



233 N. Michigan Ave., 21st Fl., Chicago, IL USA 60601-5809 | [www.ahima.org](http://www.ahima.org) | 312.233.1100

September 8, 2023

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
US Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the US Centers for Medicare & Medicaid Services (CMS) proposed changes to the CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, as published in the August 7, 2023, Federal Register (CMS-1785-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. 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 sections of the IPPS proposed rule.

## **II. Provisions of the Proposed Rule for the PFS**

### *E. Valuation of Specific Codes*

#### 4. Valuation of Specific Codes for CY 2024

##### d. Social Determinants of Health (SDOH)—Proposal To Establish a Stand-Alone G Code

##### ii. Proposed SDOH Risk Assessment Code

*CMS proposes to establish a G code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an evaluation and management (E/M) visit. The SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using ICD-10-CM Z codes. Required elements would include administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.*

AHIMA supports the establishment of a code for an SDOH risk assessment that is furnished in conjunction with an E/M visit. We also support the requirement for administration of a standardized, evidence-based SDOH risk assessment tool.

AHIMA supports CMS' proposed requirement that SDOH needs identified through the risk assessment be documented in the patient's medical record. **To promote standardized data collection and reporting, we recommend that CMS strongly encourage providers to assign ICD-10-CM codes for these identified SDOH needs and report these codes on reimbursement claims** (when there is sufficient space on the claim). For the proposals regarding community health integration (CHI) and principal illness navigation (PIN) services, CMS states that practitioners would be encouraged to record the associated ICD-10-CM Z-code in the medical record and on the claim. However, for the SDOH risk assessment furnished in conjunction with an E/M visit, CMS indicates only that SDOH needs "may" be documented using ICD-10-CM Z-codes and no mention is made of reporting these codes on the claim. We recommend that for all SDOH-related proposals, CMS include the same language pertaining to the use of ICD-10-CM Z-codes that that is in the CHI and PIN sections.

### *S. A Social Determinants of Health Risk Assessment in the Annual Wellness Visit*

#### 3. Proposal

*Medicare coverage for the Annual Wellness Visit (AWV) under Part B is primarily described in statute at section 1861(hhh) of the Act, and in regulation at 42 CFR 410.15. CMS proposes to exercise its authority in section 1861(hhh)(2)(I) of the Act to add elements to the AWV by adding a new SDOH Risk Assessment as an optional, additional element of the AWV with an additional payment. CMS recognizes that, for some patients, identification and consideration of SDOH is critical to furnishing a fully informed health assessment and personalized prevention plan in the AWV. CMS has heard from interested parties that the current elements of the AWV may not directly or adequately identify those SDOH challenges. CMS proposes that the SDOH Risk Assessment be separately payable with no beneficiary cost sharing when furnished as part of the same visit with the same date of service as the AWV.*

AHIMA supports CMS' proposed inclusion of an SDOH risk assessment as an optional, additional element of the Annual Wellness Visit (AWV). We recommend that SDOH needs identified through the risk assessment be documented in the patient's medical record, similar to CMS' requirement regarding the proposed SDOH risk assessment furnished as part of an E/M visit. We recommend that CMS strongly encourage providers to assign ICD-10-CM codes for SDOH needs identified through the risk assessment conducted as part of the AWV and report

these codes on reimbursement claims (when there is sufficient space on the claim). For the proposals regarding CHI and PIN services, CMS states that practitioners would be encouraged to record the associated ICD-10-CM Z-code in the medical record and on the claim, but there is no mention of reporting ICD-10-CM Z-codes under the proposal to add an SDOH risk assessment as an optional element of the AWW.

It is crucial for providers to have every opportunity available to them to support the utilization of this type of risk assessment to encourage the collection of SDOH data. Without thorough incentives to providers, the increase in the capture and use of SDOH will remain minimal in the near term.

