American Health Information Management Association®

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March 10, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

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 and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program* proposed rule, as published in the December 12, 2022 *Federal Register*.

AHIMA is a global nonprofit association of health information (HI) 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.

The following are our responses to selected provisions and requests for information.

II. Provisions of the Proposed Rule

A. Patient Access API

2. Enhancing the Patient Access API

AHIMA supports the CMS proposal to require impacted payers to provide patients access to information related to their prior authorization requests, decisions, and supporting documentation via a Patient Access API. The provider community has been working diligently to implement their own Patient Access API solutions as part of the 21st Century Cures Act (Cures Act) Final Rules. With this additional Patient

Access API now in development by CMS, HHS will be working to ensure all facets of the healthcare continuum are providing patients with their health information.

Providing patients access to their administrative health information, such as their prior authorization decisions and supporting documentation, is crucial to empowering and helping patients understand the cost of their care. CMS efforts related to furthering price transparency and allowing patients to know the cost of their healthcare upfront hinges on the prior authorization process. Implementing the Patient Access API will help patients better understand decisions to either seek care or dispute the coverage requirements, as well as allow them to know what treatments have already been authorized within a timeframe so they can bypass the prior authorization process entirely.

It is important to note that the Fast Healthcare Interoperability Resource (FHIR) proposed as the backbone of this API is a standard in the process of actively maturing. While AHIMA supports the development and implementation of FHIR, it should not be viewed as the sole solution to interoperability and patient data exchange problems the healthcare system currently experiences. It is important for CMS to maintain flexibility in its ongoing data exchange activities to ensure the success of interoperability programs. As currently proposed, while FHIR is promising, the Patient Access API process would experience challenges if FHIR failed to reach widespread industry adoption and maturity.

AHIMA recommends CMS include the length of time for which a prior authorization decision is valid in the information that would be communicated to a patient across the proposed FHIR API. Allowing for information to be available for a year is helpful in allowing patients to understand what Is currently covered by their health plan, but if they do not know for how long the decisions is valid for, a scenario could arise in which a patient proceeds with care thinking they do not need a prior authorization for a procedure when in fact they do. Including the length of time that a decision is valid with the other data transmitted to a patient would assuage these concerns and empower a patient to take further control of their care decisions.

AHIMA understands the need to provide one business day for patients to obtain timely access to their information and supports this proposal. As the provider community is aware, it takes time to implement new technical requirements and ensure that they function as intended. While CMS and the impacted payer community move down the pathway to implementation, we urge CMS to decrease the timeframe for response as appropriate. In an API-enabled future, timelines for response should be able to decrease as the flow of information is made easier. Once the healthcare continuum has traveled further down this pathway, patients should be able to request and receive their information near instantaneously. Even though that may not be possible now, we ask CMS and the payer community to work together to make this exchange of information possible in the future.

Finally, AHIMA continues to support the advancement of data exchange utilizing common data standards. The CMS proposal to expand the data that must be made available by this proposed API to all data classes within the United States Core Data for Interoperability (USCDI) as defined at 45 CFR 170.213 aligns with HHS' efforts to harmonize the use of standards across the health IT continuum. We support CMS' efforts to bring that harmonization forward into the electronic prior authorization space.

B. Provider Access API

2. Proposed Requirements for Payers: Provider Access API for Individual Patient Information

AHIMA supports the CMS proposal for the implementation of a Provider Access API allowing providers to request patient data and to receive that data no later than one business day after the payer receives a request for data by an in-network provider. Allowing a provider to access a patient's data from a payer can expedite the care delivery process, as well as fill in gaps in a patient's health record utilizing administrative data. AHIMA continues to actively participate in the National Committee on Vital Health Statistics' (NCVHS') Convergence 2.0 project. This proposal from CMS continues to further implement the convergence of clinical and administrative data and further supports these shared goals.

That said, it is important to reiterate that FHIR is an actively maturing standard. While AHIMA supports the development and implementation of FHIR, it should not be viewed as the sole solution to interoperability and the patient data exchange problems the healthcare system currently experiences. It is important for CMS to maintain flexibility in its ongoing data exchange activities to ensure the success of interoperability programs. As currently proposed, while FHIR is promising, the Provider Access API process could face challenges if FHIR failed to reach widespread industry adoption and maturity.

