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The Honorable Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Baltimore, MD 21244

Dear Administrator Verma:

On behalf of the Healthcare Information and Management System Society (HIMSS), we are pleased to provide written comments to the Notice of Proposed Rule Making (NPRM) regarding Medicare Program; 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 (CMS-1694-P). HIMSS appreciates the opportunity to leverage our members' expertise in offering feedback on the Promoting Interoperability Programs, as well as Inpatient Prospective Payment System (IPPS) quality measurement initiatives, and we look forward to continued dialogue with CMS on these topics.

HIMSS is a global voice, advisor, and thought leader of health transformation through health information and technology with a unique breadth and depth of expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare, and care outcomes. HIMSS designs and leverages key data assets, predictive models and tools to advise global leaders, stakeholders, and influencers of best practices in health information and technology, so they have the right information at the point of decision.

HIMSS drives innovative, forward thinking around best uses of information and technology in support of better connected care, improved population health, and low cost of care. HIMSS is a not-for-profit, headquartered in Chicago, Illinois, with additional offices in North America, Europe, United Kingdom, and Asia.

We are committed to assisting CMS in supporting the shift to value-based care delivery and facilitating greater data exchange across the healthcare community through the Promoting Interoperability Programs. In addition, HIMSS wants to continue to help CMS leverage information and technology to support the demonstration of innovative care delivery models for

coordinating smarter, safer, and more efficient high-quality care, while ensuring that individuals remain at the center of all our efforts.

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

- **Support for the New Focus and Scoring Methodology of the Promoting Interoperability Programs as well as the Accompanying Reduction in Burden**

HIMSS supports the new Programs' proposed scoring and measurement policies to move beyond the three stages of meaningful use to a new phase of electronic health record (EHR) measurement with an increased focus on interoperability and improving patient access to health information. The new performance-based scoring methodology would contribute to a more flexible, less burdensome structure, allowing eligible hospitals (EHs) and critical access hospitals (CAHs) to keep their focus back on patients. For example, HIMSS appreciates the decrease in the total number of required measures from 16 to six, which provides a greater degree of flexibility not provided under the existing Meaningful Use Stage 3 scoring methodology.

In addition, the Health Information Exchange and Provider to Patient Exchange Objectives proposed for 2019, and the points assigned to each measure within those objectives, are in line with our expectations given the focus of the Programs on exchanging data. HIMSS also endorses a 90-day reporting period in 2019 and 2020 for new and returning Program participants as a solid glide path for providers to become accustomed to as well as meet the new Promoting Interoperability Programs objectives and measures.

- **Endorsement of Use of 2015 Edition Certified EHR Technology (CEHRT) in 2019**

HIMSS would like to reinforce the importance of adopting the 2015 Edition criteria as a significant part of our commitment supporting healthcare transformation beginning January 1, 2019. The benefits of requiring the use of the 2015 Edition cannot be overstated, with its focus on greater interoperability for clinical health purposes—opening up the certification program to other types of health information and technology, addressing health disparities, and including a new streamlined approach to privacy and security.

Use of 2015 Edition CEHRT in 2019 should apply to EH and CAH reporting under the Promoting Interoperability Programs as well as to capture electronic clinical quality measures (eCQMs).

In addition, the 2015 Edition Final Rule facilitates the accessibility and exchange of data by including enhanced data export, transitions of care, and application programming interface (API) capabilities. Overall, the 2015 Edition helps propel forward reforms to our healthcare delivery system and strengthen the ability of providers to share and exchange health information. The API component of the 2015 Edition is of particular importance as the healthcare market continues to evolve. The 2015 Edition API functionality requirements focus on several areas, including allowing third parties easy access to individual data requests as well as requests for larger data sets. In addition, health IT developers will be required to make the full documentation of their API information as well as their syntax and programming information publicly available. Requiring greater use of APIs and increasing their interaction with EHRs will increase engagement

possibilities, improve user experience, and provide innumerable benefits to all healthcare stakeholders.

In an April 2017 letter to HHS, HIMSS recommended an extension around the requirements for the use of the 2015 Edition. However, the Office of the National Coordinator for Health IT (ONC) and market suppliers now have all the pieces in place for full implementation of the 2015 Edition to commence in 2019. HIMSS applauds CMS' proposal to align the Promoting Interoperability Programs with the Hospital Inpatient Quality Reporting (IQR) Program, and the requirement that hospitals use only 2015 Edition CEHRT beginning with the calendar year 2019 reporting period/fiscal year 2021 payment determination.

