American Health Information Management Association
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June 2, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and 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) fiscal year (FY) 2027 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule published in the April 14, 2026 *Federal Register* (CMS-1849-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 IPPS proposed rule.

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

1. Antibiotic-eluting Bone Void Filler

In MDCs 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) and 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), CMS proposes to redesignate ICD-10-PCS procedure code XW0V0P7 (Introduction of antibiotic-eluting bone void filler into bones, open approach, new technology group 7) from a non-O.R. procedure to a non-O.R. procedure, and to reassign cases reporting this procedure code from the lower severity level to the higher severity level, for specified MS-DRGs. If these proposals are finalized, and if a new procedure code for the introduction of vancomycin-eluting bone void filler is approved as was proposed in the Spring 2026 ICD-10-PCS code update, we recommend that this new procedure code also be designated as a non-O.R. procedure affecting MS-DRG assignment and be assigned to the same MS-DRGs as code XW0V0P7. The MS-DRG assignments for both codes describing antibiotic-eluting bone void fillers should be consistent.

2. SDOH – Homelessness, Inadequate Housing, and Housing Instability

CMS proposes to change the severity level designation of ten social determinants of health (SDOH) Z codes related to homelessness, inadequate housing, and housing instability from complication or comorbidity (CC) to non-complication or comorbidity (NonCC).

AHIMA opposes the proposed change of severity level designation from CC to NonCC for the codes related to homelessness, inadequate housing, and housing instability. We supported the changes in previous IPPS proposed rules from NonCC to CC for these codes and continue to believe that they are valuable to hospitals gaining insight into how homelessness, inadequate housing, and housing instability can impact both patients' clinical complexity and health outcomes, and increase hospital resource use.[1] In the proposed rule, CMS states the categorization of a diagnosis code as an MCC, CC or NonCC should recognize the clinical complexity and expected resource consumption for the treatment of an underlying medical condition or illness. However, a patient's housing status does impact the clinical complexity of their medical state and over time increases resource consumption.

Only 20 percent of patients' health is related to access to care and quality of healthcare services, with around 80 percent of patients' health determined by societal factors, including housing status.[2] The US Centers for Disease Control and Prevention (CDC) indicates people experiencing homelessness are at increased risk for diseases, and commonly face mental illness, substance use disorder, diabetes, and heart and lung disease, all of which are exacerbated by inadequate housing or homelessness in a cyclical nature.[3] Further, CMS has consistently highlighted evidence in previous years discussing the impact of homelessness and inadequate housing on patient health, clinical complexity, and resource use.

CMS noted in the FY 2025 IPPS proposed rule that "studies and evidence suggesting that housing instability is associated with higher prevalence of overweight/obesity, hypertension, diabetes, and cardiovascular disease, worse hypertension and diabetes control, and higher acute health care utilization among those with diabetes and cardiovascular disease."[4] Additionally, in the FY 2024 IPPS proposed rule, CMS stated, "healthcare needs for patients experiencing homelessness may be associated with increased resource utilization compared to other patients due to difficulty finding discharge destinations to meet the patient's multifaceted needs which can result in longer inpatient stays and can have financial impacts for hospitals. Longer hospital stays for these patients can also be associated with increased costs because patients experiencing homelessness are less able to access care at early stages of illness, and also may be exposed to communicable disease and harsh climate conditions, resulting in more severe and complex symptoms by the time they are admitted to hospitals, potentially leading to worse health outcomes. Patients experiencing homelessness can also be disproportionately affected by mental health diagnoses and issues with substance use disorders."[5] The preservation of these Z codes as CC would accurately represent the impact housing status can have on patients' clinical complexity and the resource use associated with addressing these risk factors and secondary health issues.

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:

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[1]Available at: https://www.ahima.org/media/dokdnk24/ahima-final-comments-fy-25-ipps-proposed-rule.pdf.
[2]Available at: https://www.commonwealthfund.org/blog/2023/lets-get-it-right-consistent-measurement-drivers-health.
[3]Available at: https://www.cdc.gov/homelessness-and-health/about/index.html.
[4]Available at: https://www.federalregister.gov/documents/2024/05/02/2024-07567/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient.
[5]Available at: https://www.federalregister.gov/documents/2023/08/28/2023-16252/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.
[6]Available at: www.dataforbetterhealth.com.

- 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 an 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 appropriate and accurate data collection of codes related to homelessness, inadequate housing, and housing instability, to inform improved assessments of patients' clinical complexity and anticipated hospital resource use. 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 and overall health, including data on patients' housing status.

