August 21, 2017

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) and the Personal Connected Health Alliance (PCHAlliance), we are pleased to provide written comments to the Notice of Proposed Rule-Making (NPRM) regarding CMS-5522-P Medicare Program: CY 2018 Updates to the Quality Payment Program which was published in the Federal Register on June 30, 2017. We appreciate the opportunity to leverage our members’ expertise in commenting on this NPRM, and look forward to continuing to dialogue with the Centers for Medicare and Medicaid Services (CMS) on the implementation of the Quality Payment Program (QPP) to advance our healthcare system toward the goal of value-based care delivery.

HIMSS is a global, cause-based, not-for-profit organization focused on better health through information technology (IT). HIMSS leads efforts to optimize health engagements and care outcomes using information technology. HIMSS North America, a business unit within HIMSS, positively transforms health and healthcare through the best use of information technology in the United States and Canada. As a cause-based non-profit, HIMSS North America provides thought leadership, community building, professional development, public policy, and events. Founded in 1961, HIMSS encompasses more than 68,000 individuals, of which more than two-thirds work in healthcare provider, governmental and not-for-profit organizations across the globe, plus over 630 corporations and 450 not-for-profit partner organizations, that share this cause.

PCHAlliance aims to make health and wellness an effortless part of daily life. The PCHAlliance, a non-profit organization formed by HIMSS, believes that health is personal and extends beyond healthcare. The Alliance mobilizes a coalition of stakeholders to realize the full potential of personal connected health. PCHAlliance members are a vibrant ecosystem of technology and life sciences industry icons and innovative, early stage companies along with governments, academic institutions, and associations from around the world. To support its vision, the PCHAlliance convenes the global personal connected health community at the annual Connected Health Conference, the premier international event for the exchange of research, evidence, ideas, innovations and opportunities in personal connected health. The Alliance publishes and promotes adoption of the Continua Design Guidelines. Continua is recognized by the International Telecommunications Union (ITU) as the international standard for safe, secure, and reliable exchange of data to and from personal health devices. The PCHAlliance accelerates technical, business, policy and social strategies necessary to advance personal connected health through its flagship healthy longevity efforts to promote lifelong health and wellness.
HIMSS and PCHAlliance appreciate the additional flexibilities provided for clinicians in the 2018 QPP Proposed Rule. The approach taken by CMS to encourage successful participation in QPP while reducing burden aligns with our vision for how the program should proceed in 2018. HIMSS and PCHAlliance offer the following comments and recommendations on the FY 2018 Proposed Rule:

- **Endorsement of Maintaining 2018 as a QPP Transition Year**

  Our focus as cause-based organizations is on using health IT to enable healthcare transformation. As the QPP 2018 program requirements included in the NPRM maintain incremental progress toward the goal of sustaining value-based care delivery and the concomitant improved patient outcomes as well as higher quality care, HIMSS and PCHAlliance express our support for 2018 as an additional QPP transition year. With QPP, CMS has laid the groundwork for expansion toward an innovative, outcome-focused, patient-centered, resource-effective health system that leverages health IT to support clinicians and patients and builds collaboration across care settings.

  HIMSS and PCHAlliance agree with CMS that there is great diversity among clinician practices in their experience with quality-based payments and that QPP should evolve over multiple years in order to achieve national goals. As clinicians continue to increase their understanding of the program and the push to value-based care in future years, HIMSS and PCHAlliance support the idea of reviewing the requirements and balancing them with the reporting and regulatory burden placed on clinicians to ensure that there is equilibrium going forward.

  In addition, we support the proposed changes in the low-volume thresholds for 2018. However, to accompany the new language on exclusions, HIMSS and PCHAlliance ask CMS to be more straightforward in its request for the clinicians that will not be required to report under QPP in 2018. The agency should encourage these clinicians to use this additional time as a trial period to figure out how to participate in the program and implement value-based care without the requirement that they participate in the program and report to CMS. Perhaps the most critical Merit-based Incentive Payment System (MIPS) Performance Category is cost. Although CMS is proposing that cost be weighted at 0 in 2018, HIMSS and PCHAlliance ask the agency to provide as much episode-based measure feedback, as quickly as possible, to clinicians in 2018 (even those that are not required to report), so they understand how vital cost is in providing Medicare beneficiaries with high-value care and clinicians are better prepared to be measured on their cost performance in 2019 and beyond.

