HIMSS
transforming health through information and technology™

33 West Monroe Street
Suite 1700
Chicago, IL 60603-5616 USA
Phone 312.664.HIMSS (664.4667)
Phone 312.664.6143
www.himss.org

May 31, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-1850

Dear Ms. Verma:

On behalf of the Healthcare Information and Management Systems Society (HIMSS), we appreciate the opportunity to offer the Centers for Medicare & Medicaid Services (CMS) a revised set of recommendations for enacting electronic clinical quality measure (eCQM) reporting requirements, eCQM specification development, as well as how to ultimately generate true value through improved clinical outcomes from these policies. With these recommendations, HIMSS anticipates improved accuracy, better alignment with clinical workflows, and shortened implementation timeframes for reporting clinical performance and quality. HIMSS remains at the forefront of innovations on these topics, and we look forward to continuing our dialogue with CMS on the continued improvement of the quality measures program.

HIMSS is a global voice, advisor, and thought leader of health transformation through health information and technology with a unique breadth and depth of expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare, and care outcomes. HIMSS designs and leverages key data assets, predictive models and tools to advise global leaders, stakeholders, and influencers of best practices in health information and technology, so they have the right information at the point of decision.

Core to the HIMSS mission is promoting the use of health information and technology to improve the quality of healthcare delivery through effective performance measurement and clinical decision support. HIMSS demonstrated its interest in improving clinical quality measurement in our letter to CMS on February 26, 2016. Today, HIMSS updates its thoughts on these topics and offers the following recommendations to CMS:

- CMS should not adopt claims-only quality and outcomes reporting. Measurement programs should select the form of measurement that best measures the appropriateness and quality of care of the organization being measured
- CMS quality reporting policies should strive to enhance the value proposition of participating in quality reporting programs and ensure that eCQMs are actionable for hospitals, providers, and patients to drive improvement in care outcomes

- CMS measures should promote accurate provider attribution for quality measures to ensure equitable value-based payments and public reporting
- CMS policies should reduce the implementation and data collection burden on providers, hospitals and health information and technology developers by using information already collected for care and reducing the introduction of new inefficient workflows; we encourage CMS to select eCQMs that are proven to be feasible across all care delivery environments; and ensure that eCQMs accurately reflect the quality of care delivered
- Timelines following substantive changes to eCQMs should allow appropriate time for implementation and testing of measures by end users before becoming required components to measure data sets
- CMS should continue to enhance post-regulatory guidance offerings to assist stakeholders with implementing and field testing new eCQMs and changes to measure specifications

Further details on these recommendations are included below.

CMS should not adopt claims-only quality and outcomes reporting. Measurement programs should select the form of measurement that best measures the appropriateness and quality of care of the organization being measured

HIMSS supports the idea that the accuracy and the ability to report measures across the nation are better supported by capturing the actual clinical data elements that demonstrate a quality measure was met. While HIMSS understands the appeal of using different types of coding schemes and repurposing them as proxy measurements of quality, we do not believe they truly capture the quality of care provided to patient populations.

The specifications and rules regarding how a coding professional determines the codes to associate to a specific patient encounter are completely removed from how a quality measure abstractor determines how a measure was met or not met. Some HIMSS members report that their quality measure abstractors interact frequently with their coding department personnel to request coding corrections that support a quality measure specification only to be informed that the coding, submitted for reimbursement, does not support the quality abstractor's finding. More often, provider resources are used to make documentation improvements rather than clinical care improvements to support claims-based quality reporting and, in some cases, providers are driven to forgo higher levels of reimbursement to meet the quality measure.

In essence, the majority of decisions regarding these types of codes are driven towards optimizing the provider's reimbursement and Diagnosis-Related Grouping (DRG), not to support measuring the quality of care provided. In addition, the aforementioned claims-based codes do not incorporate nor support robust risk-adjustment models that would make comparability of providers' performance across the nation more accurate and reflective of their patient population. While HIMSS supports the inclusion of these claims code systems in quality measurement, we believe they should be used to strengthen the validity of eCQMs and not as a stand-alone quality measure.

