American Health Information Management Association
201 West Lake Street, 226
Chicago, IL 60606

August 29, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Oz:

On behalf of the American Health Information Management Association (AHIMA), I am writing in response to the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) proposed rule published in the July 16, 2025 *Federal Register* (CMS-1832-P).

AHIMA is a global nonprofit association of health information (HI) professionals, with over 61,000 members and more than 88,500 credentials in the field. 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 clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

Following are our comments and recommendations on selected sections of the PFS proposed rule.

II. Provisions of the Proposed Rule for the PFS

I. Policies to Improve Care for Chronic Illness and Behavioral Health Needs

4. Technical Refinements To Revise Terminology for Services Related to Upstream Drivers of Health

CMS proposes to replace the term "social determinants of health (SDOH)" with the term "upstream driver(s)" and proposes HCPCS code changes accordingly to reflect the updated terminology.

AHIMA supports CMS' mission to continue driving uniformity and consistency in terminology across its healthcare programs. While we support the use of consistent terminology and CMS' attempts to examine opportunities to update that terminology, AHIMA cautions CMS about replacing the term "social determinants of health (SDOH)"with "upstream driver(s)." "Upstream driver(s)" is not a widely used term in healthcare, whereas "social determinants" or "social drivers" has a widely recognized definition across the healthcare ecosystem. Notably, CMS did not define "upstream driver(s)" in the proposed rule. Current literature on "upstream drivers" describes

the concept as approaches and interventions to help improve patient health that may be affected by SDOH,[1] and does not generally include patient behaviors.[2] This term is understood to be distinct from SDOH.[3]

AHIMA recommends CMS refrain from adopting "upstream drivers" and continuing to use the widely adopted and well-defined terms of social drivers and social determinants. If a more robust definition of "upstream drivers" is developed, and CMS chooses to pursue adopting this term, AHIMA recommends CMS repropose the adoption of the term for additional public feedback. Providing a clear definition to the term will allow AHIMA to appropriately understand CMS' goals and allows us to provide more robust support to CMS in its mission of broadening the conversation around the societal factors impacting a patient's health.

K. Payment for Skin Substitutes

D. Proposed Payment of Skin Substitute Products under the PFS and OPPS

AHIMA fully supports alignment of Medicare payment and coding policies for the application of skin substitute products across the physician office and hospital outpatient department settings. We agree with CMS' proposal to treat skin substitutes in a uniform manner across different outpatient care settings, to the extent permitted by law. We support CMS' proposal to group skin substitutes based on FDA regulatory categories, as this represents a clear, logical, transparent, and consistent approach.

We also support CMS' proposal to maintain the current structure of HCPCS codes for skin substitutes.

IV. Updates to the Quality Payment Program

d. Well-Being and Nutrition Measures Request for Information (RFI)

CMS seeks input on well-being and nutrition measures for future years in the Quality Payment Program (QPP), including feedback on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.

AHIMA encourages CMS to consider the value that SDOH-related screening and reporting measures can contribute to understanding and managing patients' well-being and nutrition. The rule states that well-being is a comprehensive approach to disease prevention and health promotion that emphasizes person-centered care by promoting the well-being of patients and family members. Social risk factors contribute significantly to patients' well-being and nutritional status, and no comprehensive approach to promote health and prevent disease can be effective without considering social risk factors. Growing evidence demonstrates that specific social risk factors are directly associated with patient health outcomes as well as healthcare utilization, costs, and performance in quality-based payment programs.[4] Health-related social needs negatively impact a person's health or healthcare and are significant risk factors associated with worse health outcomes as well as increased healthcare utilization. Consistent collection of high-quality data on SDOH and understanding how many patients experience challenges

[1]Available at: https://www.healthaffairs.org/sponsored-content/quantifying-upstream-drivers-of-health-can-help-compound-improvement-in-downstream-outcomes.
[2]Available at: https://info.primarycare.hms.harvard.edu/perspectives/articles/addressing-social-determinants-of-health.
[3]Available at: https://healthcity.bmc.org/upstream-healthcare-sdoh-root-causes/.
[4]Available at: https://aspe.hhs.gov/topics/health-health-care/social-drivers-health/social-risk-factors-medicares-valuebased-purchasing-programs.

in these areas will enable clinicians to work together with patients, leveraging community support services and resources to manage chronic disease, improve health outcomes, prevent disease, and promote health.

