet state and private payer requirements. For example, Texas hospitals must capture acute kidney injuries for the 3M Potentially Preventable Complications (PPC) program. When configuring the clinical workflow for patients at risk for an AKI, hospitals are forced to choose between building clinical guidelines based on one of the two versions of the measure, while still capturing the data required to meet compliance requirements for the other.

Data segmentation, meaning different data mapping requirements and measure specifications for different payers and accreditation bodies, are often cited by our stakeholders as burdensome without significant benefit in clinical quality improvement. Administrative burden reduction for provider and health systems through alignment of various quality reporting programs has been a long-standing objective that does not appear to have made significant progress. HIMSS is eager to engage in this effort and like to understand how we may be able to contribute to this effort going forward.

In addition to reconsidering the inclusion of the Pressure Injury eCQM, HIMSS recommends CMS reinvigorate efforts to improve the alignment of quality measures across payers, accreditation bodies, and the federal government. HIMSS strongly encourages CMS to expand this effort to include private payers and accreditation bodies, similar to the Core Quality Measure Collaborative (CQMC) effort, which concluded in March 2023 without gaining significant traction with industry partners. HIMSS would support a similar initiative to improve measure alignment as digital quality measures (dQMs) are introduced in the coming years.

HIMSS would be happy to facilitate discussions between CMS staff, HIMSS Quality Task Force members, HIMSS Davies Awards recipients and HIMSS Analytics Maturity Model Stage 7 validated healthcare organizations from around the country, and HIMSS members with unique subject matter expertise who have experience participating in measure development programs and quality measure implementation.

We look forward to the opportunity to discuss these issues in more depth. Please feel free to contact Jonathan French, Senior Director of Informatics, or David Gray, Director of Government Relations, with questions or for more information.

Thank you for your consideration.

Sincerely,

Thomas M. Leary, MA, CAE, FHIMSS
Senior Vice President, Government Relations
HIMSS