June 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the Healthcare Information and Management Systems Society (HIMSS), we are pleased to provide public comments on CMS 1808-P Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes.

HIMSS is a global advisor and thought leader and member-based society committed to reforming the global health ecosystem through the power of information and technology. As a mission-driven non-profit, HIMSS offers a unique depth and breadth of expertise in health innovation, public policy, workforce development, research, and analytics to advise global leaders, stakeholders, and influencers on best practices in health information and technology driven by health equity. Through our innovation engine, HIMSS delivers key insights, education and engaging events to healthcare providers, governments, and market suppliers, ensuring they have the right information at the point of decision. HIMSS serves the global health information and technology communities with focused operations across North America, Europe, the United Kingdom, the Middle East, and Asia Pacific. Our members include more than 127,000 individuals, 480 provider organizations, 470 non-profit partners, and 650 health services organizations. Our global headquarters is in Rotterdam, The Netherlands and our Americas headquarters is in Chicago, Illinois.

Increasing eCQM reporting requirements for the Inpatient Quality Reporting (IQR) Program and the Promoting Interoperability Program (PIP.)

HIMSS support the CMS proposal to increase the number of electronic clinical quality measures (eCQMs) which must be reported to successfully meet the requirements of the Inpatient Quality Reporting program (IQR) and the Promoting Interoperability Program (PIP) starting in calendar year 2026. The increase in the number of measures (from three self-selected eCQMs and three mandatory eCQMs presently to three self-selected eCQMs and six mandatory eCQMs) in 2026, and eight mandatory eCQMs in 2027, represents an appropriate timeline for eligible hospitals (EHs) and critical access hospitals (CAHs) to successfully implement the mechanisms for capturing and reporting the needed data to meet the measures. The newly mandated measures all currently reside in the self-selected eCQM measure set and should already be supported in certified health information technology. HIMSS feels the increased requirements are a reasonable forward step in moving towards CMS's stated goal to transition all quality measure reporting to digital measures.

HIMSS supports CMS' inclusion of the Hospital Harm - Opioid-Related Adverse Events eCQM to the mandatory eCQM measure set for eligible hospitals. While the efforts of policymakers and clinicians have made an impact on opioid-related adverse events, the effects of opioid addiction are still being felt. CMS has taken an approach consistent with HIMSS recommendations by adding Hospital Harm-Opioid-Related Adverse Events to the self-selected eCQM list in CY 24, allowing eligible hospitals two years to prepare for mandatory reporting.

In addition, HIMSS continues to encourage CMS support of the USCDI+ Quality Domain, as digital quality measures will require a more sophisticated and clinically nuanced health data classes and constituent data elements to ensure digital measures produce comparable and consistent results against the measure's intent.

Finally, HIMSS encourages CMS to continue to define digital quality measures as "quality measures organized as a framework of self-contained measure specifications and code packages, that use one or more valid and reliable sources of health information that is captured and can be transmitted electronically via interoperable systems." HIMSS welcomes the opportunity to engage our members in discussions about the value proposition and ways to make digital quality measurement effective to meet the goal of improving the health of every human everywhere.

Proposed eCQM additions to the IQR and PIP menu sets

HIMSS supports the CMS proposal to include the Hospital Harm Patient Falls eCQM and the Postoperative Respiratory Failure eCQM for inclusion in the Inpatient Quality Reporting and Promoting Interoperability Program self-selected eCQM menu set starting in calendar year 2026. HIMSS assesses proposed measures using a framework to ensure those measures are accurate assessments of the quality of care delivered; meaningful in that the interventions required to improve measure performance will also improve clinical care and patient outcomes; not overly burdensome to collect and report as part of a normal clinical workflow and are actionable. At a high level, the framework calls for new measures to be:

- Meaningful measure of care quality:
    o Any new quality measure should utilize data to present a meaningful and actionable assessment of patient care. Emphasis should be placed on the development of measures which are clinician-driven to support care delivery meeting the standard of care, not meeting the data collection needs of payers only.
- Accurate measure of care quality:
    o Any new quality measure should be lab/simulation tested, field tested, and validated to produce comparable and consistent results against the measure's intent.
- Actionable measure of care quality:
    o Whenever possible, clinical quality measure data should be available in as close to real time as possible to drive needed changes in workflow to eliminate gaps in care. The latency of data for clinical quality measures should be driven by measure type. Performance data should be

interoperable with summarized formats and data visualization tools that can easily identify gaps in care at the patient level.
- Not overly burdensome to collect and report:
  - Any new quality measure and associated policies should reduce the implementation and data collection burden on health systems, providers, and health information technology developers by using data already collected for care and without introduction of new inefficient workflows. We must ensure that data facilitates effective process change without overwhelming clinicians and resources.

