

June 28, 2021

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 the nearly 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 FY22 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Proposed Rule (CMS-1752-P). 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,



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Modernizing Medicine

Netsmart

Nextech

Nextgen Healthcare

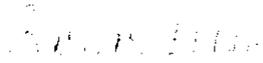
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About the HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of nearly 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 FY22 IPPS Proposed Rule

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

Measure Suppression Policies

CMS requested public comments on various measure suppression policies for the duration of the public health emergency for COVID-19.

The policies proposed and rationale seem reasonable to us.

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

Digital Quality Measurement and the Use of FHIR

We are requesting comments on four potential future actions that would enable transformation to a fully digital quality measurement enterprise by 2025.

EHRA Response:

Today, quality measures are primarily reported through eQMs, a standard familiar to most EHR developers and organizations. The industry should move to dQMs if such a move will lead to other efficiencies, such as alignment of all measures required by various CMS programs. If CMS were to move to dQMs, a number of prerequisites would be necessary.

First, the necessary building blocks of such measures, such as FHIR R4, would need to be widely adopted by program participants. Then, the implementation of QI Core would be required for quality reporting with dQMs.

CMS should only adopt mature and piloted IGs for quality reporting standards into regulatory programs. Because of this 2025 is an overly ambitious goal for a conversion to dQMs.

CMS will need to provide a robust set of testing and validation tools to allow developers to ensure their implementation of the capabilities is consistent and accurate. Also, allow developer access to test-submission portals so they can provide better support to their clients.

If CMS intends to aggregate quality data in the dQM framework, they should provide API(s) to allow for real-time performance feedback and reporting from their measure calculation system, back to the EHR so clinicians can understand how to improve. For transparency, CMS should continue to publish specifications and logic for dQMs in how hospital performance is evaluated.

Does CMS intend to replace all eQMs with dQMs?

We are seeking feedback on the goal of aligning data needed for quality measurement with interoperability requirements and the strengths and limitations of this approach.

EHRA Response:

Quality reporting should not impose extra data collection or documentation requirements on providers, so aligning quality reporting with interoperability data requirements and standards helps leverage data already captured in the course of clinical care. We believe that the current process used with electronic quality measures allows for the integrated workflow capture of the data.

However, without the implementation of QI core and patient matching tools there may be limitations to the ability to aggregate data for quality measures.

We are also seeking feedback on the importance of and approaches to supporting inclusion of PGHD and other currently non-standardized data.

EHRA Response:

While some PGHD elements are not pertinent to the hospital context, we consider Patient Reported Outcomes measures to hold a great deal of value for hospitals.

Are there specific FHIR Implementation Guides suggested for consideration?

EHRA Response:

We recommend leveraging the QI Core FHIR Implementation Guides from the Da Vinci project for implementing FHIR-based quality reporting.

What are possible approaches for testing data quality and validity?

EHRA Response:

Current processes for eQCM and CMS validity testing appear effective. If other applicable approaches are considered in the future we would encourage offering a proposal with a comment period.

Do you have feedback on policy considerations for aggregation of data from multiple sources being used to inform measurement?

EHRA Response:

CMS proposes a complex mechanism for distributed aggregation using a common tool and we would like a better understanding of the proposal to give feedback. Aggregated data can make it more complicated to understand the contribution of each organization to the overall quality of the patient's experience.

Aggregation challenges will include ensuring data is retrievable and accurately codified. Aggregators will need to be able to reliably match patients for accurate reporting.

Improving Demographic Data Collection

We are interested in learning about, and are soliciting comments on, current data collection practices by hospitals to capture demographic data elements (such as race, ethnicity, sex, sexual orientation, and gender identity (SOGI), language preference, tribal membership, and disability status).

EHRA Response:

Much of this demographic and social determinative data is currently possible to be captured in EHRs. Some of these elements are already required by other programs, such as accreditation by The Joint Commission, ACS programs, state requirements, and others.

Notably not all of the listed demographics would be captured by the same users or in the same workflows. For example, sexual orientation may be important information for a clinician, but patients might consider it intrusive if they are asked to identify their sexual orientation at registration. ONC can be helpful as a convener of stakeholders who need to collaborate to create standards and clear data definitions. Additional questions that must be considered include how data will be used and shared, and the appropriateness of exchanging patient data with non-covered entities that may become part of health conversations.

Proposal to Remove Three Measures

We invite public comments on our proposal to remove Admit Decision Time to ED Departure Time for Admitted Patients (ED-2) measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

EHRA Response:

We support CMS' proposal to retire this measure based on the considerations it described in the proposed rule.

We are proposing to remove two stroke-related eCQMs.

