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June 24, 2019

Seema Verma  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Verma,

On behalf of the more than 30 member companies of the Electronic Health Record (EHR) Association, we are pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System (IPPS). We appreciate this opportunity to provide input on CMS' efforts to facilitate interoperability and to reduce clinician burden by focusing on high-value reporting measures.

EHR Association members serve the vast majority of hospitals and ambulatory care organizations that use electronic health records (EHRs) and other health information and technology (IT) to deliver high quality, efficient care to their patients. The Association, established in 2004, operates on the premise that the rapid, widespread adoption of health IT has and will continue to help improve the quality of patient care as well as the productivity and sustainability of the healthcare system. Our core objectives focus on collaborative efforts to accelerate health IT adoption, enhance usability of EHRs, advance interoperability, and improve healthcare outcomes through the use of these important technologies.

The EHR Association supports introduction of new measures, particularly in high priority clinical areas such as opioid use disorder. New measures provide flexibility to providers and improve clinical process and outcomes, provided that measures are technically feasible and are introduced within attainable timeframes. Pushing poorly specified measures into the Promoting Interoperability (PI) program leads to wasted time and effort on the part of providers, healthcare organizations, developers, and regulators.

Regarding timeframes, we appreciate CMS' willingness to provide EHR developers sufficient time to implement new opioid-related electronic clinical quality measures (eCQMs), until CY 2021. We continue to encourage reasonable timeframes that do not have to be re-evaluated or pushed to a later date.

We are supportive of the 2021 EHR Reporting Period proposal and appreciate the consistency of continuing to allow a 90-day reporting period. We encourage CMS to allow this 90-day reporting period permanently, so that hospitals and developers can appropriately plan in advance, instead of waiting for annual rulemakings. Also, CMS' efforts at consistency across programs is welcome.

We note that, historically, PI measures have not measured primarily clinical items, which are based on narrative specifications that health IT developers must interpret and translate into software code that is implemented in their individual systems. When Promoting Interoperability measures move toward measuring clinical concepts, but do not provide the detailed specifications and value sets that are necessary for electronically implementing measures that are evaluating clinical concepts, they are not successful.

Our detailed comments follow. We appreciate this opportunity to provide CMS with our input and look forward to continued collaboration toward improved patient care. For future updates, we invite CMS to work with developers to identify appropriate and technically feasible activities in order to avoid additional burden on providers and developers.

Sincerely,



Cherie Holmes-Henry  
Chair, EHR Association  
NextGen Healthcare



Sasha TerMaat  
Vice Chair, EHR Association  
Epic

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**About the EHR Association**

Established in 2004, the Electronic Health Record (EHR) Association is comprised of more than 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit [www.ehra.org](http://www.ehra.org).

## **Electronic Health Record Association Detailed Comments on 2020 IPPS Proposed Rule**

### **Proposed New Measures for the Hospital IQR Program Measure Set**

The EHR Association supports introducing new measures, particularly in high priority clinical areas such as opioid use disorder. Also, we appreciate that CMS has allowed EHR developers until CY 2021 to implement these new measures.

### **Proposed Adoption of Two Opioid-Related eQMs**

The EHR Association supports introducing new measures, particularly in high priority clinical areas such as opioid use disorder. Also, we appreciate that CMS has allowed EHR developers until CY 2021 to implement these new measures.

### **Proposed Adoption of Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data**

The EHR Association appreciates CMS' willingness to provide sufficient time to implement new measures. We encourage CMS to set reasonable timeframes that do not have to be re-evaluated or pushed to a later date.

### **Confidential Feedback Reports**

The EHR Association appreciates CMS' acknowledgement and response to previous feedback and are supportive of this proposal.

### **Proposed Removal of Claims-Based Hospital-Wide All-Cause Unplanned Readmission Measure**

*Proposing to remove the Claims-Based Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789) in conjunction with our proposal to replace the measure by making the Hybrid HWR measure mandatory beginning with the reporting period which runs from July 1, 2023 through June 30, 2024, impacting the FY 2026 payment determination.*

The EHR Association supports this proposal.

