

American Health Information Management Association (AHIMA) 35 W. Wacker Dr., 16th Floor, Chicago, IL 60601

September 3, 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 writing in response to the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule published in the July 31, 2024 <u>Federal Register</u> (CMS-1807-P).

AHIMA is a global nonprofit association of health information professionals, boasting over 61,000 members and more than 88,500 credentials in the field. The AHIMA mission of empowering people to impact health® drives its members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

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

B. Request for Information on Services Addressing Health-Related Social Needs

CMS seeks comments about coding Z codes on claims associated with billing for Community Health Integration (CHI) services, Principal Illness Navigation (PIN) services, and Social Determinants of Health (SDOH) risk assessment codes. CMS is interested in learning whether practitioners are capturing unmet social needs on claims using Z codes for social risk factors or in some other way, and any barriers or opportunities to increase coding of Z codes when social risk factors screen positive.

AHIMA supports policies to encourage the collection, access, sharing, and use of social determinants of health (SDOH) data to improve health outcomes. We also support CMS' desire to advance widely adopted, consistent SDOH documentation and Z code reporting. Capturing social needs through SDOH Z codes provides an opportunity to better integrate social and clinical data such that clinicians have a more comprehensive picture of their patients. The SDOH Z codes represent a way to standardize documentation and reporting of SDOH information. This coded data can be used to improve health



outcomes, address health disparities, support quality measurement, and identify and address community needs.

Among several recommendations detailed in our response, AHIMA recommends CMS:

- Call for expansion of the diagnosis code fields on both the professional and institutional claim form to enable clinicians to report SDOH Z codes;
- Expand educational initiatives and resources to better inform clinicians and organizations on the benefits of collecting, coding, and using accurate SDOH information to support meaningful improvements in health outcomes for patients;
- Incentivize the documentation and reporting of SDOH Z codes, collaborating with end-users engaged in the collection, sharing, and use of SDOH data to determine the best regulatory pathway to increase the documentation, sharing, and use of Z codes; and
- Collaborate with AHIMA and other industry partners to share best practices and guidance on the collection, documentation, coding, and use of clinically relevant, complete, and accurate SDOH data.

AHIMA supports CMS' efforts to improve the identification and documentation of health-related social needs and using those data to connect individuals to the appropriate social services, if desired. For example, AHIMA supported proposals in the CMS fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) proposed rule¹ and the CMS FY 2025 IPPS proposed rule² to designate codes that describe homelessness, inadequate housing, and housing instability as complication or comorbidity (CC) rather than non-complication or comorbidity (NonCC).

Consistent collection of high-quality data on SDOH is needed to address health-related social needs and improve health outcomes. The availability of quality SDOH information could help clinicians and organizations, including state and federal agencies, better understand the prevalence and trends of 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. More widely adopted consistent documentation and reporting would also aid in work toward formulating more comprehensive and actionable policies to improve health outcomes, address health equity and promote the highest quality care for all patients.

AHIMA continues to live its commitment to improving health outcomes through its Data for Better Health™ initiative.³ Data for Better Health provides tools, resources, and education to advance the collection, sharing, and use of SDOH data to improve health outcomes. The goals of the initiative include:

¹Available at: https://www.ahima.org/media/vlicemgo/ahima-comments-ip-pps24_final_signed-lr.pdf.

²Available at: https://www.ahima.org/media/dokdnk24/ahima-final-comments-fy-25-ipps-proposed-rule.pdf.

³Available at: <u>www.dataforbetterhealth.com</u>.



- Engaging healthcare professionals working with SDOH data to understand the business case for the collection of SDOH data 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 data with healthcare professionals;
- Advancing policy and advocacy among policymakers by developing and promoting a SDOH advocacy agenda; and
- Supporting innovation within the healthcare ecosystem to accelerate the adoption of best practices and new models related to SDOH.

Despite widespread support for the collection, use, and sharing of SDOH data and growing recognition of the impact on individual and population health, there is a persistent lack of uptake of reporting of SDOH Z codes. A major barrier contributing to the underuse of Z codes is insufficient space on the claim forms (a limit of twelve diagnosis codes on the professional claim and twenty-five diagnosis codes on the institutional claim form). Since the available diagnosis fields are often used for codes describing medical conditions, there are often no available data fields for SDOH codes, leaving clinicians with an inability to report Z codes. AHIMA strongly recommends that CMS call for expansion of the diagnosis code fields on both the professional and institutional claim form to enable clinicians to report SDOH Z codes. 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 distinguishing SDOH data from other diagnostic information and make it clear 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.

Assigning codes for SDOH can be a time-consuming and labor-intensive process. SDOH documentation may be difficult to find in electronic health records (EHRs), as documentation of SDOH is not standardized and often unstructured. SDOH information is often documented in sections of the medical record that coding professionals do not typically review, and they may not know to look there, or it is in a location that is hard to find or inaccessible to coding staff, or it is located outside the EHR system altogether. Seventy-eight percent (78%) of respondents to an AHIMA-NORC survey reported they could not find SDOH information in the patient record, and half of respondents reported a lack of discrete EHR fields and/or functionality to capture SDOH information as an SDOH data collection challenge.⁴ Computer-assisted coding or artificial intelligence tools may offer an opportunity to reduce labor intensity associated with assigning codes for SDOH, making the process of coding SDOH more accurate and efficient.

⁴Available at: https://www.ahima.org/news-publications/press-room-press-releases/2023-press-releases/ahima-whitepaperidentifies-opportunities-and-challenges-with-collecting-integrating-and-using-social-determinants-of-health-data/.



