



January 27, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9911-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

Dear Secretary Becerra and Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 133,500 family physicians and medical students across the country, I write in response to the [proposed rule](#) on the 2023 Notice of Benefit and Payment Parameters as published in the January 5, 2021 version of the *Federal Register*. The AAFP shares the Department of Health and Human Services' (HHS') commitment to improving access to comprehensive, affordable health coverage for all and believes many of the policies in the proposed rule will also facilitate equitable access to comprehensive primary care. It is with these goals in mind that we offer the following comments on the proposed rule.

Guaranteed Availability of Coverage: Past Due Premiums

HHS proposes to reinstate the previous interpretation of the guaranteed availability requirement to state that an issuer may not apply any premium paid for new coverage (in the same or different plan or product) to any outstanding debt owed from any previous coverage and then refuse to effectuate the new enrollment based on the failure to pay premiums. HHS is concerned that the current interpretation, which allows issuers to apply premiums paid to past due premiums and permits them to refuse to effectuate coverage, may be creating a barrier to comprehensive coverage for low-income enrollees, including those eligible for advanced premium tax credits (APTC). HHS also indicates that the current policy may disincentivize enrollment in health coverage, ultimately increasing the rate of uninsurance and worsening health disparities. The AAFP shares HHS' concerns and supports the proposal. We strongly believe that all individuals should have affordable access to comprehensive health care coverage and this proposal would advance this shared goal.

Nondiscrimination Based on Sexual Orientation and Gender Identity

HHS proposes to amend existing regulations to explicitly prohibit a health insurance issuer and its officials, employees, agents, and representatives from discriminating in its marketing practices or benefit designs on the basis of sexual orientation and gender identity. **The AAFP strongly supports this proposal.** We [opposed](#) previous regulations that weakened non-discrimination protections for individuals who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals and [urged](#) President Biden to take swift action to restore these protections once he took office. The AAFP

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agrees that these protections are vital and will help ensure LGBTQ+ individuals can access gender affirming and other evidence-based, inclusive care.

HHS further proposes to refine nondiscrimination requirements by requiring plan limits and coverage requirements to be based on clinical evidence in order to qualify as a plan providing essential health benefits (EHB). HHS proposes to define a nondiscriminatory benefit design that provides EHB as one that is clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources. HHS specifically cites the AAFP as one source of reputable, evidence-based practice guidelines that should be used. HHS believes creating this standard will ensure all enrollees are able to access covered benefits fairly.

HHS noted that it would monitor whether insurers are incentivizing certain methods of delivery, such as telehealth, to ensure these policies are not inadvertently resulting in discrimination. CMS indicates in the proposed rule that the source of the discriminatory benefit design is immaterial and therefore an insurer could not justify discriminatory practices using the state's EHB-benchmark or a state benefit mandate.

HHS provides a number of examples of presumptively discriminatory practices that HHS believes amount to discrimination. The examples included age restrictions or limits on various services, limitations on certain services for those with a specific diagnosis, benefit designs that restrict coverage of EHB due to gender identity, and adverse drug tiering.

The AAFP is supportive of this regulatory framework and believes that requiring EHB benefit [design](#) to be based on clinical evidence will improve equitable, timely, and affordable access to evidence-based care. The AAFP [supports](#) access to gender-affirming care for LGBTQ+ patients and recognizes gender-affirming health care as part of comprehensive primary care for many gender-diverse patients, including supportive behavioral health care, gender-affirming hormones, puberty blockade, medical procedures, and surgical interventions.