Organizations involved with the feasibility testing of de-novo eCQMs designed to extract data from an electronic health record (EHR)-enabled clinical workflow have indicated that significant progress is being made to extract meaningful clinical data from the EHR while minimally affecting current workflow. The eCQMs are much more meaningful measures of care than claims data. eCQMs can be much easier to risk adjust to account for socioeconomic status and health history for appropriate national comparisons of care.

Through the HIMSS Davies Award Program and the HIMSS Value Suite collection, we have observed how CMS requirements for quality measurement and improvement have been the impetus for quality improvement initiatives across the United States. The Medicare and Medicaid EHR Incentive Program, Inpatient Quality Reporting Program (IQR), Quality Payment Program (QPP), Hospital-Acquired Condition Reduction Program, and Hospital Readmissions Reduction Program, as well as negative payment adjustments have driven the utilization of information and technology to improve patient care.

Overall, HIMSS supports a transition to more eCQMs and decreasing the utilization of claims codes for quality measure reporting. While there is a decrease in the burden of reporting with claims coded for quality and outcomes, we believe the inherent incongruities between claims codes and the quality of care provided to the patient are much greater when using eCQMs than other methods of quality reporting.

CMS quality reporting policies should strive to enhance the value proposition of participating in quality reporting programs and ensure that eCQMs are actionable for hospitals, providers, and patients to drive improvement in care outcomes

HIMSS believes that CQMs must be meaningful to improve care provided by eligible hospitals and professionals. The measures should be actionable for providers to leverage to improve clinical outcomes.

We agree with the recent shift by CMS to more outcomes measures, and encourage CMS to work to support the development of outcomes-driven clinical quality measures that can be extracted from electronic clinical data.

HIMSS strongly recommends reliable and robust risk adjustment of all outcomes measures. We are encouraged by the recent development of risk adjustment models using EHR data elements and the inclusion of sociodemographic adjustment in the Hybrid Readmission measures.
Measures should clearly support improving the patient experience of care (including quality, outcomes, and satisfaction); improving the health of populations; and, reducing the per capita cost of health care.

CMS can provide a business and clinical case demonstrating that the eCQM presents a value proposition for providers, including a cost to implement/collect versus benefit analysis of each measure. HIMSS defines value through its HIMSS STEPS™ value optimization framework. The STEPS™ framework provides an easily understood vocabulary for stakeholders to take advantage of when formulating their value strategies. The STEPS™ model is built around five categories: Satisfaction; Treatment/Clinical; Electronic Secure Data; Patient Engagement & Population

Management; and, Savings as well as case studies demonstrating examples of how technology has been leveraged to produce value in each category.

HIMSS recommends that CMS develop a robust de-novo menu measure set of eCQMs for use by providers and hospitals that are designed specifically to capture eCQM data as part of an EHR-enabled clinical workflow. Selected CQMs should present a clear pathway to value and fit into an analytics capability for use by healthcare professionals and hospitals as a meaningful scorecard on performance. While HIMSS is not calling on HHS to require that certified electronic health record technology (CEHRT) include a real-time performance dashboard, such functionality would be very valuable for providers. HIMSS recommends CMS engage with developers, in a voluntary and collaborative manner, on identifying and implementing the most promising ways to present quality results for action.

In addition, eCQMs selected for HHS programs should be actionable, meaning that reported clinical quality measure data can be utilized to identify gaps in care, conduct workflow analysis and root cause analysis for performance outcomes, and trigger change management to adjust workflows and best practice guidance that will drive improved outcomes. Access to accurate, clinically relevant, and as close to real time trended data is critical to ensure that quality measurement reporting is not just "reporting for compliance."

Moreover, HIMSS encourages CMS to collaborate with accreditation organizations (e.g., the Joint Commission), private payers, and state governments to develop consensus supporting a core measure set that closely aligns to the CMS eCQM menu set.

CMS measures should promote accurate provider attribution for quality measures to ensure equitable value-based payments and public reporting

Accurate provider attribution to quality measure results in all settings of care (including inpatient facilities) are crucial for equitable value-based payments and public reporting. One of the most important goals in CQMs is for providers to be able to measure and evaluate their own quality improvement without being overly burdensome to collect and report data.

