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June 12, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1390-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Mr. Weems:

The American Health Information Management Association (AHIMA) is pleased to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IP-PPS) and fiscal year 2009 Rates, as published in the April 30, 2008 *Federal Register* (CMS-1390-P).

AHIMA is a professional association representing more than 51,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnosis and procedure classification systems that serve to create the diagnosis related groups (DRG) discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM). AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including that associated with quality measurement and in the development, planning, implementation and management of electronic health records.

In previous years, AHIMA's recognition of the industry's need for consistency in medical coding, improved data integrity, and more precise and contemporary data reflecting 21st century medicine has led to out advocating for adoption and coordinated implementation of ICD-10-CM and ICD-10- PCS in our comments on the IP-PPS. It is unfortunate that, as new initiatives have come forward, (initiatives such as present on admission reporting, pay-for-performance, and DRG refinements to better recognize severity of illness) and rely heavily on coded data gain momentum, ICD-10-CM and ICD-10-PCS still have not been implemented as replacements for ICD-9-CM.

If the obsolete ICD-9-CM coding system had been replaced earlier, claims data that would significantly add to the knowledge needed to measure severity, quality, and other factors under consideration would now be available. We are concerned that the longer the industry waits to upgrade its principle classification systems, the more expensive the conversion and implementation will be for providers and CMS. **We urge CMS and the Department of Health and Human Services (HHS) to take immediate action to secure the adoption and implementation of these two classification systems and the supporting HIPAA transaction standards as early as possible.**

Our detailed comments and rationale on the NPRM for IP-PPS are below.

II-D-4 – Potential Additional Payment Adjustments in FYs 2010 through 2012 (73FR23541)

AHIMA appreciates that CMS plans to undertake a thorough retrospective evaluation of claims data in order to determine any necessary payment adjustments for FYs 2010 through 2012. This will ensure that payment adjustments are based on actual, rather than expected, documentation and coding improvements under the MS-DRG system.

II-F – Preventable Hospital-Acquired Conditions (HACs), Including Infections (73FR23547)

Our comments regarding the HACs are focused on coding issues and do not address the preventability of these conditions.

II-F-6a – Foreign Object Retained After Surgery: Proposed Inclusion of ICD-9-CM Code 998.7 (73FR23552)

We support the addition of the code 998.7, "acute reaction to foreign substance accidentally left during a procedure" to the list of codes subject to the HAC payment provision.

II-F-6b – Pressure Ulcers: Proposed Changes in Code Assignments (73FR23552)

AHIMA opposes CMS' proposal to change the codes identifying pressure ulcers for the purpose of applying the HAC payment provision from the existing site-specific pressure ulcer codes to the new codes for pressure ulcer stages. Since there is currently no way to identify the pressure ulcer stage from past ICD-9-CM coded data and since the existing codes do not identify the stage, it is unclear what data CMS used to determine that new codes 707.23 and 707.24 (Pressure ulcer, stages III and IV, respectively) should be MCCs and new codes 707.20, 707.21, and 707.22 (Pressure ulcer, unspecified stage, stage I, and stage II, respectively) should be non-CCs. Also, these codes have not been implemented yet and will require education and experience in order to achieve a high level of coding accuracy. Guidelines on the use of the new codes have not been issued yet. **We do not believe any changes to the codes used to identify pressure ulcers as a HAC should be made for one year, until data is available to accurately determine the appropriate MCC/CC status of each of the new codes and until the industry has gained experience with assigning these codes.**

The new pressure ulcer codes provide an excellent example of the increasing necessity for CMS to process more than nine diagnosis codes. If a patient has two pressure ulcers, assigning codes for the sites and stages would require four diagnosis fields. Since claims under the Medicare program are submitted electronically and capable of support more than 9 codes, CMS, for accuracy should be accepting all the codes associated with an admission or encounter.

II-F-7a – Surgical Site Infections following Elective Surgeries (73FR23552)

We concur with the codes identifying surgical site infections following certain elective surgeries. However, we question how often ligation and stripping of varicose veins is performed on Medicare patients in an inpatient hospital setting.

II-F-7b – Legionnaires' Disease (73FR23553)

We agree with the ICD-9-CM code to identify Legionnaires' Disease.

II-F-7c – Glycemic Control (73FR23554)

The ICD-9-CM codes for nonketotic hyperosmolar coma and hypoglycemic coma are incorrect in the narrative text, but they are correctly listed in the table on page 73FR23554.