- **Opioid-Related Measures Should be More Outcomes-Focused**

HIMSS is very supportive of the inclusion of opioid-related measures in the e-Prescribing Objective of the Promoting Interoperability Programs. CMS' proposed approach signals the importance of leveraging Medicare and Medicaid payment policy to address our nation's opioid crisis. In addition, we appreciate the intent of the proposals for *Query of Prescription Drug Monitoring Program (PDMP)* and *Verify Opioid Treatment Agreement* measures that would be optional in 2019 and required in 2020.

More broadly, HIMSS recommends CMS consider utilizing opioid measures that have a stronger focus on outcomes. The query of a PDMP would measure how often an EH or CAH queries a PDMP before prescribing a Schedule II opioid. While this may be beneficial for identifying patients who could be at risk for opioid misuse, outcomes-based measures would help drive treatment decisions and improve patient safety. For example, HIMSS members have discussed the increasing evidence that correlates inpatient administration of opiates with subsequent dependence and overdose. Structuring a measure where the denominator is the total number of hospital encounters during a reporting period and the numerator is total Morphine Equivalent Doses (MEQ) prescribed would be much closer to an outcomes-based measure.

HIMSS suggests that the measures that CMS proposes for 2019 remain in place as optional bonus points to ensure EHs and CAHs contribute to addressing the opioid crisis. Ultimately, we want to support efforts to have PDMP information fully integrated or embedded in EHRs to allow for optimal provider workflows and reduced clinician burden. Over the long term, HIMSS pledges to work with CMS and other stakeholder organizations to find the appropriate clinically-focused outcomes measures for use as soon as possible beyond 2019.

For example, several organizations have already developed National Quality Forum (NQF)-endorsed measures that would be good candidates for inclusion in an opioid measure group. HIMSS wants to help the agency determine appropriate outcomes-focused opioid measures and an achievable implementation and reporting timetable.

- **Place Greater Emphasis on Public Health Measures in the Promoting Interoperability Programs**

HIMSS remains supportive of the Public Health and Clinical Data Exchange Objective of the Promoting Interoperability Programs, and its inclusion of public health measures. The current

proposal from CMS requires reporting on two measures under this objective, with *Syndromic Surveillance Reporting* a required measure, and several options available for EHs and CAHs to choose an additional measure.

HIMSS recommends that CMS require the reporting of two measures under this objective, but not mandate *Syndromic Surveillance Reporting*. EHs and CAHs should be free to choose any two measures from the menu of options, including syndromic surveillance. Given the importance of public health and the critical contribution that it makes to care delivery, HIMSS suggests that CMS require reporting on two measures under this objective in 2019, even if a provider meets the exclusion criteria for one: an EH or a CAH needs to choose two measures where it can actually report data.

Moreover, HIMSS supports requirements around the continued reporting to public health and clinical data registries in 2022 and beyond, either through the Promoting Interoperability Programs or other appropriate venues where reporting is possible. Public health and registry reporting is critical to the functioning of the entire health system and must continue until a suitable alternative can be found or another policy lever is available. We are cognizant of the associated burden issues, but HIMSS commits to working with CMS and other stakeholders to identify the balance between burden on EHs and CAHs, while ensuring relevant information flows to public health and clinical data registries.

- **Use the Trusted Exchange Framework and Common Agreement and Other Policy Activities to Minimize/Replace Reporting Requirements in the Promoting Interoperability Programs**

CMS is exploring the creation of a set of priority health IT activities that would serve as alternatives to the traditional EHR Incentive Program measures. Given the interconnected nature of and overlap between many federal initiatives that focus on health system-wide goals such as facilitating value-based care delivery and greater data exchange, HIMSS supports CMS action in this area. In addition, exploring these alternatives is in alignment with the spirit of minimizing burden across the community.

For example, HIMSS supports the concept of using participation in a modified version of the Trusted Exchange Framework and Common Agreement (TEFCA) as a health IT activity that could count for credit within the Health Information Exchange Objective in the Promoting Interoperability Programs.

Moreover, CMS could seek further alignment between a modified TEFCA and the *Support Electronic Referral Loops by Receiving and Incorporating Health Information* measure. Right now, this measure focuses on electronic summary of care records received as well as clinical information reconciliation completed using CEHRT. CMS could align this measure with TEFCA and incentivize query-based exchange as the Promoting Interoperability Programs evolve. This focus on query-based exchange could help replace programmatic reporting requirements as well as allow clinicians to receive the clinical data that they can use, fits into their workflow, and improves patient outcomes.

