



July 10, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Dear Administrator Verma:

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; 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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals](#) (CMS-1735-P). HIMSS appreciates the opportunity to leverage our members' expertise in offering feedback on the Promoting Interoperability Programs, as well as Inpatient Quality Reporting (IQR) Program quality measurement initiatives, 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 supporting the transformation of the health ecosystem through 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. 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. Headquartered in Chicago, Illinois, 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 80,000 individuals, 480 provider organizations, 470 non-profit partners, and 650 health services organizations.

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

Electronic Clinical Quality Measure (eCQM) Reporting for the IQR 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 risk-adjusted decision support. These actions drive improved adherence by clinicians to recognized standards of care. All quality measurement and reporting programs launched by government as well as private payers should reinforce the utilization of clinical interventions, which have the most significant impact on improving patient outcomes. The information collected through these programs must

be utilized by the healthcare industry to identify gaps in care and opportunities to improve care outcomes.

As of calendar year (CY) 2021, the CMS IQR Program; Hospital Acquired Conditions (HAC) and Infections (HAI) Program; Hospital Readmissions Reduction Program (HRAP); and, the Promoting Interoperability Programs (along with its predecessor, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs) have together completed a full decade of quality data collection. During that time, CMS has collected a significant amount of process improvement measurement and outcome measurement data on healthcare delivery in the United States. Unfortunately, HIMSS notes that despite the adoption of the Meaningful Measures Initiative criteria in 2017, the quality measurement programs discussed in the IPPS NPRM have seemingly stalled.

In this rulemaking, CMS proposes that eligible hospitals (EHs) will be responsible for reporting three measures from the CMS eCQM measure set to avoid a negative payment adjustment as part of the IQR Program and the Promoting Interoperability Program. The measure set will remain stable through reporting period 2024, except for a proposed mandate for reporting the Safe Use Opioids measure starting in reporting period 2022. Meanwhile, new challenges like COVID-19 present opportunities to leverage new quality measures to address emerging clinical challenges as we enter a new paradigm of care delivery.

Through the massive amount of data on clinical quality collected by CMS since 2011, CMS has an opportunity to frame the most impactful opportunities for health systems to improve care quality outcomes by sharing data demonstrating the care delivery practices that drive improved outcomes. The data demonstrating which processes correlate to improved outcomes also should drive CMS's development of priority measures for inclusion in future iterations of the CMS eCQM measure set. CMS should take steps to grow the eCQM measure set in relation to known evidence of best practices for delivering care during a pandemic, virtual care, subsequent disparities in care delivery, and other emerging opportunities.

In past iterations of the IPPS rulemaking process, HIMSS offered the following additional overarching recommendations for the development of quality reporting policies for the IQR Program. We continue to reinforce these recommendations while encouraging CMS to promote the creation of new eCQMs to measure quality as healthcare transforms:

- Any new eCQMs which CMS considers adding to the current EH eCQM measure set should be feasible, actionable in as close to real-time as possible, accurately reflect the quality of care delivered, and be designed to capture data as part of a normal care delivery workflow.
- CMS quality reporting policies should strive to enhance the value proposition of participating in quality reporting programs and ensure that eCQMs are actionable and meaningful for EHs as well as patients to drive improvement in care outcomes. As previously discussed, highlighting which measures directly correlate to the most significant improvement in outcomes will be an important demonstration of the value proposition for delivering quality care.
- While CMS policies should reduce the implementation and data collection burden on EHs and health information technology developers by using data

already collected for care and without introduction of new inefficient workflows, the removal of a measure from the CMS measure set should not only characterize where a gap in care can be prevented, but the remaining measures should continue to fully represent the high impact areas of the care domain.

- When considering removing measures from the CMS measure set, CMS policies should balance reducing burden on providers and developers by using data already collected for care and without introduction of new inefficient workflows.
- Instructions accompanying the removal of a measure from the CMS measure set should characterize where a gap in care can be prevented, and clarify how the remaining measures will continue to fully represent the high impact areas of the care domain.
- CMS should incentivize, perhaps through scoring bonuses, EH participation in the development and testing of new eQMs.
- CMS should incentivize, perhaps through scoring bonuses, utilization of technology that visualizes real-time performance on eQMs.
- HIMSS encouraged CMS to continue collaborating 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 eQM menu set.

Increasing the Quarterly Reporting of Quality Data

HIMSS supports the CMS proposal to progressively increase the numbers of quarters of eQM data reported, from one self-selected quarter of data to four quarters of data over a 3-year period. One self-selected quarter of data does not advance the value proposition of collecting data for actionable intelligence about care delivery. The utility of reporting a quarter of data for driving resilient care redesign to improve quality is minimal.