As CMS works to implement these APIs, AHIMA recommends the agency engage in stakeholder feedback sessions with health IT end users to better understand their real-world needs before prior to mandating the implementation of this API. As a founding member of the Health IT End Users Alliance,[1] AHIMA also strongly believes federal programs need to work with health IT end users to ensure a robust real-world testing process is undertaken related to this API and the standards that surround them. This includes real-world implementations, production pilots, the collection of metrics regarding staff training needs, the extent to which the standards achieved the stated goal and estimates of costs and benefits of implementation. By engaging with end users, CMS increases the potential for these proposed programs to succeed and achieve the goals CMS set out to accomplish through this rulemaking process.

3. Additional Proposed Requirements for the Provider Access API

Ensuring patients are actively matched between an in-network payer and provider will be crucial to maintaining patient trust in the Provider Access API and ensuring data flows seamlessly between the payer and the provider. AHIMA recommends CMS reevaluate the process outlined in this proposed rule in which impacted payers are able to dictate how best to associate patients with their appropriate in-network or enrolled providers. Instead, AHIMA recommends CMS propose a standardized process for associating patients as part of the Provider Access API. With each payer maintaining the ability to create proprietary, specific association processes, the provider community has the potential to be inundated with multiple different workflow processes. Many provider organizations participate in multiple payment networks, and if each network has its own process for identifying patients, a tremendous burden would be placed on the provider and administrative staff. By implementing a standardized workflow and process for a payer to identify enrolled patients, providers would more easily be able to attribute these patients and begin the data transfer process.

In addition to the proposed attribution process creating additional burden on providers, there are concerns related to accurately finding patients and ensuring they are matched correctly to their information on both ends of the API. We recommend CMS implement a patient identification framework as part of this process to ensure patient data is not co-mingled incorrectly, posing a threat to both patient privacy and safety. As a founding member of the Patient ID Now Coalition, AHIMA

[1] https://hitenduser.org/wp-content/uploads/2022/09/Real-world-testing-consensus-statement_FINAL.pdf

recommends CMS require that patients be matched in line with the Patient ID Now Framework[2] as part of the attribution standardized process.

The revised standardized process AHIMA urges CMS to implement for patient attribution should also include specific details on how to account for recurring scenarios in the patient enrollment process. Those scenarios include accounting for how the attribution process will function when a new patient hasn't put a claim in with their provider yet, how a new patient enrollee or re-enrollee will be accounted for, how Medicaid Managed Care plans will maintain accurate information when there are delays in the state exchange process, and how Medicare Advantage plan participants will be accounted for if they go to a provider other than their self-selected primary care provider. Finally, it is crucial for CMS to define the timeline for which the roster of patients for attribution on both the payer and provider side must be updated and ensure it is never shorter than the 30 days mandated by many states. Incorporating these considerations into a framework for implementation will alleviate burden on both providers and patients and foster widespread utilization of the API.

AHIMA also supports CMS' proposal for impacted payers to create an opt-out for patients to prevent the sharing of their information from a payer to a provider. It is crucial for patients be presented with the opt-out option as early as possible to prevent the unintended sharing of patient data. AHIMA recommends CMS require impacted payers to provide patients with an opt-out option at the time of enrollment in their health insurance plan. By providing the opt-out upfront, patients can take more control of their data and expedite the sharing of their information if they do want it included in the provider access API. While an opt-in process better protects patient choice and privacy, opt-out encourages data sharing. CMS should consult with patient advocates to determine how best to educate patients upfront about the importance of sharing this data to continue to justify holding an opt-out process.

CMS should also require details on the opt-out process in the resources impacted payers are required to generate and distribute related to the API. It is crucial for CMS to hold payers responsible for providing these resources and that the resources are presented in a format that is easily understandable by patients. The Agency for Healthcare Research and Quality (AHRQ) recommends a fourth to sixth grade reading level for health-related communications to promote health literacy.[3] AHIMA recommends CMS amend the requirements of the patient resources to require impacted payers to provide resources at the fourth to sixth grade reading level. By ensuring the resources are not only non-technical, but also easy to read, CMS could mitigate the potential that the task of educating patients is passed from the payer to the provider.

C. Payer-to-Payer Data Exchange on FHIR

3. Payer-to-Payer Data Exchange on FHIR

AHIMA supports the creation of a Payer-to-Payer Data Exchange API utilizing the FHIR standard. Implementation of this API will further the ability of patients to seamlessly move from one payer to another and bring past payment data with them. Doing so can expedite the process of onboarding with a new payer by preventing a patient from needing to complete updated paperwork for all past medical

[2] 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/
[3] https://psnet.ahrq.gov/primer/health-literacy

conditions, or other crucial medical information. Just as a patient can direct providers to exchange their health data, allowing a patient to direct payers to exchange their information continues to push the healthcare continuum down the interoperability roadmap.