The continued inclusion of key SDOH tools by CMS throughout proposed and final regulations demonstrates the commitment from the Biden-Harris Administration to close the health equity gap across all of healthcare. AHIMA remains steadfast supporters of policy efforts aimed at increasing the collection and use of SDOH data to improve individual and community health and healthcare outcomes.

In 2022, AHIMA commissioned a study,<sup>1</sup> conducted by NORC at the University of Chicago, to better understand the operational realities of how SDOH data is collected, coded, and used in real-world healthcare scenarios. AHIMA subsequently published a white paper that identified the key findings of the survey including:

- Lack of standardization and integration of the data into an individual’s medical record, even when the data is collected within the organization;
- Insufficient workforce training and education on how to capture, collect, code, and use SDOH data; and
- Limited uses of SDOH data to communicate between healthcare providers and community-based referral organizations.

AHIMA continues to live its commitment to improving health equity through its Data for Better Health initiative™.<sup>2</sup> Data for Better Health will provide tools, resources, and education to support a better understanding of the importance of SDOH data and how it can be used to improve health and healthcare outcomes. The goals of this initiative include:

- Engaging healthcare professionals working with SDOH to understand the business case for the collection of SDOH and share strategies for success;
- Educating and engaging with consumers to build trust and a greater understanding of SDOH and the benefits of sharing SDOH information with healthcare professionals;
- Advancing policy and advocacy among policymakers by developing and promoting an SDOH data advocacy agenda; and
- Supporting innovation within the healthcare ecosystem to accelerate the adoption of best practices and new models.

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<sup>1</sup> <https://www.ahima.org/news-publications/press-room-press-releases/2023-press-releases/ahima-white-paper-identifies-opportunities-and-challenges-with-collecting-integrating-and-using-social-determinants-of-health-data/>

<sup>2</sup> <https://ahima.org/advocacy/data-for-better-health/>

As CMS works to finalize this proposal, AHIMA remains a committed partner in this work and, through both its research activities and Data for Better Health, stands ready to further support CMS in its SDOH activities.

*CMS proposes that the SDOH Risk Assessment service include the administration of a standardized, evidence-based SDOH risk assessment tool, furnished in a manner that all communication with the patient be appropriate for the patient's educational, developmental, and health literacy level, and be culturally and linguistically appropriate.*

AHIMA supports requirements for the SDOH Risk Assessment to be provided through a tool that is furnished in a manner that meets the patient's needs. If the tool does not meet the patient's needs or account for their current SDOH limitations, then the tool will have little relevancy and utilization. CMS is increasing the likelihood a provider participates in this voluntary program by requiring the tool to be relevant and useful to the unique situations they encounter.

*CMS recognizes that SDOH risk assessments are an emerging and evolving tool in healthcare and so CMS does not restrict the proposal to a specific list of approved assessments.*

AHIMA understands the need to remove limitations on the type of tools utilized to support the SDOH Risk Assessment and support the forward-looking nature of the proposed language. However, declining to provide specifications on what must be included in the tool or how the tool should function may risk creating an environment where no two providers are collecting the same or similar information. While it would be ideal from a data standardization and comparability standpoint to use the same SDOH risk assessment tools across the healthcare industry, AHIMA agrees with CMS that these tools will continue to emerge and evolve, and therefore, risk assessment tools should not be restricted to a specific list of approved assessments at this time.

With additional experience and research, it may be appropriate to designate a specific set of assessment tools at some point in the future. In the near-term, AHIMA recommends CMS periodically evaluate provider experiences and additional research on SDOH screening instruments and consider whether it may be appropriate to recommend a limited set of the best SDOH screening instruments in the future to promote data standardization and interoperability. Overall, AHIMA is encouraged by this proposal and remains a partner to CMS and the provider community in determining the most optimal risk assessment tools to assess SDOH and in turn improve patient-centered, comprehensive healthcare delivery.