Based on our assessment, HIMSS feels the digital health information collected through these eCQMs can be utilized to identify gaps in care, optimize clinical care delivery, and improve patient outcomes. The proposed eCQMs have a timeline consistent with the 18 months the industry needs to implement the specifications, code sets, and workflows in a manner where the data can be collected to produce comparable and consistent results with the measure's intent. HIMSS commends CMS for listening to the industry's recommendations and strongly recommend that CMS continue to use the 18-month implementation timeline for future eCQMs.

While the inclusion in the self-selected eCQM menu allows CMS additional data to validate each of the proposed eCQMs, the two proposed eCQMs were each only tested at 12 sites, with only two of the acute care EHRs on the market. As CMS works towards transitioning from eCQMs to digital quality measures (dQMs), addressing the need for more robust and diverse testing will be critical to successful adoption. To facilitate increased participation, HIMSS strongly recommends CMS consider three potential approaches to help encourage more end-user participation in real world testing:

1. Ensure that the testing cohort for new and/or substantively updated eCQMs and dQMs include a significant sample size, including large and small hospitals across a wide geographic and patient demographic spectrum.
2. Provide a significant scoring bonus for hospitals participating in testing in the Inpatient Quality Reporting program and other value-based care models. This heightens critical access, rural, and community hospitals opportunities to receive incentive program dollars.
3. Implement a requirement for CMS-funded measure development and testing contracts to allocate sufficient funding to facilitate testing, mapping, and implementation work for field testing at testing sites.

Proposed Patient Safety Structural Measure for IQR

HIMSS supports CMS goal of improving patient safety and achieving zero harm. HIMSS believes the actions required to meet the proposed patient safety structural attestation measure will help drive improved patient safety outcomes.

While HIMSS supports intended outcome of the proposed patient safety structural measure, the measure's scoring methodology may stand as a barrier to gathering critical information on existing gaps within the healthcare ecosystem. The structure of the measure requires the eligible hospital (EH) to attest yes to all sub-questions within each domain. If the EH can't meet a single sub-question within the domain, they must

attest no. This structure deprives CMS of valuable insight on specific patient safety improvement strategies health systems are struggling to implement. If the measure was revised to require a Yes/No attestation for each of the sub-questions within each domain, CMS would gather important information on the state of the industry. Restructuring the measure in this manner would also allow the industry more time to implement the changes to meet the measure.

Promoting Interoperability Program Public Health Request for Information

HIMSS welcomes the opportunity to participate in a discussion about industry readiness for moving from attestation to measurement for reporting public health data elements.

- **Should CMS shift to numerator/denominator reporting requirements for current and future measures in the Public Health and Clinical Data Exchange objective?**

  o **If so, should CMS prioritize only certain measures for numerator/denominator reporting?**

HIMSS supports a future state that requires mandatory performance measures with numerators and denominators for successfully reporting required public health data elements to public health agencies (PHA.) However, two barriers make implementation of such a measure at the present time unnecessarily burdensome and not meaningful for health systems.

Currently, many public health agencies do not have the infrastructure to support standards-driven FHIR-enabled public health data elements. We are concerned that there are a significant number of PHAs that can't facilitate the proposed reporting requirement. HIMSS does not believe it would be CMS' intent to potentially penalize eligible hospitals and eligible providers who are capable of electronically reporting the required data elements but can't successfully meet the measure due to the current level of their PHA's readiness to receive the data in a format proposed by CMS. We recommend that CMS consider including an expansive hardship exemption to a potential measure, which will address the problem of well-intended hospitals and providers not having a PHA with the requisite technological capabilities. We recognize that a hardship exemption could have a short-term negative effect on the value of the measure and suggest the measure will be more valuable as the federal government's Data Modernization Initiative improves public health readiness for such a critical exchange.