EHRA Response: We do not recommend removing these eCQMs in 2024. Some small hospitals, CAHs, and specialty hospitals don't see patients who meet the IPP/denominator criteria of the other available measures. For example, some do not have ICU or delivery wards, and specialty hospitals may not offer an emergency department. These hospitals must report the stroke measures to meet the minimum measure requirements.

New proposed measures may offer an opportunity to meet the IPP/denominator, but the burden to implement these new measures is challenging for smaller, rural and specialty hospitals as they often have fewer staff dedicated to quality measurement. We recommend removal of the stroke-related measures 2 years after the implementation of the new measures NQF 3503e and NQF 3533e.

Transformation of CMS' quality measurement

Would vendors, including those that service post-acute care settings, such as LTCHs, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?

EHRA Response:

Developers would generally be appreciative of being approached for these models, and interested in continued opportunities.

PDMP

We seek comments on our proposal to maintain the Query of PDMP measure in the EHR reporting period in CY 2022 as optional and to increase the bonus points associated with the measure to 10 bonus points.

EHRA Response:

We continue to support CMS' efforts to encourage utilization of PDMPs and support the measure remaining as an optional measure for bonus points.

Would changes to the Query of PDMP measure be necessary to accommodate other technical approaches that may be implemented in the future, such as exchange of information with a PDMP or with multiple PDMPs using HL7® FHIR®?

EHRA Response:

We are aware of issues with PDMP reports, and an overall lack of standards adoption and interoperability with eligible hospitals on the part of PDMPs, which will lead to challenges in converting the Query of PDMP measure into a performance-based measure in the program. Absent the adoption of a consistent set of standards by each PDMP, there will be additional burden on providers and health IT developers to accommodate dozens of technical variations to accomplish PDMP integration.

CMS should work with states to consistently allow data from PDMPs to be incorporated into the EHR when queried. Currently, many states do not provide a technical mechanism to incorporate discrete PDMP data or only permit a read-only view of the data. This inhibits clinicians' ability to maintain a complete patient record in the EHR that includes PDMP data, which has negative downstream effects, such as an inability to use clinical decision support features of the EHR that are based on medication dispense data from the PDMP.

Before CMS can make the PDMP measure performance-based, it must clearly define what it considers to be a qualifying PDMP query. For example, it is currently unclear whether a Single Sign On (SSO) integration with a PDMP (perhaps using the SMART on FHIR specification) that does not return discrete data to the EHR would qualify as a query for the purposes of the measure. In that situation, the EHR would have no way of programmatically evaluating whether the query was successful without requiring manual documentation from the clinician. Conversely, if the PDMP supported integration using the NCPDP SCRIPT 2017071 interface standard, discrete data would be returned from the PDMP, allowing the EHR to automatically verify that a successful query took place. If CMS' goal is to promote true integration between PDMPs and EHRs, we recommend that it clarify that the latter approach qualify as a query, and that it work with PDMPs to adopt the NCPDP SCRIPT 2017071 standard to facilitate interoperable data sharing between PDMPs and EHRs.

What technical considerations exist for intrastate vs. interstate PDMP queries? How could health information exchange networks play a role in expanding access to PDMP data? In what ways could FHIR® applications be supported to safely share PDMP data within a clinician's workflow?

EHRA Response:

Increased adoption of standards-based exchange capabilities by PDMPs and consistent data use policies by states will improve exchange, whether between PDMPs or PDMPs and EHRs.

Bi-Directional Exchange Measure

We propose to add this new HIE Bi-Directional Exchange measure to the HIE objective as an optional alternative to the two existing measures.

EHRA Response:

Examples of the types of transactions CMS sees as pertinent to this measure would be helpful.

Additionally, we ask that CMS clarify what types of audit evidence it expects for this measure.

As we believe that fulfillment of this measure is an extremely high value action, a “yes” response would enable eligible hospitals and CAHs to earn the 40 points allotted to the HIE objective.

EHRA Response:

We support availability of this measure as “optional.”

While our proposed attestation statements for this measure do not explicitly refer to participation in a health information network, or partnering with a health information network that participates in the Trusted Exchange Framework and Common Agreement (TEFCA) described in section 4003 of the 21st Century Cures Act, we recognize that this is likely to be an important way for eligible hospitals and CAHs to enable bi-directional health information exchange in the future

EHRA Response:

HIN should be clarified to include HIEs and national networks, as well using Direct.