HIMSS members previously requested clarification if this goal aligns with the planned transition from Quality Data Model (QDM) common data layout (CDL) based specifications for eQMs to QI Core FHIR clinical quality language (CQL) based specifications for eQMs.

A finalized timeline for the transition to QI Core FHIR CQL was not published as part of this rulemaking, however, our members assume that the “ramp up” proposal to increase the data reporting period is intended to facilitate the transition to QI Core FHIR CQL specifications in 2022-2024. The underlying standards changing for certified EHR technology and the potential impact on workflows would require a slower transition. HIMSS asks that CMS clarify the timeline for the transition to QI Core FHIR CQL in the final rulemaking.

HIMSS members noted that, if the transition to QI Core FHIR CQL will take place after CY2024, HIMSS recommends that CMS transition to four quarters of reporting in CY2021. All nine of the eQMs currently available for reporting have been established as part of the measure set for nearly a decade. EHs should have workflows in place to capture data related to the nine measures with little additional burden. Overall, full year data collection is more meaningful to capture trends and eliminates the impact of seasonal bias on quality performance.

Proposed Mandatory Reporting of the Hybrid Hospital-Wide Mortality (HWR) Measure Starting in 2024

As we have stated in [past IPPS Public Comment responses](#), HIMSS strongly encourages moving away from claims-based measurement for CMS programs measuring patient outcomes. HIMSS supports the Reporting Hybrid Hospital-Wide Readmission (HWR) with EHR Data quality measure as part of the IQR Program.

Since the Hybrid HWR uses clinical data elements, it 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, reporting data through Quality Reporting Document Architecture (QRDA) I for hybrid measures continues to be burdensome for EHRs.

In addition, HIMSS continues to support a mandate approach for reporting the Hybrid HWR starting in CY2021, not CY2024 as proposed in the NPRM. Voluntary reporting will not generate the capture and reporting of the measure in enough volume to identify solutions to challenges with data capture for the Hybrid HWR measure before it becomes mandatory. Past quality reporting initiatives conducted on a voluntary basis (for example, voluntary electronic reporting of quality measures in Stage 2 of the Meaningful Use program), failed to generate enough voluntary submissions to identify potential problems with electronic data submissions once it became a requirement.

Through mandating reporting on the Hybrid HWR measure, CMS will have an opportunity to identify potential barriers and challenges with data capture and reporting of the measure. During this validation period, CMS should not include the results in any public reporting or use this measure as a factor in payment adjustments. Once CMS confirms that the data generated by Hybrid HWR measure submissions is a feasible, properly risk adjusted, and accurate reflection of the care delivered in cases of mortality (hopefully by CY2024), the Hybrid HWR should be factored in for determining payment adjustments.

Mandatory Reporting of the Safe Use Opioid Measure

HIMSS supports the inclusion and mandatory reporting of the Safe Use of Opioids— Concurrent Prescribing eCQM in the IQR eCQM measure set. The measure aligns with model clinical practices currently being employed at [HIMSS Davies Award of Excellence](#) recognized hospitals like [Ochsner Health](#).

HIMSS notes that the Safe Use of Opioids measure has not received endorsement by the National Quality Forum. Several providers in our community commented that initial iterations of the measure included triggers that could penalize EHRs without reflecting the care they delivered. For example, patients who were already on a pain regimen which featured an opioid or benzodiazepine, that were admitted to a hospital where the attributed clinician determined that it was best to keep the patient on the regimen, would be penalized by CMS. It is our understanding that CMS is partnering with EHRs to correct these issues. HIMSS supports efforts by CMS to ensure the Safe Use measure is an accurate reflection of care delivery.

Like the Hybrid HWR measure, HIMSS recommends that CMS require the mandatory reporting of the Safe Use of Opioids measure in CY2021. HIMSS has observed that voluntary reporting for CMS measures does not historically generate the capture and reporting of the measure in enough volume to identify solutions to challenges with data mapping and capture.

By mandating reporting of the Safe Use of Opioids measure, CMS will capture the volume of data required to identify challenges with mapping and reporting. CMS can then provide feedback to the measure steward (Mathematica) to refine the measure. As recommended with the Hybrid HWR measure, HIMSS strongly recommends that CMS not include the data collected for the Safe Use of Opioids measure in public reporting or factor these results into payment adjustments until the data has been tested and affirmed for validity and reliability.

We look forward to the opportunity to discuss these issues in more depth. Please feel free to contact [Jonathan French](#), Senior Director of Thought Advisory, or [Jeff Coughlin](#), Senior Director of Government Relations, with questions or for more information.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Harold F. Wolf III". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Harold F. Wolf III, FHIMSS
President & CEO