  CMS should also ensure that its Technical Assistance Grants to the 11 regional organizations continue to focus their outreach on those small and rural clinicians that may not have to participate in the program in 2018, but will have to meet the requirements in the near future.

  Moreover, HIMSS and PCHAlliance applaud the NPRM’s inclusion of bonus points in the 2018 scoring methodology for clinician participation, especially for clinicians in small practices, care of complex patients, and for use of the 2015 Edition Certified Electronic Health Record (EHR) Technology (CEHRT). This bonus point structure incentivizes and rewards those clinicians that are ready to keep pushing forward to greater value-based care delivery models, while recognizing that everyone is not able to meet more stringent threshold or reporting requirements at this time.
HIMSS and PCHAlliance also support the idea of offering QPP bonus points for use of the 2015 Edition to report on electronic Clinical Quality Measures (eCQMs) in 2018 since there are bonus points in place for using 2015 Edition CEHRT to report on the Advancing Care Information (ACI) measures. As discussed below, use of the 2015 Edition is an overwhelming positive for our healthcare system.

Overall, maintaining the proposed structure for 2018 as a second transition year is a sensible strategy. HIMSS and PCHAlliance see QPP in 2018 as the next part of a staged approach to allow clinicians to develop competencies around value-based care delivery so they understand their responsibilities as the program evolves and moves forward expeditiously.

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

HIMSS and PCHAlliance are committed to helping CMS move robustly in 2019 toward more rigorous requirements around value-based care delivery. In 2019 and beyond, the agency should renew its focus on using QPP to push all clinicians toward value-based care and position them to fully participate in healthcare transformation efforts. This renewal includes returning to the low-volume thresholds used in the 2017 performance period, which only excludes individual MIPS eligible clinicians or groups with less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Part B beneficiaries. HIMSS and PCHAlliance, as cause-based organizations, are focused on this strategic goal and by 2019 the entire community should be focused on moving toward this end-state.

Over the next several months, HIMSS and PCHAlliance pledge to work with partners across the healthcare enterprise to formulate principles and recommendations for CMS on how the federal government can work with the provider community on adopting value-based care delivery models in such a way that minimizes the clinician regulatory and reporting burden. We intend to have these recommendations to present to you in time for inclusion in the 2019 QPP Proposed Rulemaking Process. Our collaborative process to devise our recommendations has already begun, so we have two critical recommendations to offer CMS on what we would like to see occur in 2019 QPP rulemaking:

  o Affirm the Start Date Around the Requirements for the Use of 2015 Edition CEHRT as January 1, 2019

In an April 2017 [letter to HHS Secretary Tom Price, MD](https://www.himss.org/), HIMSS recommended an extension around the requirements for the use of the 2015 Edition. However, the Office of the National Coordinator for Health IT (ONC) and the vendor community now have all the pieces in place for full implementation of the 2015 Edition to commence by 2019. A January 2019 start date allows providers, vendors, and consultants to have the necessary time to ensure products complete the certification process, are fully tested and implemented, and staff training and workflow adjustments are achieved to ensure safe, effective and efficient implementation and use of 2015 Edition.
HIMSS and PCHAlliance would like to reinforce the importance of adopting the 2015 criteria as a significant part of our commitment to health IT supporting healthcare transformation.

The 2015 Edition focuses on greater interoperability for clinical health purposes—opening up the certification program to other types of health IT, addressing health disparities, and including a new streamlined approach to privacy and security. 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. In addition, health IT developers will 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.

- **Create More Advanced Alternative Payment Model Options for Clinicians**

HIMSS and PCHAlliance encourage CMS to utilize the Center for Medicare & Medicaid Innovation to work with the broader community on creating more risk-bearing alternative payment models (APMs) that can serve clinicians as Advanced APMs in QPP. CMS has taken a critical step with the creation of the Medicare Shared Savings Program Accountable Care Organization Track 1+ model, but more diverse models that can serve clinicians in multiple settings and different specialties are needed. As CMS has relayed in the past, the Advanced APM Track in QPP holds the greatest promise for positively impacting healthcare, so creating further compelling options for clinicians to adopt in the future will allow greater provider participation in broader transformation efforts.