HIMSS recommended significant changes to the TEFCA proposed guidance in a February 2018 letter to ONC. Even so, we supported the underlying concept behind TEFCA. We believe there is applicability for using participation in a modified version of TEFCA in lieu of additional health IT reporting requirements. We also encourage the Department to explore utilizing the NPRM being developed by ONC and other Department of Health and Human Services (HHS) agencies focused on implementing 21st Century Cures Act (Public Law 114 -255) provisions on conditions and maintenance of certification requirements for health information technology developers and reasonable and necessary activities that do not constitute information blocking.

Going forward, HIMSS would like to work with CMS and other stakeholders to find other areas where a health IT activity could minimize/replace additional reporting to CMS.

- **Explore Using Medicare and Medicaid Conditions of Participation, Conditions for Coverage, and Other Requirements for Participation to Facilitate Greater Data Exchange**

As a cause-based organization, HIMSS is focused on using health information and technology to transform healthcare. Facilitating greater data exchange is a key component of efforts to transform care; HIMSS supports further exploration of all available policy levers to promote interoperability, including the Medicare and Medicaid Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and other participation requirements.

Our HIMSS Call to Action: Achieve Nationwide, Ubiquitous, Secure Electronic Exchange of Health Information reinforces our thought leadership on and commitment to these topics. HIMSS and our valued collaborators have worked relentlessly for many years to ensure individuals and organizations routinely use secure, trust-worthy, interoperable technologies and work flows to promote wellness, as well as protect and improve the health status of patients and populations. While we've made progress, and significant building blocks are in place, our work is not complete. Our work to achieve secure, appropriate, and ubiquitous data access and electronic exchange of health information continues and should include examining CoPs and CfCs as a potential policy lever.

CMS included this Request for Information in several other 2019 payment policy NPRMs and HIMSS supports looking at Medicare and Medicaid CoPs and CfCs across the care continuum and all care settings. If changes in this area are structured appropriately, they would likely contribute to reducing information blocking and decreasing the burden on patients to access their information.

Overall, CMS should carefully consider this issue and ensure that any CoPs and CfCs changes under consideration moves forward in alignment and coordination with other public policy initiatives focused on facilitating greater data exchange. As previously discussed, TEFCA is voluntary guidance currently under development, and HHS is working to propose further requirements around conditions and maintenance of certification requirements for health information technology developers as well as reasonable and necessary activities that do not constitute information blocking. HIMSS is not supportive of duplicative or onerous regulation on providers, and believes that any CoPs and CfCs on facilitating data exchange must work in combination with these other oversight mechanisms.

For example, a modified TEFCA could serve as a means to share information across the community and allow participation in that framework to contribute to meeting any CoPs or CFCs requirements. Before any changes to Medicare or Medicaid CoPs and CfCs are considered, we encourage CMS to conduct further outreach to ensure that hospitals and other health system partners would have a means or the availability of appropriate infrastructure to comply with new conditions or requirements.

HIMSS will work with CMS to examine these issues and help to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and ancillary providers as well as care delivery across the entire community. Moreover, when discussing facilitating greater data exchange, CMS should prioritize the importance of patient data matching and call on HIMSS as a thought leader in this area. We have been focused on developing a nationwide patient data matching strategy and worked very closely with partners across the healthcare community to understand the barriers to the accurate, efficient matching of patients to their health information and how critical it is to broader interoperability initiatives.

- **Quality Reporting Policies Should Support the Shift to Value-Based Care Delivery**

As CMS continues to evolve quality reporting programs, HIMSS supports a shift that enhances the value proposition of participating providers and ensures that eCQMs are feasible, actionable, and meaningful for all eligible providers, including EHs and CAHs, to drive improvement in care outcomes.

CMS must continue to phase out claims-only outcomes reporting. Measurement should focus on the appropriateness and quality of care of the organization being measured. Quality reporting can also contribute to reducing the implementation and data collection burden on EHs and CAHs by using data already collected as a part of normal care delivery without the introduction of new inefficient workflows.

CMS should incentivize, perhaps through scoring bonuses, EH and CAH participation in the development and testing of new eCQMs. In addition, the agency should also consider scoring bonuses that focus on the utilization of technology which visualizes real-time performance on eCQMs. Overall, as HIMSS has emphasized in previous public comment letters, timelines following substantive changes to eCQMs should allow appropriate time (a minimum of 18 months between publication of the measure and inclusion in the measure set) for implementation and testing of measures by end users before being made mandatory for reporting.

