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

September 10, 2018

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Baltimore, MD 21244

Dear Administrator Verma:

On behalf of the Healthcare Information and Management Systems Society (HIMSS), we are pleased to provide written comments to the Notice of Proposed Rule Making (NPRM) regarding Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P). HIMSS appreciates the opportunity to leverage our expertise in offering feedback on the Physician Fee Schedule (PFS), as well as the Quality Payment Program (QPP) and telehealth services, and we look forward to continued dialogue with CMS on these and other relevant policy topics.

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. Through our innovation companies, 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.

As an association, HIMSS encompasses more than 73,000 individual members and 655 corporate members. We partner with hundreds of providers, academic institutions, and health services organizations on strategic initiatives that leverage innovative information and technology. Together, we work to improve health, access, as well as the quality and cost-effectiveness of healthcare. Headquartered in Chicago, Illinois, HIMSS serves the global health information and technology communities with focused operations across North America, Europe, United Kingdom, the Middle East, and Asia Pacific.

We are committed to assisting CMS in supporting the shift to value-based care delivery and facilitating greater data exchange across the healthcare community through the Promoting Interoperability Programs. In addition, HIMSS wants to continue to help CMS leverage information and technology to support the demonstration of innovative care delivery models for coordinating smarter, safer, and more efficient high-quality care, while ensuring that individuals remain at the center of all our efforts.

For our public comment, HIMSS offers the following thoughts and recommendations on this NPRM:

- **Reduction of Clinician Burden Through Streamlining Evaluation and Management Documentation Coding**

HIMSS supports the actions proposed in this rule to reduce the burden on clinicians by expanding the current policy on recording patient history and previous exam details in clinical notes. This would allow providers to focus their documentation on what has changed since a patient's last visit, rather than re-documenting information that has remained the same between visits. As HIMSS noted in a joint letter with the Association of Medical Directors of Information Systems (AMDIS) in June 2018, it is critical to include Evaluation and Management (E/M) documentation requirements as part of any discussion around minimizing the clinician burden. E/M documentation requirements and coding concerns are a significant source of burden. HIMSS and AMDIS asked CMS to review and revise E/M policies, and called on our organizations - as well as other stakeholder groups - to collaborate on developing workable solutions to address issues CMS is proposing in this rule.

The unintended consequences that E/M coding have had on EHR usability is significant, especially with what should be digestible information about a patient encapsulated in a clinical note. However, these notes are often providing only minimal value to collaborating clinicians. The extreme length of some notes are written a way to justify payment or the medical necessity of a service, instead of being used to derive benefit for other practitioners or to improve the patient experience.

Given that some current reporting requirements are structured in such a way that they necessitate a level of documentation that is not workflow-informed, and more burdensome than completing the actual service(s) for the patient, the proposed changed will be welcomed by providers.

- **Expansion of Virtual Care under the Physician Fee Schedule**

Interoperable, connected health requires a broad ecosystem of shared digital health information and use of digital health technology. This proposed rule takes an important step forward in these areas. We extend our appreciation to CMS for the incorporation of evidence-based chronic care remote patient monitoring (RPM) CPT codes, inter-professional consultation codes, virtual check-in, and remote evaluation of pre-recorded patient information. Together, HIMSS believes this set of policies offers great opportunities for the modernization of Medicare physician payment, and the innovative and appropriate utilization of technology in care delivery

In the proposed rule, CMS made an important and well-reasoned policy decision to allow for the broad utilization of digital health medical technologies, including medical telecommunication technologies in healthcare service delivery. HIMSS agrees and encourages CMS to continue to review and consider digital health medical technologies as evidence-based tools for delivery of patient-centered care with an eye toward continued modernization of the physician fee schedule. We welcome the opportunity to engage CMS in further discussions for future rulemaking on available and innovative medical technologies.

In terms of the chronic care remote monitoring CPT codes, HIMSS highlights the depth of the evidence base and how it is clear that the quality of care improves, and hospitalization rates[1] are reduced, when employing remote monitoring for a patient's heart failure, chronic obstructive pulmonary disease, sleep apnea, and multiple chronic conditions.

In addition, we support and appreciate CMS' proposal to reimburse for inter-professional internet consultation. The unbundling and addition of these codes is important to modernizing the practice of medicine. HIMSS also appreciates and thanks CMS for working to create the brief virtual check-in as well as remote evaluation of patient-generated, digitally-delivered health information, but seeks additional clarification about the proposed brief virtual visit code.