The proposed rule offers 10 bonus points in the ACI performance category for those clinicians that are prepared and able to move to the use of 2015 Edition CEHRT. As HIMSS and PCHAlliance have discussed the multitude of benefits that accompany the use of the 2015 Edition, we encourage CMS to offer clinicians an even greater incentive to fully implement this CEHRT Edition in time to meet the reporting requirements in 2018. Clinicians that are using the 2015 Edition in 2018 will be better prepared when the requirements around its use are completely in place and will be full participants in the reforms to our healthcare delivery system that come from the use of the 2015 Edition as well as enhancing their ability to share and exchange health information. HIMSS and PCHAlliance encourage CMS to provide clinicians an incentive of at least 20 bonus points in the ACI performance category in 2018 for the use of 2015 Edition CEHRT.
Endorsement of Proposed Criteria for the MIPS Quality Performance Category

HIMSS and PCHAlliance support the proposed criteria for the MIPS Quality Performance category to facilitate the transition to MIPS in 2018. Reporting six clinical quality measures for a full calendar year via one of the proposed submission methods (CEHRT, QCDR, claims, registries, and the CMS Web Interface) allows the flexibility needed given the current state of industry readiness. HIMSS and PCHAlliance express support for the general direction and the intent of the proposed Quality category reporting and performance requirements. The direction is very positive in terms of expressing the value proposition for this model of care delivery and reimbursement versus the traditional fee-for-service model.

HIMSS and PCHAlliance also applaud CMS for making every effort to drive forward adoption of technologies that can enable improved quality outcomes (through bonus scoring and incentives for the use of CEHRT to calculate and report eCQMs) while not excluding late adopters from the possibility of avoiding the negative payment adjustment by allowing multiple avenues for reporting.

However, HIMSS and PCHAlliance members have expressed concern about the lack of proposals designated to address the current barriers to capturing electronic quality measures, reporting them to CMS, and using those measures to identify opportunities and strategies for improving care outcomes. Core to the HIMSS and PCHAlliance missions are promoting the use of health IT to improve the quality of healthcare delivery, while also ensuring that data collection is not an overly burdensome part of a workflow. HIMSS and PCHAlliance believe that incentivizing improvement of care outcomes reported via eCQMs is critical to driving the utilization of health IT for improving care.

For eligible clinicians to have full faith and confidence in the value proposition of eReporting quality measures, they must believe that the eCQMs available for MIPS and Advanced Alternative Payment Model reporting accurately reflect the quality of care being delivered in their practice.

Beyond the 2018 transition year, the key to making the QPP a success is not merely reducing the administrative burden on providers. The HIMSS Davies Award of Excellence case studies have demonstrated that CMS tying reimbursement to performance goals (like improving HgbA1C and blood pressure control) drives quality improvement efforts in ambulatory care practices. Since CMS launched the EHR Incentive Program and EHR-enabled PQRS reporting, HIMSS has received well over 100 case studies demonstrating a correlation between identifying health IT-enabled best practices and workflows designed to improve measures in those areas and resulting outcomes. Quality reporting—when measures credibly reflect the quality of care delivered, when measures are available in as close to real-time as possible as a tool for identifying opportunities for improvement, and when data can be collected as part of a normal health IT-enabled clinical workflow—is an effective driver for improving care outcomes.

To emphasize the need for correct and appropriate metric development and reporting, HIMSS and PCHAlliance have heard from many provider members who have expressed an interest in focusing on reporting metrics that have more connection to care delivery, especially goals and metrics that create a provider-patient relationship that improves provider-patient relationship that improves
patient awareness and health. They advocate for the removal of reporting metrics that do not enhance the reporting experience or clinical outcomes.

