



1 August x, 2011

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3 Donald Berwick, M.D.

4 Administrator

5 Centers for Medicare and Medicaid Services

6 U.S. Department of Health and Human Services

7 7500 Security Boulevard

8 Baltimore, MD 21244

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11 Dear Dr. Berwick:

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13 On behalf of the Board of Directors and members of HIMSS, we are pleased to submit written
14 comments to the Department of Health and Human Services' Centers for Medicare and Medicaid
15 Services regarding the Notice of Proposed Rulemaking (NPRM) published in the Federal
16 Register on July 19th, entitled, "Medicare and Medicaid Programs: Hospital Outpatient
17 Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing
18 Program; Physician Self-Referral; and Provider Agreement Regulations on Patient Notification
19 Requirements" [CMS-1525-P RIN 0938 July 19, 2011]. HIMSS appreciates CMS efforts to
20 promote improved quality outcomes through the reporting of clinical quality measures. HIMSS
21 welcomes the opportunity to comment on the proposed changes to Clinical Quality Measures
22 reporting requirements and the proposed Electronic Reporting Pilot detailed in Section J. of the
23 NPRM.

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25 HIMSS is a cause-based; not-for-profit organization exclusively focused on providing global
26 leadership for the optimal use of information technology (IT) and management systems for the
27 betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have
28 offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the
29 United States. HIMSS represents more than 37,000 individual members, of which two-thirds
30 work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes
31 over 500 corporate members and more than 120 not-for-profit organizations that share our
32 mission of transforming healthcare through the effective use of information technology and
33 management systems. HIMSS frames and leads healthcare practices and public policy through its
34 content expertise, professional development, and research initiatives designed to promote
35 information and management systems contributions to improving the quality, safety, access, and
36 cost-effectiveness of patient care.

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38 We have chosen to comment specifically on the proposed changes to the CMS EHR Incentive
39 Program's quality measure reporting requirements for eligible providers and the proposed
40 Electronic Reporting Pilot discussed in Section J of the rulemaking.

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42 **CMS EHR Incentive Program: Allowing Attestation of Clinical Quality Measures for**
43 **Eligible Hospitals and Critical Access Hospitals for Payment Year 2012**

44 HIMSS appreciates the opportunity to comment on the proposed change to the CMS EHR
45 Incentive Program that would allow eligible providers to continue to attest to the clinical quality

46 measure criteria published in the July 2010 CMS EHR Incentive Program in payment 2012. As
47 noted in our [public comments](#) on the CMS EHR Incentive Program NPRM published in March
48 2010, the data necessary to calculate many of the measures is not available in many EHR
49 systems, either because the function is not automated or the data necessary must have manual
50 interpretation to calculate value. HIMSS agrees with CMS's conclusion that the process by
51 which clinical quality measures are reported electronically from EHRs is immature for today's
52 hospital-based EHR technology.
53 HIMSS supports CMS allowing eligible hospitals and critical access hospitals to continue to
54 attest while CMS and their public and private partners continue to develop an electronic
55 transmission method of reporting clinical quality measures. HIMSS recommends CMS should
56 attestation for hospitals and critical access hospitals until CMS is ready to receive clinical quality
57 measures electronically, including resolution and piloting of all standards, including QRDA, as
58 noted in [HIMSS public comments](#) on the CMS EHR Incentive Program NPRM.

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61 **Electronic Reporting Pilot**

62 HIMSS appreciates the opportunity to comment on CMS proposing to also allow eligible
63 hospitals and critical access hospitals to participate in the Electronic Reporting Pilot as an
64 additional avenue for eligible hospitals and critical access hospitals to comply with the clinical
65 quality measure reporting requirements found in [the July, 2010 CMS EHR Incentive Program
66 Final Rule](#). HIMSS commends CMS for continuing to advance quality measure reporting as a
67 method to improve the quality of healthcare delivery.

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69 **Alignment of the EHR Incentive Program with the Hospital Outpatient Quality Reporting 70 Program (OQR) and the Hospital Inpatient Quality Reporting Program (IQR)**

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72 HIMSS strongly supports all federal efforts to align the CMS EHR Incentive Program quality
73 reporting requirements with other Federal quality reporting initiatives, as highlighted in [HIMSS
74 Policy Principle 2.9](#). Specifically, HIMSS supports CMS efforts to align the EHR Incentive
75 Program with the CMS Outpatient Quality Reporting Program (OQR) and the Hospital Inpatient
76 Quality Reporting Program (IQR). HIMSS supports the CMS stated goal of allowing eligible
77 hospitals and critical access hospitals to move to a system of reporting where eligible hospitals
78 and CAHs can qualify for CQM reporting for both the Hospital IQR and Hospital OQR
79 Programs, and the EHR Incentive Program.. Alignment of these Federal requirements will ease
80 the burden on providers, streamline data collection workflows, and increase the success of
81 provider participation in the adoption and use of interoperable health IT.

