June 10, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: CMS-1771-P
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) and fiscal year 2022 rates, as published in the May 10, 2022, Federal Register (CMS-1771-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. AHIMA's 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 providers. Our leaders 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** (87FR28125)

**II-D – Proposed Changes to Specific MS-DRG Classifications** (87FR28127)

AHIMA supports the proposed changes to MS-DRG classifications.

**II-D-13d - Request for Information on Social Determinants of Health Diagnosis Codes** (87FR28177)

AHIMA supports the use of public policy to encourage the collection, access, sharing, and use of social determinants of health (SDOH) to enrich clinical decision-making and improve health outcomes, public

health, and health inequities in ways that are culturally respectful.[1] Consistent collection of high-quality data on SDOH is needed to be able to address social issues and improve health outcomes. The availability of better SDOH information could help CMS better understand the prevalence and trends for various social risk factors and enable the analysis of the impact of these factors on severity of illness, resource utilization, and health outcomes. More consistent collection of standardized SDOH data would enhance healthcare organizations' and CMS' ability to collect, analyze, and report disparity- and equity-related data. AHIMA agrees that 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. We fully support CMS' desire to achieve more widely adopted, consistent SDOH documentation and Z code reporting in the hospital inpatient setting.

There are several reasons why SDOH Z codes may be underreported. Insufficient space on the institutional claim is a significant barrier to reporting SDOH Z codes. Since many hospital inpatients have multiple complex medical conditions, there are often no available data fields for SDOH codes. **We recommend that CMS advocate for expansion of the secondary diagnosis code fields on the institutional claim form**. An alternative option to an expansion of the secondary diagnosis code fields would be to create a separate set of data fields designated for SDOH Z codes. This option would have the benefit of clearly distinguishing SDOH data from other diagnostic information and would also make it clearer that coding guidelines pertaining to secondary diagnosis codes do not necessarily apply to SDOH codes. Additional guidance is needed regarding the use of these separate fields if this suggestion is adopted. For example, the SDOH data fields would need to be optional, since SDOH codes would not apply to all patients, and the categories of ICD-10-CM codes that should be reported in the SDOH code fields would need to be clearly defined.

SDOH Z codes also may be underreported as a result of confusion regarding the circumstances in when SDOH codes should be reported, where to find SDOH documentation, and whose documentation can be used for coding purposes. The *ICD-10-CM Official Guidelines for Coding and Reporting* state that for reporting purposes, the definition for "other diagnoses" is interpreted as additional conditions that impact patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring. There is confusion as to whether SDOH need to meet this definition in order to be reported as a secondary diagnosis. **Clarification that SDOH do not need to meet this definition for SDOH codes to be reported on claims would help to increase the reporting of SDOH Z codes.**

Recent changes to the official coding guidelines are intended to promote the use of SDOH Z codes and provide direction on appropriate use of these codes. Despite the expanded guidance, confusion and misunderstanding persist. For example, the guidelines allow these codes to be based on documentation from healthcare professionals other than the patient's provider, but not everyone is aware of, or understands, this change. The FY 2023 version of the official coding guidelines includes a revision stating that the SDOH Z codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor. The purpose of this revision is to prevent inappropriate use of the ICD-10-CM SDOH codes. For example, code Z60.2, Problems related to living alone, should not be assigned for every patient who lives alone, but rather, only when there is a problem associated with living alone. It is important for the documentation to be clear as to the existence of a problem or risk factor. Healthcare professionals responsible for documenting SDOH information as well as coding professionals need to be educated on the documentation and coding requirements to ensure SDOH

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[1] https://www.ahima.org/advocacy/policy-statements/social-determinants-of-health/

information is appropriately documented to support SDOH codes and that those SDOH codes are properly reported.