As we prepare for the next phase of value-based care, HIMSS and PCHAlliance suggest a broader focus on Electronic Clinical Quality measurement; we are drawn to highlight improvements in the overall system. As highlighted in our March 2016 letter to CMS on Electronic Clinical Quality Measurement, Reporting, and Improvement, for all CMS quality performance programs:

1. eCQM reporting should accurately reflect the quality of care delivered.
2. eCQM reporting should minimize the implementation and data collection burden on providers and health IT developers by using information already collected for care and reducing the introduction of new care delivery workflows.
3. eCQMs and its associated data must be relevant, useful and able to be used by providers and healthcare organizations to enhance care delivery and ultimately improve patient care outcomes.

HIMSS and PCHAlliance recommend that CMS continue to develop de-novo eCQMs that meet these three criteria. Each new measure must be tested and validated to meet the following criteria before being included in the eCQM set for MIPS or a qualifying Advanced Alternative Payment Model.

1. HIMSS and PCHAlliance recommend that HHS require CMS and 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 IT.
   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.)

2. No measure should be included without fully completing this testing program, and upon submission in professional journals (as proposed in CMS’ draft Quality Measure Development Plan) or submission for National Quality Forum (NQF) endorsement, CMS
should develop a checklist for inclusion in the submission validating that the measure in question has met the criteria in recommendation 1.

3. HIMSS and PCHAlliance continue to recommend that CMS should not include an eCQM in an eCQM reporting program measure set that has not been fully endorsed by the NQF. Unfortunately, NQF endorsement does not ensure that eCQM specifications are accurate, as there is currently no established standard testing process for ensuring the accuracy of electronic quality measures specifications. Given the need to assure providers that the technology they are buying (built to the electronic measure specifications) accurately reports their provision of care, CMS investment should be made to develop an electronic specification testing process (preferably a CMS funded/supported public-private partnership as envisioned in the National Test Collaborative) and that NQF endorsement include evidence of passing that testing process. All eCQMs should be required to go through reliability and validity testing and present that data to NQF before they would be considered endorsed, including newly retooled eCQMs.

4. CMS should not include any eCQM in MIPS or a qualifying APM unless the eCQM has been:
   a. Fully tested to confirm:
      i. The data needed to populate the measure can be collected as part of a normal care delivery workflow (which includes the role of patients/patient reflected data).
      ii. The measure is an accurate reflection of care delivered.
      iii. The measure is actionable for providers to leverage to improve clinical outcomes.
      iv. The measure clearly supports the goals of the Triple Aim: 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.
   b. 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.
   c. The measure is deemed feasible by an appropriate process that considers the views of applicable multiple stakeholders.
   d. The measure is fully field tested.

   o Encouragement to Close the eCQM Measure Gap

As HIMSS noted in our response to the 2017 QPP proposed rulemaking, only 53 eCQMs are available for CEHRT reporting and only 17 eCQMs are available for the CMS Web Interface that large groups can utilize for quality reporting for MIPS. 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. Clinical registries rely heavily on chart-abstracted data that may not be interoperable back to the CEHRT. This presents a significant challenge to the viability of CMS interoperability goals and raises the issue of measurement via registry not being an “apples to apples” comparison to structured EHR 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.

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 and PCHAlliance recommend 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 CMS Quality Payment Programs. These new CQMs should support meaningful measurement of care delivery, be actionable for eligible clinicians, and feature data elements that measure both process improvement and improved care outcomes. Before a measure is added to the MIPS eCQM set, it must pass all the criteria mentioned in the section titled “Measurement Testing, Field Testing, and Feasibility of Clinical Quality Measures for MIPS and APMs.”

- Continued Push for New eCQM Implementation Timelines

New measures or changes to measure specifications will be completed with the publication of the annual MIPS/APM Final Rule, which in statute is required by November 1 of the year prior to the performance period. The 2-month window between publication of the final MIPS rule and January 1 of the following year (start date of the performance period) will not allow vendors and eligible clinicians, groups, and 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 eligible clinicians.

HIMSS and PCHAlliance continue 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 Annual Update and IPPS rulemaking 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 MIPS rulemaking and Annual Update but should not go live until 18 months following the publication of the final rulemaking. For example, a new measure in a final MIPS rule published in 2018 should not “go live” (be incorporated into the eCQM measure set) until the 2020 data collection/performance period.
Emphasize the Importance of Clinical Quality Data Visualization

HIMSS and PCHAlliance commend CMS for requiring outcomes improvement as a key metric in determining the score for the Quality Performance Category of MIPS and qualifying Alternative Payment Models. HIMSS and PCHAlliance urges CMS to emphasize the importance of key process improvement measures on quality outcomes.