- **Support for Reporting of Four eCQMs in 2019**

HIMSS supports CMS moving the quality reporting program forward in the least burdensome manner possible, while maintaining a parsimonious set of the most meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients. As de-novo eCQMs meeting the Meaningful Measures Initiative criteria are not currently in place to increase the size of the eCQM measure set in 2019, HIMSS supports EHs and CAHs submitting one, self-selected calendar quarter of data on four self-selected eCQMs. If they do not, they would face a negative Inpatient Quality Reporting (IQR) payment adjustment. In addition, HIMSS supports reporting eCQMs to QualityNet using QRDA-I by February 28, 2020.

Moreover, HIMSS endorses the idea of EHs and CAHs that can't report electronically be allowed to attest to all 16 eCQMs for the full year to the Promoting Interoperability Programs. HIMSS asks CMS to consider aligning the hardship exception requirements for eCQM reporting between the Promoting Interoperability Programs and IQR as the programs evolve. If a hospital meets a hardship exception, it should cover both programs so that they do not avoid a negative payment adjustment for eCQM reporting under one program but receive an adjustment under the other program.

As new eCQMs that meet the Meaningful Measures Initiative criteria become available, we strongly encourage CMS to expand the measure set to target gaps in care and advance meaningful opportunities to improve care quality outcomes.

- **Removal of Seven eCQMs from the Menu Set**

In the NPRM, CMS proposes the removal of seven of the 15 eCQMs currently available in the CMS eCQM menu set. CMS indicated that the seven eCQMs proposed for removal had either been "topped out" or had been reported so infrequently that CMS believes they are overly burdensome for EHs and CAHs to collect and report.

HIMSS concurs with the CMS assessment that the seven eCQMs targeted for removal do not effectively meet with Meaningful Measures Initiative criteria for retention. However, HIMSS is concerned that, with only eight available eCQMs for the IQR program in CY2020, some EHs will not have enough patients to meet the denominator for four of those eight remaining eCQMs. HIMSS recommends that CMS provide EHs who potentially can't report four eCQMs in 2020 with additional guidance on how to avoid a negative payment adjustment.

HIMSS also expresses concern that the benefits associated with removing these eCQMs and other quality measures from CMS measure sets were determined entirely by the cost and times savings associated with reduced administrative burden on hospitals. In order to promote improved quality of care, HIMSS strongly encourages CMS to publish annual assessments of how quality measures have impacted patient care and clinical outcomes.

HIMSS members are also concerned with the lack of discussion in NPRM for how CMS determined the cost savings and return on investment associated with the removal of measures from CMS quality reporting programs. HIMSS strongly encourages CMS to publish an explanation of their Meaningful Measures assessment methodology as part of the Final Rule.

- **Pull Back from Claims-Based Measurement of Patient Outcomes**

HIMSS recommends moving away from claims-based measurement for CMS programs assessing patient outcomes. Using the Meaningful Measures Initiative criteria, HIMSS has the following observations regarding the proposed Hospital-Wide Mortality (HWM) and Hybrid Hospital-Wide Mortality (HWR) with EHR data quality measures.

From the HIMSS perspective, the claims-based HWM measure does not meet two Meaningful Measures criteria. First, claims measures do not contain the data to determine if the standard of

care was appropriately met for the patient. This limits the potential for the claims-based measure to drive clinical improvement activities. To conduct a root cause analysis on performance, manual abstraction would be required. This increases provider and administrative burden, failing a second Meaningful Measure Initiative criteria.

Because the Hybrid Hospital Quality Reporting (HQR) System uses clinical data elements, the Hybrid HQR is more conducive to quick and detailed root-cause analysis, and therefore is a more meaningful driver of care improvement. It also negates the need for burdensome manual chart abstraction and review. However, data collection for hybrid measures also continues to be burdensome for EHs and CAHs as well. HIMSS members also acknowledged concern that using a voluntary approach for reporting the Hybrid HWR will not generate the capture and reporting of the measure in enough volume to identify solutions to challenges with data capture.

Based on the feedback of HIMSS membership, HIMSS does not endorse adding the HWR to the IQR program at this time. HIMSS' perspective is that the Hybrid HWR more appropriately meets Meaningful Measure Initiative criteria and HIMSS standards for meaningful measurement of care. HIMSS recommends that CMS include the Hybrid HWR in the 2019 IQR measure set even though it is burdensome to collect the clinical data elements necessary to populate the measure. As a result, CMS should not include the results of the Hybrid HWR in any public reporting or payment programs until the data has been tested for validity and reliability.