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83 The NPRM also proposes six new chart abstracted measures for OQR in CY 2014. HIMSS
84 suggests that CMS reconsider the addition of new chart abstracted measures so close to its stated
85 goal of FY 2015 to transition the Hospital IQR and Hospital OQR Programs to EHR-based
86 submission and phase out manual chart abstraction. Adding new chart-abstracted measures
87 would require duplicate effort for providers, and detracts from the efforts of both vendors and
88 providers to continue solidifying the current infrastructure for health IT-enabled quality
89 measurement. Building this foundation requires time for establishing the necessary data

90 standards, completing adequate field testing and developing implementation guidelines to ensure
91 data quality and consistent, efficient clinical workflows.

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93 **Beneficiary Level Data Reporting**

94 HIMSS members have observed that there are significant technical legal complexities (untested
95 measures, transmission overhead, potential HIPAA violations, etc.) associated with sending
96 beneficiary level data to CMS for the proposed Pilot.

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98 HIMSS [Policy Principle 5.5](#) calls on the Federal government to promote compliance with
99 privacy and security provisions of federal and state laws and regulations to protect patient health
100 information. HIMSS is concerned that the request for large amounts of beneficiary level data
101 may not meet the minimum necessary HIPAA requirement for the disclosure of personal health
102 information. ARRA/HITECH clarified that it is the sender of data that is responsible for making
103 the minimum necessary determination- in this case, the hospital. For the pilot and future uses like
104 it, it would be difficult for the hospital to be fully confident that it has met the minimum
105 necessary requirement, because it is not clear what the data will be used for and/or if any
106 particular data will be used at all. Also, it is not clear that CMS is asking for de-identified data.

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108 HIMSS recommends that CMS provide clarification as to why aggregate quality measures from
109 certified EHR technology or approved data submission vendors would not be sufficient for the
110 Pilot and/or the IQR/OQR and EHR Incentive Program.

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112 HIMSS also recommends that CMS consider either using only aggregate data in the Pilot, or
113 CMS should test both aggregate and patient-level data submission.

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115 **Incentives for Eligible Hospital and Critical Access Hospital Participation in the Electronic 116 Reporting Pilot**

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118 HIMSS members have observed that the proposed one year period of measurement, which would
119 start October 1, 2011, could serve as a disincentive for hospitals and critical access hospitals to
120 participate in the pilot if they are in their first year of meaningful use in 2012, when they would
121 have a 90-day reporting period.. HIMSS members have observed that this disincentive and the
122 lack of meaningful incentives to participate in the pilot may not overcome the bandwidth
123 requirements for addressing regulatory compliance for the CMS EHR Incentive Program Stage
124 2, ICD 10/5010 compliance, and Affordable Care Act provisions. Additionally, according to the
125 NPRM, determination of successful submission for 2012 to CMS could take place as late as
126 November 30, 2013, causing a significant delay in payments to the EH/CAH.

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128 The NPRM notes that CMS anticipates that Quality Reporting Document Architecture or QRDA
129 will serve as the data submission format for the pilot. We have concerns with the maturity of this
130 standard for quality reporting and also have concerns that EHs and CAHs may be reluctant to
131 commit to participate in a pilot until the Final Rule and associated requirements are finalized.

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133 In light of these observations HIMSS recommends that CMS should clarify that hospitals and
134 critical access hospitals can attest to Clinical Quality Measure Reporting requirements for the

135 EHR Incentive Program and, if meeting all required criteria, can receive full EHR Incentive
136 Program payment concurrent to participating in the Pilot. Under such a scenario, the hospitals
137 and critical access hospitals will be assured of receiving the EHR Incentive payment at the
138 conclusion of their applicable reporting period, while their submission to the Pilot is being
139 evaluated. Specifically, we urge CMS to allow for a 90-day reporting period for EHs and CAHs
140 in their first year of meaningful use.

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142 Also, CMS should explore the creation of an additional incentive for hospitals to participate in
143 the Pilot in order to ensure hospital participation.

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145 We look forward to continuing the dialogue between our members and the Centers for Medicare
146 and Medicaid Services to ensure the development of an interoperable healthcare system to
147 support healthcare transformation in the U.S. If you have any questions, please contact [Thomas](#)
148 [M. Leary](#) via email or at 703.562.8814

149 Sincerely,

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154 Charlene S. Underwood, MBA, FHIMSS
155 Chair, HIMSS Board of Directors
156 Senior Director, Government and Industry Affairs
157 Siemens Healthcare



H. Stephen Lieber, CAE
President/CEO
HIMSS