3. Prolonged First Stage (of Labor)

In response to a request CMS received to change the severity level designation of ICD-10-CM diagnosis code O63.0 (Prolonged first stage (of labor)) from a NonCC to a CC, CMS proposed maintaining the current severity level designations of both codes O63.0 and O63.9 (Long labor, unspecified). Since code O63.9 is an unspecified code and it is the only code in category O63, Long labor, that is currently designated as a CC, **we recommend that CMS evaluate all of the codes in category O63** to determine if the severity level designation of any of the more specific codes in this category should be changed to a CC. As stated in the *ICD-10-CM Official Guidelines for Coding and Reporting*, codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code, and specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition. CMS has acknowledged in previous IPPS rules that reporting the most specific diagnosis codes supported by the available medical record documentation and clinical knowledge of the patient's health condition would more accurately reflect the health care encounter and improve the reliability and validity of the coded data.

IX. Proposed Quality Data Reporting Requirements for Specific Providers

F. Proposed Changes to the Medicare Promoting Interoperability Program

4. ONC Health IT Certification Program Proposed Updates Relevant to the Medicare Promoting Interoperability Program

CMS proposes to revise the definition of certified electronic health record technology (CEHRT) by removing certification criteria that has been proposed for removal in the Office of the National Coordinator for Health Information Technology (ONC) HTI-5 proposed rule.

AHIMA supports CMS' intention to promote regulatory alignment by removing references to certification criteria that would be removed from the ONC Health IT Certification Program via the HTI-5 proposed rule. We support consistency in definitions of terms like CEHRT across all the HHS programs eligible hospitals and CAHs participate in and comply with. However, we feel this proposal is premature and we urge CMS to wait for ONC to finalize the HTI-5 policies prior to taking any concordant action in the Promoting Interoperability Program to support

consistency and predictability in compliance across HHS programs. If the ONC HTI-5 final rule does not include the removal of those criteria, these proposed policies within the Promoting Interoperability Program will cause confusion in efforts for compliance.

In the rule, CMS states it believes the longstanding presence of some of these criteria, including the "family health history" and "patient health information capture" criteria, are fully embedded into certified health IT and widely available and used, thus warranting their removal from the Certification Program with the understanding developers will continue to offer those functionalities in their products. As we indicated in our comments to ONC on the HTI-5 proposed rule, there is no guarantee these functionalities will continue to be offered as part of the health IT product.[7] If finalized, these proposed removals create the ability for health IT developers to charge provider organizations for the inclusion of these functionalities, shifting cost burden onto the provider community. We urge CMS to refrain from finalizing the removal of these criteria from the definition of CEHRT at this time.

5. Proposal To Remove ONC Direct Review and ONC-ACB Surveillance Attestations

CMS proposes to remove the required ONC Direct Review Attestation measure and the optional ONC-Authorized Certification Bodies (ONC-ACB) Surveillance Attestation measure beginning with the EHR reporting period in CY 2026.

AHIMA supports the proposed removal of these two measures to reduce unnecessary reporting and administrative burden, as long as these processes continue to exist and are required under the purview of ONC. The ONC Direct Review and ONC-ACB Surveillance processes are robust, comprehensive, and necessary safeguards to monitor developers' adherence to requirements, mitigate issues with health IT products, and provide assurances to healthcare providers that CEHRT functions as intended. We encourage CMS to continue to support ONC in upholding and strengthening these direct review and surveillance activities to ensure the integrity and performance of certified health IT for entities participating in the Promoting Interoperability Program.

6. Proposal To Remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures

CMS proposes to remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures beginning with the CY 2028 EHR reporting period.

AHIMA supports the goals of the Health Information Exchange Objective to promote data sharing, care coordination, and interoperability, and the measures within that provide choice to eligible hospitals and CAHs to fulfill the measure. We however oppose CMS' proposal to remove the electronic referral loops measures given CMS' observation that 26.6 percent of eligible hospitals and CAHs use these measures to fulfill the objective, and they are still widely used functionalities in healthcare. It is important for CMS to continue to support this measure as it is important to maintaining the interoperability floor. While a majority of the healthcare system may use alternative means to meet this measure, nationwide interoperability is only as strong as the least capable party within a data exchange conversation. Removing this objective will signal that HHS endorses a move away from the technologies used to meet these requirements, jeopardizing that floor.

[7]Available at: https://www.ahima.org/media/04aegclb/astp-onc-hti-5-ahima-comments-final-2.pdf.

The electronic referral loops measures rely on ONC Health IT Certification Program criteria that are based on the Consolidated Clinical Document Architecture (C-CDA) standard, and enable entities to send, receive, and reconcile summary of care records. As previously stated, while we understand CMS' intention to remove these measures and references to certification criteria proposed to be removed or descoped in the ONC HTI-5 proposed rule, we believe these proposals are premature given the proposed state of those policies, the current level of industry use of these measures, and the continued prevalence of the C-CDA standard.

