

May 31, 2022

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 Association (EHRA) is pleased to provide feedback on the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Federal FY 2023 and Updates to the IRF Quality Reporting Program (QRP) (CMS-1767-P). We appreciate this opportunity to provide input on CMS' efforts to strengthen the healthcare services and information available to patients and the healthcare providers who serve them.

EHRA member companies serve the vast majority of hospital, post-acute, specialty-specific, and ambulatory healthcare providers using electronic health records (EHRs) and other health IT across the United States. Together, we work to improve the quality and efficiency of care through the adoption and use of innovative, interoperable health information technology.

We offer the following considerations regarding the proposed rulemaking.

Sincerely,



Hans J. Buitendijk
Chair, EHR Association
Cerner Corporation



David J. Bucciferro
Vice Chair, EHR Association
Foothold Technology

AdvancedMD
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Endosoft
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Greenway Health
Harris Healthcare Group
Lumeris
MatrixCare

MEDHOST
MEDITECH, Inc.
Medsphere
Modernizing Medicine
Netsmart
Nextech

NextGen Healthcare
Office Practicum
Sevocity
STI Computer Services
TenEleven Group
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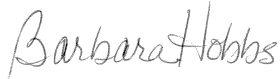
HIMSS EHR Association Executive Committee



Pamela Chapman
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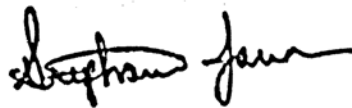
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Established in 2004, the Electronic Health Record (EHR) Association is comprised of 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that 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.

Electronic Health Record Association

Comments on the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2023 and Updates to the IRF Quality Reporting Program (CMS-1767-P)

Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

C. IRF QRP Quality Measure Concepts Under Consideration for Future Years: Request for Information (RFI)

CMS solicits feedback on a range of topics within the IRF Quality Reporting Program including on the incorporation of cross-setting and cross-domain measures into the program. Specifically, CMS notes that it is considering a future measure that would incorporate the domains of self-care and mobility across settings. Based on our experience supporting healthcare organizations' success in other quality reporting programs, EHRA members have concerns regarding the complexity and readiness of the industry to implement cross-setting measures that would require the aggregation of data from disparate sources.

The complexity of aggregating quality reporting data across disparate settings is best illustrated by the challenges organizations are facing while preparing to transition to eCQM reporting within CMS's Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) program. Aggregating electronic quality measure data across facilities or locations, particularly those that do not utilize the same EHR instance is time and resource-intensive. Organizations must generate quality reporting exports (typically using the QRDA I format), designate a system to ingest them, and then resolve numerous patient matching discrepancies given the limited demographic information currently available to facilitate patient matching within the QRDA I specification. Care settings with robust adoption of certified and interoperable EHR technology that participate in the MSSP ACO program are struggling to prepare for the transition. The inconsistent adoption of interoperable EHR technology across IRFs could make the adoption of cross-setting electronic quality reporting an unreasonable expectation in the near term.

Performance measures should offer a beneficial impact to clinical users and their facilities through the opportunity for improvements in patient care and operational efficiencies. Aggregation across multiple stakeholders diminishes that possibility by diluting accountability as combined scores make it difficult to identify who is responsible for improvements and limit the ability to manage performance on the measure. Further, to achieve maximum accountability and usefulness, EHRA recommends that domains should be calculated and reported separately, with a single outcome per measure. Merging the domains of self-care and mobility creates unnecessary complexity and diminishes the utility of the measure, as it limits clinical users' ability to monitor and improve their performance without the transparency of clearly identifying the action being measured and which domain failed.

Given these challenges, EHRA strongly urges CMS to maintain single-outcome measures, calculated per care setting.

CMS also solicits input on the adoption of a COVID-19 vaccination coverage measure in the IRF setting. When defining such a measure, the EHRA recommends providing clear guidance on how vaccination coverage will be defined. The definition of “up to date” on COVID-19 vaccination has evolved throughout the course of the pandemic as guidance from the FDA and CDC has evolved. Any measure would need to account for the potential for the definition of “fully vaccinated” to change throughout the reporting period. As EHR developers, our members and the healthcare organizations we support would be challenged to accommodate such a measure with varying requirements.

The EHRA seeks the establishment of a nationwide definition for vaccination and booster expectations if a quality measure regarding COVID-19 vaccinations were to be implemented.

D. Inclusion of the National Healthcare Safety Network (NHSN) Healthcare-Associated Clostridioides Difficile Infection Outcome Measure in the IRF QRP—Request for Information

The EHRA strongly agrees with the CMS comment regarding the immense value of EHR adoption across clinical settings in providing safer, more efficient care, including in IRFs. We agree with the CMS that the utilization of EHRs can improve the ability to diagnose diseases and reduce (or even prevent) medical errors, improving patient outcomes. **EHRA members clarify that a significant reason for this value delivered by EHRs is in providing clinicians with timely access to information by offering unified patient records and advanced interoperability tools to retrieve records from disparate care settings.**

One benefit to the adoption of interoperable health IT across care settings is the potential to improve quality reporting using sophisticated electronic tools. Although we are not certain that moving to fully digital quality measures (dQMs) will reduce reporting and regulatory burden on providers in the short or medium term, EHR adoption is a prerequisite to streamlined quality reporting. IRF adoption of EHR technology will require significant financial and time investment. CMS should not underestimate the transition time that will be necessary to implement and train on EHR technology before IRFs will be ready to report using dQMs. Incentive programs may be needed to spur investment in EHR technology amongst IRFs.