SDOH documentation can be difficult to find in electronic health records (EHRs), as it may be in various places such as social history and is often located in sections of the health record that coding professionals have typically not been expected to review for coding purposes in the past. Documentation of SDOH is not standardized and is often unstructured. Half of participants in an AHIMA survey reported a lack of discrete EHR fields/functionality to capture SDOH information as an SDOH data collection challenge.[2]

Staffing shortages and coding productivity standards also contribute to the underreporting of SDOH Z codes. Twenty-seven percent (27%) of respondents to an AHIMA SDOH survey indicated coding productivity standards are a key challenge in collecting SDOH data – a higher percentage than those who cited lack of financial incentives as a challenge (22%).[3] Since these codes do not impact MS-DRG assignment, coding of SDOH data may be a low priority or hospital policy may discourage assigning codes that do not impact reimbursement. Assigning codes for SDOH can be a time-consuming and labor-intensive process, since SDOH documentation may be difficult to find. Computer-assisted coding or artificial intelligence tools could reduce the manual labor involved and make the process of coding SDOH more accurate and efficient.

An additional challenge is ensuring that SDOH information is kept up-to-date and that SDOH codes do not continue to be reported when a personal social, economic, or environmental condition is no longer applicable. Patients' circumstances change, so assessments and codes need to be updated regularly to ensure the SDOH information documented in the EHR and reported on the claim is still accurate.

Reporting of SDOH Z codes depends on the availability of SDOH documentation. Patients are not always screened for social risk factors, or they may be screened for some SDOH, but not all. Due to the time and resources involved for both patients and providers, it is not feasible for hospitals to screen for every SDOH. Also, the more SDOH information that is collected, the less likely it is that all the identified issues may be followed up on and addressed.[4] Consensus focused around high-priority SDOH has been lacking, with widespread disagreement on what SDOH have the greatest impact on health and can more readily be addressed, or how different SDOH may interact and impact each other. Over half of the respondents to an AHIMA survey cited lack of organizational policy around SDOH data collection as a challenge in collecting SDOH data.[5] SDOH screening may not be done due to the unavailability of community resources to address social issues, or because the healthcare organization may lack systems and processes to connect patients to community resources. Also, patients may be unwilling to answer questions regarding social risk factors due to the sensitive and intimate nature of this information.

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[2] https://ahima.org/sdoh/.

[3] https://ahima.org/sdoh/.

[4] American Health Information Management Association. 2021. Social Determinants of Health: Improving Capture and Use by Applying Data Governance Strategies. https://journal.ahima.org/page/social-determinants-of-health-improving-capture-and-use-by-applying-data-governance-strategies.

[5] https://ahima.org/sdoh/.

AHIMA believes public policy must prioritize a set of standardized SDOH data elements to be included in EHRs.[6] To minimize provider burden and facilitate the collection of consistent, comparable SDOH data, CMS should target a few high-priority SDOH domains for SDOH screening and data collection. Ideally, the selected domains should be aligned across federal healthcare programs and CMS reporting requirements. **We recommend that CMS adopt housing stability, food security, and access to transportation as the top three SDOH for which hospitals should be encouraged to screen inpatients.** Targeting these three domains would align with a recent final rule[7] that requires Medicare Advantage Special Needs Plans to include questions on housing stability, food security, and access to transportation as part of their health risk assessments. As stated in the Medicare Advantage final rule, these three domains have the strongest currently available evidence base, suggesting they have a particularly significant influence on health outcomes. While there are many important social risk factors, alignment of high-priority SDOH across multiple programs and requirements will provide more consistent data for aggregating and evaluating prevalence and trends. Limiting the initial focus to three domains would encourage hospitals to, at a minimum, consistently collect and report SDOH information in these areas. As experience with SDOH data collection is gained and better, more complete data in these three domains is available, CMS could consider expanding its focus to additional SDOH domains.

CMS should encourage hospitals to use validated, widely-used SDOH screening tools in order to ensure reliable, actionable information is collected and to facilitate data exchange and interoperability. Standardization of SDOH collection would help to improve both healthcare organizations' and CMS' ability to analyze prevalence and trends in social risk factors across populations and geographic areas.