Removing C-CDA functionality without understanding the readiness and ability of healthcare organizations to support routine use of the other HIE bi-directional exchange and TEFCA measures jeopardizes ongoing nationwide interoperability. Finalization of this proposal in both the ONC Certification Program and Medicare Promoting Interoperability Program will prevent patient information from traveling to where it needs to be, when it needs to be there. Due to the cost of HL7® Fast Healthcare Interoperability Resources (FHIR) implementation and its lack of widespread adoption at this point, C-CDA is often used by under resourced provider organizations and HI professionals to support participation in nationwide data exchange. Removing C-CDA-supported criteria from the Certification Program and in turn the Promoting Interoperability Program would open the possibility for health IT developers to charge provider organizations for the use of C-CDA, as well as the new FHIR APIs. This would further stretch provider organizations by potentially requiring them to pay for already used technology. C-CDA today is the technology that maintains the highest adoption rate for providers to enable the sharing of patient health information. While AHIMA agrees with ONC and CMS that the health system must look to new, innovative technologies for data sharing, innovation cannot happen in a vacuum with no alternate means for patient data to be moved easily in a trusted manner. Thus, we caution CMS on the premature proposed removal of these electronic referral loop measures.

If finalized, AHIMA urges CMS to provide a later implementation date to allow the remaining providers using the electronic referral loops measures more time to transition to implement and comfortably use the HIE bi-directional exchange or TEFCA measures. While developers might be ready with this technology and functionality in their product offerings, smaller or otherwise lesser resourced entities may not have as much time, resources, and staff to implement capabilities for HIE bi-directional exchange. Further, TEFCA is still very new for most entities, with just over four percent of entities using the TEFCA measure. We encourage CMS to provide support, resources, flexibility, a longer timeframe, and consider the costs associated for entities that would need to switch from using the electronic referral loops measures to the HIE bi-directional exchange or TEFCA measures. CMS may consider providing flexibility through an exception or longer transition period for smaller and lower-resourced entities.

7. Proposed Updates to the Electronic Prior Authorization Measure

CMS proposes to modify the Electronic Prior Authorization measure by revising language in the measure description and by making the measure optional for 10 bonus points in CY 2027. If finalized, CMS proposes making the measure required in CY 2028.

AHIMA appreciates CMS' attentiveness to the healthcare industry's progress on implementing policies finalized under the 2024 CMS Patient Access and Interoperability Final Rule. As is well known, the healthcare industry's implementation of the required application programming interfaces (APIs) and implementation guides (IGs) to enable prior authorization workflows for providers is taking more time than anticipated. We agree with CMS that, while work on implementation is underway, the community needs more time to implement and test the prior authorization APIs, modify workflows, update policies, and train staff. According to the most recent Workgroup for Electronic Data Interchange (WEDI) industry survey, one-third of providers have yet to start implementation and

only 13 percent of payers report being at or near completion of implementation.[8] We appreciate the flexibility proposed in making the measure optional in CY 2027 but we urge CMS to refrain from proposing or finalizing any policies to make the measure required. We believe CMS should continue to follow the progress of the industry's implementation of the APIs and IGs as payers and developers of certified health IT may need more time beyond CY 2028 to test, implement, and provide these functionalities. Eligible hospitals and CAHs depend on their EHR vendors and health plans they work with to be able to successfully report on this measure, so efforts at this time are best spent working on propping up the capabilities on the developer and plan side rather than moving towards required attestations on the provider side. A shorter timeline of required reporting in CY 2028 will not spur quicker implementation.

The FHIR standard is still not mature enough to test robustly and there has not been enough testing to verify if these FHIR standards, APIs, and IGs for prior authorization would work in all real-world settings. While AHIMA supports moving the industry towards use of the FHIR standard, it is still an actively maturing standard, and we encourage CMS to refrain from any measures that require the successful use of FHIR until FHIR is fully developed, tested, and implemented. We appreciate the flexibility in the proposal to make the measure optional, but we believe it should remain optional for the time being. AHIMA supports making the measure optional to provide CMS and ONC insight into industry adoption of electronic prior authorization as providers voluntarily report on this measure, and we urge CMS to focus efforts on payer and developer capabilities in the meantime. We encourage CMS to coordinate with ONC and work with the health IT vendor and payer communities to ensure that any new technical standards and/or capabilities that providers are required to report on are operational, scalable, and usable prior to provider implementation and required reporting in the Promoting Interoperability Program.

Thank you for the opportunity to comment on the proposed rule. AHIMA continues to stand as a partner to CMS in improving meaningful policies to improve data exchange and patient health outcomes within the IPPS and LTCH PPS, including the Medicare Promoting Interoperability Program. If you have any questions or would like to discuss our recommendations further, please contact Sue Bowman, senior director of coding policy and compliance, at Sue.Bowman@ahima.org, or Tara O'Donnell, manager of regulatory affairs, at Tara.Odonnell@ahima.org.

Sincerely,

Lauren Riplinger, JD
Chief Public Policy and Impact Officer

[8]Available at: https://www.wedi.org/2026/03/11/wedi-survey-shows-progress-in-implementing-cms-interoperability-and-prior-authorization-final-rule/.