The Academy recommends HHS clarify in the final rule that the requirement for EHB benefit design to be based on clinical evidence also applies to utilization management processes, such as step therapy and prior authorization. Evidence indicates that prior authorization requirements may be discriminatory and worsen health disparities, as documented in one study examining access to treatment for HIV pre-exposure prophylaxis and a white paper which examined the disproportionate impact of prior authorization requirements on cardiovascular care for Black and other patients of color.^{1,2} We are concerned that the unnecessary increase in prior authorization requirements, even among evidence-based, medically necessary services and medications, is creating barriers to care that disproportionately impact medically underserved patients, patients of color, those identifying as LGBTQ+, and those at-risk for poor health outcomes. We urge HHS to

¹ McManus KA, Powers S, Killelea A, Tello-Trillo S, Rogawski McQuade E. Regional Disparities in Qualified Health Plans' Prior Authorization Requirements for HIV Pre-exposure Prophylaxis in the United States. *JAMA Netw Open*. 2020;3(6):e207445. doi:10.1001/jamanetworkopen.2020.7445

² Association of Black Cardiologists. Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients. Available at: <http://abcario.org/wp-content/uploads/2019/03/AB-20190227-PA-White-Paper-Survey-Results-final.pdf>

clarify that utilization requirements can create discriminatory barriers to covered services and conduct oversight to address discriminatory practices.

The AAFP is strongly supportive of permanently expanding equitable, affordable access to telehealth services. However, the AAFP [believes](#) telehealth is best utilized when it is provided within the context of the medical home and utilized as a component of, and coordinated with, longitudinal care. The Academy thanks HHS for noting that benefit designs incentivizing enrollees to seek telehealth services instead of in-person services, including by offering to waive co-pays for telehealth services provided by a telehealth vendor, could be inadvertently discriminatory. We are similarly concerned that this type of benefit design could result in care fragmentation and disproportionately disadvantage low-income enrollees, those lacking access to transportation, or other populations at-risk for poor health outcomes. As such, HHS should ensure that issuers are not steering enrollees away from primary care physicians in favor of direct-to-consumer telehealth providers.

Copay Accumulators

Copay assistance is a lifeline, allowing many individuals to access critical, life-saving medications. Over the years, insurers have shifted more costs to enrollees, with higher deductibles and increasing coinsurance. As a result, many people with chronic health conditions, especially those who rely on specialty medications, have had to seek financial help to cover the cost of prescription drugs. While many individuals will never hit an out-of-pocket limit of \$9,100 (the proposed amount for 2023), people requiring chronic health conditions may have to pay this amount every single year, often in the first few months of the year. For many individuals with chronic health conditions, copay assistance is often the only way they can afford the medication they need, even if they have insurance. The proposed rule HHS directly addresses the issue of discriminatory benefit design, intending to ensure that insurance plans do not discriminate against people living with chronic illness through adverse tiering schemes. While we support HHS' intention to ensure that benefit design reflects clinical evidence rather than an effort to discriminate against people with high health care needs, we also strongly recommend HHS include language in this section also prohibiting use of copay accumulator adjustment policies, which discriminate against people living with chronic illness.

Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers or qualified employees enrolling in QHPs

HHS proposes a number of modifications to improve transparency of brokers and conduct additional oversight of their activities. We support the additions to this section, especially since agents, brokers and web-brokers have not been required, unlike navigators funded by marketplaces, to provide accurate and unbiased information to individuals.

Currently, web brokers in the federally facilitated marketplace are required to display all plans available to a consumer in their rating area. Web brokers display the plans they support enrollment in – generally, those that pay commissions – but display only the insurer, plan name and type, and metal tier for those they do not sell, along with a disclaimer that more information can be found at HealthCare.gov. The lack of additional comparative information, such as the premium and deductible, hinders consumers' ability to make meaningful comparisons between plans. The proposed rule specifies additional plan elements that must be displayed when a web broker facilitates enrollment in a plan and, for web brokers that do not, changes the disclaimer to specify that *enrollment*, not just more information, is available at HealthCare.gov. This change is a positive step but does not go far

enough to allow consumers to compare plans. For example, HHS could direct web brokers to display unsupported plans in their cost comparison tools instead of segregating them at the bottom of the page. We support other important provisions that are included in the proposed rule to improve transparency for consumers. The rule would prohibit advertising or other fee-based preferential displays of plans and require web brokers to explain their rationale and methodology for recommending a plan to a consumer.