It is important to note that FHIR is a standard actively maturing. While AHIMA supports the development and implementation of FHIR, it should not be viewed as the sole solution to interoperability and patient data exchange problems the healthcare system currently experiences. It is important for CMS to maintain flexibility in its ongoing data exchange activities to ensure the success of interoperability programs. This is especially true of the FHIR Bulk Data Access and OpenID Connect Core that is proposed in this section of the regulation. Significant limitations still exist for the FHIR Bulk Data standard, and it is yet to be seen when the technology will be ready for implementation and use on a large scale. As currently proposed, while FHIR is promising, the Payer-to-Payer API process could face implementation challenges if FHIR failed to reach widespread industry adoption and maturity.

As stated above, for patient matching activities conducted by payers looking to identify a patient's previous and/or concurrent payer(s), AHIMA recommends CMS require that patients be matched in line with the Patient ID Now Framework.[4] As a founding member of the Patient ID Now coalition, AHIMA believes one of the best things the healthcare sector can do to ensure patient safety is to have a robust matching framework. That belief also extends to matching frameworks needed to protect patient privacy. By requiring a patient matching solution grounded in the Patient ID Now Framework, CMS can ensure that patient matching is prioritized by payers, and that patient safety and privacy are protected.

AHIMA supports CMS' proposal to utilize an "opt-in" approach for patient consent for the payer-to-payer API. While the "opt-out" process generally increases the use of a specific technology or function, an "opt-in" process protects patient choice and privacy. In this instance, given the sensitive nature related to another payer possessing information about previous medical treatment, AHIMA supports the proposal to leave the payer-to-payer API as an opt-in process. We do note that it will be crucial for CMS to provide robust education to the healthcare continuum and patients on which processes are opt-in and which are opt-out given there are different requirements depending on the API.

Mandating payers to incorporate in their records the information gained about a patient through the payer-to-payer API is crucial to ensuring the long-term utility and success of the API. AHIMA recommends CMS continue developing this requirement to include a timeline for data inclusion in payer-held patient records. As currently proposed, payers only need to exchange the data and include it in their records but do not state how quickly they must do so. We recommend CMS work with industry stakeholders and patient advocates to determine the appropriate speed at which this information should be included in the patient's updated record in the payer system.

AHIMA supports the requirement for patient education information to be provided by the payer community on the payer-to-payer API. It is crucial for CMS to hold payers responsible for providing these resources and that the resources are presented in a format that is easily understandable by patients. As stated above, AHRQ recommends a fourth to sixth grade reading level for health-related communications to promote health literacy.[5] AHIMA recommends CMS amend the requirements of the patient resources to require impacted payers to provide resources at the fourth to sixth grade reading

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[4] 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/
[5] https://psnet.ahrq.gov/primer/health-literacy

level. By ensuring the resources are not only non-technical but also easy to read, CMS will ensure that the responsibility of educating patients is not passed to the provider or another entity in the health system.

Finally, AHIMA urges CMS to maintain strict oversight of the way impacted payers utilize the data gained through the payer-to-payer API. The era of preexisting condition coverage denials is over, but risk remains for patients to be denied coverage or access to care given past medical history. Ensuring payers do not misuse this data to prevent patients from accessing healthcare will be crucial to ensuring patients feel comfortable opting into the API. If patients do not feel they can trust payers to use information from former or concurrent payers as required by law, this could lessen the success of the payer-to-payer API.

D. Improving Prior Authorization Processes

2. Electronic Options for Prior Authorization

CMS notes in its proposed rule that the current adopted HIPAA standards for referral certifications and authorizations, also referred to as the prior authorization transaction standards, are the National Council for Prescription Drug Programs (NCPDP) Implementation Guide Version D.0 for pharmacy drugs and ASC X12 278 for dental, professional, and institution requests for review and response. While this proposed rule is updating these standards to move to a FHIR -based environment, the companion, *The Adoption of Standards for Healthcare Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard*[6] that updates the standards for transporting documents associated with Electronic Prior Authorization, remain the X12 278 v. 6020 standards and not FHIR. This means providers will potentially need to implement and utilize multiple different types of standards to complete an Electronic Prior Authorization request. In other words, one part of the request may be handled by FHIR, with supporting documentation handled by X12.