*Proposing to remove the HWR claims-only measure and replace it with the Hybrid HWR measure.*

The EHR Association supports this proposal.

## **Possible future inclusion of three measures in the Hospital IQR Program and Promoting Interoperability Program**

The EHR Association supports introducing new measures, to provide flexibility to providers and improve clinical process and outcomes, provided that measures are technically feasible and are introduced with attainable development and implementation timeframes.

### **Form, Manner, and Timing of Quality Data Submission**

*Proposing to extend the current eCQM reporting and submission requirements, such that hospitals would be required to report one, self-selected calendar quarter of data for four self-selected eCQMs.*

The EHR Association supports this proposal and appreciate the consistency of continuing to allow a 90-day reporting period. We encourage CMS to allow this 90-day reporting period permanently, so that hospitals and developers can appropriately plan in advance, instead of waiting for annual rulemakings.

*For the CY 2021 reporting period/FY 2023 payment determination, we are proposing to extend the same eCQM reporting and submission requirements, such that hospitals would continue to be required to report one, self-selected calendar quarter of data for four self-selected eCQMs*

The EHR Association supports this proposal and appreciate the consistency of continuing to allow a 90-day reporting period. We encourage CMS to allow this 90-day reporting period permanently, so that hospitals and developers can appropriately plan in advance, instead of waiting for annual rulemakings.

*For the CY 2022 reporting period/FY 2024 payment determination, we are proposing to modify the eCQM reporting and submission requirements, such that hospitals would be required to report one, self-selected calendar quarter of data for: (a) three self-selected eCQMs, and (b) the proposed Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e), for a total of four eCQMs*

The EHR Association supports introducing new clinical quality measures measures, particularly in high priority clinical areas such as opioid use disorder, although we would encourage CMS to allow sufficient time for implementation by healthcare organizations. For example, we appreciate that CMS has allowed EHR developers until CY 2021 to implement the Safe Use of Opioids--Concurrent Prescribing, however, we hesitate to support the proposal to require all participating hospitals to report on the Safe Use of Opioids--Concurrent Prescribing CQM in CY 2022. Instead, we suggest delaying this requirement until CY 2023 to allow more time for appropriate development and testing of the new measure. Allowing more time for development and perhaps even a beta testing period for this measure would improve adoption and reduce clinician burden for new workflow for this important measure.

*Proposals regarding the Hybrid HWR measure.*

The EHR Association supports the proposal that hospitals use EHR technology certified to the 2015 Edition to submit data on the Hybrid HWR measure, as this aligns with CMS's goals to transition hospitals from 2014 Edition to 2015 Edition EHR technology. We appreciate the proposed alignment with current reporting standards and timelines.

### **EHR Reporting Period**

The EHR Association supports the change to yes/no for the Query PDMP measure, as well as the proposal to eliminate the October 1 deadline.

### **EHR Reporting Period 2021**

The EHR Association supports this proposal and appreciates the consistency of continuing to allow a 90-day reporting period. We encourage CMS to allow this 90-day reporting period permanently, so that hospitals and developers can appropriately plan in advance, instead of waiting for annual rulemakings.

### **PI Measures: Actions Must Occur within the EHR Reporting Period**

The EHR Association is concerned that CMS repeatedly changes the expectation for measurement of actions happening outside the reporting period with regulatory guidance and FAQs. Changes of this type generate waste for EHR developers and providers to implement trivial measure updates. We strongly urge CMS to clearly specify their measures, ensure the specifications are aligned across programs (MIPS, Medicare PI, Medicaid PI, etc.), and keep the specifications consistent to avoid this waste.

### **Query of PDMP**

*Proposing to make the Query of PDMP measure optional in CY 2020 and eligible for 5 bonus points.*

The EHR Association supports this proposal because, as we stated in comments submitted in response to the PY 2019 IPPS NPRM, we feel there is a wide range of implementations across the country related to integration with PDMPs, and we do not believe that all hospitals are in a position to report this measure.