II-F-7d – Iatrogenic Pneumothorax (73FR23554)

We agree with the code to identify iatrogenic pneumothorax.

II-F-7e – Delirium (73FR23555)

We do not agree with the code selected for identification of the HAC candidate "delirium." The ICD-9-CM code CMS is proposing is code 293.1, Subacute delirium due to conditions classified elsewhere. A "code first" note indicates that the associated physical or neurological condition should be coded first. Code 293.1 is limited to subacute delirium and only the type of delirium that is associated with an underlying medical condition. This code does not appear to represent the general term of "delirium" listed as an HAC candidate nor the patient population CMS describes in the narrative text. The appropriate ICD-9-CM code for a diagnosis of "delirium" is code 780.09, Other general symptoms, which is not a CC or MCC.

II-F-7f – Ventilator-Associated Pneumonia (73FR23555)

In addition to the new code for ventilator-associated pneumonia, a code would also be assigned to identify the specific type of pneumonia.

We disagree with the methodology used to identify cases of ventilator-associated pneumonia in current Medicare data. The presence of a mechanical ventilation code with a specific pneumonia code does not mean the patient the pneumonia is necessarily associated with use of the ventilator.

II-F-7g – Deep Vein Thrombosis (DVT)/Pulmonary Embolism (73FR23557)

We agree with the codes selected to identify deep vein thrombosis and pulmonary embolism. Since the selected deep vein thrombosis codes are limited to the lower extremity, the description of the HAC Candidate should be revised to specify deep vein thrombosis of lower extremity.

II-F-7h – *Staphylococcus aureus* septicemia (73FR23557)

Only code 038.11 specifically identifies *Staphylococcus aureus* septicemia. The other codes listed for this HAC Candidate do not identify *Staphylococcus aureus* septicemia. These codes represent conditions that may not be septicemia and may involve an organism other than *Staphylococcus aureus*. Code 999.3 is not a valid code because it requires a fifth digit. Codes 995.91, 995.92, and 998.59 require additional codes to specify the infection. Code 038.11 is very specific and is the only code that should be used to identify *Stapylococcus aureus* septicemia.

II-F-7i – *Clostridium Difficile* Associated Disease (73FR23558)

We agree with the ICD-9-CM code to identify *Clostridium Difficile* Associated Disease.

II-F-8 – Present on Admission (POA) Indicator Reporting (73FR23559)

Although AHIMA agrees that the "U" POA indicator should only be used in limited circumstances and hospitals should strive for improved medical record documentation in order to be able to report the POA indicator accurately, we feel that POA reporting is still a new process and hospitals are still learning how to document and report POA information accurately and completely. **Therefore, we recommend that applying the HAC payment provision when the "U" POA indicator is reported be delayed for a year.**

We are confused by CMS' proposal to allow payment for a HAC when the "U" indicator is reported in conjunction with certain patient discharge status codes. If death, elopement, and transfers preclude making an informed determination of whether an HAC was present on admission, POA indicator "W" would seem more appropriate than "U." The inability of the physician to make an informed determination regarding POA status is appropriately reported as a "W," not a "U." Also, the proposal does not indicate that length of stay would be taken into consideration. For example, a patient's death after a 20-day hospitalization should not be a justification for being unable to determine the POA status.

AHIMA appreciates CMS' acknowledgement of our Standards of Ethical Coding, which require accurate coding regardless of the payment implications of the diagnoses. We are currently in the

process of updating the Standards of Ethical Coding to strengthen and clarify our commitment to ethical principles for coding practices.

We urge CMS to clarify that hospitals should continue to report HACs on the claim, even though they will not impact the MS-DRG assignment. We are disturbed by reports that a small number of hospitals believe that conditions they are not billing for, such as HACs and "never events," should not be reported on claims. However, reporting codes only when payment is affected would skew data and not be consistent with the *ICD-9-CM Official Guidelines for Coding and Reporting*. Because many quality initiatives and personal health records models use claims-based information, not reporting this information will further impact data integrity and thus provide erroneous information as it is collected and reported.

II-F-9 – Enhancements and Future Issues (73FR23560)

- AHIMA commends CMS for striving to achieve higher data validity and integrity of POA data through data comparison and analysis; however we do have concerns about the uniformity and consistency of the data that will be analyzed. As POA reporting requirements are not consistent across states, we do not feel that comparing state POA data with Medicare data would provide meaningful information. Therefore, collecting, compiling and analyzing the data will not yield consistent results and thus integrity of the database will be compromised with the introduction of state POA data. AHIMA recommends CMS conduct further analysis on how it can integrate state POA data to ensure uniformity, consistency, and integrity of the data collected.