In addition, examples exist of health systems that have the capability to report and public health agencies that can receive data electronically. However, the health system has not been onboarded yet by the public health agency. The onboarding process for electronic reporting to PHAs varies wildly, and rarely is aligned with CMS's reporting period. Any measure should consider that health systems may be delayed in onboarding for reporting because of backlogs at the PHA. HIMSS would welcome the opportunity to speak with health systems facing these challenges and discuss how to structure measures in a manner which make them meaningful, actionable, and not overly burdensome to meet the reporting requirements.

Creating the appropriate public health IT infrastructure to support Promoting Interoperability Program reporting requirements is critical to improving public health response and strengthening public health's ability to provide critical insights to decision-makers. In HIMSS's [Public Health Information and Technology Infrastructure Modernization Funding Report](#), HIMSS estimates that the nation's state, local, and territorial public health agencies would require an investment of over $36 billion dollars over the next ten years to have the infrastructure (hardware, software, interoperability, staffing, and sustainability) needed to accept the data elements required for reporting by the Promoting Interoperability Program in a standardized, FHIR-enabled manner (along with supporting other critical public health functions.) HIMSS continues to encourage HHS and the underlying agencies to invest in data modernization and encourage state and local PHAs to improve capabilities to electronically receive data from hospitals and providers.

HIMSS has a suite of digital health [maturity models](#), packages of on-sight assessments, consultancy, and advisory services through the [Digital Health Technology Partners Program](#) (DHTP), and an enterprise-wide digital health assessment of an enterprise's governance and workforce, analytics capability, interoperability, and person-enabled health tools (the [Digital Health Indicator](#)) to aid PHAs (and all healthcare delivery sites) in achieving the digital maturity required to maximize a PHA's ability to receive, analyze, and leverage data to improve public health.

- **How should CMS account for varying levels of public health readiness and capacity for expanding conditions reported electronically, such as in rural areas?**
- **What levers besides PIP should CMS explore to improve the completeness of reporting to public health?**

Public health measures are crucial and should be prioritized by CMS. Traditionally, CMS has gradually increased the requirements for public health reporting. HIMSS notes and recommends the following:

- Allow healthcare organizations to choose measures from a menu set based on regional or healthcare system importance. This approach could align with specific public health needs and reduce burdensome reporting.
- Create learning laboratories whereby healthcare organizations should work more closely with Public Health Agencies (PHAs) to determine the adequacy of data being submitted by healthcare organizations. PHAs could assess the data quality and provide feedback to organizations. This approach may also help to identify and alleviate burdens on PHAs, such as requiring them to issue compliance letters. It is noted that public health agencies may struggle with administrative complexities.
- Establish incentives to encourage healthcare organizations to adopt and support public health reporting requirements. This includes fostering meaningful engagement between healthcare systems and vendors.
- Address the data standards and associated with potential public health reporting, including the administrative and financial burdens they may impose. There are both administrative and financial burdens associated with data reporting. Healthcare facilities incur costs related to data formatting, submission, and maintenance. A debate exists around who should bear these costs—whether it's the facilities, vendors, or a collective effort. This is a major aspect

thwarting interoperability across the spectrum. HIMSS recommends leveraging key stakeholder meetings including the HIMSS Global Conference to address the challenges related to system standardization across different healthcare facilities and public health agencies. While there are national standards, those standards are not employed or fully adhered to in jurisdictional reporting consistently, often because of disparate requirements set by state and local law. This contributes to complexity and cost.

- Evaluate process and programmatic improvements that need to be implemented to increase the likelihood of achieving improvements in program scalability and cost-effectiveness. There is a recognition of the need for scalable and cost-effective solutions in public health data reporting. However, the challenge lies in investing upfront to develop systems that can support scalable and standardized data exchange.

Overall, HIMSS emphasizes the complexity of public health data reporting, the financial implications for healthcare organizations, and the necessity of incentivizing engagement to facilitate effective data exchange between healthcare systems and public health agencies. The focus is on streamlining reporting processes, reducing burdens, and fostering collaboration to enhance public health outcomes.