- **Utilize eCQMs for the Hospital-Acquired Condition Reduction Program**

HIMSS encourages CMS to utilize eCQMs for the Hospital-Acquired Condition Reduction Program (HACRP) once de-novo eCQMs have been developed which meet the following criteria:

- Thoroughly tested for validity, reliability, and feasibility and determined to produce comparable and consistent results;
- Required data elements for selected HACRP eCQMs must be accurately and efficiently gathered in the healthcare provider workflow, using data elements already collected as part of the care process and stored in EHRs or other interoperable clinical and financial technology; and,
- An accurate reflection of care delivered, and be actionable to drive meaningful improvements in care delivery.

HIMSS supports the idea that the accuracy and the ability to report measures across the nation are better supported by capturing the actual clinical data elements that demonstrate a quality measure was met. While HIMSS understands the appeal of using different types of coding schemes and repurposing them as proxy measurements of quality, we are not convinced they truly capture the quality of care provided to patient populations.

When utilizing the Meaningful Measures Initiative criteria, claims-based measurement does not meet several of the qualifications. The specifications and rules regarding how a coding professional determines what to associate to a specific patient encounter are completely removed from how a quality measure abstractor determines the status of a measure. Some HIMSS members report that their quality measure abstractors interact frequently with their coding department personnel to request coding corrections that support a certain quality measure specification—only to be informed that the coding, submitted for reimbursement, does not support the quality

abstractor's finding. More often, provider resources are used to make documentation improvements rather than clinical care improvements to support claims-based quality reporting and, in some cases, providers are driven to forgo higher levels of reimbursement to meet the quality measure.

In essence, the majority of decisions regarding these types of codes are driven towards optimizing the provider's reimbursement and Diagnosis-Related Grouping (DRG), not to support measuring the quality of care provided. In addition, claims-based codes do not incorporate nor support robust risk-adjustment models that would make comparability of providers' performance across the nation more accurate and reflective of their patient population. While HIMSS supports the inclusion of these claims code systems in quality measurement, we believe they should be used to strengthen the validity of eCQMs and not as a stand-alone quality measure.

Because of these challenges, HIMSS feels that claims-based measurement for HACRP fails to meet the following Meaningful Measures Initiative criteria for retention as these measures are not patient-centered and meaningful to patients. Moreover, claims-based HACRP measures do not reflect a significant opportunity for improvement, as claims data does not demonstrate if the standard of care was met, plus are not actionable enough to drive activities that improve care delivery and outcomes.

Organizations involved with the feasibility testing of de-novo eCQMs designed to extract data from an EHR-enabled clinical workflow have indicated that significant progress is being made to extract meaningful clinical data from EHR while minimally affecting current workflow. eCQMs are much more meaningful measures of care than claims data. And, they can be much easier to risk adjust to account for socioeconomic status and health history for appropriate national comparisons of care.

However, eCQM alternatives to claims-based reporting of measures for sepsis, catheter-associated urinary tract infection, central line-associated bloodstream infection, pressure ulcers, pulmonary embolisms, and other hospital-acquired conditions do not exist. At the present time, HIMSS does not support the removal of these patient safety measures from the IQR measure set, nor the Hospital Compare public reporting website. Through the HIMSS Davies Award Program and the HIMSS Value Suite collection, we have observed how CMS public reporting and reimbursement based on HACRP scores has driven efforts to improve clinical documentation and reduce hospital-acquired conditions and infections. The Centers for Disease Control and Prevention also reports significant outcome improvements correlating to the HACRP program, including:

- 17 percent decrease in surgical site infections (SSI) related to the 10 select procedures tracked in previous reports.
- 17 percent decrease in abdominal hysterectomy SSI between 2008 and 2014.
- 2 percent decrease in colon surgery SSI between 2008 and 2014.
- 8 percent decrease in hospital-onset Clostridium difficile (C. difficile) infections between 2011 and 2014.
- 13 percent decrease in hospital-onset methicillin-resistant Staphylococcus aureus (MRSA) bacteremia (bloodstream infections) between 2011 and 2014.

While claims-based reporting is far from a perfect assessment of care quality, elimination of these measures represents a significant risk to patient safety. HIMSS recommends the retention of PSI90

and other patient safety measures for the HACRP program, as well as public reporting of PSI90 measures on Hospital Compare until feasible eCQMs are available which accurately reflect if the standard of care has been met, without being overly burdensome to hospitals to collect.

