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June 10, 2024

Chiquita Brooks-LaSure Administrator Centers for Medicare & Medicaid Services US Department of Health and Human Services 7500 Security Boulevard Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), we are responding to the US Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2025 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) proposed rule published in the May 2, 2024 *Federal Register* (CMS-1808-P).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. The AHIMA mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Our members work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

Following are our comments and recommendations on selected sections of the IPPS proposed rule.

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

Unless otherwise noted below, AHIMA generally supports the proposed MS-DRG classification changes.

We appreciate that CMS will make available, in association with the annual proposed rule, a draft version of the Definitions of Medicare Code Edits (MCE) Manual to provide the public with an opportunity to review any changes that will become effective October 1 for the upcoming fiscal year. However, we recommend that CMS provide a list of the draft MCE changes each year (including any additions or deletions of diagnosis or procedure codes or MCE edits), as it is difficult to identify the changes in the draft version of the Definitions of Medicare Code Edits Manual.

II-C. Proposed Changes to Specific MS-DRG Classifications

1b. Basis for Proposed FY 2025 MS-DRG Updates

We agree with CMS' proposal to continue to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2025. We request that CMS make available updated alternative test software and other data files that have been provided each year since the introduction of the NonCC subgroup, so that the healthcare industry may continue to assess the impact of the application of the NonCC subgroup criteria on existing MS-DRGs.

AHIMA remains concerned about expanding the criteria for creating MCC and CC subgroups to include the NonCC subgroup for a three-way severity level split. CMS' own data over the last few years show significant fluctuations in the MS-DRG changes that would result from applying the expanded criteria to existing MS-DRGs. Also, the impact of CCs would decrease as a result of the application of the expanded criteria, which means that complications/comorbidities will increasingly need to be MCCs in order to impact case complexity and severity. For example, in Table 6P.10 associated with the FY 2024 proposed rule, none of the potential new MS-DRGs resulting from application of the NonCC subgroup criteria involves a with and without CC/MCC split. The potential new two-way severity splits are all with and without MCC only. We are not aware that CMS intended to reduce the impact of CCs when the criteria were expanded to include the NonCC subgroup.

We recommend that CMS conduct further analysis to identify the reasons for annual fluctuations in the potential MS-DRG changes resulting from applying the NonCC subgroup criteria to existing MS-DRGs and for the decline in the number of MS-DRGs affected by the presence of a CC. We encourage CMS to consider adjusting the methodology to correct for these and any other unintended consequences.

6b. Interbody Spinal Fusion Procedures

Since CMS is proposing significant revisions to spinal fusion MS-DRGs, we recommend that ALL spinal fusion MS-DRGs be included in their review and analysis, including MS-DRGs 471, 472, and 473 (Cervical Spinal Fusion with MCC, with CC, and without CC/MCC, respectively).

We also recommend that CMS consider deleting MS-DRGs 459 and 460 and creating new MS-DRGs for Single Level Spinal Fusion Except Cervical with MCC and without MCC, as the proposed revisions would significantly change the types of cases classified to these MS-DRGs.

We recommend that CMS delay implementation of revisions to the spinal fusion MS-DRGs until analysis of all of the spinal fusion MS-DRGs has been completed, including the additional analysis of MS-DRGs 456, 457, and 458 that CMS noted in the proposed rule would be needed prior to considering any modifications to the current structure of these MS-DRGs, as well as incorporating MS-DRGs 471, 472, and 473 in the analysis.

The titles of the ICD-10-PCS procedure codes identifying spinal fusion procedures using the aprevoTM customized interbody fusion device were revised, effective October 1, 2023, as a result of the manufacturer's concerns that some claims may have been unintentionally miscoded. Per the materials from the March 2023 ICD-10 Coordination and Maintenance Committee meeting, the manufacturer requested the title revision to help minimize misinterpretation of the term "customizable."

CMS was unable to confirm that some claims reporting the use of the aprevoTM device had in fact been miscoded, and they noted in the proposed rule that while a newly established ICD-10 code may be associated with an application for a new technology add-on payment, such codes are not generally established to be product specific. CMS further stated that if, after consulting the official coding guidelines, a provider determines that an ICD-10 code associated with a new technology add-on payment describes the technology that they are billing, the hospital may report the code and be eligible to receive the associated add-on payment. However, AHIMA believes that some ICD-10-PCS codes are intended to be product specific, as the code titles often represent a manufacturer's specific technology, particularly in the New Technology section. The *Coding Clinic for ICD-10-CM/PCS* Editorial Advisory Board has determined that some ICD-10-PCS codes are only intended for a specific product and should not be used for other devices or substances. In the case of the aprevoTM device, it is not clear why the titles of the associated procedure codes were revised to more clearly describe this specific device and address the manufacturer's concerns regarding miscoding, if it was appropriate to assign the codes for spinal fusion procedures using devices other than the aprevoTM device. Further, we are concerned that a continued lack of clarity regarding device specific codes may have a chilling effect on the use of new technology due to concerns of possible non-reimbursement, which may have a negative impact on clinical outcomes.