Public Health and Clinical Data Exchange Objective

We are proposing to require four of the measures associated with the Public Health and Clinical Data Exchange Objective, beginning with the EHR reporting period in CY 2022: Syndromic Surveillance Reporting; Immunization Registry Reporting; Electronic Case Reporting; and Electronic Reportable Laboratory Result Reporting

EHRA Response:

Investments in public health are vital to modernizing the nation’s healthcare infrastructure. We do have concerns with the significance of this scope change hospitals – particularly critical access hospitals – who, if all measures are required, may find it challenging to identify solutions by the end of 2021. We suggest awarding bonus points for four public health measures in 2022 and required in 2023.

In the event an eligible hospital or CAH is able to claim an exclusion for three or fewer of these four required measures, we are proposing they would receive 10 points for the objective if they report a “yes” response for one or more of these measures and claim applicable exclusions for which they qualify for the remaining measures

EHRA Response:

The exclusions described make sense.

If an eligible hospital or CAH claims applicable exclusions for which they qualify for all four required measures, we propose to redistribute the points associated with the objective to the Provider to Patient Exchange objective.

EHRA Response:

We suggest that if an EH or CAH is excluded from two measures, that the points be reweighted.

We are proposing to retain the Public Health Registry Reporting and Clinical Data Registry Reporting measures and to make them optional and available for bonus points beginning with the EHR reporting period in CY 2022. We are proposing an eligible hospital or CAH may earn a maximum of 5 bonus points if they report a “yes” response for either the Public Health Registry Reporting measure OR the Clinical Data Registry Reporting measure.

EHRA Response:

We support this proposal.

eCQM Removals

We propose to remove STK-03, STK-06, PC-05, and ED-2 from the previously finalized set of eCQMs for the Medicare Promoting Interoperability Program beginning with the reporting period in CY 2024.

EHRA Response:

We are concerned that removal of the stroke-related measures leaves few options for smaller hospitals to choose from, see our comment above.

eCQM Adoption

We welcome public comments on these proposed eCQM adoptions. (Table IX.F-06:)

EHRA Response:

The EHR Association supports these proposed adoptions.

Measures Adopting FHIR®-based API Standards

EHRA Response:

HL7 FHIR-based exchange is in a very early stage. National networks have started efforts to FHIR-enable. Some already support the FHIR-based equivalent of document exchange (where the query is FHIR-based, but the payload is the typical CDA C-CDA or PDF document), but efforts are primarily focusing on FHIR-based exchange using new FHIR R4 US Core.

We recommend following the progress of Carequality and CommonWell, as well as local and state HIEs. FHIR has started to be deployed in public health, and is also being explored around case reporting (HL7 FHIR-based data collection with HL7 CDA eICR report format), and there have been early developments around operational statistics reporting. eCR via HIE and document exchange using FHIR are furthest along.

To what degree are stakeholders currently using or interested in using APIs to exchange information in support of the numerator/denominator measures under the HIE objective? What revisions to the measures under the HIE objective should CMS explore to facilitate use of standards-based APIs in health IT modules certified under the 2015 Edition Cures Update?

EHRA Response:

FHIR is not frequently used for this today.

What are promising FHIR-based approaches to public health reporting use cases that ONC and CMS should explore for potential future consideration as part of the Promoting Interoperability program and the ONC Health IT Certification Program?

EHRA Response:

eCR could be a method using either IHE document exchange or eCR NOW on FHIR. Both yield the same CDA based eICR report, but the method of collecting and transporting is different.

Local health departments have already had technical challenges using the various formats. States appear to be under-resourced and should consider making existing technologies more robust before exploring other technologies.

We are concerned that shifting health systems from current reporting methods (HL7 v2, HL7 CDA) to HL7 FHIR would not yield substantive benefits that would justify making that shift a primary focus. Green field reporting may be able to take advantage of starting with HL7 FHIR.

What potential policy and program changes in CMS and other HHS programs could reduce health care provider and health IT developer burden related to measures under the Health Information Exchange and the Public Health and Clinical Data Exchange objectives?

EHRA Response:

Standardization at federal public health agencies would reduce developer and provider burden.

What do stakeholders believe would be useful ways to measure patients' access to their electronic health information using health IT methods such as patient portals and/or third party applications? What actionable figures related to users' medical record behavior, including but not limited to, the frequency of logins, number of messages sent, or lab results viewed could be captured?

EHRA Response:

The recommended measures are not necessarily a good sign of engagement. More revealing than the number of lab results viewed, for example, may be the number of people who have accessed their electronic health information at least once in the past year. Providers should not be measured by how frequently patients log in, but their systems should allow patients to access the information they want to retrieve.

EHRA would be happy to give feedback on implementability of CMS' draft proposed measure.

How effectively is the Medicare Promoting Interoperability Program currently measuring the use of health IT-enabled processes to improve patient outcomes? What measures in the current program are most relevant to patient outcomes?

EHRA Response:

PI measures today are primarily process-based.