Other findings from the AHIMA-NORC survey found that insufficient training and education on how to capture, collect, code, and use SDOH data is a significant challenge. SDOH codes may be underreported as a result of confusion regarding the circumstances when SDOH Z codes should be reported and whose documentation can be used for coding purposes. While the *ICD-10-CM Official Guidelines for Coding and Reporting* have been updated 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. Healthcare professionals and coding professionals responsible for documenting SDOH information need to be educated on the documentation and coding requirements to ensure SDOH information is appropriately documented to support SDOH codes and that SDOH codes are properly reported. Federal financial and technical support is needed to train clinicians and coding staff on how best to collect, code, and use SDOH information. This should include continued and expanded research on how best to collect and code SDOH data, and the workforce skills needed to do so.

Coding productivity standards also contribute to the underreporting of SDOH Z codes. One quarter of respondents to a 2020 AHIMA survey on the collection of SDOH data cited coding productivity standards as a key challenge.⁵ Overworked providers, significant time pressures, and lack of access to appropriately skilled individuals to assess SDOH are additional factors.⁶

Since patients' circumstances are ever-changing, it is a challenge to ensure SDOH information documented in the EHR is up-to-date and has not been carried over from prior encounters without being validated. 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.

Due to the time and resources involved for both patients and clinicians, it is not feasible to screen for every SDOH. Consensus focused around high-priority SDOH has been lacking, with a lack of consensus on what SDOH have the greatest impact on health and require minimal intervention, or how different SDOH may interact and impact each other. Over half of the respondents to the AHIMA survey cited lack of organizational policy around SDOH data collection as a challenge in collecting SDOH data.⁷

SDOH screening may not be done due to a lack 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.

To continue progress in this area and address barriers to improve the consistent collection, documentation, and coding of SDOH information, **AHIMA recommends CMS expand its educational**

⁵Available at: https://ahima.org/sdoh/.

⁶Available at: https://www.ahima.org/news-publications/press-room-press-releases/2023-press-releases/ahima-whitepaperidentifies-opportunities-and-challenges-with-collecting-integrating-and-using-social-determinants-of-health-data/.

⁷Available at: https://www.ahima.org/news-publications/press-room-press-releases/2023-press-releases/ahima-whitepaperidentifies-opportunities-and-challenges-with-collecting-integrating-and-using-social-determinants-of-health-data/.



initiatives and resources to inform clinicians and organizations on the benefits of collecting, coding, and using accurate SDOH information to support meaningful improvements in health outcomes for patients (e.g., reduction in hospital readmissions, better patient outcomes, reduced healthcare costs, improved coordination of care). This education should include strategies on how best to discuss SDOH screening with patients as there is still limited understanding of the value of collecting and using SDOH information. AHIMA welcomes the opportunity to collaborate with CMS on the development and provision of SDOH educational resources.

AHIMA also recommends CMS incentivize the reporting of SDOH Z codes, collaborating with stakeholders engaged in the collection, sharing, and use of SDOH data to determine the best regulatory pathway to increase the use of Z codes. However, expanding the number of diagnosis fields on the standard claim forms is a prerequisite for requiring the reporting of SDOH Z codes. If the reporting of SDOH Z codes becomes mandatory, the requirement should start with the subset of codes that directly align with the five core domains required by the Social Drivers of Health quality measures (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety).

Additionally, we recommend CMS collaborate with AHIMA and other end-users to share best practices and guidance on the collection, documentation, coding, and use of clinically relevant, complete, and accurate SDOH data.

AHIMA remains a committed partner to improving the collection and use of SDOH data to improve community and individual health outcomes, including collaboration to increase uptake of Z code use in minimally burdensome ways.

(G) Request for Information (RFI) Regarding Public Health Reporting and Data Exchange

CMS seeks comment related to a number of goals to enhance the Public Health and Clinical Data Exchange objective of the Medicare Promoting Interoperability performance category.

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

While AHIMA supports the development and implementation of FHIR, it is important to note that FHIR is still an actively maturing standard. 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 FHIR-based APIs, but it is important for CMS to maintain flexibility to ensure the success of interoperability programs. CMS should monitor the development of FHIR across all HHS programs and initiatives to study the applicability, maturity, real-world adoption, and potential success of using FHIR for data exchange with PHAs.

⁸Available at: https://www.ahima.org/media/tsfbd54h/ahima-cms-hipaa-attachment-standards-proposed-rule-comments-final.pdf.



Adequate and inclusive, real-world 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. CMS should prioritize the use of standards that were developed with processes that include diverse end-user feedback to ensure they are appropriate in a wide array of clinical settings. We encourage CMS to work with the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP), other relevant federal agencies, and the broader health IT community to identify expectations and needed elements for the successful real-world testing of standards. 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 ASTP 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 under resourced organizations. 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 ASTP 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 clinicians and prioritizing goals of improved public health response, efficient workflows, and better health outcomes.

That said, any added standards and certification criteria must include feedback from end-users during development and should undergo robust real-world testing in a variety of healthcare settings before mandating 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 the Trusted Exchange Framework and Common Agreement (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

⁹Available at: https://hitenduser.org/wp-content/uploads/2022/09/Real-world-testing-consensus-statement_FINAL.pdf. Copyright © 2024 AHIMA®. All rights reserved.



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 ASTP and the Recognized Coordinating Entity (RCE), The Sequoia Project, to operationalize the 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 ASTP 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.

Thank you for the opportunity to comment on the CY 2025 MPFS 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 Sue.Bowman@ahima.org or Tara O'Donnell, regulatory health policy associate, at Tara.ODonnell@ahima.org.

Sincerely,

Mona Calhoun, PhD, MS, Med, RHIA, FAHIMA

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President/Chair

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