*Proposing that, in the event we finalize the proposed changes to the Query of PDMP measure, the e- Prescribing measure would be worth up to 10 points in CY 2020 and subsequent years.*

The EHR Association supports this proposal.

*Beginning with the EHR reporting period in CY 2019, we are proposing to remove the numerator and denominator that we established for the Query of PDMP measure in the FY 2019 IPPS/LTCH PPS Final rule and instead require a "yes/no" response.*

The EHR Association supports this measure being modified to a yes/no. We encourage CMS to consider the approach of allowing providers to report new measures as yes/no from the onset, to avoid unnecessary development work when measures are not fully vetted.

Concerns regarding the ability to capture data and calculate this measure were expressed by the EHR Association and others during the comment period for the 2019 IPPS NPRM. While EHR Association members fully recognize and support efforts to combat the opioid crisis, pushing poorly specified measures into the PI program leads to wasted time and effort on the part of providers, healthcare organizations, developers, and regulators.

*Proposing to remove the exclusions associated with the Query of PDMP measure beginning in CY 2020*

The EHR Association supports this proposal if the Query of PDMP measure is finalized as optional for CY 2020.

### **Verify Opioid Treatment Agreement Measure**

The EHR Association supports this proposal to remove the Verify Opioid Treatment Agreement (OTA) measure from the PI program, beginning with the EHR reporting period in CY 2020. However, we strongly recommend that CMS consider one of the following two modifications to what was originally proposed:

1. Remove the Verify OTA measure completely for PY 2019, or
2. Make the Verify OTA measure a yes/no measure for PY 2019. This would potentially reduce reporting burden on hospitals choosing to report on this measure in 2019 for the 5 bonus points. Unfortunately, the late timing of this change would mean that EHR developers have already had to invest in a measure which is quickly going to be retired.

The treatment agreement does serve a purpose when providing care to patients. We believe the concept is important; but the current measure is not valuable. We would be interested in working with CMS to vet a measure that would be more relevant.

*Proposing to adopt two opioid clinical quality measures beginning with the reporting period in CY 2021 in lieu of this measure.*

The EHR Association supports introducing new measures, particularly in high priority clinical areas such as opioid use disorder, and we appreciate that CMS has allowed EHR developers until CY 2021 to implement the Safe Use of Opioids - Concurrent Prescribing.

*Proposing that the CY 2022 CQM reporting period and criteria under the Medicare Promoting Interoperability program for eligible hospitals and CAHs reporting CQMs electronically would be as*

*follows-- report one, self-selected calendar quarter of data for: (a) three self selected CQMs from the set of available CQMs; and (b) the proposed Safe Use of Opioids- Concurrent Prescribing CQM, for a total of four CQMs.*

The EHR Association supports the introduction of additional measures; however, we hesitate to support the proposal to require all participating hospitals to report on the Safe Use of Opioids - Concurrent Prescribing CQM in CY 2022. Participating hospitals should continue to have the flexibility to select measures that are most appropriate to their care setting and patient population.

*Proposing to revise to better reflect our intended policy that the Verify Opioid Treatment Agreement is worth a full 5 bonus points (not up to 5 bonus points) in CY 2019, and in the event we do not finalize our proposal to remove the measure beginning with CY 2020, in CY 2020 as well.*

As stated above, EHR Association members support the proposal to remove the Verify Opioid Treatment Agreement measure from the PI program, beginning with the EHR reporting period in CY 2020. The treatment agreement does serve a purpose when providing care to patients. We believe the concept is important, but under the current measure it is not valuable. We welcome the opportunity to work with CMS to develop a measure that makes sense.

#### **Medicare HIE Objective: Support Electronic Referral Loops by Receiving and Incorporating Health Information**

The EHR Association supports this proposal. However, we would appreciate clarification from CMS that this proposal--that clinical information reconciliation must be conducted using CEHRT--is applicable only to the HIE objective within the Medicare Promoting Interoperability program.