We urge CMS to reconsider making these separate technologies and recommend providing multiple options for implementing these requirements, including allowing providers to complete an entire electronic prior authorization request in either the FHIR or X12 standard language. By giving providers options related to fulfilling the electronic prior Authorization process, CMS would be alleviating significant administrative burden and help streamline the prior authorization request process. This burden reduction would potentially decrease the amount of time patients would need to wait for decisions related to their prior authorization decisions.

As CMS works to implement these APIs, AHIMA recommends the agency engage in stakeholder feedback sessions with health IT end users to capture and understand the real-world needs prior to mandating the implementation of this API. As a founding member of the Health IT End Users Alliance,[7] AHIMA strongly believes federal programs need to work with health IT end users to ensure a robust real world testing process is undertaken related to this API and the standards that surround them. This includes public reporting of the outcome of such testing. Through engaging with end users, CMS further increases the potential for these proposed programs to succeed and achieve the goals CMS set out to accomplish through this rulemaking process.

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[6] https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic
[7] https://hitenduser.org/wp-content/uploads/2022/09/Real-world-testing-consensus-statement_FINAL.pdf

3. Proposed Requirement for Payers: Implement an API for Prior Authorization Requirements, Documentation, and Decision (PARDD API)

AHIMA supports the creation and implementation of the PARDD API to further advance the convergence of clinical and administrative data to advance patient care and improve price transparency activities. By enabling providers to request and receive a prior authorization decision on behalf of the patient electronically, CMS is expediting the time needed for a patient to receive care and understand the cost of that care. Electronic prior authorization activities are a laborious process often utilizing outdated technologies that delay patient access to care. By leveraging the PARDD API, patients and providers in a much shorter amount of time, could better appropriately care plan and determine treatment pathways.

As stated above, AHIMA supports the work to streamline the price transparency process but urges CMS to align the proposed HIPAA attachment technical standards for sending electronic documents with the technical standards proposed in this rule for sending the prior authorization request to the payer from the provider. CMS creates an overly complex and burdensome electronic prior authorization environment by proceeding down the pathway of two different technical standards to complete a prior authorization request. Instead, CMS should provide those participating in electronic prior authorization multiple technical standard options to participate in the process. This would lower the barrier to entry and the burden associated with utilizing electronic prior authorization.

Similarly, providing multiple options for impacted payers and providers to participate in prior authorization means CMS would not be solely reliant on the FHIR standard, which is not fully mature. Impacted payers and providers would be able to utilize the standards most suited to their technical environment and health IT deployment. AHIMA remains supportive of FHIR but believes in all circumstances that relying on one technical solution is not the best path forward for regulatory planning or implementation.

4. Requirements for Payers to Provide Status of Prior Authorization and Reasons for Denial of Prior Authorizations

AHIMA supports the inclusion of the reason for denial in the PARDD API when an impacted payer declines to grant prior authorization. Kaiser Family Foundation (KFF) analysis found that Medicare Advantage (MA) plans declined six percent of all prior authorizations, and of the 11% of those denials that were appealed, 82% resulted in a full or partial overturning of the decision.[8] With such a large number of contested decisions overturned, it is crucial for those challenging the decisions to have information on why the initial request was denied available to them. Mandating the reason for denial in the data transfer requirements of the PARDD API provides additional information a patient could use to contest and overturn a prior authorization decision.

5. Requirements for Prior Authorization Decision Timeframes and Communications

AHIMA recommends CMS convene stakeholders from relevant sectors of the health IT landscape to understand the technical and operational capabilities needed for the timeframes to respond to prior authorization that are proposed within this rule. While AHIMA may support the CMS proposals if they

[8] https://www.kff.org/medicare/press-release/medicare-advantage-plans-denied-2-million-prior-authorization-requests-in-2021-about-6-of-such-requests/

are the most common-sense options, we encourage CMS to explore fully the ability for prior authorization response to increase in speed and responsiveness over time. It is crucial for CMS to fully understand the ability for payers to respond expeditiously to prior authorization requests and to work with patient advocates to understand the cost of not proposing more expeditious timelines.

E. Electronic Prior Authorization for the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

AHIMA supports the creation and implementation of revised Promoting Interoperability Program categories reflecting CMS' new initiative of increasing the utilization of electronic prior authorization, provided eligible professionals' technology can support the reporting of this measure and the technical standards and implementation guides supporting the PARDD API have been subjected to robust real-world testing. CMS should continue to evaluate the numerator and denominator proposals as part of this measure and adjust the requirements accordingly to ensure the adoption and utilization of electronic prior authorization continues to advance at a rate acceptable to CMS and patient advocates.