When considering the use of a fully digital measure using a Measure Calculation Tool (MCT) that pulls data directly from the EHR via standardized FHIR APIs, the EHRA offers a number of considerations when evaluating the potential benefit and burden to IRFs.

Most importantly, we stress the need for real-time feedback. **To make dQMs meaningful, clinical users need a bi-directional exchange of data that returns real-time feedback to make the information meaningful and actionable to the facility.** As an example, we offer the success of clinicians and hospitals in promoting interoperability and MIPS quality reporting requirements is their ability to view quality reports and dashboards in their EHR workflows. Storing measures data only in a separate CMS portal would make accessing actionable information and improving scores much more difficult, and therefore decrease the benefit of digital measures. Additionally, continued transparency into the exact measure definitions used must be maintained, even when only source data is being shared to enable CMS to calculate measures.

While we appreciate the CMS consideration of burden reduction and cost savings for IRFs generated by the MCT extracting, calculating, and submitting measure data automatically, **we point out that implementing a FHIR API represents a considerable undertaking for developers and provider facilities.** This would start with understanding the meaning of “FHIR APIs” as that can range from utilizing FHIR US Core based APIs to FHIR Bulk Data to FHIR MeasureReport, other FHIR resources yet to be profiled, or some combination thereof. Great consideration must be given that the approach taken does not impact operational use of the source HIT, and that not all or possibly any source HIT already supports the appropriate FHIR-based APIs necessary to fully support the necessary processes. In addition to the upfront cost of implementing an EHR for those who do not already have one as mentioned above, or enabling dQMs sourced from other HIT that do not have any FHIR-based API support yet, the development, testing, rollout, and maintenance of the API itself would require significant time and resources. Infrastructure must also be created to establish and support a process for managing out-of-date tokens, invalid user names, etc.

Further, dQMs have the potential to increase the burden on provider facilities if they require data that is not routinely collected for patient care or other day-to-day operational activities or extend to measures that offer no meaningful value to the provider facilities. **The EHRA cautions CMS against adding extraneous data collection requirements under the mistaken assumption that FHIR-based technologies would accomplish this without additional work.**

We agree that there are likely a number of advantages to implementing FHIR-based dQMs longer term. For systems and facilities already expressing data in a FHIR-based format, having quality measures defined in a FHIR-based format can enhance consistency. However, **the EHRA seeks clarity regarding FHIR API technology requirements and implementation approaches.** As described above, FHIR terminology remains open to interpretation. It is important to ensure that the dQM implementation guides and standards are well-established and consistent. For example, would the proposed MCT utilize FHIR US Core APIs or would developers be expected to generate FHIR bulk data? Further, it is important to note that performance degradation could result if systems are expected to add a bulk data request to the same FHIR APIs that are utilized for production applications in clinical workflows and other operational purposes, such as patient and provider access. It will be crucial to have clarity regarding the exact expectation of interface interactions and define associated timelines and upfront costs.

It is important to clarify that **the EHRA does not seek to dissuade CMS from the eventual adoption of dQMs, but urges realistic expectations and a highly orchestrated approach to this complex transition.** We acknowledge that just as in the evolution to claims-based measures and then to electronic quality measures, the transition to dQMs has the potential to yield long-term benefits, but comes with upfront costs and will require details to be clearly defined and communicated. There may be tremendous value in having a well-defined, FHIR-based approach that clearly establishes the measure definition, data collection, and calculation that creates consistency with a process to which each system can individually align.

A significant transition period is necessary to move IRFs from the current data submission method to electronic submission. This transition will take several years, making the previously mentioned target of 2027 too aggressive. FHIR remains very new, and it has not yet been established what the best approaches are for various kinds of access. **The EHRA recommends aligning timelines for the**

implementation of dQMs across various care settings and then providing additional lead-time for IRFs, which have not achieved consistent adoption of EHRs.

EHRA members agree that pilot programs are generally preferred, but we stress IRFs are not the ideal setting to introduce dQMs. **We encourage CMS to use care settings other than IRFs to pilot dQM utilization.** In order to most effectively monitor and evaluate the success of dQM, it is advisable to begin implementation in a setting that has already established some level of electronic quality reporting. Further, we suggest that there is value in aligning the timing of this program with other CMS initiatives in progress, including the Inpatient Prospective Payment System (IPPS), Hospital Inpatient Quality Reporting (IQR) Program, The Quality Payment Program (QPP), and shift MIPS to the dQM format. Once the model is well-established across other programs, a more mature pilot program could be introduced for a small number of measures in IRF QRP to begin the process.