*CMS proposes that Medicare would pay 100 percent of the fee schedule amount for the SDOH Risk Assessment service (beneficiary cost sharing would not be applicable) when this risk assessment is furnished to a Medicare beneficiary as an optional element within an AWW (as part of the same visit with the same date of service as the AWW).*

AHIMA supports CMS' proposal to pay 100 percent of the fee schedule amount for the SDOH Risk Assessment service. Removing the cost barrier from this process increases the likelihood that providers will engage in this optional process. Providers are already tasked with the collection of numerous data elements related to the patient and adding requirements without

appropriate reimbursement from CMS makes it unlikely that optional collection activities will take place. By ensuring this data collection is fully reimbursable CMS increases the likelihood of the collection of SDOH data.

#### **IV. Updates to the Quality Payment Program**

##### *A. CY 2024 Modifications to the Quality Payment Program*

### 3. Transforming the Quality Payment Program

#### f. MIPS Performance Category Measures

##### (4) Promoting Interoperability Performance Category

##### (c) Certified Electronic Health Record Technology Requirements

*As further discussed in section III.R. of this proposed rule, CMS is proposing to modify the definition of CEHRT for purposes of the Quality Payment Program at § 414.1305 to no longer refer to year-specific editions, and to incorporate any changes made by ONC to its definition of Base EHR and its certification criteria for health IT.*

AHIMA recognizes CMS' need to ensure alignment with other agency rulemaking as the reason behind modifying the definition of CEHRT for the Quality Payment Program. However, it is premature to propose this requirement prior to the finalization of ONC's Health Technology and Interoperability 1 (HTI-1) proposed rule that itself modifies the definition of CEHRT. Until that rule is finalized, we urge CMS to refrain from making changes to the definition of CEHRT. Without doing so CMS creates an environment where providers are unable to understand compliance activities or whether they remain in compliance due to the lack of finalization of the referenced rule. Once HTI-1 is finalized, CMS should propose this change so those governed by the proposal will have the opportunity to fully grasp the implications.

##### (d) Promoting Interoperability Performance Category Measures for MIPS Eligible Clinicians

##### i. Changes to the Query of Prescription Drug Monitoring Program Measure Under the Electronic Prescribing Objective

AHIMA supports the proposed amendment to this section of the Promoting Interoperability program allowing providers that do not electronically prescribe Schedule II opioids or Schedule II and IV drugs to claim the second exclusion under the Electronic Prescribing Objective for Promoting Interoperability.

##### iii. Changes to the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) Measure

*CMS proposes to modify the SAFER Guides measure beginning with the CY 2024 performance period/2026 MIPS payment year such that only a "yes" response on the attestation will*

*constitute completion of this measure, and a “no” response will result in a score of zero for the whole Promoting Interoperability performance category, indicating that the MIPS eligible clinician failed the requirements of the Promoting Interoperability performance category and is not a meaningful user of CEHRT.*

AHIMA recommends CMS reconsider the proposal to require the SAFER Guides measure to be completed with a “yes” response to receive Promoting Interoperability performance category points. While the SAFER Guides provide a guidepost for organizations to assess their health IT deployments, completion of these guides is onerous for an organization. We recommend CMS pursue other avenues for accomplishing these goals to ensure the burden of completion on providers is minimal and that the proposed tool is easy to use and up to date, with relevancy having particular emphasis given the ONC-provided SAFER Guides continue to remain out of date and require an update. CMS should work with industry stakeholders to determine the best tool to accomplish these regulatory goals and revise this requirement to reflect that consensus decision.

CMS should continue to view AHIMA as partners in the agency’s work and priorities. If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please feel free to contact Sue Bowman, senior director of coding policy and compliance, at (312) 233-1115 or [sue.bowman@ahima.org](mailto:sue.bowman@ahima.org), or Andrew Tomlinson, director of regulatory affairs, at (443) 676-7106 or [andrew.tomlinson@ahima.org](mailto:andrew.tomlinson@ahima.org).

Sincerely,



Lauren Riplinger, JD  
Chief Public Policy & Impact Officer