CMS should encourage hospitals to report Z codes for SDOH whenever this information is documented, focusing in particular on the three high-priority domains of housing stability, food security, and access to transportation. ICD-10-CM Z codes already exist, or will soon be implemented, for SDOH pertaining to these three domains (a new ICD-10-CM code for transportation insecurity will go into effect October 1, 2022). While hospitals may choose to screen and assign ICD-10-CM Z codes for additional SDOH, encouraging hospitals to, at a minimum, screen patients for housing stability, food security, and access to transportation and report the corresponding ICD-10-CM codes would minimize the administrative burden and enable more consistent SDOH data collection and reporting in at least these three domains.

In the proposed rule, CMS solicited comments on whether certain Z codes should be required to be reported on hospital inpatient claims. AHIMA fully supports CMS' efforts to encourage SDOH Z code reporting. However, as noted above, there are circumstances when SDOH Z codes might reasonably not be reported on claims, such as lack of sufficient space on the claim form, or SDOH were not assessed (for any number of reasons). While recent updates to the *ICD-10-CM Official Guidelines for Coding and Reporting* are intended to promote more consistent and widespread reporting of SDOH Z codes, confusion or lack of awareness regarding Z code reporting and appropriate supporting documentation persists. Rather than creating new requirements for reporting Z codes, **we recommend that CMS collaborate with the healthcare industry to provide education to coding professionals as well as healthcare professionals involved in assessing and documenting SDOH in order to increase understanding around accurate and complete SDOH data collection and coding**, including the applicable official coding guidelines. **We also recommend that CMS explore approaches to overcome**

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[6] https://www.ahima.org/advocacy/policy-statements/social-determinants-of-health/,

[7] Centers for Medicare and Medicaid Services. Medicare program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. Federal Register 87 (89):27704–27902.

**identified barriers and challenges to the collection of SDOH data**, such as insufficient space on the claim form and administrative burdens on clinical and coding staff.

CMS should continue to advance the collection and use of SDOH in quality metrics and population health initiatives, as this will incentivize healthcare organizations to assess patients for social risk factors and document this information in EHRs, thus improving the availability of documentation needed for code assignment.

AHIMA also recommends that CMS undertake extensive educational efforts to educate healthcare providers and organizations on the benefits of collecting and using SDOH information (e.g., reduction in hospital readmissions, better patient outcomes, reduced costs, improved coordination of care). We believe there is still limited understanding of the value to hospitals and other healthcare providers of collecting and using SDOH information.

**II-D-15 – Proposed Changes to the Medicare Code Editor (MCE)** (87FR28182)

AHIMA supports the proposed MCE changes.

**II-D-19a – Comment Solicitation on Possible Mechanisms To Address Rare Diseases and Conditions Represented by Low Volumes Within the MS–DRG Structure** (87FR28195)

We agree that appropriately addressing rare diseases in the MS-DRG system is challenging because these diseases affect small numbers of patients, and this system depends on aggregation of similar cases with a range of costs, and thus requires a sufficiently large set of claims data.

One possible approach for CMS' consideration would be to establish an add-on payment for rare diseases and conditions, similar to the add-on payment for new technologies.

**II-F-8 – Proposed Use of National Drug Codes (NDCs) To Identify Cases Involving Use of Therapeutic Agents Approved for New Technology Add-On Payment** (87FR28353)

We fully support CMS' proposal to use NDCs to identify cases involving the use of therapeutic agents approved for new technology add-on payment (NTAP) rather than creating ICD-10-PCS codes. We applaud CMS for implementing this longstanding AHIMA recommendation. CMS should clearly identify which NDC(s) should be used to identify a particular drug/therapeutic agent for NTAP purposes, as some drugs/therapeutic agents may have more than one applicable NDC.