F. Interoperability Standards for APIs

2. Recommended Standards to Support APIs

AHIMA recommends CMS revise its proposal to APIs to utilize implementation guides to support the implementation process, opposed sufficiently mature. CMS should be as prescriptive as possible when proposing multiple new technical practices to ensure the different payers that providers must interact with do not use slightly different implementation practices. Even slight variations to API implementation can increase burden significantly on the provider community. As such, AHIMA continues to support the use and requirement of industry industry-recognized implementation guides when appropriate to ensure the burden for implementation is not passed from the impacted payer, who is mandated to create the API, to the provider, who will be required to implement the API. CMS should work with stakeholders across the health IT community to propose and finalize implementation guides that are not mature prior to mandating their use.

<u>III. Requests for Information</u>

A. Request for Information: Accelerating the Adoption of Standards Related to Social Risk Factor Data

AHIMA released a white paper in February 2023 outlining the current status and challenges related to the collection, integration, and use of social determinants of health (SDOH) data.[9] The white paper is the result of a national survey of health information (HI) professionals nationwide conducted by NORC at the University of Chicago. Key findings from the survey include:

- Nearly eight in 10 survey respondents indicated that their organization collected SDOH data;
- There is a lack of standardization and integration of the data into an individual's medical record;
- There is insufficient training and education on how to capture, collect, code, and use SDOH data;
- Currently limited pathways exist to use the data to communicate between healthcare providers and community-based referral organizations.

[9] https://ahima.org/media/03dbonub/ahima_sdoh-data-report.pdf

To address these key findings and support the continued collection and use of SDOH data, AHIMA puts forward the following policy recommendations:

1. CMS and other relevant agencies within HHS should establish, in collaboration with standards-setting organizations, health information professionals, physicians, hospitals, and other front-line healthcare providers and organizations, a set of standardized, clinically valid, and actionable SDOH data elements for collection. This might include a limited set of evidence-based domains, such as food and housing, as priorities while other domains are considered optional. This would allow for a subset of standardized data elements to be collected in a consistent and comparable manner, while recognizing that diverse care settings may not have the same amount of time or resources to collect and act upon these data. Domains prioritized for collection should also align across federal and state healthcare programmatic and reporting requirements.

2. To enhance use of a prioritized set of clinically relevant data to improve outcomes and health, CMS should consider providing financial incentives to providers, Medicare Advantage plans, Medicaid plans, and commercial payers to collect and share SDOH data. Aligning incentives and protocols across CMS programs, commercial payers, and providers would ensure that stakeholders are working together to meet their community's needs.

3. Federal financial and technical support is needed to train providers and operations staff on how best to collect, code and use social needs information. This should include a focus on cultural competency coupled with the recognition that different care settings may require different approaches. It should also include continued and expanded research on how best to collect and code SDOH data, and the workforce skills needed to do so. Government agencies, professional societies, and other organizations—such as AHIMA, CMS' Office of Minority Health, CMS' Center for Medicare & Medicaid Innovation, HL7's Gravity Project—should also leverage their learning collaboratives to share best practices and guidance on the collection, coding, and use of clinically relevant SDOH data for care team members and operations staff, so that they can efficiently use existing knowledge. This may include training appropriate staff on how to use standardized formats to collect and code the data from patients in ways that are effective and adhere to high standards of cultural competency, privacy, and confidentiality.

4. The federal government should provide funding, technical resources, and infrastructure to support coordination and connectivity at the state and local level between healthcare organizations and CBOs. Many of the solutions to addressing SDOH needs rely on collaboration between the health and social services sectors. This type of cooperation is happening in pockets at the local level. Many providers are reticent to ask their patients about their SDOH needs without first having the community-based support system to which they can refer the patient so that these needs can be met. Federal incentives are needed for states to create better alignment—across coordinating agencies to improve coordination, collection, and, ultimately, impact.

In addition to providing specific feedback on how best to improve the collection and use of SDOH data to further efforts to accelerate the adoption of standards related to social risk factor data, earlier this year, AHIMA put forward the following recommendations to further health equity efforts in US federal policy.[10] These recommendations include:

[10] https://ahima.org/media/nr5enxrw/final-ahima-health-equity-recommendations-fall-2022-v2.pdf

1. Advance the consistent and standardized collection of Social Determinants of Health (SDOH) data in the care setting;
2. Develop inclusive and complete data standards that ensure SOGI and REL data accurately reflect the patient's background and demographic information;
3. Close the healthcare access gap by maintaining permanent, widespread access to telehealth services;
4. Narrow the digital divide that hinders the ability for patients to research, shop for, and attain care nationwide;
5. Address patient identification and matching to ensure patients are accurately matched to their health record;
6. Bias must be accounted for in the development of Artificial Intelligence (AI) and other physician assisted technologies;
7. Further the use of quality measures and payment models that prioritize addressing inequities in healthcare; and
8. Ensure the healthcare workforce is properly equipped to understand and handle current day health equity challenges.