For example, we strongly believe in the need for an evidence base to guide patient-centered care and the appropriate use of new means of care delivery. The current literature supports use of in-depth virtual visits as a substitute for evaluation and management visits, but does not appear to include brief virtual visits. We note that these visits may have value, but are concerned that the evidence base currently provides little guidance to providers on appropriate use cases. The guardrails proposed by CMS—that this may only be billed for established patients and when there is no evaluation and management visit in the 7 days prior, or the 24 hours following the brief virtual visit—may, in fact, be the right approach to appropriate use. We are excited about the potential of brief virtual visits, but remain concerned that there is no evidence base guiding the establishment of the parameters for when this type of visit is appropriate and helpful to patient care.

Moreover, HIMSS fully supports the new code and ability for a provider to bill for remote evaluation of patient-generated, digitally-delivered health information. We support that requiring that this must be patient-initiated is critical to support and incent patient-centered care. We also support the proposed guardrails that this may only be billed when there is no evaluation and management visit in the 7 days prior, or the 24 hours following, the remote evaluation of patient-generated and transmitted data.

HIMSS also encourages that virtual care delivery approaches be explicitly included in the creation of a bundled episode of care for management and counseling treatment of substance abuse disorders. The evidence base is developed and growing, demonstrating efficacy of virtually-delivered behavioral health services. According to a 2013 Health Resources and Services Administration Report, virtual behavioral health may be one of the more successful applications of telehealth across the spectrum of clinical services, as outcomes and patient acceptance for virtual behavioral health are comparable to face-to-face visits. The report went into detail about how virtual behavioral health can improve care delivery, expand staff capacity, enhance training capacity, and achieve cost savings.

- **Support for CMS' Efforts to Move Toward Value-Based Care Delivery Through QPP in 2019 and Beyond**

The Medicare Access and CHIP Reauthorization Act (MACRA) created QPP in part to incentivize improving patient care and outcomes through the reporting of quality measures, the utilization of

[1] Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews

electronic health record (EHR) technology, and implementation of care improvement activities. QPP provides meaningful incentives in support of the shift to value-based care for providers serving Medicare Part B patients.

However, HIMSS acknowledges that a large percentage of Medicare Part B providers are exempt from MIPS reporting and do not participate in an approved Advanced Alternative Payment Model (APM). As a result of a lack of participants, top performing MIPS eligible clinicians could receive significantly less incentive payments than the much larger and more meaningful incentives envisioned in MACRA. The current incentive is already viewed by clinicians to often be less than the costs associated with delivering value-based care and to achieve top performance on MIPS metrics. This structure functions as a disincentive for Medicare providers to deliver meaningful value-based care. In order to drive true value-based care delivery, the business case must be stronger for eligible clinicians to aspire to perform well above MIPS thresholds. If MIPS doesn't provide meaningful incentives for eligible clinicians, MIPS won't serve as a mechanism to improve quality and lower costs.

Accordingly, HIMSS recommends that the MIPS minimum threshold return to $30,000 in Part B claims or 100 Part B patients that CMS utilized for the program in calendar year 2017. This lower threshold will mandate increased eligible clinician participation and expand the available incentives. Alternatively, if the proposed minimum threshold for participation is not lowered, then HIMSS proposes the opt-in criteria be lowered to meet any one of the three criteria, including: $30,000 in Part B claims; 100 Part B patients; or, 100 Part B covered services.

HIMSS also recognizes the concern that eligible clinicians could drop Medicare Part B patients from their practices in an effort to move under a new threshold. While HIMSS advocates for an expanded business case for eligible clinicians to deliver value-based care, HIMSS does not want to see Medicare patients lose access to quality care. To alleviate these concerns, HIMSS recommends that CMS add a large bonus to the Improvement Activities MIPS performance category for newly eligible clinicians (eligible clinicians that serve between 100-200 part B patients and bill $30,000-90,000 in Part B claims) which would demonstrate that Part B patients were not removed from a particular eligible clinician's practice.

Moreover, as QPP continues moving forward and evolving, HIMSS would like to engage CMS in a discussion on how our health care system generally, as well as our payment, incentive, and reporting programs specifically, measure value. As QPP rewards quality and cost separately in different performance categories, the MIPS Final Score may not fully reward those eligible clinicians who deliver the highest value to beneficiaries. To support our national drive toward value, HIMSS commits to working with CMS to ensure that all payment and incentive programs are aligned to fully reward value.

