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June 7, 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of our 30 member companies, the HIMSS Electronic Health Record (EHR) Association appreciates the opportunity to provide feedback to CMS on the *Medicare Proposed Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System and Policy Changes and FY 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals (CAHs); Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership Proposed Rule (CMS-1785-P)*.

The EHR Association is dedicated to improving the quality and efficiency of care through innovative, interoperable health information technology (IT) adoption and use. In doing so, we are committed to working toward a healthcare ecosystem that leverages the capabilities of EHR and other health IT to efficiently deliver higher-quality care to patients in a productive and sustainable way.

We appreciate this opportunity to provide CMS with the following detailed comments and look forward to continued collaboration toward improved patient care.

Sincerely,

David J. Bucciferro
Chair, EHR Association
Foothold Technology

William J. Hayes, M.D., M.B.A.
Vice Chair, EHR Association
CPSI

AdvancedMD	CureMD	Experity	MEDITECH, Inc.	Oracle Cerner
Allscripts	eClinicalWorks	Flatiron Health	Modernizing Medicine	PointClickCare
Altera Digital Health	Elekta	Foothold Technology	Netsmart	Sevocity
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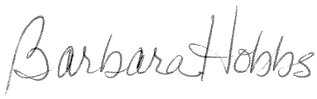
Altera Digital Health



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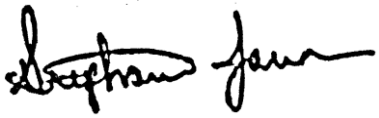

Stephanie Jamison
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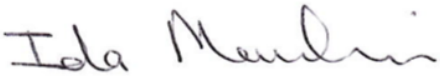
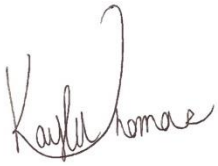


Ida Mantashi
Modernizing Medicine



Kayla Thomas
Oracle Cerner

V.K.6 - Proposed Change to the Scoring Methodology (p382)

We propose to define the points that a hospital can earn based on its performance and proportion of patients with DES as the Health Equity Adjustment (HEA) bonus points. We believe the awarding of these HEA bonus points is consistent with our strategy to advance health equity and will incentivize high-quality care across all hospitals.

The EHR Association recommends that CMS provide detailed specifications for proposed Health Equity Adjustment (HEA) bonus points under the Value-Based Purchasing Program and release them with sufficient time for adoption.

IX.C.5 - Proposed New Measures for the Hospital IQR Program Measure Set (p422)

We are proposing to adopt three new measures, all of which are electronic clinical quality measures (eCQMs):

(1) Hospital Harm—Pressure Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination and for subsequent years;

(2) Hospital Harm—Acute Kidney Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination and for subsequent years; and

(3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Inpatient) eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination and for subsequent years.

The EHR Association encourages CMS to make available the specifications for those proposed new eCQMs that are more than one year out so that informed feedback and recommendations can be developed and shared.

IX.C.5 Proposed Changes to the Hospital Inpatient Quality Reporting (IQR) Program (p - 424)

Proposed Adoption of Hospital Harm—Acute Kidney Injury eCQM, Beginning with the CY 2025 Reporting Period/FY 2027 Payment Determination and for Subsequent Years

The EHR Association encourages CMS to make available the specifications for the proposed new eCQM so that informed feedback recommendations can be developed and shared.

IX.C.5.c. Proposed Adoption of Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Inpatient) eCQM (p939-940)

(3) Data Sources: The Excessive Radiation eCQM uses hospitals' EHR data and radiology electronic clinical data systems, including the Radiology Information System (RIS) and the Picture Archiving and Communication System (PACS). Medical imaging information such as Radiation Dose Structured Reports and image pixel data are stored according to the universally adopted Digital Imaging and Communications in Medicine (DICOM) standard. Currently, eCQMs cannot access and process data elements in their original DICOM formats. The measure developer has created software, called the Alara Imaging Software for CMS Measure Compliance, to address this gap. This software links primary data elements, assesses CT scans for eligibility for inclusion in the measure, and generates three data elements mapped to a clinical terminology for eCQM consumption: CT Dose and Image Quality Category, Calculated CT Size-Adjusted Dose, and Calculated CT Global Noise.

The translation software would be available to all reporting entities free of charge and would be accessible by creating a secure account through the measure developer's website. Education materials would provide step-by-step instructions on how hospitals can create an account and then link their EHR and PACS data to the translation software. Reporting entities and their vendors would be able to use the data elements created by this software to calculate the eCQM and to submit results to the Hospital IQR Program as they do for all other eCQMs

We are proposing the adoption of the Excessive Radiation eCQM as part of the Hospital IQR Program measure set, we invite public comment on this proposal.

The EHR Association does not support requiring adoption of the Excessive Radiation eCQM in CY 2025. Rather, we recommend adoption be delayed until a trial period is completed to allow for a full assessment of the measure's feasibility, as well as to determine what is feasible for reporting. We also recommend certification be optional.