As AHIMA has stated in the past, the ICD-10-PCS coding system is not intended to represent unique drugs/therapeutic agents and is not an appropriate code set for this purpose. Also, ICD-10-PCS codes have often been created unnecessarily because the drug/therapeutic agent was not approved for an NTAP. In the absence of an NTAP, administration of drugs/therapeutic agents is not typically coded in the hospital inpatient setting. Assignment of ICD-10-PCS codes by coding professionals solely for NTAP purposes, for services that would not otherwise be coded in the inpatient setting, is administratively burdensome.

We understand that ICD-10-PCS codes may still need to be established for a therapeutic agent subject to an NTAP, but for which an NDC has not been assigned by the FDA.

**IX. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS** (87FR28477)

**IX-E-5b – Hospital Inpatient Quality Reporting (IQR) Program: New Measures Being Proposed for the Hospital IQR Program Measure Set - Proposed Adoption of Two Social Drivers of Health Measures Beginning With Voluntary Reporting in the CY 2023 Reporting Period and Mandatory Reporting Beginning With the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years** (87FR28497)

AHIMA supports the adoption of measures for social drivers of health, which will help to drive increased screening for SDOH and thus improve collection of SDOH information. However, requiring screening to be performed in five domains is too burdensome. We also believe that selected domains should align across federal programs and reporting requirements. We recommend that the new measures only address screening for food insecurity, housing instability, and transportation needs, which would align with our recommendations above for SDOH Z code reporting and also with the above referenced Medicare Advantage regulation.

We agree with CMS' proposal to allow hospitals flexibility with selection of screening tools. However, CMS should encourage hospitals to use validated, widely accepted, health-IT enabled assessment instruments to ensure reliable, actionable responses are being collected and that data is comparable within and across populations. The ability to aggregate SDOH data within and across populations is important in order to use the data to inform policy changes and risk adjustment and develop strategies to improve population health.

We recommend that CMS use consistent terminology when describing social risk factors. The term "social drivers of health" is used to describe the proposed measures under the IQR Program, but "social determinants of health" is the term widely used by the healthcare industry and by CMS, including in other sections of this proposed rule.

**IX-H – Changes to the Medicare Promoting Interoperability Program** (87FR28576)

*EHR Reporting Period*

AHIMA applauds CMS for previously providing multiple years notice to eligible hospitals and critical-access hospitals (CAHs) of the increase in reporting period for CY 2023 to any continuous 90-day period and to any continuous 180-day period within CY 2024. AHIMA however does urge CMS to reconsider these proposals due to the ongoing Public Health Emergency (PHE) and issues the ongoing pandemic has generated related to provider burnout and staffing shortages. In our comments[8] to CMS on the 2022 IPPS proposed rule we urged CMS to reconsider these proposals and to delay the implementation of these extended reporting periods until a time when the medical system has fully recovered from the impact of the COVID-19 pandemic. Hospitals and CAHs continue to feel the burden both in resources and staffing as a result of the pandemic and need additional time to recover from the burden COVID-19 placed upon their organizations. COVID-19 is continuing to produce additional variants and administration officials are signaling that the nation is heading towards another COVID-19 surge in the fall.[9] We again urge CMS to delay the implementation of the extended reporting periods until the future

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[8] https://ahima.org/media/koibtxna/ahima-comments-ip-pps22_final-signed-wwh.pdf
[9] https://khn.org/morning-breakout/a-fall-covid-surge-likely-coming-fauci-forecasts/

when the PHE is no longer in place and eligible provider organizations are better equipped to return to normal business and cope with the burden associated with an extended reporting period.