- We completely agree that the adoption of ICD-10 would facilitate more precise identification of HACs. The IP-PPS NPRM only mentions ICD-10-PCS, which is a procedure coding system. ICD-10-CM, the diagnosis coding system, should have been mentioned as well. As AHIMA has noted many times previously, it is unfortunate that, as new initiatives that rely heavily on coded data gain momentum (such as POA reporting and pay-for-performance), ICD-10-CM and ICD-10-PCS still have not been implemented as replacements for ICD-9-CM. If the obsolete ICD-9-CM coding system had been replaced earlier, claims data that would significantly add to the knowledge needed to measure severity, quality, and other factors under consideration would now be available.

- **AHIMA continues to recommend that CMS process all reported diagnoses and procedures.** The necessity for CMS to process more than nine diagnoses and six procedures has become increasingly critical The implementation of new initiatives, such as the MS-DRG system, POA reporting, and the HAC payment provision, depend on capture of all of the patient's diagnoses and procedures in order to fully represent the patient's severity of illness, complexity of care, and quality of care provided. Also, the adoption of "component" codes, such as the new ICD-9-CM codes for pressure ulcer stages, requires multiple diagnosis fields to represent a single diagnosis. **AHIMA urges CMS not to delay making this change any longer.**

II-G – Proposed Changes to Specific MS-DRG Classifications (73FR23562)

AHIMA has no objection to the proposed MS-DRG modifications.

II-G-5 – MDC 18 (Infections and Parasitic Diseases (Systemic or Unspecified Sites)): Severe Sepsis (73FR23574)

While we have no objection to the proposal to revise the titles of MS-DRGs 870, 871, and 872 to reflect severe sepsis, we are confused as to the purpose of this proposal. We don't understand how merely revising the titles of the MS-DRGs would better assist in the recognition and identification of severe sepsis. Since the code for severe sepsis is already classified to these MS-DRGs, research involving these MS-DRGs would include cases of severe sepsis without modification of the MS-DRG titles. Due to the wide range of ICD-9-CM codes classified to a particular MS-DRG, the MS-DRG titles do not always fully capture the conditions classified to that MS-DRG. Research and data analysis involving MS-DRGs should be based on the classification of ICD-9-CM codes to MS-DRGs, not on the MS-DRG title.

II-G-6 – MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs): Traumatic Compartment Syndrome (73FR23574)

AHIMA appreciates CMS adding the traumatic compartment syndrome codes to the multiple trauma MS-DRGs in order to correct a previous omission.

IV-A-2 – Proposed Policy Change Relating to Transfers to Home with a Written Plan for the Provision of Home Health Services (73FR23640)

We are concerned about CMS' proposal to extend the timeframe from 3 days to within 7 days of discharge to home under a written plan for the provision of home health services. Our members continue to report that the 3-day timeframe is administratively burdensome, since resource-intensive follow-up is often necessary for hospital personnel to determine if a patient received home health care within the 3-day window. Extending the timeframe to 7 days would significantly increase this administrative burden. For every patient who is discharged to home with one of the Post Acute Transfer MS-DRGs, he or his physician's office must be contacted seven days after discharge to determine if he has received home health services. Submission of the claim must either be delayed until this can be determined, or if the claim has already been submitted and it is determined that the discharge status was reported incorrectly, a claim adjustment must be submitted. The proposed policy change creates a tremendous administrative burden for hospitals because of the increased number of patients subject to the transfer policy, increased delays in submission of claims, and frequent claim adjustments.

IV-B-1a – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Background - Overview (73FR23642)

AHIMA agrees that well-accepted measures are critical elements of value-based purchasing, it is also critical to assess cost and feasibility associated with the quality measure data collection and reporting requirements. This is especially important as CMS continues to increase the number of measures that require submission of data through manual chart abstraction. AHIMA must again point out that had ICD-10-CM been put in place, CMS would have considerably more detailed data in which to evaluate quality.

IV-B-1b – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Background – Voluntary Hospital Quality Data Reporting (73FR23643)

The two mortality outcome measures (30-Day Risk Standardized Mortality Rates for Heart Failure and AMI) do not require data submission due to their claims-based nature. AHIMA believes it is a misperception to state that the addition of these two measures will intrinsically ***reduce*** the data collection and reporting burdens for hospitals. Instead, AHIMA recommends CMS indicate the addition of these two measures ***will not further increase*** the burden associated with collection of data for quality reporting.

IV-B-1d – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Background – Hospital Quality Data Reporting under Section 5001(a) of Pub. L. 109–171 (73FR23643)

Uniform data content standards are crucial in the effort to reduce burdens for hospitals. These standards will facilitate a process for automated data transmission, and electronic health record (EHR) vendors will be more apt to integrate measurement reporting capabilities into EHR products if measure specifications are standardized across the industry. This will streamline hospital data submission procedures and enable providers to view real-time measurement results to initiate their own improvement interventions in a more timely and efficient manner.

AHIMA recommends that CMS engage in and promote the development and adoption of data content and information technology standards that will support automated data collection and reporting of clinical data from EHR systems.

IV-B-2a – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Proposed Quality Measures for FY 2010 and Subsequent Years (73FR23646)

- AHIMA supports efforts to discontinue data collection and reporting requirements for measures that are topped out, especially in situations where the burden associated with data collection and reporting outweighs the benefit of public reporting.

Hospitals that are currently collecting data for the RHQDAPU program are struggling to keep up with the new measures and changes being introduced by the Joint Commission, CMS, health plans, and payers. While the intent of the RHQDAPU program is important, it is critical to understand that as long as the emphasis on the measures used relies on manual data collection, at some point organizations will sink under the weight of this burden. It is crucial that CMS consider these issues as measures are evaluated for retirement or discontinuation.

- AHIMA agrees that timely updates to quality measures are necessary for maintaining comparable and credible measurement results. We support CMS' plans to provide notifications through the QualityNet and specification manual venues.

- The addition of 43 quality measures (of which 31 measures impose additional data collection burdens) in one year will impose substantial burden and cost to hospitals. Before the National Committee on Vital and Health Statistics (NCVHS) June 19, 2007, AHIMA presented testimony on the burdens and challenges associated with data collection and reporting. We presented information from a member who experienced, in just three years, an increase of 72% in required resources to support the increased burden of reporting. The testimony can be accessed at this link: http://www.ncvhs.hhs.gov/070619p1.pdf.

- AHIMA is concerned with the timing of the requirement to report on four new nursing measure sets. Actual reporting of the measures sets will not occur until FY 2010, the specifications and data collection tools will not be available until December 2008 in preparation for the new reporting. The release of the specifications does not allow an appropriate amount of time to prepare for the April 1, 2009 discharges; particularly if there are delays. AHIMA recommends CMS to provide information on the specifications and data collection tools as soon as possible to allow time for hospitals to prepare their data beginning with the April 1, 2009 discharges.

- AHIMA is concerned about the timing of the requirement to add six additional measures to begin reporting by January 1, 2009. We would like clarification on when the measure and data collection specifications are made available to hospitals. It is imperative that hospitals receive this information well in advance of the January 1, 2009 deadline in order to prepare for data collection and submission.

- CMS is proposing to use AHRQ's Patient Safety Indicators (PSI) and Inpatient Quality Indicators (IQI) as endorsed by NQF, and the current specifications for these indicators provides for the use of POA indicators in the measures. According to a recent study published in **Medical Care** (February 2008) "*Impact of the Present-on-Admission Indicator on Hospital Quality Measurement: Experience With the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators*" it reported an analysis of the IQI measures with and without the use of POA and showed a very different ranking of hospitals in terms of their classification using these indicators when POA was added. AHIMA recommends CMS provide further clarification regarding the intent to use this version of specifications when reporting these indicators.

AHIMA requests further clarification on how the collection and reporting of the AHRQ PSIs and IQIs differ from the activities under the AHRQ Patient Safety and Quality Improvement Act. We also request further clarification on whether hospitals will be asked to submit this data to both CMS and Patient Safety Organizations (PSOs). Considering the reporting to CMS is required based on this proposed rule for PSIs, we are curious to understand further why hospitals would then choose to submit data to PSOs on a voluntary basis, this appears to be duplicative. AHIMA also requests that CMS provide further information on when the technical specifications manual will be available for review and consideration.

- AHIMA commends CMS for considering the utilization of a data registry that is currently established to minimize duplication of effort and resources. However, we would like further clarification on some issues pertaining to this particular initiative:
  1. Does CMS anticipate STS will charge hospitals a fee for submitting their data to CMS on their behalf? We are concerned this would impose an additional cost to an already costly and burdensome process. If there is an additional cost for STS to submit the data to CMS, it may be beneficial for the hospitals to conduct a cost benefit analysis to assess and determine which option is least burdensome.
  2. We would like further clarification on what would be the impact on a hospital if STS misses a deadline when submitting data? We request CMS describe what penalties, if any, will occur if a deadline is missed.
  3. We would like further clarification on the process for hospitals receiving confirmation when data are received from STS. It is important to close the information gap so that hospitals are made aware and can confirm the information has been submitted and received.

IV-B-2b – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Possible New Quality Measures, Measure Sets, and Program Requirements for FY 2011 and Subsequent Years (73FR23651)

AHIMA recommends CMS make every effort to avoid duplication or overlap with the reporting requirements of the AHRQ Patient Safety and Quality Improvement Act. We recommend that CMS align and harmonize initiatives wherever possible in order to streamline efforts and increase efficiencies for data reporting requirements. We also recommend CMS promote and participate in the development and adoption of information technology standards that support automated data collection and reporting of data from EHRs.

IV-B-2c – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Consideration in Expanding and Updating Quality Measures Under the RHQDAPU Program (73FR23653)

- AHIMA commends CMS for considering reduction of the administrative burden on hospitals and alignment of efforts to leverage existing initiatives as important goals to consider as CMS looks ahead to further expansion of the RHQDAPU program.

AHIMA appreciates CMS' solicitation of comments on ways to reduce the burden of hospitals participating in the RHQDAPU program. We recommend the following actions that would help to reduce the administrative burden:

1. Implement ICD-10-CM. By implementing this updated classification system, hospitals have the ability to capture data more accurately thus providing higher quality and more accurate data for reporting purposes.
2. Adoption of uniform data content standards. These standards are crucial in the effort to achieve an effective quality reporting program. These standards will facilitate a process for automated data transmission, and electronic health record (EHR) vendors will be more apt to integrate measurement reporting capabilities into EHR products if measure specifications are standardized across the industry. This will streamline hospital data submission procedures and offer the ability for providers to view real-time measurement results to initiate their own improvement interventions in a more timely and efficient manner.

- AHIMA appreciates CMS' consideration of staggering the reporting dates to lessen the burden on hospitals as they incorporate new measures; however we are concerned that this may provide for additional confusion to the overall submission process and difficulty in keeping track of the information submitted.

- Regarding the goal of simplifying the data abstraction specifications, AHIMA requests further clarification on what the process will be and if CMS anticipates seeking input from hospitals on this as well.

- AHIMA commends CMS for considering additional measures by which to measure the quality of care in hospitals. However, as these measures are added, we are concerned with the expansion of the population that is measured and the administrative burden for those that require manual collection. The data collection impact burden will increase tremendously. We recommend CMS reduce the rate of adding measures and focus on what hospitals with an EHR, could actually do to use that data to support current measures.

- AHIMA supports the use of the CMS Internet-based CARE tool as long as CMS promotes the development of consistent data content and data transmissions standards that support electronic transmission of data from certified EHR products to the CARE and QIO clinical data repositories. AHIMA submitted a letter on September 21, 2007 in response to CMS' notice for a data collection request that was published in the Federal Register [72 FR 41328] dated July 27, 2007. AHIMA's detailed comments can be accessed at the following link: http://www.ahima.org/dc/documents/AHIMAResponse_CMSCAREInstrument_070921.pdf.

IV-B-4b – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Proposed RHQDAPU Program Procedures for FY 2010 (73FR23656)

Earlier in this proposed rule, CMS stated "We are proposing to accept these data from the STS registry…" (page 73FR23649). If STS is submitting the data to CMS on behalf of the hospitals, how can CMS expect the submission deadline to be the same? STS may need time to get the data submitted to CMS. AHIMA recommends CMS consider a gap in the timeline required to meet the deadline as STS may end up requiring hospitals to submit the data even earlier to them which will be very difficult for hospitals.

IV-B-6a – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Chart Validation Requirements for FY 2009 (73FR23657)

- As long as hospital medical records continue to reside in a paper-based format or non-compatible electronic formats and don't allow for the necessary data capture and architecture to permit uniform automated reporting, the validation process will remain labor intensive. During the interim between now and when a substantial number of hospitals have implemented EHRs, we request that CMS consider a process for accepting electronic copies of medical records from those hospitals that are leading the way in EHR adoption and implementation. In addition, AHIMA recommends decreasing validation reviews for specific measures in which individual hospitals continually demonstrate consistent patterns and high validation rates.

- AHIMA supports random sampling as long as there is a limit on the maximum number of charts per quarter that can be selected from any one hospital. Sample selection by clinical topic is preferable, as long as there is a limit on the maximum number of charts that can be requested of a hospital in a quarter.

IV-B-7a – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Data Attestation Requirements – Proposed Change to Requirements for FY 2009 (73FR23659)

AHIMA commends CMS for deferring the data attestation requiring hospitals to report on a quarterly basis through the submission of a paper based attestation process. This process would add further burden and tracking for hospitals in this program.

IV-B-12 – Reporting of Hospital Quality Data for Annual Hospital Payment Update: Electronic Medical Records (73FR23660)

- AHIMA commends CMS for continuing its acknowledgement and support for the widespread adoption and implementation of EHRs for the purposes of collection and reporting of quality measures. However, AHIMA requests clarification on the statement that hospitals should conform to both industry and Federal Health Architecture (FHA) standards. Due to the strong and encouraging work the Certification Commission for Health Information Technology (CCHIT) is conducting, it would be beneficial for the community to have a better and more clear understanding of what CMS is referring to. AHIMA recommends that CMS provide more detailed information in regards to "industry standards" to guide providers in a more comprehensive manner.

- Leveraging health information technology to support the data collection, aggregation, and reporting of data for quality reporting and other uses of data provides an opportunity to strive for the uniformity and consistency of the data that is being used.

IV-C-1 – Medicare Hospital Value-Based Purchasing (VBP): Medicare Hospital VBP Plan Report to Congress (73FR23660)

- AHIMA agrees with CMS' criteria for evaluating VBP measures, but must stress the importance of assessing the feasibility of the data collection and reporting process for quality measures. As CMS continues to increase the number of required measures for VBP, the feasibility of collecting high quality data in an efficient and effective manner, in today's paper/electronic environment, should be a top priority.

- The "Report to Congress" (November 21, 2007) indicates that CMS anticipates retiring some measures from VBP for a variety of reasons, including changes in science or policies. The document then states, "CMS may determine that a measure no longer warrants a financial incentive even though the measure continues to have value for public reporting. In this case, hospitals still would be required to report data on the measure in order to be eligible for the VBP financial incentive." AHIMA recommends that CMS further clarify the rationale and criteria for assessing measures for VBP financial incentive versus those measures that could be required strictly for public reporting. In addition, the paragraph is confusing as there does not appear to be a differentiating factor among those measures that are retired due to changes in science and are no longer effective versus those measures that are continued for the purpose of public reporting. AHIMA recommends that CMS separate the two different but associated concepts and explore their value added to the health care system.

IV-C-2 – Medicare Hospital Value-Based Purchasing (VBP): Testing and Further Development of the Medicare Hospital VBP Plan (73FR23661)

- AHIMA supports CMS' effort to conduct pilot testing efforts for the VBP Plan and to use the information gathered during the testing to further develop and improve this initiative. We support the consideration to publicly post the results of the test so that information and lessons learned can be shared among providers as they move toward planning and preparing for the plan implementation.

  As a result of the VBP testing and plans to further develop the VBP Plan, AHIMA recommends CMS collect information regarding lessons learned and develop a document which outlines some lessons learned from the testing so that others can learn more about the program, what the challenges and successes were. We also recommend CMS incorporate those lessons learned into process changes or other changes as needed to further improve the plan and program and make this information publicly available to ensure transparency. Stakeholders will benefit from being a part of this learning process and would see value in reviewing the information as posted on the CMS website with a supporting press release the report has become available.

- AHIMA supports CMS' expectation to collect information regarding the financial impacts this program will have for organizations. By sharing the information early in the planning process, organizations will have the ability allocate resources in preparation for the plan.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for FY 2008.

AHIMA urges CMS to actively promote HHS' adoption and implementation of the ICD-10-CM and ICD-10-PCS coding systems in order to ensure the availability of appropriate, consistent, and accurate clinical information reflective of patients' medical conditions and care provided. This will allow us to measure quality, implement value-based purchasing, identify hospital-acquired conditions, and continue to refine a prospective payment system that improves recognition of variances in severity of illness.

AHIMA continues to recommend that CMS process all reported diagnoses and procedures. Until CMS has a full picture of the severity and services received by its Medicare patients, any system will result in inaccurate data and flawed decisions based on this data.

AHIMA stands ready to work with CMS and the healthcare industry to improve the quality healthcare data for reimbursement, quality reporting, and other purposes. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS
Allison Viola, MBA, RHIA