Additionally, we do not believe that this specific radiation measure is best served as an eCQM. Historically eCQMs are measures based upon clinical information that is stored in an EHR system and that the EHR can extract from system data. However, the Excessive Radiation eCQM would rely more heavily on third-party data and, as such, the data may not be stored in the applicable EHR system or may not be stored in a manner that is suitable to extraction for QRDA purposes. Therefore, we do not believe this eCQM will work well within the IQR and PI programs. It would also significantly impact those EHRs that do not store the necessary images and data, creating concerns regarding the mapping of HL7 results data.

IX.C.6.a. Proposed Modification of Hybrid Hospital Wide All Cause Mortality Measure (p948)

The cohort expansion of the Hybrid HWM measure to include MA admissions is the only change to the Hybrid HWM measure being proposed. We are proposing to include MA admissions in the Hybrid HWM beginning with the admissions data from July 1, 2024 through June 30, 2025,

The EHR Association supports the proposed expansion of the Hybrid HWM measure to include MA admissions beginning with admissions data from July 1, 2024 through June 30, 2025.

IX.C.6.b. Proposed Modification of Hybrid Hospital Wide All Cause Readmission HWR Measure (p954)

The cohort expansion of the Hybrid HWR measure to include MA admissions is the only proposed change to the Hybrid HWR measure. We are proposing to include MA admissions in the Hybrid HWR cohort beginning with the discharge data from July 1, 2024 through June 30, 2025

The EHR Association supports the proposed expansion of the Hybrid HWR measure to include MA admissions beginning with discharge data from July 1, 2024 through June 30, 2025.

IX.C.10.e.1.(b) Requiring EHR Technology to be Certified to all Available eCQMs (p994)

FY 2020 IPPS/LTCH PPS final rule (84 FR 42505 through 42506), we finalized the requirement that EHRs be certified to all available eCQMs used in the Hospital IQR Program for the CY 2020 reporting period/FY 2022 payment determination and subsequent years. In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45418), we finalized the requirement for hospitals to use the 2015 Edition Cures Update beginning with the CY 2023 reporting period/FY 2025 payment determination; then all available eCQMs used in the Hospital IQR Program for the CY 2023 reporting period/FY 2025 payment determination and subsequent years would need to be reported using certified technology updated to the 2015 Edition Cures Update. We are not proposing any changes to this policy in this proposed rule.

The EHR Association has previously been supportive of these requirements. However, the introduction of new measures that have not been fully tested and/or for which specifications have not yet been provided creates several concerns. Specifically, this policy creates burden on EHR developers when new measures are proposed for which we cannot review specifications and provide detailed feedback regarding the feasibility of a measure for a future year. We also suggest that additional flexibility may be necessary.

Additionally, while we find this policy of requiring eCQMs that rely exclusively on EHR data manageable, we are unable to support requiring measures that rely on outside products or tools, as would be the case for the new Excessive Radiation eCQM. Doing so raises several questions requiring additional guidance from CMS:

- Would risk assessments be conducted for anyone with whom that company shares data?
- Are business agreements or internal approvals required?
- What costs would be incurred for establishing the interfaces necessary to automate connection to the third party?
- Would data be received back as a flat file or QRDA?

Clarification is also needed on whether the returned data is only for quality measure reporting or if it is also expected to be displayed in the EHR.

IX.F. Medicare Promoting Interoperability Program (p1111)

While the EHR Association understands that CMS is not making any current proposals related to adoption and use of Certified EHR Technology (CEHRT) in the Medicare Promoting Interoperability program, we would like to take this opportunity to include comment on a topic from the ONC's recently published Health Data, Technology, and Interoperability (HTI-1) proposed rule which we feel compels action from CMS for their reimbursement programs and payment models requiring implementation and use of CEHRT. In HTI-1, ONC proposes several changes to existing criteria under the HIT Certification Program that are part of CMS' CEHRT definition – either as part of the Base EHR or criteria required to be a meaningful user based on being cited as part of a Promoting Interoperability program measure.

As proposed, ONC would adopt updates to these criteria as of a specific date (proposed as January 1, 2025 for most) and certified developers would be required to certify and provide those updates to their customers by that date. ONC proposes that to "provide" the updates means "the action or actions taken by a health IT developer of certified Health IT Modules to make the certified health IT available to its customers" (see here). In other words, developers would be required to make these updates available for their customers to implement as of that deadline. However, since CMS' CEHRT definition points directly to these criteria, the CEHRT definition, as it stands today, would also change as of that same date. This means that healthcare providers participating in CMS reimbursement programs and payment models requiring implementation and use of CEHRT would be subject to that updated scope of CEHRT by the start of the next performance/measurement period for the applicable programs in which they participate. Depending on the program, this could be the same date as the ONC deadline or soon after.

This structure is problematic as it ignores the need for additional runway for healthcare providers to adopt and implement updates once they are provided by ONC's defined deadline. Without this additional runway being built into regulation, providers are faced with the unachievable task of adopting and implementing updates to CEHRT as of the same date (or soon after) that certified developers must make it available for implementation.