#### **Proposed Changes to the Scoring Methodology for Eligible Hospitals and CAHs Attesting to CMS Under the Medicare Promoting Interoperability Program for an EHR Reporting Period in CY 2020**

The EHR Association supports this proposal, as stated above.

#### **Proposed CQM Reporting Periods and Criteria in CY 2020 and 2021**

*Proposing that the CQM reporting period and criteria under the Medicare and Medicaid Promoting Interoperability Programs for eligible hospitals and CAHs participating only in the Promoting Interoperability Program, or participating in the both Promoting Interoperability Program and the Hospital IQR program, report one, self-selected calendar quarter of data for four selected CQMs from the set of available CQMs.*

The EHR Association supports this proposal, and we appreciate CMS' consistency across these programs.

*Proposing the following reporting criteria for eligible hospitals and CAHs that report CQMs by attestation under the Medicare Promoting Interoperability Program as a result of electronic reporting not being feasible - report on all CQMs from the set of available CQMs. For eligible hospitals and CAHs that report CQMs by attestation, we previously established a CQM reporting period of the full CY.*

The EHR Association supports this proposal. We appreciate CMS' consistency regarding reporting requirements, as long as attestation is an option to participating hospitals and CAHs.

*Proposing a submission period for the Medicare Promoting Interoperability Program that would be the 2 months following the close of the calendar year, ending February 28, 2021 and February 28, 2022 (for the CQM reporting period in CY 2021).*

The EHR Association supports this proposal.

### **Proposed CQM Reporting Periods and Criteria in CY 2022**

*Proposing that the CQM reporting period and criteria under the Medicare Promoting Interoperability program for eligible hospitals and CAHs reporting CQMs electronically would be as follows-- for eligible hospitals and CAHs participating only in the Promoting Interoperability program or participating in both the Promoting Interoperability program and in the Hospital IQR program, report one, self-selected calendar quarter of data for: (a) three self selected CQMs from the set of available CQMs; and (b) the proposed Safe Use of Opioids- Concurrent Prescribing CQM, for a total of four CQMs.*

The EHR Association supports the introduction of new measures, particularly in high priority clinical areas such as opioid use disorder. While we appreciate that CMS has allowed EHR developers until CY 2021 to implement the Safe Use of Opioids--Concurrent Prescribing, we hesitate to support the proposal to require all participating hospitals to report on the Safe Use of Opioids--Concurrent Prescribing CQM in CY 2022. As an alternative to requiring all EH/CAHs to report these newer eCQMs in CY 2022, we suggest that CMS consider incentivizing organizations to report these measures by offering bonus points.

*Proposing that the submission period for the Medicare Promoting Interoperability Program would be the 2 months following the close of the calendar year 2022, ending February 28, 2023.*

The EHR Association supports this proposal.

### **CQM Reporting Form and Method Requirements for the Medicare Promoting Interoperability Program in CY 2020**

*Proposing to continue requiring that EHRs be certified to all available CQMs adopted for the Medicare Promoting Interoperability Program for CY 2020 and subsequent years.*

The EHR Association supports this proposal.

*For reporting period in CY 2020, proposing the following for CQM submission under the Medicare Promoting Interoperability Program: (1) Eligible hospitals and CAHs participating in the Medicare Promoting Interoperability program (single program participation)- electronically report CQMs through QualityNet portal. (2) Eligible hospital and CAH options for electronic reporting for multiple programs (that is, Promoting Interoperability program and Hospital IQR program participation)- electronically report through QualityNet portal.*

The EHR Association supports this proposal.

*For CY 2020, we are proposing to continue our policy regarding the electronic submission of CQMs, which requires the use of the most recent version of the CQM electronic specification for each CQM to which the EHR is certified.*

The EHR Association supports this proposal.