For example, poor nutrition may be related to food insecurity, which is defined as limited or uncertain access to adequate quality and quantity of food at the household level.[5] It is associated with diminished mental and physical health and increased risk for chronic conditions. Food insecurity is also associated with high-cost healthcare utilization, including emergency department visits and hospitalizations. Therefore, AHIMA believes that measuring a patient's nutritional status should include screening for food insecurity. Accordingly, the patient can be connected to appropriate resources to ensure adequate access to food so that nutritional status, and thus health, can be improved.

Screening for these social risk factors would allow healthcare providers to identify and help address health-related social needs as part of treatment plans and contribute to long-term improvements in patient outcomes and prevention and mitigation of chronic diseases. This has the potential to reduce healthcare provider burnout by systematically acknowledging patients' social needs that contribute to adverse health outcomes and linking providers with community-based organizations to enhance patient-centered treatment. The availability of quality SDOH information could help clinicians and organizations, as well as state and federal agencies, better understand the prevalence and trends of various social risk factors within communities and enable the analysis of the impact of these factors on the severity of illness, resource utilization, healthcare costs, and health outcomes. Widely adopted, consistent documentation and reporting mechanisms would aid in formulating more comprehensive and actionable policies to improve health outcomes, promote the highest quality care for all patients, and reduce healthcare costs overall.

AHIMA continues its commitment to improving health outcomes through its Data for Better Health® initiative.[6] Data for Better Health provides tools, resources, and education to advance the collection, sharing, and use of SDOH data to improve health outcomes. The goals of the initiative include:

- Engaging healthcare professionals working with SDOH data to understand the business case for the collection of SDOH data 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 data with healthcare professionals;
- Advancing policy and advocacy among policymakers by developing and promoting a SDOH advocacy agenda; and
- Supporting innovation within the healthcare ecosystem to accelerate the adoption of best practices and new models related to SDOH.

AHIMA encourages CMS to consider the importance of tools and measures that screen for SDOH to inform improved and more holistic assessments of patient well-being and nutrition. AHIMA is committed to working with CMS on appropriate policies to encourage the collection, access, sharing, and use of all data that impacts individuals' well-being, nutrition, and overall health.

(4) Promoting Interoperability Performance Category

[5]Available at: Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Managed Care. 2018 Sep;24(9):399-404.
[6]Available at: www.dataforbetterhealth.com.

(c) Proposal To Modify the Security Risk Analysis Measure

CMS proposes to modify the Security Risk Analysis measure to require eligible entities to attest "yes" to having implemented security risk management measures sufficient to reduce risks and vulnerabilities in alignment with the HIPAA Security Rule, in addition to the current required "yes" attestation to conduct a security risk analysis.

AHIMA appreciates CMS' recognition that healthcare organizations must take steps to improve the privacy, security, and protection of electronic protected health information (ePHI) to ensure patient care is provided in a trustworthy and safe manner. HI professionals directly manage ePHI and the processes and workflows that handle this sensitive data. They have unique insights into the security protections and vulnerabilities that put ePHI at risk. AHIMA believes work must continue to increase resiliency in the healthcare system, improve protection against cyber threats and attacks, and support healthcare organizations in preparation against, during, and after cyber incidents.