*CEHRT Requirements*

AHIMA thanks CMS for the additional guidance to eligible hospitals and CAHs on how best to attest to the implementation of their updated Certified Electronic Health Record Technology (CEHRT) products. Eligible hospitals and CAHs are anxiously awaiting updated products to enable electronic health information (EHI) export and move the health system further down the 21st Century Cures Act implementation timeline. While the guidance is appreciated and helps clarify that eligible hospitals and CAHs do not need to attest until the last 90-days of the reporting year, AHIMA continues to urge CMS to consider delaying the deadline for attestation until the CY 2024 IPPS rule. The additional time would allow eligible hospitals and CAHs to work with their CEHRT vendors to ensure implementation is successful before requiring them to attest. Rushed implementation increases burden on eligible hospitals and CAHs and puts the success of the new CEHRT products at risk. Eligible hospitals, CAHs, and their CEHRT vendors should have additional time to ensure the new products function well in the real-world environment and to rectify any issues that arise during implementation.

*Electronic Prescribing Objective: Proposed Changes to the Query of Prescription Drug Monitoring Program Measures and Technical Update to E-Prescribing Measure*

The nation's Prescription Drug Monitoring Program (PDMP) continues to improve and has transitioned from a program that was successful in only a handful of states nationwide into one that is nearly supported in all 50 states and the District of Columbia. As CMS demonstrates within this year's IPPS proposed rule, all 50 states now have a PDMP within them and the integration between different facets of health IT and PDMPs continues to rise year-to-year. AHIMA continues to support the ongoing enhancement of PDMP integration into the health system and the development of specific tools, such as RxCheck. AHIMA also continues to engage with ONC to learn about the development of these tools and how best we can aid in furthering the maturity and use of PDMPs.

Despite the increase in PDMP development and integration throughout the nation, more needs to be done. CMS notes in Table IX.H.-01 that only 35 of the 50 PDMPs having integration ability with the Pharmacy Dispensing Systems (PDS) and seven PDMPs are only able to engage with one of the EHR, HIE, or PDS. This data shows that the PDMP network needs more development nationwide before we are at a more fully realized integration and seamless utilization of electronic prescribing and prescription drug monitoring. While we applaud the HHS for providing federal matching funds to support PDMP development activities in 2019 and 2020, additional funding is needed to ensure PDMPs can become robust and are simple enough to promote utilization throughout the medical system. Additionally, the nation still lacks true cross-state PDMP-to-PDMP data exchange. This means multi-jurisdictional eligible hospitals and CAHs or those that function in border cities must maintain connections to multiple PDMPs. HHS should continue to work to create a nationwide PDMP network that eligible hospitals and CAHs are eligible to utilize. A national network simplifies the ability for eligible hospitals and CAHs to access PDMP data and promotes the exchange of that data nationwide to paint a more complete picture of a patient's prescription drug history.

As a result of the current status of PDMP utilization nationwide and the need for continued investment, AHIMA urges CMS to delay making the Query of PDMP Measure required until at least the FY 2024 IPPS. This additional time will allow the nation's PDMP infrastructure to continue to develop. AHIMA supports

the measure remaining as optional allowing those eligible hospitals and CAHs who live in states with robust PDMPs to attest to utilization, while also not penalizing those eligible hospitals and CAHs who not have strong PDMP infrastructures in their states.

If CMS were to finalize the change to making the Query of PDMP measure permanent, AHIMA urges CMS to expand the exceptions proposed to include a third exception that exempts an eligible hospital or CAH from needing to attest to this measure if they provide supporting documentation showing that doing so would be overly burdensome. Currently, AHIMA supports the exceptions in-place but propose this third exception to ensure eligible hospitals and CAHs are not penalized for a lack of PDMP integration on a state level that is out of their control. This additional exception would also allow CMS to continue to meet its goals by moving the Query of PDMP Measure to permanent in the future.

*Proposal to Change the Query of PDMP Measure to Include Schedules II, III, and IV*

AHIMA supports the inclusion of Schedule II, III, and IV drugs in the Query of PDMP Measure if CMS works to ensure eligible hospitals and CAHs who lack a state PDMP infrastructure to engage in this reporting are allowed an exception from the program as stated above. As previously stated, AHIMA believes PDMP infrastructure is rapidly expanding but is not at a level of ubiquity needed to ensure all eligible hospitals and CAHs will be able to meet PDMP reporting requirements with limited burden.