### **RFI on Potential Opioid Measures for Future Inclusion in the Promoting Interoperability Program**

*Seeking comment on Promoting Interoperability program measures in addition to the CQMs we are proposing to adopt in section VIII.D.6.b. of the preamble of this proposed rule ((1) Safe Use of Opioids-Concurrent Prescribing CQM; and (2) Hospital Harm- Opioid Related Adverse Events eCQM) that might be relevant to specific clinical priorities or goals relating to addressing OUD prevention and treatment.*

The EHR Association supports this proposal to add two new eCQMs; however, we encourage CMS to work with stakeholders to vet potential new measures to ensure they are clinically valuable and technically feasible prior to their inclusion in rulemaking.

The CQM Hospital Harm, for example, uses ambiguous language and lacks clarity, leaving developers with many questions, such as:

- How does CMS define harm?
- Is the only adverse event overdose?
- What encoded values are CMS looking to be counted?

*Seeking comment specifically on possible OUD prevention and treatment measures that include the following characteristics: (1) Are applicable to all hospital settings; (2) Are represented by a measure description, numerator/denominator or "yes/no" attestation statement, and possible exclusions; (3) Include evidence of positive impact on outcome focused improvement activities, and the opioid crisis overall; (4) Leverage the capabilities of CEHRT, including: automatic calculation and reporting of numerator, denominator, exclusions and exceptions, and timing elements to reduce quality measurement and reporting burdens to the greatest extent possible; (5) are based on well-defined clinical concepts, measure logic and timing elements that can be captured by CEHRT in standard clinical workflow and/ or routine business operations. (6) Align with clinical workflows in such a way that data used in the calculation of the measure is collected as part of a standard workflow and does not require any additional steps or action by the health care provider.*

EHR Association members support the introduction of new measures, and we encourage CMS to work with stakeholders to create and vet potential new measures to ensure they are clinically valuable and technically feasible prior to their inclusion in rulemaking. Aligning new measures with clinical workflow is critical to ensuring measures are not disruptive and do not add unintended burden. Measures need to be fully realized and provide clarity on the expectations of the clinician and their health IT. Additionally, the EHR Association wants to ensure that measures are applicable to the care setting in which they are being measured and provide results that are a value-add to the clinician in OUD prevention and treatment efforts.

### **Developing new PI measures**

EHR Association members support the introduction of new measures, and we encourage CMS to work with all stakeholders to develop potential new measures to ensure they are clinically valuable and technically feasible prior to their inclusion in rulemaking.

### **NQF Quality Measures**

The EHR Association generally supports the introduction of additional measures to provide flexibility to providers and improve clinical process and outcomes, provided that measures are technically feasible and are introduced within attainable timeframes. To this end, we are concerned specifically about the aggregation of opioid data from multiple providers who could be using EHRs from disparate developers. Such a measure would require sufficient time with detailed specifications to ensure that data systems are able to report the necessary data for successful measurement. Moreover, the language used, “multiple providers” and “timeframes” is ambiguous; CMS should more clearly define these terms.

Historically, Promoting Interoperability measures have not measured primarily clinical items, which are based on narrative specifications that health IT developers must interpret into software code that they implement in their individual systems. As Promoting Interoperability measures move toward measuring clinical concepts, detailed specifications and value sets must be made available to developers in advance to allow adequate time for programming and implementation; this will help ensure the success of these types of measures. The Verifying Opioid Agreement measure is an example of the challenges associated with implementing a measure without clear specifications, resulting in this measure that CMS now proposes to remove.

Another challenge identified in these proposed measures is that standard PDMP rules across all states and a shared PDMP database will need to be in place before some of the proposed measures could be implemented by health IT developers, who must support providers in all states. An example of the disparity in data reporting among states is how the exception that applies to cancer patients is handled.

For instance, many states exempt cancer patients entirely while others require reporting if cancer is not an active problem thus creating data sets that are not comparable. However, more generally, EHR Association members believe a cancer versus non-cancer designation is too simplistic and is not

representative of all potential use cases. We would recommend that measuring opioids prescribed in high doses or extended release for patients who are opioid naive might prove a better measure.

Lastly, EHR Association members are concerned about the appropriateness of these measures for the inpatient setting. We feel these measures may be more appropriate and relative to clinicians operating in outpatient settings.

### **RFI on the Provider to Patient Exchange Objective**

*If ONC's proposal for a FHIR- based API certification criteria is finalized, would stakeholders support a possible bonus under the Promoting Interoperability Programs for early adoption of a certified FHIR- based API in the intermediate time before ONC's final rule's compliance date for implementation of a FHIR standard for certified APIs?*

The EHR Association supports this proposal, with the consideration that CMS should not require any specific FHIR standard in order to receive these bonus points, and that it allows for any FHIR standard to satisfy this bonus opportunity.

### **RFI on the Provider to Patient Exchange Objective: Available Data**

*Do stakeholders believe that incorporating this alternative measure into the Provider to Patient Exchange objective will be effective in encouraging the availability of all data stored in health IT systems?*

If a criteria supporting patient export of electronic health information (EHIE) is adopted into the ONC 2015 Certification Edition, then it would already be widely deployed by virtue of ONC 2015 Edition requirements and it seems ineffective to create an additional measure. Additionally, measures based on patient actions have historically proven frustrating to providers, since they are accountable for activity outside their direct control.

*In relation to the Provider to Patient Exchange objective as a whole, how should a measure focused on using the proposed total EHI export function in CEHRT be scored?*

Because the use of the functionality would be driven by patient interest, the EHR Association suggests that the measurement of provider action be “yes/no” based on their enabling of the feature included in the updated ONC 2015 Edition.

*If this certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure? Should this measure be established as an attestation measure?*

If this certification criterion is finalized, the EHR Association recommends this be a bonus attestation measure.

*What data elements do stakeholders believe are of greatest clinical value or would be of most use to health care providers to share in a standardized electronic format if the complete record was not immediately available?*

The EHR Association encourages the use of the USCDI standard when identifying the most appropriate data to be used in information exchange, rather than the vague concept described under the current EHI criteria within the ONC's NPRM.

*Do stakeholders believe that we should consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long-term care, behavioral health, and home and community based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should we consider when implementing a health information exchange across the care continuum health IT activity in the Promoting Interoperability Program?*

Eventual use of the Trusted Exchange Framework and Common Agreement (TEFCA) could be a way in which to drive the care across the continuum for this specific request.

*What criteria should we employ, such as specific goals or area of focus, to identify high priority health IT activities for the future of the program?*

When sharing data with patients, the EHR Association recommends use of the data categories in the USDCI, when the data is available.

*Are there additional health IT activities we should consider recognizing in lieu of reporting on existing measures and objectives that would most effectively advance priorities for nationwide interoperability and spur innovation.*

Increased e-prescribing of controlled substances could be an area for a new measure. There are widely accepted standards and sufficient adoption to make this focus reasonable. In general, the EHR Association notes that attestation measures are a method to introduce concepts to the program with minimal reporting burden on providers. For example, a potential health IT related activity that could be reported as a yes/no attestation measure similar to those found in the Public Health objective would be for hospitals to report whether they are integrated and engaged with one or more health information exchange (HIE) organizations.

### **RFI on the Provider to Patient Exchange Objective: Patient Matching**

*Seeking comment for future consideration on ways for ONC and CMS to continue to facilitate private sector efforts on a workable and scalable patient matching strategy so that the lack of a specific UPI does not impede the free flow of information.*

Because patient matching is consistently brought into discussions, the EHR Association recommends it be set as a priority for advancing. We recommend expansion of demographic matching by adopting a minimum data set for patient matching along with a vocabulary. In the longer term, this could potentially expand to the use of patient email/cell phone number or other similar identifiers.

### **RFI on Integration of Patient-Generated Health Data into EHRs using CEHRT**

*What specific use cases for capture of PGHD as part of treatment and care coordination across clinical conditions and care settings are most promising for improving patient outcomes? For instance, use of PGHD for capturing advanced directives and pre/post operation instructions in surgery units.*

To allow for flexibility and innovation, the EHR Association asks that CMS does not require a specific way to include this information or how it should be defined. If anything were to be adopted, we strongly suggest a transitive measure, meaning that patients who have submitted data should count for all providers who are caring for that patient. It would not make sense for patients to submit data duplicatively so each provider could receive credit in this measure.

The current API requirement within the basis of CEHRT only has a "read" requirement to where the consumer-based application is able to view EHR data; the future progression of the API to include "write" capabilities could lead to the eventual use of this type of measurement within the PI Program.

*Should the Promoting Interoperability Program explore ways to reward health care providers for implementing best practices associated with optimizing clinical workflows for obtaining, reviewing, and analyzing PGHD?*

The EHR Association warns that specifying best practices for clinical workflows can create a slippery slope for best practice recommendations for a particular healthcare organization. There are many variances that exist within a provider's workflow. The companies providing the technology then become required to modify the provider's workflow and this often creates burden upon the provider.

This could be an opportunity for incorporation into the Improvement Activities applicable within the MIPS program.

### **RFI on Engaging in Activities that Promote the Safety of the EHR**

*Seeking comment on ways that the Promoting Interoperability Program may reward hospitals for engaging in activities that can help to reduce errors associated with EHR implementation.*

The EHR Association recommends that CMS focus on training. There is ample evidence that user satisfaction and improved utilization of the EHR is directly related to the quantity and quality of

time spent in training, both before and after implementation. While many hospitals and provider groups plan (and budget) for training prior to the initial go-live, wide variability exists in compliance and effectiveness among stakeholders, particularly for physicians who are already working at maximum capacity or only expect to use the EHR occasionally (e.g. consultants).

It is not unusual that training prior to major system upgrades is inadequate, despite best practice recommendations. New features or significant improvements in existing features might be rolled out with minimal or no training (other than a general email announcement listing changes). Or an organization might defer or decline to roll out significant upgrades rather than commit the time and resources to a significant training effort. While this is understandable given competing priorities and finite resources, both of these strategies impose constraints on the clinicians' ability to use the technology safely and effectively.

Given the importance of education, training, and continuous post-implementation improvement, potential areas for incentives to better assess and improve EHR utilization include:

- Creation of specific patient-safety metrics by each organization (to ensure relevance to its providers and patient population), measured pre- and post-implementation to evaluate for improvement.
- Training participation metrics, with minimum thresholds for incentives.
- Pre- and post-training assessments of competency (especially in clinically complex functional areas).
- A measurable and verifiable program for continuous education (especially around major system upgrades) that incorporates feedback from users on problem areas or areas where they feel their knowledge is deficient.
- Ongoing assessment of build decisions to evaluate the effects of customizations, particularly to assess that updates contrary to best practices or 'standard implementation' are providing value and not contributing to usability and/or safety issues.

Given the difficulty in measuring some of these concepts, CMS could consider a combination of metrics and attestation.

*Requesting comment on a potential future change to the program under which hospitals would receive points towards their Promoting Interoperability program score for attesting to performance of an assessment based on one of the ONC Safer Guides.*

Overall, the EHR Association supports this recommendation; however, we note that there are challenges in measuring performance beyond attestation. Any measurements based on the ONC SAFER Guides should be optional or eligible for bonus credit for the foreseeable future. Some of the SAFER guidelines lend themselves to some degree of measurement, (e.g. CPOE, use of evidence-based order set, compliance structured data entry for allergies, medications and pharmacy orders, and override rates) and results reporting (e.g., structured data usage and safety monitoring recommendations). However, many of the SAFER guidelines are less

amenable to measurement or may be under the safeguard of quality assurance/patient safety work-product protections.

Given the significance of recent changes to the PI program over the past two rule-making cycles, introducing a completely new set of measurements and attestations, which may be ambiguous or technically infeasible, would introduce additional uncertainty and burden to all stakeholders. In order to minimize burden on healthcare providers and organizations, implementation of this change would require multi-stakeholder involvement with proposals released for comment to ensure the data required for reporting is technically feasible without extraordinary effort on behalf of providers and represents value to the reporting parties to affect meaningful change.