Inpatient and outpatient organizations face very different challenges on attribution. On the inpatient side, there are often admitting providers, residents, mid-levels, attending providers, different specialists, multiple hospitalists providing care and therefore, judging where the responsibilities for certain elements of care or documentation lies is very important and difficult to pin down. This would likely require some empiricism and algorithmic approach based on providers who provide "most" care.

On the outpatient side, provider groups or health systems often struggle with population and panel attributions when there are patients being taken care of by multiple providers and sometimes the clinical care for a specific condition is divided up between primary care and specialists (i.e. diabetes between endocrinology and primary care). There are all kinds of algorithmic approaches to panel management available and measuring quality in those arenas is very complex. The complexity is increased when patients change doctors, move cities or come in and out of Medicare plans such as Advantage plans. Variation and error rates will always occur and require manual

engagement and review with the data to determine the accuracy of the attribution. Workflows are too complex to accurately assign attribution without a manual case review.

HIMSS volunteers represent a wide variety of care settings and have had diverse experiences with the challenges of patient attribution. HIMSS would be happy to connect CMS policymakers with our volunteers to share their specific experiences and recommendations for each care setting. HIMSS also recommends that CMS consider utilizing telehealth technology when soliciting feedback on attribution issues.

CMS policies should reduce the implementation and data collection burden on providers, hospitals and health information and technology developers by using information already collected for care and reducing the introduction of new inefficient workflows

We encourage CMS to select eCQMs that are proven to be feasible across all care delivery environments and ensure that eCQMs accurately reflect the quality of care delivered. HIMSS believes eCQMs have the potential to achieve the critical goal of providers measuring and evaluating their own quality improvement without being overly burdensome to collect and report data. While progress has been made to improve the eCQM specifications, our members continue to have many implementation challenges. We urge CMS to continue its efforts in resolving these issues and to improve eCQM specifications.

For the nation's healthcare providers to have full faith and confidence in the value proposition of eReporting quality measures, these challenges must be addressed.

HIMSS recommends any eCQM (retooled or de-novo measure) should be tested and validated to meet the following criteria before being included in the eCQM set for any CMS quality reporting and/or value-based purchasing program, including IQR and the QPP:

- Required data elements for selected eCQMs must be accurately and efficiently gathered in the healthcare provider workflow, using data elements already collected as part of the care process and stored in the EHR or other interoperable clinical and financial health information technology. Re-using these data elements for eCQMs as a byproduct would significantly reduce provider burden. Data used in eCQMs should be easily extractable for reporting purposes. As we move into a more interconnected healthcare environment, we need to be thoughtful about assuring data quality as it is gathered and reported from multiple data sources outside of the typical clinical workflow.
- eCQMs must be thoroughly tested for validity, reliability and feasibility. Field-testing prior to general release would improve quality of the specifications and endorsement by the National Quality Forum (NQF) would ensure that the measures produce comparable and consistent results. The eCQM testing process should include a testing site with a set of sample data, testing examples and an Implementation Guide that can be used by vendors during their implementation and testing.
- HIMSS continues to strongly support the concept of a National Testing Collaborative, fully funded and supported by CMS.
- Value Sets should include all available terminology code Concept IDs represented in measures. Providers and vendors have incorporated the ability to capture many structured data elements mapped to various codes into their workflows and systems

and are often not able to electronically capture just a limited set of codes from coding systems directly into the EHR's. eCQMs should be field tested in all relevant care settings using all available vendors. There is great variation between EHR vendor system workflows for documenting, and back end builds. There is also variation in providers who use one standard health information technology (HIT) system, and providers who integrate "best of breed" systems. EHR variation leads to challenges in a hospital's or provider's ability to electronically abstract data elements and provide accurate eCQM quality reports.