*Proposed Technical Update to the E-Prescribing Measure*

AHIMA supports CMS' proposal to clarify the numerator and denominator on the ePrescribing Measure and applaud CMS for continuing to simplify the text of complex federal requirements.

*Proposed New Enabling Exchange Under TEFCA Measure*

AHIMA continues to support the efforts made by 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. Despite continued success of TEFCA development, AHIMA urges CMS to refrain from adding the voluntary new measure Enabling Exchange Under TEFCA under the Health Information Exchange Objective.

While AHIMA supports the development of TEFCA and encourages its membership to engage in TEFCA, at this time it is unclear when the TEFCA network will be fully operational for eligible hospitals and CAHs to attest to this measure. The RCE continues to release documentation supporting the advancement of TEFCA but has yet to release the final application for organizations to apply to be Qualified Health Information Networks (QHINs) or the final Standard Operating Procedure (SOP) for QHIN onboarding.[10] Without these two resources it is unclear when QHINs will be actively exchanging data or when providers will be able to apply to join a QHIN or the cost associated with doing so. The proposed measure also outlines that attestation would involve eligible hospitals and CAHs having to attest to "participating as a signatory to a Framework Agreement" and "using the functions of CEHRT to support bi-directional exchange. . .under this Framework Agreement." At this time, AHIMA is unable to provide comment on either of these attestation requirements given that we do not know what these agreements would entail or what the CEHRT functionality requirements to enable this exchange are at

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[10] https://rce.sequoiaproject.org/tefca-and-rce-resources/

this time. This is especially true given that the CEHRT products eligible hospitals and CAHs are required to implement under the Promoting Interoperability Program during the CY 2023 attestation period are FHIR enabled, while the TEFCA is not expected to implement QHIN-Facilitated FHIR API Exchange until mid-2023.[11]

With unanswered questions related to how the TEFCA will function and when eligible hospitals and CAHs will be able to receive details on how to participate, we are concerned that it is premature for CMS to include the TEFCA in the Promoting Interoperability Program. AHIMA requests CMS remove this optional measure until a timeline of when the TEFCA will be ready to exchange information is clear. During the May Health IT Advisory Committee (HITAC) Meeting, the RCE outlined that it could take more than a year for QHINs to complete onboarding once they are approved to join the TEFCA. That timeline would mean that not only would eligible hospitals and CAHs be unable to join the TEFCA via a QHIN, but that it might not even be clear who the functional QHINs are, until the end of calendar year 2023. If CMS decides to move forward with this measure, AHIMA urges CMS to wait to implement this optional measure until the TEFCA transitions from the "TEFCA Transition Council" advisory group to the full "TEFCA Governing Council." This transition would signal that the QHINs are operational and ready to govern the TEFCA themselves.[12]

Additionally, AHIMA reminds CMS of comments made by administration officials, such as National Coordinator Micky Tripathi, on how participation in the TEFCA is voluntary and that participation would be spurred by "incentives."[13] As CMS continues to develop measures related to health information exchange, AHIMA strongly urges CMS to consider the use of positive incentives and refrain from mandating participation in TEFCA in the future. Mandating participation would not only contradict long standing comments from ONC, but it would also penalize hospitals and CAHs that do not have the funds to participate in TEFCA or lack access to a QHIN that could enable that access.

*Proposed Modifications to the Reporting Requirements for the Public Health and Clinical Data Exchange Objective*

AHIMA supports the CMS proposal to make reporting of Antimicrobial Use and Resistance (AUR) data a required measure under the Public Health and Clinical Data Exchange Objective. We encourage CMS to evaluate the state and local public health entities' ability to receive AUR data and if they are not, adding an additional exception allowing providers who are unable to participate in AUR data exchange to be exempt from this reporting requirement. Ensuring eligible hospitals and CAHs can exempt from this requirement when their ability to report is impacted by a deficiency at a state or local public health agency ensures they will not be penalized for a technical deficiency outside of their control.

