EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

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September 6, 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 31 member companies, the HIMSS Electronic Health Record (EHR) Association appreciates the opportunity to provide feedback to CMS on the *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction* (CMS–1786–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.

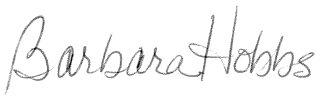
Sincerely,

David J. Bucciferro
Chair, EHR Association
Foothold Technology

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

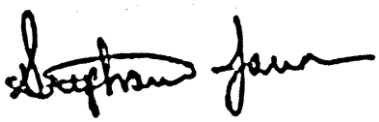
HIMSS EHR Association Executive Committee

Leigh Burchell
Altera Digital Health



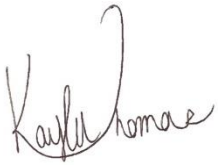
Barbara Hobbs
MEDITECH, Inc.

Cherie Holmes-Henry
NextGen Healthcare



Stephanie Jamison
Greenway Health

Ida Mantashi
Modernizing Medicine



Kayla Thomas
Oracle Cerner

Established in 2004, the Electronic Health Record (EHR) Association is comprised of 31 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.

Considerations for Data Collection Modes for the Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery Measure Beginning with the Voluntary CY 2024 Reporting Period

The EHR Association supports CMS' proposal to allow the survey instruments required for this measure to be administered by the HOPD via phone, by the patient via regular or electronic mail, or during clinician follow-up to meet reporting requirements for the Cataracts Visual Function measure. In addition to offering a patient-centric approach, this change will reduce burden for providers, streamline interactions between physicians and optometrists, and maintain the integrity of the measure.

Proposed Adoption of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) Measure Beginning with the Voluntary CY 2025 Reporting Period followed by Mandatory Reporting Beginning with the CY 2026 Reporting Period/CY 2028 Payment Determination

Historically eCQMs are based on clinical information that is stored in an EHR system and that the EHR can extract from system data. The EHR Association does not support requiring eCQMs that rely on outside products or tools. The proposed Excessive Radiation eCQM would rely 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 for extraction for QRDA purposes. We seek clarification from CMS regarding whether data would be received as a flat file or QRDA, and whether returned data is for quality measure reporting only or if it is also expected to be displayed in the EHR.

The workflow to gather this data is also concerning. Our client providers have expressed a preference for eCQMs because of their ability to stay within the EHR workflow. The integration of an additional, external software platform into EHRs for this measure would create significant additional burden for providers as it requires a disruption to their care delivery workflows.

Additionally, we ask for increased transparency with regard to developer testing on this measure. In previous measures, CMS has noted EHR developers who they have worked with on testing. We request CMS identify those developers or participants involved in the vetting of this measure.

The EHR Association does not support requiring the 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.

Solicitation of Comments on Behavioral Health and Suicide Prevention in the Hospital OQR Program

The EHR Association applauds CMS efforts to improve early risk detection and facilitate appropriate behavioral health treatment by measuring suicide screening in the hospital outpatient setting. We agree that the Adult Major Depressive Disorder (MDD): Suicide Risk Assessment measure would be appropriate and feasible for use in the Hospital OQR Program, and we encourage CMS to include additional quality measures supportive of mental health screenings.

The EHR Association supports the addition of substance use disorder-related screening and counseling measures in regard to behavioral health outcomes for the outpatient setting. We recommend the following existing Medicaid Quality Measures for inclusion:

1. **Continuity of care after medically-managed withdrawal from alcohol and/or drugs (NQF 3312):** percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18–64, that was followed by a treatment service for substance use disorder [including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy)] within 7 or 14 days after discharge. This measure is reported across all medically managed withdrawal settings.
2. **Use of pharmacotherapy for opioid use disorder (NQF 3400):** the percentage of Medicaid beneficiaries ages 18–64 with an Opioid Use Disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for OUD during the measure year. The measure will report any medications used in the medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.
3. **Continuity of care after inpatient or residential treatment for substance use disorder (NQF 3453):** percentage of discharges from inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18–64, which were followed by a treatment service for SUD. SUD treatment services include having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, filling a prescription, or being administered or dispensed medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

We also support a measure related to universal suicide risk in the ED. Further, we encourage CMS to acknowledge that effective suicide prevention is multifaceted, involving a combination of strategies that collaboratively address various aspects of the issue. These efforts encompass reducing behavioral health stigma, implementing mandatory suicide assessments, and ensuring immediate access to services. Every element within a suicide prevention model merits assessment. For instance, it is important to measure the percentage of individuals undergoing both a brief suicide prevention assessment and a comprehensive evaluation, based on screenings or medical history.

Incorporating standardized screenings and assessments is essential in any program, with measurement of both process and outcome being crucial. This evaluation should encompass post-care follow-up measurements as well. CMS must recognize that measuring and providing post-care require clinician time, and compensation should be extended for these essential components of a comprehensive program.

Solicitation of Comments on Telehealth as a Measurement Topic Area in the Hospital OQR Program

The EHR Association is supportive of the inclusion of telehealth measures in general. As such measures are created, we encourage CMS to create consistency across quality measurement programs, where applicable.

eCQM Reporting and Submission Requirements: Proposed Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed

As previously mentioned, the EHR Association is not in favor of adopting the Excessive Radiation eCQM. Should the decision to adopt the measure be made, we would support the proposed smaller number of reporting quarters during the voluntary period, in alignment with the STEMI eCQM. However, we strongly recommend that additional voluntary reporting periods be provided. This is crucial because it remains unclear how or if measures can be accurately calculated within ALARA, creating the potential that new interfaces may have to be built, tested, and deployed.