AHIMA urges CMS to consider the burden and feasibility of requiring eligible hospitals and CAHs to attest "yes" to conducting security risk management, in addition to security risk analysis, and how that may impact performance in the Promoting Interoperability Program before requiring it. Implementing adequate security risk management practices is critical to ensuring the security of an entity and its ePHI, but without resources and assistance, entities often have no choice but to prioritize the requirements they are financially able to implement.[7] AHIMA recommends CMS coordinate with the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR) to implement consistent requirements and provide funding, resources, guidance, and education for entities – particularly small, rural, and otherwise under-resourced eligible hospitals and CAHs – on how to best implement security risk management practices.

(d) Proposal To Modify the High Priority Safety Assurance Factors for EHR Resilience (SAFER) Guide Measure

CMS proposes to modify the High Priority SAFER Guide measure, which currently requires MIPS eligible clinicians to attest "yes" to completing an annual self-assessment, by specifying that MIPS eligible clinicians utilize the 2025 version of the High Priority Practices SAFER Guide beginning with the CY 2026 performance period/ 2028 MIPS payment year.

AHIMA appreciates CMS updating the SAFER Guides following widespread industry advocacy, including from AHIMA, to update the SAFER Guides.[8] AHIMA encourages CMS to consider how the SAFER Guides assessments can be onerous and burdensome for organizations, especially those that are under-resourced. AHIMA recommends CMS work with industry stakeholders to regularly assess the burdens and effectiveness of the SAFER Guides as well as explore alternative tools to assess health IT capabilities within organizations. AHIMA is eager to serve as a partner to CMS to determine optimal ways to support organizations of all sizes and resource capabilities in meeting the recommended practices within all SAFER Guides, including the High Priority Practices guide.

(e) Proposal To Adopt the Public Health Reporting Using TEFCA Measure as an Optional Bonus Measure

[7]Available at: https://www.ahima.org/media/2kwetkil/ahima-comments-ocr-hipaa-security-rule-to-strengthen-cybersecurityproposed-rule-final.pdf.
[8]Available at: https://www.ahima.org/media/m5mjy4es/ahima-final-comments-cms-cy-2025-mpfs-proposed-rule.pdf.

CMS proposes to adopt an optional bonus measure under the Public Health and Clinical Data Exchange Objective for health information exchange with a public health agency (PHA) that occurs using TEFCA beginning with the CY 2026 performance period/ 2028 MIPS payment year.

AHIMA continues to support the efforts of the Assistant Secretary for Technology Policy/ Office of the National Coordinator for Health Information Technology (ASTP/ONC) and the Recognized Coordinating Entity (RCE), The Sequoia Project, to operationalize the TEFCA. The TEFCA is a needed interoperability network that can accelerate the nation's advancement to nationwide interoperability. AHIMA is also committed to working with HHS on the best methods to promote adoption of, and effective data exchange through, TEFCA.

AHIMA supports the proposal to add an optional bonus measure to allow providers to receive credit for the Public Health and Clinical Data Exchange objective by exchanging public health information through participation in TEFCA. This option would create an incentive for providers to voluntarily join TEFCA. The use of positive incentives and voluntary participation can provide information and data on the progress of TEFCA as it continues to be applied in real-world settings.

Many healthcare organizations struggle with exchanging data with PHAs that have outdated technology platforms. PHAs are often unable to use the data received by healthcare organizations, minimizing incentives to share this data. We encourage CMS to work with ASTP/ONC to monitor the development of TEFCA and publicly share information on the progress of public health data exchange through TEFCA, including successes and challenges healthcare entities face in these efforts. Additionally, we encourage CMS to explore with the Centers for Disease Control and Prevention (CDC) opportunities to support PHAs in their continued technology transformation projects. A robust, financially supported, network of PHAs strengthens nationwide public health data exchange.

AHIMA is supportive of the recently announced CMS Interoperability Framework and its goals to prioritize patients' and providers' access to health information. We are pleased to see several of the QHINs involved in TEFCA have pledged to participate in the CMS Interoperability Framework. Given there are several shared goals and priorities between TEFCA and the CMS Interoperability Framework, AHIMA urges CMS to find opportunities to align both initiatives and find ways to collaborate to further the goals of widespread data access and exchange while minimizing regulatory burden. If the CMS Interoperability Framework is included in the Promoting Interoperability Program in the future, we encourage CMS to allow entities to participate: (1) as a CMS Aligned Network, (2) in TEFCA, or (3) both, even if it is optional, to contribute to the regulatory goals of efficient and comprehensive data access and exchange. AHIMA looks forward to working with CMS on operationalizing the CMS Interoperability Framework.

(f) Proposal To Adopt Measure Suppression Policy for the MIPS Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

CMS proposes to provide CMS with the ability to exclude a measure from scoring or the determination of a meaningful EHR user due to circumstances that impede the effective measurement outside the control of eligible clinicians, eligible hospitals, and CAHs.

AHIMA appreciates CMS exploring ways to support providers by excluding measures from scoring when circumstances may impede the ability of eligible clinicians, eligible hospitals, and CAHs from fulfilling a measure in both the Promoting Interoperability program and performance category. However, the healthcare industry needs more clarity on the influencing factors and processes that would be involved with determining whether a measure may be suppressed. A predictable regulatory environment is crucial for providers to plan and account for the

regulatory burden they face every year. At this time, it remains unclear what the pathway to measure suppression by CMS will be. While the factors CMS listed in the proposed rule are helpful framing, they are quite broad, and more specific, real-world examples of circumstances that would warrant a suppression would be helpful. Additionally, we encourage CMS to provide more information on how long a suppression would last, what would cause a measure to be reinstated, if there would be a transition period associated with a measure being reinstated and how that transition would function, how scoring would be revised both during and after a measure is suppressed, and if the public would have the ability to provide comment related to the suppression.

AHIMA encourages CMS to publish an RFI on this proposal to gather feedback from healthcare organizations on which measures are burdensome or difficult to fulfill due to the circumstances listed by CMS. We also encourage CMS to determine the implications of a measure being suppressed and the impact on the goals of the Promoting Interoperability program and performance category. We encourage CMS to share this information with the healthcare industry so stakeholders can better understand which measures may be subject to being suppressed and the associated rationale and criteria to prepare for any changes.

(g) Proposal To Suppress the Electronic Case Reporting Measure

CMS proposes to suppress the Electronic Case Reporting measure for the CY 2025 performance period/ CY 2025 EHR reporting period due to the CDC temporarily pausing electronic case reporting registration and onboarding of new healthcare organizations to establish a more efficient and automated process. Entities would continue to be required to report the measure but it would not affect their score.

AHIMA appreciates the transparency regarding the CDC's temporary pause of electronic case reporting registration and onboarding to establish a better process. We also appreciate the harmonization of requirements and reporting across HHS agencies in response to ASTP/ONC announcing enforcement discretion for the electronic case reporting certification criterion. However, electronic case reporting is an important method for providers to participate in public health reporting with limited burden and cost, and we caution CMS and its partner agencies on the impacts that reducing the broad adoption of electronic case reporting might have on the ability of PHAs to monitor disease trends and efficiently manage outbreaks. AHIMA believes case reporting should continue to be measured and we encourage CMS to work with CDC and ASTP/ONC in exploring ways to modernize electronic case reporting and determine the best path forward to include electronic case reporting in certified technology.

As written, the Electronic Case Reporting measure is proposed to be suppressed for the CY 2025 performance period and CY 2025 EHR reporting period. If finalized, CMS and CDC should provide joint updates on the progress of the development of a new process so providers can prepare for changes in workflow and procedures. Additionally, it is critical that CMS work with its agency partners to keep providers aware of the progress toward establishing a new electronic case reporting process and lifting suppression. If progress is made, CMS should notify providers as soon as possible and in future rulemaking if changes in the electronic case reporting program and measurement are set to take effect to ensure providers can prioritize resources for other efforts in the meantime.

