

September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
PO Box 8011
Baltimore, Maryland 21244-1850

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals [CMS-1753-P]

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 Outpatient Prospective Payment Systems (OPPS) and fiscal year 2022 rates, as published in the August 4, 2021, Federal Register (CMS-1753-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 OPPS proposed rule.

VII. Proposed OPPS Payment for Hospital Outpatient Visits and Critical Care Services

AHIMA is disappointed that development of a set of national guidelines for coding hospital emergency department (ED) visits has not been addressed by CMS. The June 2019 Medicare Payment Advisory Commission (MedPAC) "Report to the Congress: Medicare and the Health Care Delivery System" recommended that the Secretary develop and implement a set of national guidelines for coding hospital ED visits under the OPPS by 2022.¹ MedPAC indicated that national guidelines are necessary in order to improve the accuracy of Medicare payments for ED visits and to regain a distribution of coding frequency that is approximately normal. MedPAC found that hospitals' coding of ED visits has steadily shifted from the lower levels to the higher

¹ "Recommendation 11." Report to the Congress: Medicare and the Healthcare Delivery System, MEDPAC, June 2019, www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

levels, and they estimated that 20-25 percent of the growth in Medicare spending on ED visits was due to these visits being coded to higher levels.

In our previous comments in response to updates to the OPSS, we urged CMS to adopt MedPAC's recommendation. AHIMA believes that national guidelines would provide hospitals with a clear set of rules for coding ED visits. AHIMA has long advocated for adoption of national guidelines dating back to 2003 when we collaborated with the American Hospital Association (AHA) on a set of standardized guidelines for hospital evaluation and management coding of emergency department and clinic services. We believe standardized, national guidelines are necessary to ensure coding consistency and data comparability across hospitals and to improve payment accuracy.

AHIMA stands ready to work with CMS on both the development and the implementation of national guidelines for coding hospital ED visits. AHIMA recommends that CMS use both the guidelines developed by the American College of Emergency Physicians and the model developed by AHIMA and the American Hospital Association as a starting point for creating national guidelines for ED visit coding.

IX. Proposed Services That Will Be Paid Only as Inpatient Services

AHIMA is concerned by CMS' proposal to reverse policy finalized in the 2021 OPSS final rule to begin phasing out the "inpatient only" list (IPO). AHIMA has previously supported a thoughtful phase out of the IPO list and urges the agency to reconsider this decision. The IPO list identifies services for which Medicare will only make payment when the services are furnished in the inpatient hospital setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged.

AHIMA believes that advances in technology and medical practice have resulted in many procedures safely and effectively shifting from the inpatient to the outpatient setting. AHIMA's support for the elimination of the IPO list does not mean that we believe all the procedures on the IPO list can be safely performed in an outpatient setting. Rather, we believe that determination of the most appropriate setting should be based on the physician's clinical knowledge and judgment and the patient's individual needs. AHIMA is concerned that the current process limits patient access to care as the removal of codes from the IPO list allows for the determination of the most appropriate setting to be made based on the physician's clinical knowledge and judgment and the patient's individual needs.

XV. Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

Request for Comment on Potential Future Efforts to Address Health Equity in the Hospital OQR Program

CMS is soliciting comments relating to current data collection practices by facilities to capture demographic data elements (such as race, ethnicity, sex, sexual orientation and gender identity (SOGI), primary language, and disability status). In doing so, CMS hopes to improve the

“robustness of the disparity method results, potentially permitting reporting using more accurate, self-reported information, such as race and ethnicity, and expanding reporting to additional dimensions of equity, including stratified reporting by disability status.”²

AHIMA supports the standardized collection of accurate and complete patient demographic and social determinants of health data and notes that this data must be collected in ways that are culturally appropriate and community competent with an understanding of the community being served and related needs. AHIMA also recommends that the agency prioritize addressing workforce development needs to ensure that the healthcare workforce is more equipped to consistently and accurately collect patients’ demographic information in ways that are culturally sensitive. A culturally competent healthcare workforce will be a critical element in overcoming historical mistrust in healthcare institutions within certain communities. We also note that data on sexual orientation and gender identity is frequently not collected at the time of admission. AHIMA recommends working to ensure that there is a standardized methodology in place to capture these demographic elements since a patient’s gender identity or sexual orientation may change over time.