- **Endorsement of Use of 2015 Edition Certified EHR Technology (CEHRT) in 2019**

HIMSS would like to reinforce the importance of adopting the 2015 Edition criteria as a significant part of our commitment supporting healthcare transformation beginning January 1, 2019. The benefits of requiring the use of the 2015 Edition cannot be overstated, with its focus on greater interoperability for clinical health purposes—opening up the certification program to other types

of health information and technology, addressing health disparities, and including a new streamlined approach to privacy and security.

Within QPP, use of 2015 Edition CEHRT in 2019 should apply to eligible clinician (EC) reporting under the Promoting Interoperability Programs, as well as to capture electronic clinical quality measures (eCQMs).

In addition, the 2015 Edition Final Rule facilitates the accessibility and exchange of data by including enhanced data export, transitions of care, and application programming interface (API) capabilities. Overall, the 2015 Edition helps propel forward reforms to our healthcare delivery system and strengthen the ability of providers to share and exchange health information. The API component of the 2015 Edition is of particular importance as the healthcare market continues to evolve.

The 2015 Edition API functionality requirements focus on several areas, including allowing third parties easy access to individual data requests as well as requests for larger data sets. Health IT developers are also to be required to make the full documentation of their API information, as well as their syntax and programming information, publicly available. Requiring greater use of APIs and increasing their interaction with EHRs will increase engagement possibilities, improve user experience, and provide innumerable benefits to all healthcare stakeholders.

In an April 2017 letter to HHS, HIMSS recommended an extension around the requirements for the use of the 2015 Edition. Today, HIMSS believes the Office of the National Coordinator for Health IT (ONC) and market suppliers have all the pieces in place for full 2019 implementation of the 2015 Edition. Overall, HIMSS applauds CMS' proposal to require clinicians reporting their MIPS Promoting Interoperability Programs performance category activities to use 2015 Edition CEHRT beginning with the calendar year 2019 reporting period, as well as offering a bonus in reporting the MIPS Improvement Activities performance category using 2015 CEHRT.

- **Quality Performance Category Should Support the Shift to Value-Based Care Delivery**

HIMSS supports the proposed criteria for the MIPS Quality Performance category to facilitate the transition to MIPS in 2019. Reporting six clinical quality measures for a full calendar year via a combination or one of the proposed submission methods (CEHRT, Qualified Clinical Data Registries (QCDR), claims, registries for eligible clinicians with the option of the CMS Web Interface for large and virtual groups) allows the flexibility needed for the current state of industry readiness. HIMSS expresses support for the general direction and the intent of the proposed Quality category reporting and performance requirements.

Quality Reporting Period

HIMSS supports CMS' proposal for eligible clinicians to report clinical quality measures for a full calendar year. While some stakeholders have advocated for a 90-day reporting period for quality measures, ambulatory clinical quality measures are patient-level measures that evaluate the care given during the measurement period, and often require more than one encounter for either provider attribution or the measure scoring itself. Given these constraints, a full-year of reporting will produce more accurate scores, which is essential for any pay-for-performance program.

Bonuses for eCQM Reporting and for Participation in eCQM Field Testing Programs

HIMSS also applauds CMS for making every effort to drive forward adoption of technologies that can enable improved quality outcomes while not excluding late adopters from the possibility of avoiding the negative payment adjustment by allowing multiple avenues for reporting.

Multiple Quality Data Submission Mechanisms

HIMSS supports CMS' proposal to allow reporting of quality measures using multiple submission methods in the MIPS program, however HIMSS has previously noted concerns that QCDR could develop and implement their own clinical quality measures without the rigorous evaluation or formal endorsement from a national consensus body such as the National Quality Forum (NQF), compared to other MIPS measures that have undergone more stringent evaluation. This would create a potential inconsistency in the comparability of quality measures performance used for payment adjustments. HIMSS agrees with the new proposed requirements of applying the Call for Measures criteria in the selection of QCDR measures starting with the 2019 performance period. However it is only a step towards having a common national framework for endorsement of measures by a national consensus body (which currently is the NQF). CMS should set expectations when accepting QCDR measures that they would be expected to get endorsement after a certain defined time period.