- In order to make field testing robust, providers should be incentivized to participate. This incentive should provide both small hospitals who lack resources, and large hospitals who have resources allocated to other priorities, the ability to participate in in-depth field testing programs.
- eCQM standards and value sets should be harmonized across all measures used in CMS and other reporting programs. Providers have expressed frustration with variation in value sets developed for the same or very similar concepts. In addition, some of the measure specifications for very similar measure intents are not fully aligned in different programs. HIMSS fully supports the movement of quality and clinical decision support to embrace the FHIR® standard but recommends harmonization with existing standards and profiles to fully achieve interoperability and facilitate a smoother transition for providers, hospitals, EHR vendors, and implementers.

No eCQM should be included in CMS quality reporting or value-based payment programs without fully completing this testing program. Upon submission in professional journals (as proposed in CMS' draft Quality Measure Development Plan) or submission for NQF endorsement, CMS should develop a checklist for inclusion in the submission documents validating that the measure in question has met the criteria in this recommendation.

Timelines following substantive changes to eCQMs should allow appropriate time for implementation and testing of measures by end users before becoming required components to measure sets

CMS published a request for information (RFI) inquiring about the value of certifying electronic health record technology to the most recent version of electronic specifications. More important than re-certifying, CMS must follow the steps outlined in the subsection titled "Measurement Testing, Field Testing, and Feasibility of Measures" to ensure that a measure has been properly tested, field tested, and verified to produce comparable and consistent results before inclusion as part of the quality measure set for the MIPS or other federal quality reporting programs.

The time required for vendors and providers to implement any single eCQM can be highly variable, depending on the complexity of the measure, the extent to which new eCQM authoring tools and representation approaches have been used, and the scope to which the measure draws on data elements already collected in EHRs.

HIMSS strongly supports eligible hospital and eligible professional quality reporting and updates taking place on a calendar year schedule. However, HIMSS has concerns with the proposal to

annually update eCQM sets and reporting requirements via the eCQM Annual Update and the annual Inpatient Prospective Payment Systems (IPPS) and QPP rulemaking process. With a May publication date, there is only a seven-month window for vendors and providers to incorporate any changes to eCQM sets and specifications. Given the continuing evolution of technology and clinical standards, as well as the need for a predictable cycle from measure development to provider data submissions, HIMSS makes the following recommendations:

- Only non-substantive changes in eCQM measure sets and specifications that do not require corresponding changes in provider workflow or systems should be made annually through the Annual Update and Physician Fee Schedule/IPPS rulemaking for the following reporting year
- Substantive changes (for example, a new CQM or a change in a current CQM that requires a workflow/system change) should be published in the IPPS/MIPS rulemaking and Annual Update but should not be required for data collection until 18 months following the publication of the final rulemaking. For example, a new CQM published in the 2016 Annual Update should not "go live" until the 2018 data collection period
- Every effort should be made by CMS to publish annual updates and final rules well before the legislatively established deadlines to give the industry adequate time to meet the requirements

CMS needs to continue to enhance post-regulatory guidance offerings via the eCQI Resource Center to assist stakeholders with implementing and field testing new eCQMs and changes to measure specifications

It is absolutely critical for CMS and partner organizations to create broader awareness among frontline clinicians to understand the vision and mission of what electronic clinical quality measurement can accomplish, how accurate quality reporting benefits providers and patients, and how CMS and stakeholders are planning to overcome current barriers to effective reporting and utilization of eCQMs.

The quality measure specifications on many CMS web sites are difficult to locate and use, and lack good versioning or change logs to clearly indicate when changes were made. The launch of the CMS eCQM Library and the eCQI Resource Center has been a helpful step forward.

Due to the complexity of quality measurement systems, their multitudes and the limited resources of many hospitals and clinics across the United States, any effort towards better tools to manage measures will go a long way. We are encouraged by the CMS Quality Measures Inventory Tool (CMIT). The CMIT contains measures under development along with all other measures from the different Medicare Programs. The ability to filter through the different measures and identify each measure attribute is of added value (such as anticipated CMS program, measure type, NQF endorsement status, measure steward, and measure developer) to hospitals or other healthcare entities. Such efforts to centralize and compile comprehensive repositories of quality measures should be expanded on and allow access to all measure details.