Flexibility and Adaptability of the Public Health Reporting Enterprise

- **How can PIP support or incentivize response ready reporting capabilities for healthcare providers? What, if any, challenges exist around sharing data with PHAs?**

- **How can CMS and ONC work with vendors to ensure that provider systems are being continually updated to meet new data needs, such as those in rural areas?**

Overall, the discussion highlights the need for streamlined and flexible approaches to public health reporting, including aligning EHR regulations with public health needs, incentivizing vendor support for new reporting requirements, and improving bidirectional data exchange using standardized APIs. Addressing administrative burdens and ensuring accountability in data transmission are key focus areas to enhance the effectiveness and efficiency of public health reporting systems.

- HIMSS acknowledges the significant complexity and volume of data that must be exchanged for public health reporting. The burden on EHR vendors and healthcare systems is substantial due to regulatory requirements and standards. Therefore, HIMSS supports the suggestion to integrate public health reporting requirements into EHR regulations and certified EHR technology rules. Aligning these regulations with public health needs could facilitate more effective data reporting.

- Moreover, HIMSS encourages CMS to study the potential benefits of using intermediaries and decentralized decision support to manage variability in reporting requirements. This approach could streamline reporting processes and reduce burdens on healthcare organizations. For instance, there is a proposal to incentivize EHR vendors to support trigger code sets, making it easier for healthcare organizations to implement new reporting requirements without extensive manual effort. HIMSS supports interoperability demonstrations leveraging these code sets to develop model practices.

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Increasing Bi-Directional Exchange with Public Health Agencies

- **How, if at all, could the PIP support or incentivize PHA adoption of certified systems and technologies?**
- **How can CMS use the PH & CDE objective to incentivize early adoption of FHIR-based APIs for public health data exchange?**
- **Should CMS introduce a measure to allow providers to receive credit for the HIE objective by exchanging public health data through participation in TEFCA?**

HIMSS emphasizes the importance of bidirectional exchange between clinical care and public health agencies using standards-based solutions in the Integrating the Healthcare Enterprise (IHE) Quality, Research, and Public Health domain with the plan to evolve to FHIR-based APIs. Such an exchange could improve patient care outcomes and facilitate automated data queries. It is important however to note concerns related to the lack of standards in reporting that the PIP should attempt to address include:

- Challenges with bulk query capabilities from public health registries make FHIR-based reporting challenges. If a FHIR-based API bonus is considered, simplifying reporting measures and focusing on capabilities rather than percentages is suggested.
- Alignment with CDC's data modernization efforts may be the solution so addressing administrative burdens associated with reporting, particularly ensuring that hospitals are not penalized when public health agencies are unable to receive data due to technical or policy limitations. PHAs technical and policy solutions must evolve to ensure accountability in data transmission and to prevent hospitals from being unfairly penalized for data transmission failures on the public health agency's end.

Eliminating Reporting Burden for Healthcare Providers

Under the PH & CDE objective, which measures, or other requirements result in the most administrative burden for eligible hospitals and CAHs?

- HIMSS emphasizes the complexity of reporting burdens faced by hospitals and the importance of thoughtful policy solutions and infrastructure investments to alleviate these challenges effectively. HIMSS also recognizes two different forms of healthcare burden, (1) the technical work, and (2) the financial impacts. The lack of easy national standards is reflected in issues reporting to their local PHAs. For national systems the technical compliance issues can be compounded when responding to 50 – 100+ different public health agencies. HIMSS urges CMS to:
  - Address the administrative burdens on hospitals due to discordant requirements between disparate state reporting requirements and an overall lack of alignment with national standards. This inconsistency forces hospitals to manage separate data pulls and methodologies, adding to confusion and workload. Working to harmonize federal, state, and jurisdictional PHA reporting standards and requirements would reduce errors and mitigate burden for both hospitals, providers, and PHAs.

- Develop consensus around the disparate quality measurement requirements across different entities (CMS, states, accreditation bodies) that result in multiple workflows and increased burden for hospitals and clinicians as well. The addition of PHA reporting adds to the burden even though it is recognized as crucial to disease surveillance, case reporting and emergency response.