AHIMA welcomes the opportunity to meet with key CMS leadership to further discuss the findings contained within the above mentioned SDOH white paper and/or the recommendations to further health equity in policy activities.

B. Electronic Exchange of Behavioral Health Information

The behavioral health and long-term post-acute care (LTPAC) communities have long been left behind by the EHR incentive programs previously authorized under the HITECH Act. These providers were not included in the initial program and thus could not receive federal funds to purchase and implement an EHR. As a result, these providers have either had to retrofit certified technology to meet their clinical needs with little to no monetary support or purchase non-certified products. As a result, behavioral health and LTPAC providers often do not have the technology stack to implement the latest technological advancements, such as FHIR. In cases where these providers can adopt FHIR, they are generally under-resourced, so adopting new technology, such as FHIR, comes at a significant monetary cost.

CMS and other relevant HHS agencies should work to determine the best way to include behavioral health and LTPAC providers in programs to assist them in attaining certified products. By including these providers in existing Medicare programs that incentivize the use of certified health IT, behavioral health and LTPAC providers can gain technology certified through ONC programs. In addition, having different types of providers involved in HHS programs strengthens these programs and can help ensure no provider is left behind and unable to use new technologies like FHIR for data exchange.

C. Request for Information: Improving the Exchange of Information in Medicare Fee for Service

AHIMA continues to support the creation, development, adoption, and implementation of predictable health IT data standards in federal programs, such as those administered by CMS. Incentivizing industry-recognized data standards throughout CMS programs ensures that most providers utilize the same common language to communicate and exchange information. Lowering the barrier to participating in data exchange is crucial for widespread adoption of information-sharing practices with other providers, government entities, and healthcare continuum stakeholders.

We encourage CMS to continue supporting the development of these technical standards and implementing requirements for their use in its rulemaking activities. CMS is also encouraged to participate in the United States Core Data for Interoperability (USCDI) process governed by ONC. By taking an active role in the development of standards, CMS can ensure that what is adopted and implemented enhances the goals the companion programs hope to achieve. Similarly, CMS should continue to collaborate with the National Committee on Vital Health Statistics (NCVHS) to support further convergence of clinical and administrative data.

By utilizing the data standards development processes in place, CMS can help create a predictable health data exchange environment. Such an environment will encourage the electronic exchange of medical information and increase the number of health data holders participating in that exchange. For these reasons, CMS must remain active in the standards development process and continue to push HHS' data standards activity forward.

E. Request for Information: Advancing the Trusted Exchange Framework and Common Agreement

AHIMA actively supports efforts to develop and implement the Trusted Exchange Framework and Common Agreement (TEFCA). The Sequoia Project acting as the Recognized Coordinating Entity (RCE) and ONC, have made significant strides toward making TEFCA a reality. However, much work remains to be done, and currently, it is unclear when TEFCA will be a viable data exchange pathway. Additionally, ONC has previously signaled that 2023 rulemaking will include proposals for expanding the data exchange purposes included as part of the TEFCA. That rulemaking is yet to be released, and it remains unknown when it will be released. We recommend CMS monitor the ONC rulemaking and comment as appropriate to ensure CMS' goals related to exchanging payer data are accomplished.

As a result of the lack of clarity related to both the TEFCA timeline and approved data exchange purposes, AHIMA recommends CMS refrain from including requirements related to the exchange of data via TEFCA until TEFCA has been fully implemented. At that time, the provider and payer communities can better assess the policy levers available to CMS to incentivize TEFCA adoption.

AHIMA and its membership remain steadfast supporters of CMS' work and efforts to converge clinical and administrative data and create improved price transparency. As CMS continues down this regulatory pathway, please know AHIMA and its membership remain ready to provide real-world operational insights into the realities of the above proposals and how they will impact the lives of patients and providers. If AHIMA can provide any further information related to the requests in this letter, or if there are any questions regarding this letter and its recommendations, please contact Andrew Tomlinson, Director of Regulatory Affairs, at 443-676-7106 or andrew.tomlinson@ahima.org.

Sincerely,

Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer