HIMSS Electronic Health Record Association

33 W Monroe, Suite 1700
Chicago, IL 60603
knicholoff@ehra.org
Phone: 517-930-1198
Twitter: @EHRAssociation

July 10, 2020

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 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), which was published in the Federal Register on May 29, 2020. 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.

The EHR Association's member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs across the United States. Our core objective is to collaborate to accelerate health information and technology adoption, advance information exchange between interoperable systems, and improve the quality and efficiency of care through the use of these important technologies.

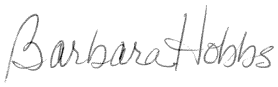
Our detailed comments follow. We appreciate this opportunity to provide CMS with our input and look forward to continued collaboration toward improved patient care.

Sincerely,

Hans J. Buitendijk
Chair, EHR Association
Cerner Corporation

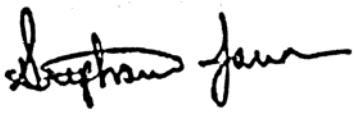
David J. Bucciferro
Vice Chair, EHR Association
Foothold Technology

HIMSS EHR Association Executive Committee



Barbara Hobbs
MEDITECH, Inc.

Cherie Holmes-Henry
NextGen Healthcare



Stephanie Jamison
Greenway Health

Rick Reeves, RPh
CPSI

Alya Sulaiman

Alya Sulaiman, JD, CIPP/US
Epic

Courtney E. Tesvich, RN
Nextech

About the HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of 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.

Market-Based MS-DRG Relative Weight Proposed Data Collection

This proposed reporting requirement would mean sizable work for our hospital clients and cause an increase in regulatory burden during a time when they're focused on pandemic response. On behalf of our clients, we suggest CMS seriously consider the comments submitted by hospitals on this proposal to understand the impact this would have on them, and to consider other alternatives that would serve to more easily switch to a market-based calculation.

File Format for EHR Data

We support the proposed requirements that hospitals submit specific elements to identify the QRDA 1 file. The EHR ID is useful information for submission.

Electronic Clinical Quality Measures (eCQM)

CMS proposes to progressively increase the number of calendar quarters for which hospitals are required to report eCQM.

As the number of quarters in which submission can occur increases, we suggest that CMS clarify the submission deadlines/requirements. For example, it is unclear whether there would be a requirement to report consecutive quarters or if the selection would be allowed for non-sequential quarters (e.g., Q2 and Q4 selections). When hospitals are eventually required to begin running these types of reports for an entire year (and even the scenario of submitting for multiple quarters), we and our clients would need clearer submission requirements; for example, if the client selects Q2 and Q4, would they submit this data separately for individual quarters or as a whole at the end of the year? If reporting is required at the end of the year, would the measures be reported cumulatively (even if tracked in non-sequential quarters) or would they need to be submitted as separate reports?

We suggest CMS maintain a single data submission deadline, which for anyone reporting for non-sequential quarters (if allowed) would mean a single report at the end of the year. Data submission volumes would need to be considered, with the submission of patient-level individual files for multiple quarters being required for IQR.

We note that some hospitals will change health IT systems within a given reporting year. CMS should recognize that this could make submitting data for regulatory programs challenging, and provide additional guidance on flexibilities available for those hospitals.

Promoting Interoperability Programs

The EHR Association supports CMS' proposal to maintain a continuous 90-day reporting period for Promoting Interoperability in 2021 and 2022. We appreciate this continuity with past reporting years.

We also support the proposal to keep the Query of a PDMP measure optional and worth five bonus points in 2021. PDMPs have still not consistently adopted standards-based integration with EHRs, and state and local data use rules continue to present barriers for many provider organizations seeking to integrate PDMP data into their local patient records. The measure should remain an optional Yes/No attestation measure until these challenges are holistically resolved.

While it seems like a minor change, we oppose CMS' proposal to change the name of the "Support Electronic Referral Loops by Receiving and Incorporating Health Information" to "Support Electronic Referral Loops by Receiving and Reconciling Health Information." Multiple name changes can be confusing for healthcare organizations and health IT developers supporting those organizations, since a new measure name has frequently been used (historically) to imply that the measure's requirements have changed. Name changes also result in software developers and other stakeholders needing to make tedious and burdensome updates to tools, processes, and materials, including report name changes, changes to documentation preserved for audits, updates to training materials, and updates to end-user facing documentation. Time spent on name changes diverts resources from more impactful projects requested from users, such as usability enhancements.

Future Direction of the Medicare Promoting Interoperability Program

We appreciate CMS' solicitation of proposals to assist in reducing regulatory burden and aligning programs. It is unclear that CMS has successfully met the goal set several years ago, however, to more closely tie CMS measurement programs to improvement in and reporting related to patient outcomes, and we encourage CMS to work with measure developers and clinical stakeholders to continue to expand the number of measures available with that focus to ensure that patients benefit from the increased investment in Pay for Value programs.

Special Consideration during COVID-19 Crisis

Given the high volume of attestation activity that usually occurs in Q4, CMS should be prepared for potential problems across the industry as EH/CAHs attempt to attest in that last quarter if COVID-19 flares up again towards the end of 2020. CMS could alleviate anxiety by publishing an advance plan for how COVID-19 flexibilities will be accommodated during submission.