AHIMA recommends CMS reconsider its proposal to make reporting Active Engagement mandatory for the reporting of all Public Health Data Exchange measures. The public health measures included as part of the Promoting Interoperability Program continue to evolve every year with the yearly release of the IPPS proposed rule, including this year with the addition of the AUR reporting requirements. With this continued yearly development, we recommend CMS allow eligible hospitals and CAHs at least one year of stable reporting of the public health measures without any changes prior to implementing this active

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[11] https://rce.sequoiaproject.org/wp-content/uploads/2022/01/FHIR-Roadmap-v1.0_updated.pdf

[12] https://rce.sequoiaproject.org/wp-content/uploads/2022/01/SOP-Transitional-Council-FINAL.pdf

[13] https://www.healthcaredive.com/news/onc-head-micky-tripathi-on-info-blocking-complaints-provider-penalties-and/620860/

engagement reporting requirement. Additionally, we recommend CMS wait one year after the initial implementation of the mandatory active engagement requirement before requiring eligible hospitals and CAHs to increase Validation levels every year. By doing a more measured approach to implementing these requirements, CMS ensures eligible hospitals and CAHs will be able to accurately report on Active Engagement and ensures CMS is able to receive the types of responses they are hoping to receive.

Finally, CMS notes in its proposed changes to the Public Health and Clinical Data Exchange Objective that eligible hospitals and CAHs who fail to submit data to public health authorities could be considered information blockers. AHIMA continues to support implementation of the information blocking regulations contained within the 21st Century Cures Act. Currently the authority for implementing the appropriate disincentives for providers who violate information blocking requirements is with the HHS Secretary and there has been no final rule released by the Office of the Inspector General (OIG) detailing how the investigation of information blocking claims would take place. As a result, AHIMA strongly urges CMS to remove language from the FY 2023 IPPS final rule implying providers who do not, or are unable, to share information with public health agencies are potential information blockers. Leaving this language in place implies providers subject to information blocking could face a negative Medicare adjustment and be subject to information blocking penalties if they fail the Public Health and Clinical Data Exchange objective under the Promoting Interoperability Program. Implying information blocking disincentives are a part of the Promoting Interoperability Program framework without HHS formally announcing the provider disincentive policies also creates regulatory confusion for provider actors. It is crucial HHS, and its sub-agencies, maintain a clear and concise communications posture to ensure provider actors fully comprehend their compliance burden. Failure to do so jeopardizes the information blocking implementation pathway and would create unnecessary burden throughout the actor community.

*Proposed Public Reporting of Medicare Promoting Interoperability Program Data*

AHIMA does not see the utility of having Promoting Interoperability Program scores made public. Promoting Interoperability Program scores will not hold meaning for patients or other members of the health IT community who are not intimately aware of the details of the program. Additionally, CMS needs to provide further clarity on whether eligible hospitals and CAHs can request clarification on their posted scores or appeal for an amendment to the score itself. Finally, prior to implementing this program CMS must ensure that once publicly available, this information will not be utilized in an unintended manner that may impact a provider or the broader health system.

**PATIENT ACCESS TO HEALTH INFORMATION MEASURE – REQUEST FOR INFORMATION (RFI)**
(87FR28610)

*Would allowing patients to add information to their records be useful in promoting patient access and utilization? Are there other incentives that would promote patient access? Are there potential unintended consequences in allowing patients to add information to their records? What could be done to mitigate any potential unintended consequences? Are there certain tools found to be useful in promoting patient access and use of their health information?*

It is crucial to allow patients to review and suggest edits to their health records to correct inaccuracies within those records consistent with the requirements under HIPAA. Allowing patients to add

information to their record through a digital means is just one way to accomplish this goal. As it currently stands there are limited technology solutions allowing patients to view and amend their record. AHIMA recommends CMS work with ONC to develop and implement the technical capabilities necessary to increase patient engagement through allowing them the ability to amend or update their records.