Overall, AHIMA applauds CMS for working with CDC on supporting the technological advancements of PHAs to strengthen nationwide data exchange. To enhance this effort, CMS should work with CDC to include eligible clinicians, eligible hospitals, and CAHs in the development of this new process. Many healthcare organizations struggle with exchanging data with PHAs that have outdated technology platforms and processes. Healthcare organizations and health IT end-users best understand the challenges and opportunities associated with

exchanging data with PHAs and can provide valuable insights on how best to improve the process and reporting relationships.

(k) RFI Regarding Data Quality

CMS requests information on improvements in the quality and completeness of the health information eligible hospitals and CAHs are exchanging across systems. CMS seeks input on data quality challenges healthcare organizations face, barriers to collecting high-quality data, needed resources, and suggestions for CMS to drive further improvement in the quality and usability of health information being exchanged.

Health information is complex, nuanced, and ever-changing. The data that comes with every healthcare encounter generates essential information that can impact a patient's personal and collective well-being, and the quality and integrity of this information is essential. The responsible collection, protection, and analysis of health information allows providers to deliver tailored and safe medical care, fosters innovation, encourages researchers to make lifesaving discoveries, and offers individuals the opportunity to maintain good health. HI professionals are key to this conversation as they are at the forefront of health information exchange, overseeing accurate and high-quality documentation, storage, use, and sharing of patient health data, and are best positioned to be a part of solutions to address those challenges. For over 90 years, AHIMA certified professionals have been dedicated to ensuring the accuracy and integrity of a patient's health information while keeping it private, confidential, and secure. We take this role seriously as a member of one of the designated Cooperating Parties for ICD-10 coding guidance with CMS, the CDC, and the American Hospital Association, as well as via a variety of coding usage and standardization activities both in the US and internationally, in our professional education coding products and services, and with our Standards of Ethical Coding.

Data Quality Challenges and Barriers to Collecting High-Quality Data

Variability in Data Management Practices. The collection of patient data can vary across hospitals, clinics, and providers. Data inconsistencies can include legal name versus nicknames, middle name versus middle initial, use of suffixes and hyphens in names, and address standards. The lack of discrete data fields and standardization of clinical information, such as consistent definition of terms and data elements, various abbreviations, a lack of consistency in what information is captured (e.g., SDOH data), and how to standardize information in narrative or free text reports is an ongoing challenge. Varying documentation standards and coding and billing guidelines across clinicians, healthcare organizations, and payers also hinders data quality and integrity. This includes how and in what format files are saved, as some organizations struggle to support and access external files from other organizations. Additionally, the appropriate use of copy-paste and copy-forward in EHRs varies across organizations and can lead to medical errors if inaccuracies are introduced, outdated information is added, or notes become so long that essential clinical information is difficult to find.[9] As large health systems continue to grow, each merger or acquisition brings potential non-alignment with how data is documented, stored, shared, and reported.

Regulatory burden. EHR use is increasingly associated with clinician burnout, as a result of design inefficiencies that impact end-users' workflows, which includes HI professionals, who are often left out of policy discussions and standards development activities. As a result, end-users have found that new technical approaches and regulatory requirements are not sufficiently grounded in real-world experiences and do not adequately consider the implementation pathway before mandating use. This includes issues such as how new technology and/or

[9]Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10349911/.

standards work with the existing infrastructure, workflow constraints to adopting new technology, technology costs, engaging with and educating patients on their role in utilizing the technology, and how new requirements will fit into the array of regulatory requirements that health IT end-users face. Implementing new EHRs and standards and complying with new or changing regulations can impact the timeliness of ensuring that health IT systems are operating in a way that supports the collection and sharing of high-quality data. These challenges result in inefficiencies, inadequate standards and policies that do not achieve the desired goals, and end-user burden and burnout, which can lead to reduced data quality and integrity in patient records.