Furthermore, ONC has also proposed to transition to an "edition-less" HIT Certification Program. This means that instead of large, bundled updates to criteria there may be individual criteria updated on an ongoing basis, each of which would have its own deadline for certified developers to provide them to their customers. Thus, the need for a well-established policy of implementation runway for healthcare providers participating in CMS programs requiring implementation and use of CEHRT will likely be heightened as we move into the future.

Given this, we urge CMS to address this critical topic in their own rulemaking by adopting policy establishing a 12-month runway following the ONC-defined deadline for certified developers to provide updates to CEHRT criteria to their customers by which healthcare providers would need to implement and use those updated capabilities for purposes of compliance with CMS reimbursement programs and payment models.

IX.F.2-5-i. Medicare Promoting Interoperability Program (p1111)

In this proposed rule, we are proposing several changes to the Medicare Promoting Interoperability Program. Specifically, we are proposing to:

(1) amend the definition of ''EHR reporting period for a payment adjustment year'' at 42 CFR 495.4 for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program, to define the electronic health record (EHR) reporting period in CY 2025 as a minimum of any continuous 180-day period within CY 2025;

(2) update the definition of ''EHR reporting period for a payment adjustment year'' at § 495.4 for eligible hospitals such that, beginning in CY 2025, those hospitals that have not successfully demonstrated meaningful use in a prior year will not be required to attest to meaningful use by October 1st of the year prior to the payment adjustment year;

(3) modify our requirements for the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure beginning with the EHR reporting period in CY 2024, to require eligible hospitals and CAHs to attest ''yes'' to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs;

(4) modify the way we refer to the calculation considerations related to unique patients or actions for Medicare Promoting Interoperability Program objectives and measures for which there is no numerator and denominator;

The following measures would be affected by this proposal because they do not have a numerator and denominator and they require a ''Yes/No'' response: Query of PDMP measure; HIE BiDirectional Exchange measure; Enabling Exchange under TEFCA measure; Immunization Registry Reporting measure; Syndromic Surveillance Reporting measure; Electronic Case Reporting measure; Electronic Reportable Laboratory (ELR) Result Reporting measure; Public Health Registry Reporting measure; Clinical Data Registry Reporting measure; Antimicrobial Use and Resistance (AUR) Surveillance measure; Security Risk Analysis measure; and the SAFER Guides measure

(5) adopt three new eCQMs beginning with the CY 2025 reporting period for eligible hospitals and CAHs to select as one of their three self-selected eCQMs: the Hospital Harm—Pressure Injury eCQM, the Hospital Harm—Acute Kidney Injury eCQM, and the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Inpatient) eCQM.

The EHR Association supports the proposed changes to the Medicare Promoting Interoperability Program. Specifically, we are in favor of amending the EHR reporting period in CY 2025 for participating eligible hospitals and CAHs to a minimum of any continuous 180-day period within CY 2025, as it maintains consistency with the current CY 2024 reporting period definition. We also support eliminating the requirement for eligible hospitals to attest to meaningful use by October 1 of the year prior to the payment adjustment year if they have not successfully demonstrated meaningful use in a prior year, as it will reduce confusion and is a solid go-forward plan – one that levels the playing field for all – for the larger reporting periods that are being required. Nor do we have any concerns with the proposal to modify how CMS refers to calculation considerations related to unique patients, or actions for Program objectives and measures for which there is no numerator and denominator.

However, while the EHR Association supports the addition of the three new eCQMs to the program, we have concerns with the Excessive Radiation eCQM because of the requirement to work with data captured by a third party to calculate it. This gives rise to several questions on which we seek guidance from CMS:

- Would risk assessments be conducted for anyone with whom that company shares data?
- Are business agreements or internal approvals required?
- What costs would be incurred for establishing the interfaces necessary to automate connection to the third party?
- Would data be received back as a flat file or QRDA?
- Is returned data only for quality measure reporting or is it also expected to be displayed in the EHR?

Given these concerns, we suggest a slower adoption timeframe and a voluntary period for testing and validation prior to requiring this measure. We also recommend that certification be optional.

IX.F.7.a. Proposed Changes to Clinical Quality Measures in Alignment with the Hospital IQR Program (1134)

Specifically, we propose to add the following two eCQMs that address factors contributing to hospital harm to the Medicare Promoting Interoperability Program eCQM measure set on which hospitals can self-select to report, beginning with the CY 2025 reporting period:

(1) the Hospital Harm – Pressure Injury eCQM (CBE #3498e); and

(2) the Hospital Harm – Acute Kidney Injury eCQM (CBE #3713e).

In addition, we propose to add the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM (CBE #3663e) to the Medicare Promoting Interoperability Program eCQM measure set on which hospitals can self-select to report, beginning with CY 2025 reporting period. We invite public comment on these proposals.

We support measure alignment between eCQMs used in the IQR and Promoting Interoperability program. Although, as we have stated with the IQR proposals for these new eCQMs, the EHR Association does recommend providing detailed specification on the eCQI for proposed measures and delaying adoption of the Excessive Radiation eCQM until a trial period is completed to fully assess the measure's feasibility and to determine what is feasible for reporting. We also recommend certification optionality.