Overall, HIMSS supports a transition to more eCQMs that coincides with decreasing the utilization of claims codes for quality measure reporting. While there is a decrease in the burden of reporting with claims coded for quality and outcomes, we believe the inherent incongruities between claims codes and the quality of care provided to the patient are much greater when using eCQMs instead of claims quality measurement.

- **Toward Improving the Future State of eCQM Reporting**

In the proposed rule, CMS asks a series of questions focused on reducing the burden and enhancing the value of eCQM reporting for hospitals. HIMSS offers that CMS quality reporting policies should strive to enhance the value proposition of participating in quality reporting programs and ensure that eCQMs are actionable for hospitals, providers, and patients to drive improvement in care outcomes.

HIMSS believes that CQMs must be meaningful; defined as actionable to drive improved care provided by eligible hospitals and professionals. The measures should be actionable for providers to leverage to improve clinical outcomes.

We agree with the recent shift by CMS to more outcomes measures. We encourage CMS to work to support the development of outcomes-driven clinical quality measures that can be extracted from electronic clinical data.

HIMSS recommends reliable and robust risk adjustment of all outcomes measures. We are encouraged by the recent development of risk adjustment models using EHR data elements and the inclusion of sociodemographic adjustment in the Hybrid Readmission measures. Measures should clearly support improving the patient experience of care (including quality, outcomes, and satisfaction); improving the health of populations; and, reducing the per capita cost of health care.

CMS can provide a business and clinical case demonstrating that the eCQM presents a value proposition for providers, including a cost to implement/collect versus benefit analysis of each measure. HIMSS defines value through its HIMSS STEPS™ value optimization framework. The STEPS™ framework provides an easily understood vocabulary for stakeholders to take advantage of when formulating their value strategies. The STEPS™ model is built around five categories: Satisfaction; Treatment/Clinical; Electronic Secure Data; Patient Engagement & Population Management; and, Savings as well as case studies demonstrating examples of how technology has been leveraged to produce value in each category.

HIMSS recommends that CMS develop a robust de-novo menu measure set of eCQMs for use by providers and hospitals that are designed specifically to capture eCQM data as part of an EHR-enabled clinical workflow. Selected CQMs should present a clear pathway to value and fit into an analytics capability for use by health care professionals and hospitals as a meaningful scorecard on performance. While HIMSS is not calling on HHS to require that CEHRT include a real-time performance dashboard, such functionality would be very valuable for providers. HIMSS

recommends CMS engage with developers, in a voluntary and collaborative manner, on identifying and implementing the most promising ways to present quality results for action.

In addition, eCQMs selected for HHS programs should be actionable, meaning that reported clinical quality measure data can be utilized to identify gaps in care, conduct workflow analysis and root cause analysis for performance outcomes, and trigger change management to adjust workflows and best practice guidance that will drive improved outcomes. Access to accurate, clinically relevant, and as close to real-time trended data as possible is critical to ensure that quality measurement reporting is not just "reporting for compliance."

Moreover, HIMSS encourages CMS to collaborate with accreditation organizations (e.g., the Joint Commission), private payers, and state governments to develop consensus, supporting a core measure set that closely aligns to the CMS eCQM menu set.

Finally, CMS measures should promote accurate provider attribution for quality measures to ensure equitable value-based payments and public reporting. Accurate provider attribution to quality measure results in all settings of care (including inpatient facilities) are crucial for equitable value-based payments and public reporting. One of the most important goals in CQMs is for providers to be able to measure and evaluate their own quality improvement without being overly burdensome to collect and report data.

Inpatient and outpatient organizations face very different challenges on attribution. On the inpatient side, there are often admitting providers, residents, mid-levels, attending providers, different specialists, multiple hospitalists providing care and therefore, judging where the responsibilities for certain elements of care or documentation lies is very important and difficult to pin down. This would likely require some empiricism and algorithmic approach based on providers who provide "most" care.

HIMSS volunteers represent a wide variety of care settings and have had diverse experiences with the challenges of patient attribution. HIMSS would be happy to convene our volunteers with CMS policymakers to share specific experiences and recommendations for each care setting.

We look forward to the opportunity to further discuss these issues in more depth. Please feel free to contact Jeff Coughlin, Senior Director of Federal & State Affairs, at 703.562.8824, or Eli Fleet, Director of Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,

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