- **Continued Emphasis on Improving the Future State of eCQM Reporting**

As discussed in our May 31, 2018 letter to CMS, HIMSS supports CMS' drive toward removal of claims-based clinical quality measures from the MIPS quality reporting measure while replacing those measures with well-developed eCQMs. HIMSS believes this could reduce provider burden and facilitate a more effective method for determining if the standard of care was met and taking action to address gaps in care through clinical decision support. HIMSS notes that it is critical for these new eCQMs to not increase the burden of documentation. And, the appropriate data elements to populate the measure must be captured during a normal care delivery workflow.

As CMS continues to develop new eCQMs for QPP, CMS must take steps to ensure that de-novo eCQMs are accurate reflections of the quality of care delivered, specifications work properly in all care settings, and are actionable by eligible clinicians to identify gaps in care and take action to improve quality in real time. Required data elements for selected eCQMs must be accurately and efficiently gathered in the healthcare provider's workflow, using data elements already collected as part of the care process and stored in the EHR or other interoperable clinical and financial health IT. 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.

For eligible clinicians to have full faith and confidence in the value proposition of reporting quality measures, they must believe that the eCQMs available for MIPS and Advanced APM reporting accurately reflect the quality of care being delivered in their practice. This can only be achieved

through a robust field testing program. HIMSS recommends that the Department of Health and Human Services (HHS) require CMS and the ONC to implement an aggressive and thorough quality measures testing program to ensure that measures have been adequately specified and tested before adding them to the MIPS EHR Reporting eCQM and qualifying Advanced APM measure sets. All eCQMs should meet the following criteria:

a. The eMeasures specifications are tested and piloted to confirm they are accurate, with the correct clinical category defined and mapped to the correct vocabulary standards (taxonomy) and codes, along with the correct attributes and state(s).
b. The eMeasures are validated by the measure steward and tested for validity and reliability against the measures intent.
c. Required data elements can be efficiently and accurately gathered in the healthcare provider workflow, if at all possible using data elements that are already collected as a byproduct of the care process and stored in the EHR and other certified clinical and financial health information technology.
d. CQM reports based on eMeasures accurately reflect the care given by the applicable healthcare provider(s).
e. The testing evaluates the output from translation of the measure to established standards in the health quality measure format (HQMF) and successful transport using the quality reporting document architecture format to CMS. The eMeasure 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. (This process has been launched in the form of the National Testing Collaborative, however it needs to be fully funded and endorsed by CMS.) The eCQM development process needs to receive input and feedback from clinicians and other stakeholders at every step of the development and testing process.

Currently, there is minimal incentive for eligible clinicians, particularly small practice and specialist eligible clinicians, to participate in eCQM testing and field testing initiatives. In order to make field testing robust, HIMSS recommends that CMS incorporate a scoring bonus in the Quality performance category for eligible clinicians to participate in eCQM field testing programs for new measures.

As HIMSS noted in past QPP responses, there are only a limited number of eCQMs available to for eligible clinicians to report, especially in clinical specialties. Upon review of the specialty specific eCQM measure sets, many do not include enough relevant EHR-reportable measures to meet the baselines for MIPS reporting, and some only have quality measures that are reportable via registries. Specialists, in particular, are limited in their reporting options and opportunities for scoring bonuses.

Clinical registries have deep penetration in many specialties, which use heavily chart-abstracted that may not be interoperable to CEHRT because the chart-abstracted data may be in an unstructured format. This presents a significant challenge to the viability of CMS interoperability goals, and raises the issue of measurement via registry not being directly comparable to structured CEHRT data. Encouraging ongoing adoption of the standards and the interoperability of clinical registry data so that it becomes interoperable with structured EHR clinical data will be a step forward in the short term.

The HIMSS Immunization Integration Program (IIP) represents an example of quality data capture within the EHR that ensures better workflow and usability to enhance the content within conformance testing. We are available to work with you and your team to provide additional details on the HIMSS IIP program and progress in this critical area.

Long term, the value of the MIPS program to specialties will require the development of eCQMs specifically designed to measure process improvement and improved outcomes relevant to a particular specialty. Specific specialties may face inherent problems in capturing the data because data was not available in a standardized format, not codified to the national standard, and could not be utilized except with manual abstraction and correction.

HIMSS recommends that CMS promote the development of a robust de-novo menu measure set of CQMs for use by specialty eligible clinicians that are designed specifically to capture CQM data as part of an EHR-enabled care delivery for use in future iterations of the CMS QPP. These new CQMs should support meaningful measurement of care delivery, be actionable for ECs, and feature data elements that measure both process improvement and improved care outcomes.