One notable area where healthcare organizations see challenges in upholding strong and consistent data quality is lack of standardization across hospital rating systems, including the Leapfrog Hospital Safety Grade, Healthgrades, and CMS Quality Reporting Programs. These programs are not consistent in the definitions required to fulfill a measure, which leads to variability in scores for providers and hospitals. Specifically, the variability in how hospice measures should be reported across these programs poses a significant challenge for healthcare organizations. Organizations are required to understand the different requirements involved with each program's unique hospice measure, which can include different requirements for numerators, denominators, inclusions, and/or exclusions. As these measures continue to evolve in different ways and require new or additional elements, organizations are forced to change how their clinicians practice medicine to fulfill a measure. A common example noted by one AHIMA member related to the hospice measure is when a patient is admitted as an inpatient but then transitioned into a hospice after diagnosis. In this case, keeping the patient in the same bed while transitioning care and documentation to hospice saves time, administrative efforts, and financial resources. However, once that patient dies, their case would be counted under a mortality measure rather than a hospice measure since the patient was initially admitted to an inpatient bed, which would lead to a bad score for the organization. As a result, the organization must discharge and readmit the patient to a hospice bed, which costs a significant amount of time, money, and administrative burden, not to mention hardship on the patient's family during the grieving process. This causes variation in how patient care is delivered and how data is documented, leading to inconsistencies and thus reduced data quality.

Lack of workforce support. HI professionals are the backbone of data exchange within healthcare organizations because they understand the nuances of data structure and content, data exchange processes, and health IT system workflows. Lack of adequate training in healthcare technology and EHR systems for staff can directly impact the quality of patient data documented in EHRs and exchanged between institutions. This is particularly true for smaller organizations that may rely on one staff member to handle the traditional IT portfolio and the health information management portfolio. Additionally, as workflows increasingly become automated in healthcare, HI professionals need additional training and support to understand and manage the use of artificial intelligence (AI) and machine learning (ML) tools in workflows. Improving training on the use of AI and ML in healthcare is essential to understand what data is involved with these processes and tools and how it is used. More comprehensive education, upskilling for current professionals, and resources for the healthcare industry on how to effectively produce high-quality clinical documentation in health IT systems are necessary.

Lack of a national strategy for patient identification. Patient misidentification can occur when a patient has multiple, separate patient medical records, or overlaid records, which occur when two or more patients' information is combined into one health record because of similar demographic information. Patient misidentification can stem from inadequate organizational practices on patient matching such as a lack of standardized processes at patient registration, the inability of health IT systems to mitigate duplicate or overlaid records, and more. This results in decreased data quality within patient records whereby clinicians are working with incomplete or inaccurate patient information. Inaccurate patient identification also raises the risks of jeopardizing patient privacy and safety in the delivery of patient care. On the federal level, the inclusion of Section

510 in the Labor, Health and Human Services, Education, and Related Agencies of the federal budget has stifled work around patient identification between the private sector and HHS for more than two decades, as it prohibits the creation of a national unique patient identifier.[10] The lack of a national strategy on patient identification also causes financial burdens to patients, clinicians, and institutions, resulting in uncoordinated, unnecessary or duplicative testing or services, denied claims, and delays in billing and reimbursement.

Privacy and security challenges. Privacy and security are integral to data quality and trust between patients and providers. The HIPAA regulatory framework is a strong basis for protecting the privacy and security of health data held by covered entities and their business associates. However, there is a gap in the protection of sensitive health information that resides in consumer-facing technologies, applications, and products that are not covered by HIPAA. States have begun to enact their own laws to ensure types of health information held by HIPAA-covered and non-HIPAA-covered entities are protected, with some states implementing stronger protections than others, but this has led to a patchwork of laws that creates a compliance burden for healthcare organizations. In the absence of a national privacy law or framework that addresses health information within and outside of traditional healthcare environments, healthcare organizations struggle to comply with contradictory and/or overlapping protections. This is especially true for larger health systems that serve multiple states, or smaller healthcare organizations that may not have the resources to comply with conflicting requirements.

Recommendations for CMS to Drive Improvement in Health Information Quality and Usability

Data quality, integrity, and interoperability. To foster strong data quality and integrity in healthcare, it is crucial to implement policies that promote data completeness, including consistent data standards for content, mapping, and documentation, while also encouraging the accuracy and timeliness of health data. CMS should consider conducting a survey to assess workflows, data governance processes, and barriers to data quality and sharing to understand shared industry challenges and successes. Furthermore, policies should promote the adoption of technologies that support high-quality data collection and support incentives for workforce development to maintain data quality and integrity as technology evolves. AHIMA encourages CMS to explore methods to drive better data quality and usability across payers, which may include positive incentives to drive data standardization to reduce the level of variability when exchanging data. Additionally, AHIMA encourages CMS to collaborate with ASTP/ONC to consider including standardized fields as part of the Health IT Certification Program to ensure a base level of standardization across EHRs.

Patient misidentification. The development and adoption of a nationwide, public-private sector patient identification strategy is crucial to ensuring complete, accurate, and quality health information for all patients. Such a framework should include standardized demographic data elements and policies across various care settings and IT systems. The framework should consider underlying and fundamental data integrity and quality processes and practices, as well as the adoption and implementation of technology that could improve patient identification, including associated costs and workflow reorganization. Throughout the development, implementation, and use of a national patient identification strategy, new standards and approaches to mitigate patient identification errors and improve data quality must recognize the operational expertise of HI professionals in understanding how health information flows through the healthcare system.

AHIMA encourages CMS to continue working with ASTP/ONC on initiatives to address these challenges, such as promoting improvements to and use of the United States Core Data for Interoperability (USCDI), to ensure

[10]Available at: https://patientidnow.org/wp-content/uploads/2025/05/FY26-Patient-ID-Now-Letter-to-House-Appropriators-onRepeal-of-Section-510-1.pdf.

healthcare organizations are collecting data in standardized ways to improve interoperability and exchange. The USCDI has been integral to the standardization of available data elements within certified health IT products. However, many elements within the current version of USCDI (e.g., first name, last name, and date of birth) do not have standards that dictate how these data should be entered, causing variation across systems and challenges in data usability and care coordination. Thus, additional standards and research are needed to improve and evaluate USCDI. These challenges led to the introduction of HR 2002, the Patient Matching and Transparency in Certified Health IT (MATCH IT) Act of 2025. AHIMA encourages the Administration to continue to address patient identification and matching through improving definitions and standardization, including standardization within USCDI.

Privacy. Any privacy policy framework must guarantee individuals' access to their health information. A regulatory framework must ensure that data holders develop, document, communicate, and are held accountable for their privacy policies and procedures, while also limiting the collection, use, and disclosure of health information to what is minimally necessary in accordance with HIPAA. CMS, in collaboration with ASTP/ONC and OCR, should consider providing guidance and best practices to healthcare organizations in proper retention, disposition, and destruction of health information when appropriate, and how best to implement oversight and enforcement responsibilities. CMS should also consider areas where it can provide support and flexibility for organizations to safeguard data privacy and address cybersecurity threats and attacks, particularly for small, rural, and otherwise under-resourced entities.

AHIMA supports the existing HIPAA framework to protect the privacy of patients and consumers when health information is held by HIPAA-covered entities and business associates. However, there is a rise in consumer-facing applications and technologies that ingest health data outside the scope of HIPAA that could jeopardize data privacy, quality, and integrity. While HIPAA protects health information held by covered entities, when health information is exported from a HIPAA-covered entity's technology (such as a patient portal) and incorporated into a consumer-facing app or technology, the information is no longer protected. AHIMA believes a national privacy framework should be established at the federal level for privacy and security requirements for health data held by HIPAA-non-covered entities to ensure patient health information held by non-HIPAA-covered apps and technologies is protected.[11] This will reduce confusion and uncertainty around the security of health information in any environment and improve compliance with privacy standards, as varying federal statutes have different requirements around privacy which adds to complexity and compliance burden. A strong privacy environment for these non-HIPAA covered activities will also support CMS' Interoperability Framework by expanding patient and provider trust in applications that assist patients in taking more control of their health data. While congressional action is required to establish a national data privacy framework, AHIMA encourages CMS to work with Congress to consider situations in which health information is transmitted to HIPAA non-covered entities and how a national data privacy framework could offer protection. In the meantime, CMS should collaborate with ASTP/ONC on resources for providers to better educate patients on the privacy risks associated with HIPAA non-covered technologies and applications.

The HIPAA Security Rule requirements are also critical to ensuring the security of an individual's health information. However, these requirements are not adequately funded and the lack of flexibility in the number of compliance pathways poses barriers to compliance for smaller organizations. Without resources and assistance, covered entities may have no choice but to prioritize the requirements they are financially able to implement. AHIMA recommends CMS consider approaches to work with OCR to provide funding, resources, guidance, and

[11]Available at: https://www.ahima.org/media/zxgl0cal/ahima-privacy-and-security-rfi-response-1.pdf.

education for covered entities and business associates on how to best implement current and future HIPAA Security Rule requirements to reduce compliance burden.

Workforce support and engagement. HI professionals require resources and support in operationalizing best practices in data quality and integrity. While some organizations have training on data governance and quality, many organizations are limited in resources to do so. AHIMA stands ready to partner with CMS and ASTP/ONC to provide industry education and resources to healthcare providers on best practices related to data quality, literacy, and governance to ensure all healthcare organizations, regardless of size, financial resources, or geographic location, can confidently establish baseline data policies that are industry aligned. Such education and resources should be flexible and routinely evaluated to accommodate evolving technology. This should include training for clinical and business informaticists, tasked with building workflows that understand the importance of data reporting, which could include best practices in standardizing data entry fields and reducing reliance on free-text inputs to promote as standardization. In any policy development, we welcome the opportunity to engage with CMS and HHS to improve data quality and usability in our healthcare system. As HI professionals face a growing set of federal mandates, AHIMA encourages CMS to consider areas where documentation requirements can be standardized and streamlined across quality reporting programs to reduce burden and enable healthcare organizations to focus on collecting quality patient health information that is usable and shareable.[12] AHIMA encourages CMS to include HI professionals in the different phases of policy development, including real-world testing of new initiatives before mandating in policy to ensure programs are functioning as intended with minimal burden, which will save the healthcare industry valuable resources over time.[13]

Importance of the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT

As CMS continues to work on strategies and policies to promote high-quality health information, AHIMA encourages CMS to continue collaboration with ASTP/ONC. A strong, resourced ASTP/ONC is critical to the success of HHS initiatives to enhance the health and well-being of all Americans and ensure health information is high-quality and accessible for patients and clinicians. In its two decades of existence, ASTP/ONC has implemented programs to promote the quality and interoperability of patient health data, created avenues for end-users to participate in the standards development process, and pursued new avenues to reduce administrative burden on end-users while improving the exchange of data between providers and payers. These initiatives are crucial as health information is more important than ever in coordinating patient care to improve care outcomes.

Thank you for the opportunity to comment on the CY 2026 PFS proposed rule. If AHIMA may 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 Sue.Bowman@ahima.org or Tara O'Donnell, manager, regulatory affairs, at Tara.ODonnell@ahima.org.

Sincerely,

Lauren Riplinger, JD
Chief Public Policy & Impact Officer

[12]Available at: https://hitenduser.org/hit-end-users-alliance-releases-2024-2027-collaborative-roadmap/.
[13]Available at: https://hitenduser.org/wp-content/uploads/2022/09/Real-world-testing-consensus-statement_FINAL.pdf.