- It should be noted that the time and effort required for technical development, validation, and maintenance of reporting systems is often underestimated. This includes dedicated resources for federal and state reporting metrics. HIMSS also recognizes that while hospitals could easily access the data elements needed, the technical aspects involved in formatting the data along with data quality checks, the rejections, etc., are prohibitive. The use of USCDI and USCDI+ data elements mapped into existing reporting standards would aid in easing reporting burden.

- The implementation of Insights Conditions needs to be understood as a possible duplicative effort to PH and CDE measures.

How can PIP balance robust PH and CDE objective requirements with our desire to reduce burden on eligible hospitals and CAHs?

- HIMSS supports policy solutions that include expanding exception rules to address infeasibility, especially with bidirectional data exchange mandates, and ensuring caveats for state versus federal mandates to reduce duplication of work.

How can new technical approaches to data exchange with PHAs, such as the use of FHIR APIs, reduce burden for EHs, CAHs, and ECs? What are possible barriers to burden reduction as new approaches are implemented?

- HIMSS recommends leveraging AI and new technical approaches to alleviate administrative reporting burden only where it is tested and approved. However, we note the need for caution due to concerns about readiness, variability, and potential risks associated with AI in healthcare. As PHAs continue to modernize, the use of innovative technical approaches will become more feasible. CMS should also consider supporting/incentivizing PHA readiness through data modernization programs in concert with CAHs, EPs, etc.

- Transitioning to FHIR APIs is also viewed cautiously, as it could shift the reporting burden to public health without the necessary infrastructure or funding in place to support it effectively. HIMSS highlights the need for sustainable data modernization efforts and alignment between healthcare and public health sectors to address critical gaps in reporting requirements and data exchange. This is foundational to alleviating burden and fulfilling population health goals.

Patient Safety Request for Information

HIMSS welcomes the opportunity to discuss methods to increase EH and CAH reporting to the Centers for Disease Control National Syndromic Surveillance Program (NSSP.) HIMSS supports CMS goal to increase reporting and acknowledges that there are significant barriers currently in place to EH and CAH participation in NSSP reporting.
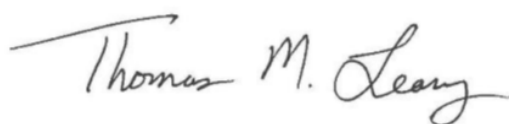
Without financial incentives, the value for EHs and CAHs to report syndromic surveillance data is the availability of local public health data aggregated to show trends and emerging public health threats within their local patient population. NSSP reporting does not provide the feedback loop required to respond to public health threats in a timely manner.

In an ideal future state, mandated NSSP reporting would need two mechanisms to drive industry support:

1. Ensuring that state, local, and territorial public health agencies would have the ability to electronically access NSSP data for their jurisdiction. While some states have the technology and human resources necessary to access and utilize that data at present, HIMSS estimated in our 2023 Public Health IT infrastructure funding report that over $36 billion of federal investment is required for all relevant public health jurisdictions to have the hardware, the standards-based interoperability, the technical support, and the expertise to leverage syndromic surveillance data and support other IT-enabled core public health functions in a sustainable manner. This localized public health IT-infrastructure will facilitate the exchange of public health analysis and insights between public health jurisdictions and their clinical partners in a real time manner, enhancing both public health and clinical leaders to respond to emerging public health threats in a much more timely and effective manner.
2. CMS has the policy lever of the Promoting Interoperability Program to encourage increased NSSP reporting. However, health systems struggle to allocate the resources needed to collect and report syndromic surveillance data without any kind of financial benefit or immediate insights to the public health of their patient population. HIMSS encourages CMS to conduct listening sessions with health systems to better understand the staffing and resource burden associated with syndromic surveillance reporting, which is not currently reimbursed by payers. Until the infrastructure is in place to have mandated reporting, HIMSS strongly encourages CMS to explore potential scoring bonuses within CMS quality reporting programs and financial incentives to encourage increased NSSP reporting.

We look forward to discussing these issues in more depth. Please feel free to contact Jonathan French, Senior Director of Public Policy and Content Development, at Jonathan.French@HIMSS.org with questions or to request more information.

Sincerely,

Thomas M. Leary, MA, CAE, FHIMSS
Senior Vice President and Head of Government Relations