CMS has been clear that quality measurement programs must focus on measures which can be tied to an improved patient outcome. Current outcomes measures have two challenges: some measure clinical markers (blood pressure control, HgbA1c control), which – because they are brief episodic findings versus longitudinal trending – are not necessarily measures that are impactful to patients. HIMSS recommends that CMS focus on developing measures of outcomes which are most directly impactful to patients; such as, reducing mortality, improving quality of life, and lowering costs.

In order to effectively measure the outcomes patient value, HIMSS recommends that in future iterations of the QPP rulemaking process, CMS seek feedback on how to best measure care delivered in health systems which coordinate team-based care. For example, the attributed EC may not have sufficient authority or capacity to affect performance on a measure. In coordinated team-based care settings, which CMS is actively promoting through Advanced APMs, having a system of care measurement that promotes care coordination and reflects the system, rather than a single member of the team, would help improve assessment of care delivery, incentivize the adoption of team-based care models, and reduce fragmentation of care.

New eCQM Implementation Timelines

New measures, or changes to measure specifications, will be completed with the publication of the annual QPP Final Rule. The 2-month window that is typically instituted between publication of the final QPP Rule and January 1 of the following year (the start date of the performance period) will not allow vendors and ECs, groups, and Advanced APMs the appropriate implementation timelines necessary for systems to be updated and the appropriate care delivery workflows to be developed and incorporated for the purpose of accurate data capture for any eCQMs that were not part of purchased CERHT systems. This requirement, therefore, places an unfair burden on ECs.

HIMSS continues to recommend that CMS adopt the following policies:

1. Only non-substantive changes in eCQM measure sets and specifications that do not require corresponding changes in provider workflow should be made annually through the PFS, QPP, and IPPS rulemakings for the following reporting year.
2. Substantive changes (for example, a new CQM or a change in a current CQM that requires a workflow change) should be published in the rulemaking and annual update. However, such changes should not go live until 18 months following the publication of the final rulemaking. For example, a new measure in a final QPP Rule published in 2018 should not "go live" (i.e. be incorporated into the eCQM measure set) until the 2020 data collection/performance period.

Clinical Quality Data Visualization

HIMSS commends CMS for requiring outcomes improvement as a key metric in determining the score for the Quality Performance Category of MIPS and qualifying Advanced APMs. HIMSS urges CMS to emphasize the importance of key process improvement measures on quality outcomes.

In order to enable ECs to improve outcomes, HIMSS strongly recommends CMS incentivize the use of technologies that improve data transparency and visualization. A consistent theme from HIMSS Davies Award winning case studies articulates that when clinical quality measures are presented as a meaningful scorecard on performance in as close to real-time as possible, those measures drive improved adherence to clinical best practice and improved care outcomes.

Access to real-time process improvement and outcomes data is a critical trigger for change management when clinicians are not adhering to standardized clinical best practices, or when adopted clinical best practices are not producing improved outcomes. Access to accurate, clinically relevant, and as close to real-time trended data is critical to ensure that quality measurement reporting isn't just "reporting for compliance." HIMSS urges HHS to engage with developers, in a voluntary and collaborative manner, on identifying and implementing the most promising ways to present quality results for action.

The MIPS program presents an opportunity to incentivize the use of data visualization technology. HIMSS strongly recommends that CMS add a Promoting Interoperability scoring bonus for ECs who attest to using dashboard technology which generates real-time performance data on all available MIPS eCQMs. Incentivizing the use of technology that provides access to actionable quality data will drive improved quality and produce cost savings for the Medicare program.

EC Attribution for Clinical Quality Measures

HIMSS notes that there were no proposals in the proposed rulemaking to improve clinician attribution for quality measures. As HIMSS previously recommended, all 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. HIMSS recommends that CMS consider using multiple provider attribution models where only certain percentages of the quality data is attributed to a particular provider. Such a method has been recently described in the Journal of Hospital Medicine for hospital measures.

For outpatient-focused measures, 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 care is typically divided 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 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. Very often, 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.

Patient Complexity Risk Adjusted Bonus

HIMSS supports CMS' proposal to provide a bonus to ECs that serve a more complex patient population. However, the current methods proposed for risk adjusting patient populations to measure their complexity are based on a review of diagnostic codes. Claims-based measures are risk-adjusted based on diagnostic codes and specificity of coding on an administrative claim, not on any clinical data related to a patient. Requiring a provider to code more specifically doesn't improve a patient's clinical outcome—it only indicates how sick the patient is. This leads to an unfortunate disconnect between measurement of adherence to best processes, and corresponding measurement of outcomes. It does not drive quality improvement.