8. MS-DRG 795 Normal Newborn

AHIMA applauds CMS' initiation of an evaluation of the GROUPER logic that would determine the assignment of cases to the MS-DRGs in MDC 15 to determine where further refinements could potentially be made to better account for differences in clinical complexity and resource utilization.

12.c.1. Proposed Changes to Severity Levels: SDOH – Inadequate Housing/Housing Instability

CMS proposes to change the severity designation of the seven ICD-10-CM diagnosis codes that describe inadequate housing and housing instability from non-complication or comorbidity (NonCC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes.

AHIMA supports designating the seven ICD-10-CM diagnosis codes that describe inadequate housing and housing instability from non-complication or comorbidity (NonCC) to complication or comorbidity (CC). In response to the FY 2024 IPPS proposed rule, we supported the proposal to designate the three ICD-10-CM diagnosis codes for homelessness as CCs. We are pleased to see CMS expanding this proposal to include the other housing insecurity codes as this will give hospitals more insight into additional circumstances that can impact patients' health outcomes. We support CMS continuing to monitor the impact on resource use of the other SDOH codes to evaluate if any others meet the criteria for CC designation and appreciate CMS' ongoing work in this area to create greater incentives for hospitals to use SDOH Z codes. We agree that consistent reporting of SDOH Z codes is necessary to evaluate the impact on resource use and determine if a change in severity level designation is warranted. Better reporting of SDOH Z codes in inpatient claims data could enhance quality improvement activities, track factors that influence people's health, and provide further insight into existing health inequities.

E. Long-Term Care Hospital Quality Reporting Program

4. Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning With the FY 2028 LTCH QRP

CMS proposes the addition of social determinants of health (SDOH) data elements into the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP), requiring LTCHs to report data elements on housing, food and utility stability, and access to transportation.

AHIMA supports the proposed addition of SDOH data elements into the LTCH QRP. We have <u>previously</u> <u>supported</u> the prioritization of these three domains to align with and build on existing rulemaking to provide more consistent data to guide resource allocation and targeted social services supports.¹ We encourage CMS to ensure this requirement includes that these data elements be standardized and documented in the patient's medical record and recommend CMS engage with other federal partners and healthcare industry stakeholders to determine the most efficient method of standardization. AHIMA recommends CMS encourage providers to assign ICD-10-CM Z-codes for any identified SDOH needs and report these codes on reimbursement claims when there is sufficient space on the claim. In addition to these data providing CMS with more awareness of the prevalence of these SDOH data elements and their impact on patient health outcomes and resource allocation, being able to use these data in meaningful ways will provide more opportunities for providers to work within their care teams and coordinate with community-based organizations to provide patients with resources and

¹Available at: <u>https://www.ahima.org/media/3o5lwcir/ahima-comments-ip-pps23_final_signed-lr.pdf.</u>

supports to address any gaps in which housing, food and utility stability, and access to transportation may be influencing their abilities to achieve improved health and health outcomes.

The continued inclusion of key SDOH tools by CMS throughout proposed and final regulations demonstrates the Administration's commitment to narrow the health equity gap across healthcare. AHIMA remains a steadfast supporter of policy efforts aimed at increasing the collection and use of SDOH data to improve individual and community health and healthcare outcomes.

In 2022, AHIMA commissioned a study, conducted by NORC at the University of Chicago, to better understand the operational realities of how SDOH data is collected, coded, and used in real-world healthcare scenarios.² Key findings of the survey included:

- Lack of standardization and integration of the data into an individual's medical record;
- Insufficient workforce training and education on how to capture, collect, code, and use SDOH data; and
- Limited uses of SDOH data to communicate between healthcare providers and community-based referral organizations.

AHIMA continues to live its commitment to improving health equity through its Data for Better HealthTM initiative.³ Data for Better Health provides tools, resources, and education to support a better understanding of the importance of SDOH data and how it can be used to improve health and healthcare outcomes. The goals of this initiative include:

- Engaging healthcare professionals working with SDOH to understand the business case for the collection of SDOH and share strategies for success;
- Educating and engaging with consumers to build trust and a greater understanding of SDOH and the benefits of sharing SDOH information with healthcare professionals;
- Advancing policy and advocacy among policymakers by developing and promoting an SDOH data advocacy agenda; and
- Supporting innovation within the healthcare ecosystem to accelerate the adoption of best practices and new models.