AHIMA also recognizes the role of technology in closing the health equity gap. We recommend leveraging technology to analyze quality-of-care and outcomes using both patient demographics and clinical data to identify and address disparities. This should include promoting the development of machine-learning and artificial intelligence techniques that identify and address biases in the data and avoid exacerbating existing health disparities and inequities.

XIX. Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

CMS is proposing “to amend several hospital price transparency policies codified at 45 CFR part 180 in order to encourage compliance.”³ CMS states that they are proposing these changes in response to a “trend towards a high rate of hospital noncompliance identified by CMS through sampling and reviews to date, and the reported initial high rate of hospital noncompliance with 45 CFR part 180 reflected in early studies.”⁴ As such, CMS is proposing to “increase the amount of the penalties for noncompliance through the use of a proposed scaling factor based on hospital bed count” and “prohibit certain conduct that we have concluded are barriers to accessing the standard charge information.”⁵

AHIMA supports the use of public policy to ensure that individuals have all the information they need to make informed choices about their healthcare. This includes both access to their personal health information and actionable information about the costs of their healthcare. AHIMA believes that public policy must support individuals in accessing both their personal health information and actionable information about the costs of their healthcare. Additionally, policy must support the development of accurate, useful, real-time tools to inform individuals of their healthcare costs.

² 86 Fed. Reg. at 42255

³ 86 Fed. Reg. at 42312

⁴ 86 Fed. Reg. at 42313

⁵ 86 Fed. Reg. at 42312

Given the observed low levels of compliance, AHIMA concurs with CMS that there is a need to strengthen the existing requirements related to price transparency. AHIMA believes that patients cannot successfully shop for services if many hospitals in a particular region do not comply with the existing price transparency requirements. AHIMA does note that it is possible that the observed low rates of compliance may be driven by confusion over existing requirements and difficulties with operationalizing transparency regulations. In addition to any potential changes that CMS makes to disincentivize non-compliance, AHIMA believes it is necessary that CMS issue additional guidance regarding compliance with transparency requirements. AHIMA believes that it would be helpful to stakeholders if CMS provided model webpages that demonstrate specifically how hospitals are expected to make price information available on their websites.

AHIMA supports CMS' proposals to prohibit certain conduct that serves as a barrier to accessing standard charge information. Specifically, AHIMA supports CMS' proposal to ensure that "standard charge information is easily accessible, without barriers, including, but not limited to, ensuring the information is accessible to automated searches and direct file downloads through a link posted on a publicly available website."⁶ Additionally, AHIMA supports the proposal to prohibit the use of "blocking codes" or CAPTCHA technology to hinder searchability or access to price information. AHIMA also supports prohibiting requiring users to agree to terms and conditions prior to accessing standard charge information. AHIMA believes that these practices are likely to hinder patients from accessing standard charge information and may in turn limit patients' abilities to compare prices and shop for care.

CMS is soliciting comments on additional barriers that may hinder access to price information. AHIMA has been made aware of instances in which patients are required to specify individual CPT codes when searching for price of care information. AHIMA believes that this may pose a significant barrier to accessing pertinent price information as patients are unlikely to have the requisite knowledge needed to complete the search. AHIMA recommends that CMS ensure that patients can search for cost information for shoppable services using plain language.

AHIMA notes that CMS should examine the practical implications of the existing transparency requirements and consider if they will achieve the goal of empowering patients to shop for more affordable care. AHIMA notes that it is likely that a standard charge list does not accurately convey what a patient can reasonably expect to pay after health insurance is taken into account. AHIMA supports that CMS has established policy that hospitals can satisfy the price transparency requirements through the use of a price comparison tool and urges the agency to focus its efforts on ensuring that these tools are as useful to patients as possible. AHIMA believes that it is important that these tools be available both on public facing websites and integrated within patient portals.

Thank you for the opportunity to provide comments in response to the 2022 Medicare Hospital Outpatient Prospective Payment System, Ambulatory Surgical Center Payment Systems, and Quality Reporting Programs Proposed Rule. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, AHIMA's Vice President, Policy &

⁶ 86 Fed. Reg at 42319

Government Affairs, at lauren.riplinger@ahima.org and (202) 839-1218 or Matt Kerschner, AHIMA's Director of Regulatory Affairs at matthew.kerschner@ahima.org and (312)-233-1122.

Sincerely,

A handwritten signature in cursive script that reads "Wylecia Wiggs Harris".

Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer