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August 30, 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) Medicare Program; Request for Information on Medicare Advantage (MA), as published in the August 1, 2022 Federal Register (CMS-4203-NC).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. The AHIMA mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and 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 questions contained within the request for information:

**What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?**

Advancing health equity is a multi-faceted effort requiring the US Department of Health and Human Services (HHS) and the US healthcare system to work together to eliminate the barriers to achieving greater equity. There are multiple areas of opportunity within HHS for CMS to capitalize on to further health equity in MA and ensure MA participants can receive equitable care.

AHIMA recommends CMS work closely with the Office of the National Coordinator for Health Information Technology (ONC) and the National Committee on Vital Health Statistics (NCVHS) to further the health equity conversation through the development, implementation, and use of health data standards – including standards that bring valuable clinical and administrative data together to paint a

complete picture of the patient. Both standardized clinical and administrative data provide valuable insight into social determinants of health (SDOH) and other key information that could be of use to a clinician. SDOH data is valuable in better understanding what external factors can impact the ability for a patient to access or capitalize on their care. Standardizing SDOH data, a recommendation the NCVHS Subcommittee on Standards continues to make progress on<sup>1</sup>, and including those standards in the health IT standards adoption process will expedite the availability, adoption, and use of SDOH data. Use of this data will undoubtedly have an impact in helping MA tailor its programs and offerings to ensure all patients are able to access care. CMS can impact the capture and standardization of this data by engaging in the United States Core Data for Interoperability Plus (USCDI+) initiative led by ONC to propose and further data standards that are utilized by MA plans.

Another burden to achieving health equity is access. Many patients in rural areas and those in urban areas without access to robust transportation face hours long voyages to attain care. Those travel times generally do not account for those that need to travel out of their region or state to achieve specialty care because none is offered in their area. Given the unique way MA is reimbursed, it provides an opportunity for CMS to further the adoption and use of telehealth. By incentivizing the use of telehealth by MA plans, CMS can expand access to care and specialized care otherwise unreachable due to where a patient lives. AHIMA continues to applaud CMS' efforts to make the COVID-19 pandemic era policies permanent and urge them to continue to find creative ways to expand the access and use of telehealth.

Finally, AHIMA strongly urges CMS to pursue all avenues available to advance the implementation and use of a patient identifier. As a founding member of the Patient ID Now coalition AHIMA encourages CMS to review the Framework for a National Strategy on Patient Identify<sup>2</sup> and pursue any opportunities to bring better patient matching to fruition. The lack of accurate patient matching and identification is a key component of furthering health equity. BIPOC patients are often victims of misidentification and record mismatch, meaning they often experience patient record misidentification at a higher rate than other patient groups which can have a downstream impact on their care. As CMS works to further develop MA and better account for health equity, it is crucial to ensure MA plans are implementing solutions to best identify and match patients to their information. This is especially true given that, as stated above, administrative data collected by plans is increasingly being used to further care outcomes.

**What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?**

AHIMA supports the use of public policy to encourage the collection, access, sharing, and use of SDOH information to enrich clinical decision-making and improve health outcomes, public health, and health inequities in ways that are culturally respectful.<sup>3</sup> Consistent collection of high-quality data on SDOH is needed 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

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<sup>1</sup> <https://ncvhs.hhs.gov/subcommittees-work-groups/subcommittee-on-standards/>

<sup>2</sup> <https://www.ahima.org/news-publications/press-room-press-releases/2021-press-releases/patient-id-now-coalition-releases-framework-for-a-national-strategy-on-patient-identity/#:~:text=In%20the%20framework%2C%20the%20Patient,protects%20patient%20safety%20and%20privacy.>

<sup>3</sup> <https://www.ahima.org/advocacy/policy-statements/social-determinants-of-health/>

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 believes 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.

AHIMA believes public policy must prioritize a set of standardized SDOH data elements to be included in EHRs. 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 patients. Targeting these three domains would align with a recent final rule 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 MA 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.

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.

**What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreement to support improved health information exchange for use cases relevant to MA plans and providers?**

AHIMA continues to support the development and implementation of the Trusted Exchange Framework and Common Agreement (TEFCA). As described by the Office of the National Coordinator for Health Information Technology (ONC) and the TEFCA Recognized Coordinating Entity (RCE) the Sequoia Project, the TEFCA is designed to alleviate some of the data exchange challenges present throughout healthcare since the HITECH Act's implementation. The documents currently available to the public by both ONC and the Sequoia Project indicate the TEFCA will initially be focused on only health data exchange using the IHE data exchange standard.<sup>4</sup> The Sequoia Project previously announced that the TEFCA will utilize the Fast Healthcare Interoperability Resource (FHIR) resource at a later date after completing its outlined FHIR roadmap.<sup>5</sup>

The lack of support for the FHIR API presents a challenge to utilizing the TEFCA for exchange of MA data. FHIR is currently the easiest and most cost-effective way to exchange the administrative data associated with MA. Until FHIR is implemented fully, data exchange will be largely limited to the use cases previously outlined and supported by IHE. While IHE may support the exchange of administrative data, the requirements for data exchange currently being implemented by ONC and CMS require the use of FHIR, providing little incentive for IHE based exchange to be supported long term for the intersection of clinical and administrative data.

The technical limitations of the TEFCA at launch related to FHIR is only one barrier to utilizing the network to assist in administrative data exchange between MA partners and providers. At this time, it is unclear when the TEFCA will be operational. While the TEFCA could have the ability to help health information exchange, the healthcare system is still awaiting information on when the application criteria will be finalized, as well as when the application window will open for the Qualified Health Information Networks (QHINs) that facilitate the data exchange. Sequoia has indicated it could be a lengthy period that may elapse between when a potential QHIN applies for and receives approved QHIN status and the QHIN becomes operational. Without knowledge of when the QHIN application period will open and then what additional time is required for the QHINs to become operational, it is difficult to fully determine and plan for when the TEFCA is ready to actively exchange information.

AHIMA will continue to support ONC and the Sequoia Project in forwarding the development and implementation of the TEFCA. Despite that support, it is too early for AHIMA to determine what impact the TEFCA will have on improving health information exchange for MA and providers. AHIMA urges CMS to remain as active participants in the development of the TEFCA with both ONC and the Sequoia Project to ensure MA use cases are accounted for in development. Through active engagement, CMS will be able to ensure the intersection of MA and provider clinical and administrative data use case is accounted for.

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<sup>4</sup> <https://www.ihe.net>

<sup>5</sup> [https://rce.sequoiaproject.org/wp-content/uploads/2022/01/FHIR-Roadmap-v1.0\\_updated.pdf](https://rce.sequoiaproject.org/wp-content/uploads/2022/01/FHIR-Roadmap-v1.0_updated.pdf)

**What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?**

Telehealth can be an equalizer, as stated above, as it helps patients receive equitable care no matter where in the US they live. By giving patients better access to a variety of care options, including specialty care they otherwise would not have access to, patients have the ability to choose the care that best fits their needs and achieve greater health outcomes because of it. This is true of MA plans as well as traditional Medicare, as many MA plans offer telehealth and telemedicine services to their private insurance members and should be encouraged to do so for MA recipients as well.

Part of expanding those efforts involves CMS working to make telehealth a permanent fixture of the Medicare and MA benefits portfolio. AHIMA continues to support CMS' pursuit of making the telehealth relaxations currently allowed under the COVID-19 Public Health Emergency (PHE) permanent. While telehealth access improves health equity across the whole healthcare system, preserving access to audio only telehealth increases telehealth equity by ensuring patients can access telehealth services no matter how or where they are located.

We urge CMS to continue to preserve audio-only telehealth – in addition to standard telehealth – access that beneficiaries currently experience under the PHE on a permanent basis. Audio only telehealth enables patients in both rural and urban areas who may not have access to stable high-speed internet or are unable to be in an area, such as a private home, where audio/visual telehealth is acceptable to access telehealth services. Eliminating the allowability of audio-only telehealth services weakens equitable access to telehealth as it makes those in rural areas and those unable to afford or access audio/video telehealth platforms unable to participate in telehealth. It is because of these reasons that CMS must ensure access to telehealth equity through working to make audio only telehealth policies permanent.

AHIMA looks forward to continuing as an active partner in working to improve the MA program with CMS now and in the future. If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please feel free to contact Andrew Tomlinson, Director of Regulatory Affairs, at (312) 223-1086 or [andrew.tomlinson@ahima.org](mailto:andrew.tomlinson@ahima.org).

Sincerely,



Lauren Riplinger, JD  
Vice President of Public Policy and Government Affairs