At the same time, other challenges can often get in the way of hindering patient access to their records including: cumbersome and decentralized processes for requesting records, lack of staff training and policies to facilitate individuals' access to the health information, lack of transparency during the record request process to allow patients to understand the status of their request and whether additional information is required. Other challenges include manual workflows for HI professional in fulfilling such requests and conditions that may limit individuals' access to their records including geographic location, social-demographic characteristics, internet access and use, and health conditions. As experts in the release of information process, AHIMA welcomes the opportunity to work with CMS to understand operational considerations related to patient access and to improve such access and add to their records.

*What policy, implementation strategies, or other considerations are necessary to address existing racial bias or other biases and prevent use of stigmatizing language?*

Addressing racial bias and promoting equity in healthcare and health IT is a goal of both AHIMA and CMS. Current work with both the Gravity Project and the ONC United States Core Data for Interoperability (USCDI) process are just two of the areas where AHIMA is supporting the health IT community in promoting racial equity and removing racial bias from health IT. AHIMA recommends CMS remain actively engaged in this work to guide its development and determine the best avenue for regulatory alignment. Similarly, to promote nationwide health equity, AHIMA recommends CMS work with the Office of Management and Budget (OMB) to update the demographic data collection standards to be more inclusive and match with several states who have already advanced these standards to be more inclusive.

*If patient portals connected to a network participating in the recently launched TEFCA, would this enable more seamless access to individual health information across various patient portals?*

AHIMA continues to support development of the TEFCA and all opportunities it provides to support increased patient access to their health information. The TEFCA remains an opportunity for widespread data interoperability, but at this time it is unclear how the TEFCA will function once it is operational or the ability for the framework to enable access to multiple patient portals through one login. CMS should continue to monitor the TEFCA's development throughout this year and reevaluate the ability for the framework to remove patient burden in next year's IPPS rule.

*What challenges do eligible hospitals and CAHs face when addressing patient questions and requests resulting from patient access of patient portals or access of data through use of a mobile app? What can be done to mitigate potential burden?*

AHIMA recommends CMS continue monitoring the challenges related to patient access of data through patient portals and mobile apps. The 21st Century Cures Act final rules from ONC and CMS do not require the app enabled application programming interfaces (APIs) to be implemented until 2023. After those APIs are appropriately implemented a clearer picture related to patient access challenges will be

available to CMS. As CMS continues to monitor these issues now and, in the future, we encourage CMS to ensure it solicits feedback from a wide swath of stakeholders, most importantly from HI professionals who are the face of record release and often field patient questions and concerns related to the access of their data.

*Do you believe the API and app ecosystem is at the point where it would be beneficial to revisit adding a measure of patient access to their health information which assesses providers on the degree to which their patients actively access their health information? What should be considered when designing a measure of patient access of their health information through portals or apps?*

AHIMA recommends CMS not pursue implementing a measure to the Promoting Interoperability Program on measuring patient access to their health information. Currently, the 21$^{st}$ Century Cures Update Edition CEHRT products that enable third-party app access via API are not due to be delivered to providers until December 31, 2022, and providers are not required to attest to the implementation of these updated products until the final 90-day period in FY 2023. Additionally, the access via these APIs is enabled without special effort, meaning patients can access their information without contacting their provider. Due to the way these APIs are being implemented it is not possible for providers to measure, track or know how often or through what means a patient is accessing their health information. Implementing a measure, such as the one proposed in this RFI, would increase burden on eligible hospitals and CAHs as they would need to create a means to capture and report this data without a similar mandate from the federal government placed on those that develop the products. CMS should look for other ways to gauge patient engagement and refrain from implementing a measure such as the one proposed.

If AHIMA can 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 (312) 233-1115 or sue.bowman@ahima.org, or Andrew Tomlinson, director of regulatory affairs, at (312) 223-1086 or andrew.tomlinson@ahima.org.

Sincerely,

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