HIMSS recommends that CMS launch an effort to develop a clinical quality measurement infrastructure necessary to transition these federal payment-for-value programs into utilizing process improvement measurement and outcomes measurement derived from CEHRT. Comprehensive Primary Care Plus (CPC+) participants like Davies Award recipient Centura Health have established models for risk adjusting patients using clinical intuition, clinical data from CEHRT, and behavioral health data to significantly reduce hospital readmissions. HIMSS encourages CMS to launch pilots evaluating risk adjustment models from Advanced APM participants and incorporate successful models for determining future bonuses for eligible clinicians that serve complex patient populations.

HIMSS would be happy to convene our volunteers with CMS policymakers to share specific experiences and recommendations for risk adjustment paradigms in each care setting.

- **Opioid-Related Measures Should be More Outcomes-Focused**

HIMSS is very supportive of the inclusion of opioid-related measures in the e-Prescribing Objective of the Promoting Interoperability Programs performance category. CMS' proposed approach signals the importance of leveraging Medicare and Medicaid payment policy to address our nation's opioid crisis. In addition, we appreciate the intent of the proposals in offering a bonus for *Query of Prescription Drug Monitoring Program (PDMP)* and *Verify Opioid Treatment Agreement* for 2019.

More broadly, HIMSS recommends CMS consider utilizing opioid measures that have a stronger focus on outcomes. The query of a PDMP would measure how often an EC queries a PDMP before prescribing a Schedule II opioid. While this may be beneficial for identifying patients who could be at risk for opioid misuse, outcomes-based measures would help drive treatment decisions and improve patient safety. For example, our members have discussed the increasing evidence correlating inpatient administration of opiates with subsequent dependence and overdose. Structuring a measure where the denominator is the total number of hospital encounters during a reporting period, and the numerator is total Morphine Equivalent Doses (MEQ) prescribed, would be much closer to an outcomes-based measure.

HIMSS suggests that the measures that CMS proposes for 2019 remain in place as optional bonus points to ensure ECs are optimally equipped for addressing the opioid crisis. Ultimately, we want to support efforts to have PDMP information fully integrated or embedded in EHRs to allow for optimal provider workflows and reduced clinician burden. Over the long term, HIMSS pledges to work with CMS and other stakeholder organizations to find the appropriate clinically-focused outcomes measures for use as soon as possible beyond 2019.

For example, several organizations have already developed NQF-endorsed measures that would be good candidates for inclusion in an opioid measure group. HIMSS wants to help the agency determine appropriate outcomes-focused opioid measures, and an achievable implementation and reporting timetable.

HIMSS realizes that CMS will likely finalize its draft opioid measure bonus point structure in 2019 to align with the Final 2019 Inpatient Prospective Payment System Regulation. We want to continue to emphasize and reinforce the importance of the move to outcomes-focused measures in this area.

- **Ensure an Emphasis on Public Health Measures in the Promoting Interoperability Programs**

HIMSS remains supportive of the Public Health and Clinical Data Exchange Objective in the MIPS Promoting Interoperability Programs performance category, and its inclusion of public health measures. The current proposal from CMS requiring reporting on two measures under this objective is directionally appropriate given the importance of public health and the critical contribution that it makes to care delivery.

HIMSS suggests that CMS clarify that an EC should not be allowed to claim an exclusion from reporting on public health measures when two of these reporting measures are available to the

provider—he/she must implement those measures rather than claim an exclusion for one of the other measures. The Final Rule should clearly elucidate this policy.

Moreover, HIMSS supports requirements around the continued reporting to public health and clinical data registries in 2022 and beyond, either through the Promoting Interoperability Programs or other appropriate venues where reporting is possible. Public health and registry reporting is critical to the functioning of the entire health system and must continue until a suitable alternative can be found or another policy lever is available. We are cognizant of the associated burden issues, but HIMSS commits to working with CMS and other stakeholders to identify the balance between burden on providers, while ensuring relevant information flows to public health and clinical data registries.

Overall, HIMSS remains committed to fostering a culture where health information and technology are optimally harnessed to transform health and healthcare by improving quality of care, enhancing the patient experience, containing cost, improving access to care, and optimizing the 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,

Harold F. Wolf III, FHIMSS
President & CEO
HIMSS