AHIMA remains a committed partner to CMS in efforts to build on this work and improve the collection and use of SDOH data to improve community and individual health outcomes.

F. Medicare Promoting Interoperability Program

5. Proposal to Change the Scoring Methodology Beginning with the EHR Reporting Period in CY 2025

CMS proposes to increase the performance-based scoring threshold from 60 to 80 points beginning with the calendar year (CY) 2025 electronic health record (EHR) reporting period.

AHIMA supports the proposal to increase the scoring threshold to 80 points in the pursuit of better alignment of health information systems with evolving industry standards and improved data exchange. We encourage CMS to further study and release de-identified data on which categories eligible hospitals and critical access hospitals (CAHs) are performing well to better understand the success rates of participation in the Promoting Interoperability (PI) program. This information can guide the direction of resources to support eligible hospitals and CAHs improve their scoring in low-performing categories. While eligible hospitals and CAHs have performed well in meeting the minimum threshold thus far, the landscape of health IT is evolving, and we

²Available at: <u>https://www.ahima.org/news-publications/press-room-press-releases/2023-press-releases/ahima-white-paperidentifies-opportunities-and-challenges-with-collecting-integrating-and-using-social-determinants-of-health-data/.</u> ³Available at: www.dataforbetterhealth.com.

encourage CMS to ensure the increased scoring threshold is scaled appropriately and considers organizations' varying capabilities in tandem with growing complexities of advancing health IT systems.

7. Potential Future Update of the SAFER Guides Measure

CMS has notified eligible hospitals and CAHs that updates to the SAFER Guides are underway.

AHIMA appreciates CMS notifying eligible hospitals and CAHs of the current work on updates to the SAFER Guides and applauds this work. In response to the calendar year (CY) 2024 Medicare Physician Fee Schedule proposed rule, AHIMA <u>noted</u> that while the SAFER Guides are a tool for organizations to assess their health IT deployments, they are currently out of date and can be onerous and burdensome for organizations to use, especially those that are under-resourced.⁴ AHIMA applauds these updates and recommends CMS work with industry stakeholders to regularly assess the burdens and effectiveness of the SAFER Guides as well as explore alternative tools to assess health IT capabilities within organizations.

8. Proposal to Update the Definition of Meaningful EHR User for Healthcare Providers that have Committed Information Blocking

CMS has notified eligible hospitals and CAHs of changes to the definition of certified electronic health record technology (CEHRT) based on revisions made in the CY 2024 Medicare Physician Fee Schedule final rule. This notification includes proposed changes to the definition of meaningful EHR user in the HHS proposed rule regarding disincentives for healthcare providers that have committed information blocking.

AHIMA appreciates CMS' efforts to harmonize definitions across regulations. As it relates to the definition of meaningful EHR user, we reiterate our <u>recommendation in previous comments</u> for CMS and the Office of the National Coordinator for Health IT (ONC) to undertake an in-depth economic analysis prior to implementing the proposed information blocking disincentives to ensure penalties are equitable across all impacted programs.⁵ If the enforcement process is not equitable, information blocking enforcement may not produce its intended objective of encouraging information sharing. AHIMA also recommends CMS and ONC examine existing policy pathways to punish repeat information blocking offenders that choose to absorb penalties as a cost of doing business. Additionally, we recommend CMS and ONC commit to holding stakeholder listening sessions to determine the best way to disincentivize provider types not covered under these proposals. AHIMA appreciates CMS considering stakeholder feedback ahead of the finalization of this policy as the healthcare industry awaits the information blocking disincentives final rule.

10. Request for Information Regarding Public Health Reporting and Data Exchange

CMS seeks feedback on their goals and principles for the Promoting Interoperability Program Public Health and Clinical Data Exchange objective and describes recommended updates to health IT certification criteria.