The CMIT could be of further value if private payers were encouraged to participate and provide their measure details as well. As the tools evolve, we recommend addressing the following gaps:

- Specifications on the eCQI web site should include the ability to drill down to the value set member level from within the specifications and identify updates to specifications from the previous version(s) similar to functionality on the *United States Health Information Knowledgebase* (*USHIK*) site
- Simplify the process so that an end user does not have to visit a different site to find the quality reporting requirements (number of measures and domains, reporting periods, submission deadlines)
- Standardize eCQM measure lists and identifiers across CMS documents and websites, and encourage supporting organizations to follow (such as the Value Set Authority Center, JIRA, etc.). This standardization should be consistent across all measure documents and references and contain both the CMS# and the NQF#. The measures should consistently be listed chronologically by either CMS#s or NQF#s and contain at least a reference name title. Examples of problems that have confirmed the need for this recommendation are:
    - On the eCQI Website: Eligible Hospital (EH) measures are listed by CMS# with a reference measure title while Eligible Professional (EP) measures are listed with only the CMS#
    - CMS eCQM Measure Table Document: EH and EP measures are listed by CMS# and contain the NQF#, PQRS#, reference title and measure set identifier
    - CMS eCQM Specifications list: EH and EP measures are listed by CMS# and contain the NQF#, and reference title
    - CMS eCQM Technical Release Notes Document: Contains CMS# only
    - CMS eCQM Logic Flows Document: EH and EP are listed as CMS#s only
    - Value Set Authority Center: All measures are listed as CMS#s only
- Develop and publish (to the eCQI Resource Center) a crosswalk tool that demonstrates which state, private payers, and accreditation programs utilize the same measures for their program.
- eCQI Resource Center should also include:
    - Sub-regulatory guidance on eCQM specifications, measure logic, fact sheets, and the JIRA mechanism for receiving CMS one-off guidance
    - Include all the reporting requirements, such as the number of measures and domains and the dates for collection and submission for all CMS quality reporting programs
    - Ensure eCQM specifications can easily be identified, downloaded, and monitored for changes.
    - Feature a process to avoid publishing ambiguous or erroneous measure specification
- Rigorous quality assurance is essential
- HHS should leverage HIMSS and other stakeholder volunteers in pre-publication workgroups that can review draft rulemakings and identify potential errors or ambiguities that could result in frequently asked questions
- A process for timely corrections and updating eCQM specifications is required to assure accuracy of measure calculations. This process should include:
- Clear delineation of eCQM changes, such as distinctive highlighting of corrections, additions and deletions as well as the checklist/coversheet from validation testing
- Well defined, standard, timely process for reporting, correcting and publishing updates to eCQM

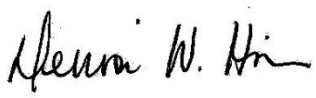
- A posted schedule of anticipated updates, perhaps annually, to assure a reasonable and predictable cadence for development of required software updates
- Collaboration with established organizations (e.g. HIMSS, American Hospital Association, American Medical Association, CHIME, American College of Physicians, EHR Association, AMIA, Executive Groups, Quality Forums) to identify the best way to incorporate the eCQM message into established communication plans
- A consolidated communications plan and model in which CMS and ONC content experts and support contractors use the same templates and branding for regulatory guidance and updates

HIMSS is committed to fostering a culture where health information and technology are fundamental to transforming healthcare by improving quality of care, enhancing the patient experience, containing cost, improving access to care, and optimizing effectiveness of public payment.

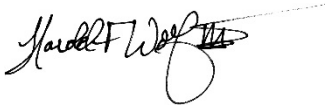
We look forward to the opportunity to further discuss these issues in more depth. Please feel free to contact Jeff Coughlin, Senior Director of Federal & State Affairs, at 703.562.8824, or Eli Fleet, Director of Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,



Denise W. Hines, DHA, PMP, FHIMSS
CEO
eHealth Services Group
Chair, HIMSS North America Board of Directors



Harold F. Wolf III
President & CEO
HIMSS