A consistent theme from HIMSS Davies Award winning case studies is 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. Clinical quality measures should be actionable.

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. HIMSS and PCHAlliance urge 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 Federal Health IT Strategic Plan states that “an opportunity exists for technology and training to improve data visualization, which can lead to improved decision-making for both individuals and providers.” The visualization of quality data will be a critical step in empowering providers to utilize quality measures to drive change management and improve outcomes in their practice.

eCQMs selected for MIPS and APMs 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 isn’t just “reporting for compliance.”

Support for the Patient Complexity Risk Adjusted Bonus

As noted above, HIMSS and PCHAlliance support CMS’ proposal to provide a bonus to eligible clinicians that serve a more complex patient population. However, 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 and PCHAlliance recommend that CMS launch an effort to develop a clinical quality measurement infrastructure necessary to transition these federal payment-for-value programs into utilizing both process improvement measurement and outcomes measurement derived from CEHRT. 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 and PCHAlliance encourage 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.

- **Encourage the Development of More Telehealth and Remote Patient Monitoring Options**

HIMSS and PCHAlliance remain disappointed at the lack of attention given to specific telehealth and remote patient monitoring (RPM) options as practice improvement activities, as originally intended by the enabling Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MACRA law specifically referenced remote monitoring and telehealth as part of MIPS Improvement Activities, in Section 101(2)(B)(iii)(III): "...The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth."

We encourage CMS to continue to work either towards the inclusion of specific telehealth or RPM activities, or towards an enhanced incentive program rewarding eligible clinicians for using telehealth or RPM to achieve existing improvement measures. An enhanced incentive scheme would reduce the burden of identifying specific objectives for RPM and encourage flexibility for eligible clinicians by allowing them to adapt existing measures to electronic collection where appropriate, furthering Congress’ stated intent of expanding the use of RPM and telehealth services while reducing clinician’s administrative burdens.

As a step in the right direction towards RPM inclusion, HIMSS and PCHAlliance applaud modification to the activity titled “Engage Patients and Families to Guide Improvement in the System of Care” that makes clear the use of patient-generated health data (PGHD) should be digital for this activity, and the inclusion of PGHD options within new ACI activities for year-two objectives, particularly the Glycemic Screening and Glycemic Referring services within the Population Management category. In future years, HIMSS and PCHAlliance encourage CMS to expand this use of PGHD to other conditions where US Preventive Services Task Force (USPTF) and other guidelines clearly recommend such inclusion, such as for hypertension diagnosis and management through home blood pressure monitoring.

HIMSS and PCHAlliance also applaud the inclusion of Patient Reported Outcome Tools as an ACI category and encourages CMS to promote their use beyond this area in conjunction with an office visit to include administration of patient-reported outcomes measures (PROMs) at home and via practice portals. By moving PROMs collection deeper into a Medicare recipient’s life, CMS can further the stated goal of enabling 24/7 care for a broader population.

A number of new proposed quality measures in the year-two proposed rule lend themselves to remote collection. The first three proposed additions (A.1 – A.3) use a PROMs measure that can be easily reported electronically from home prior to a visit, either reducing office visits for patients making sufficient progress, or better preparing patients and clinicians to address problems reported at home when a visit occurs. Additional measures that would benefit from electronic collection include:

- Tobacco Use and Help with Quitting Among Adolescents
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (via home weight monitoring with a connected scale)
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (via home-administered HbA1c testing and reporting)

HIMSS and PCHAlliance believe strongly in the potential for RPM to increase patient satisfaction, reduce clinical burden, and provide higher-quality care at lower costs. We support Congress’ intent to increase the use of these technologies where safety and effectiveness are proven or where they reduce the work burden on patients or clinicians.

HIMSS and PCHAlliance remain committed to fostering a culture where health IT is 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 welcome the opportunity to further discuss these issues with you 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
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H. Stephen Lieber, CAE
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