Making Available New Capabilities for Exchanging Data with Public Health Authorities (PHAs) Using the FHIR Standard

While AHIMA <u>supports</u> the development and implementation of FHIR, it is important to note that FHIR is still an actively maturing standard.⁶ During this time, FHIR should not be viewed as the sole solution to interoperability and the patient data exchange challenges the healthcare system currently experiences. The Public Health and Clinical Data Exchange objective may be a good area to begin to incentivize early adoption of

⁴Available at: <u>https://ahima.org//media/vq2km0wl/ahima-cy24-pfs-comment-letter-final.pdf.</u>

⁵Available at: <u>https://www.ahima.org/media/jj4jcwhd/ahima-info-blocking-provider-disincentives-proposed-rule-final-v3.pdf.</u>

⁶Available at: <u>https://www.ahima.org/media/tsfbd54h/ahima-cms-hipaa-attachment-standards-proposed-rule-comments-final.pdf.</u>

FHIR-based APIs, but it is important for CMS to maintain flexibility to ensure the success of interoperability programs.

Adequate and inclusive testing of standards, including FHIR, should be done before they are included in regulation. Health IT end-user input should be part of every phase of the development, maturity, testing, and implementation of health IT standards. We encourage CMS to work with ONC, other relevant federal agencies, and the broader health IT community to identify expectations and needed elements for the successful <u>real-world testing of standards</u>.⁷ This testing must happen in advance of inclusion in certification requirements and needs to go beyond what is included in the real-world testing requirements in the existing ONC certification regulations. Therefore, AHIMA recommends CMS refrain from including FHIR in public health certification criteria until the results of real-world testing initiatives are made public, and the standard is proven mature. Publicly available data can provide healthcare entities with lessons learned and best practices to inform the evaluation of FHIR and efficient progress toward implementation. Adopting FHIR can come at great cost for smaller and underresourced organizations, and ensuring more information is available to those organizations can aid with planning and prioritizing resources for adoption of FHIR in their workflows.

Expanding the Scope of Public Health Exchange Supported by Certified Health IT Capabilities

AHIMA applauds CMS' work with ONC and the Centers for Disease Control and Prevention (CDC) to explore how the Medicare Promoting Interoperability Program could strengthen public health infrastructure through the more advanced use of health IT and data exchange standards. An agency-wide approach to innovation and advancement in this area across HHS will ensure regulatory initiatives are harmonized and grounded in the needs of the end-user, reducing burden on healthcare providers and prioritizing goals of improved public health response, efficient workflows, and better health outcomes.

As mentioned, any added standards and certification criteria must undergo robust real-world testing in a variety of healthcare settings before mandated use in regulation. When considering efforts to expand the scope of public health exchange in certification criteria, we encourage CMS to ensure any added criteria includes disclosure of the rationale and anticipated benefits and outcomes as demonstrated via real-world testing. Introducing new requirements for the purpose of reporting to government programs without realistic opportunities to improved and effective public health responses and population health only increases burden.

CMS previously finalized the Enabling Exchange under TEFCA measure under the HIE objective for eligible hospitals and CAHs to attest to engaging in health information exchange. CMS requests information on if it should introduce a similar measure to allow providers to receive credit for the HIE objective by exchanging public health data through participation in TEFCA.

AHIMA continues to support the efforts of the ONC and the Recognized Coordinating Entity (RCE), the Sequoia Project, to operationalize the Trusted Exchange Framework and Common Agreement (TEFCA). The TEFCA is a needed interoperability network that can help hasten the nation's advancement to nationwide interoperability and AHIMA supports the development of TEFCA and encourages its membership to engage in TEFCA.

While Qualified Health Information Networks (QHINs) have been named with limited data exchange underway, AHIMA supports a future CMS proposal to allow providers to receive credit for the HIE objective by exchanging public health data through participation in TEFCA. This option would create an incentive for providers to join TEFCA, rather than mandating participation in TEFCA, as AHIMA believes participation in TEFCA must remain voluntary. The use of positive incentives and voluntary participation can provide information and data on the progress of TEFCA as it is introduced in real-world settings. We encourage CMS to work with ONC to monitor the development of TEFCA and publicly share information on any progress of public health data exchange through TEFCA, including successes and challenges healthcare entities face in these efforts.

⁷Available at: https://hitenduser.org/wp-content/uploads/2022/09/Real-world-testing-consensus-statement_FINAL.pdf.

Thank you for the opportunity to comment on the FY 2025 IPPS proposed rule. If AHIMA may provide any further information, or if there are any questions regarding this letter and its recommendations, please feel free to contact Sue Bowman, senior director of coding policy and compliance, at <u>sue.bowman@ahima.org</u>, or Tara O'Donnell, regulatory health policy associate, at <u>tara.odonnell@ahima.org</u>.

Sincerely,

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Mona Calhoun, PhD, MS, Med, RHIA, FAHIMA President/Chair AHIMA Board of Directors

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Kevin Klauer, DO, EJD Chief Executive Officer AHIMA