The proposed rule would also tighten the standards of conduct for agents, brokers, and web brokers to further protect consumers and give HHS additional grounds for enforcement. We support the proposals and urge HHS to dedicate the funding necessary to support monitoring and enforcing compliance with these and all agent, broker, and web broker standards.

Annual Eligibility Redetermination

Following annual enrollment, when enrollees do not select a new plan for the following year, HHS uses an established hierarchy to automatically enroll them in a similar plan. HHS solicits comments on incorporating the net premium, out-of-pocket costs, out-of-pocket maximum, and deductible of a plan into the re-enrollment hierarchy, as well as additional criteria or mechanisms HHS should consider, to ensure the hierarchy aligns with plan generosity and consumer needs.

The AAFP supports incorporating the net premium, out-of-pocket costs, out of pocket maximum, and deductible into the re-enrollment hierarchy. We believe these factors are important for ensuring affordability. We recommend HHS consider an additional criterion to ensure patients' established primary care physician will continue to be in-network during the following plan year. This will facilitate continuous access to longitudinal, whole-person care and help ensure re-enrollment doesn't disrupt the patient-physician relationship.

Issuer Use of Premium Revenue: Reporting and Rebate Requirements

Federal law requires health insurance issuers offering group or individual health insurance coverage to separately report the percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees, for activities that improve health care quality, and on all other non-claims (administrative) costs. This is used to determine an issuer's medical loss ratio (MLR). Issuers are then required to provide an annual rebate to each enrollee if the issuer's MLR falls below the established MLR standard.

Issuers are required to report bonus or incentive payments made to clinicians, hospitals, and health systems for activities to improve health care quality. While conducting MLR examinations, HHS has found some issuers reporting incentive or bonus payments to clinicians or health systems that are not based on quality or performance metrics and instead involve transferring excess premium revenue to hospitals, health systems, or even a non-clinical holding company to avoid paying MLR rebates.

To address this, HHS proposes to amend existing regulations to clarify that only those provider incentives and bonuses that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes. The AAFP supports this proposal. We've long

supported MLR policies that help ensure health care finances are focused on patient care rather than insurer profits.

Verification of Eligibility for Special Enrollment Periods

Pre-enrollment verification of eligibility for special enrollment periods is conducted by Exchanges (both state-based and those on the federal platform) in order to ensure new enrollees meet the necessary criteria to enroll during an SEP. This process usually includes requiring the potential enrollee to submit supporting data or materials to show they are eligible, which can be burdensome and create delays in coverage.

HHS proposes to provide State-based Exchanges (SBEs) additional flexibility to conduct pre-enrollment verification for SEPs at the option of the SBE and allow SBEs to provide an exception to pre-enrollment verification for special circumstances (e.g., public health emergencies or natural disasters). CMS further proposes that the Exchanges on the Federal platform would only conduct pre-enrollment verification of SEP eligibility for the loss of minimum essential coverage. In making these proposals, HHS presents evidence that pre-enrollment verification may worsen racial inequities, create coverage delays, and worsen risk pools. HHS believes conducting pre-enrollment verification for only the minimum essential coverage SEP, which comprises the majority of SEP enrollments, will help minimize the negative impacts of this process on coverage without threatening program integrity.

The AAFP supports the proposal to limit pre-enrollment verification on the federally-facilitated exchanges. HHS presents convincing evidence that pre-enrollment verification may have a variety of negative impacts on equitable access to continuous coverage and market stability. We believe this proposal could improve continuous coverage and facilitate access to primary care for those enrolling through SEPs. The AAFP is concerned that HHS proposes to permit SBEs to potentially implement broader pre-enrollment verification requirements. We urge HHS to monitor SBEs' use of pre-enrollment verification to ensure it is not used in a discriminatory manner or with the goal of undermining access to coverage. To remove barriers to enrolling in coverage, HHS should consider limiting SBEs' flexibility or eliminating pre-enrollment verification in future rulemaking.

Network Adequacy and Essential Community Providers

Time and Distance Standards

For the plan certification cycle for plan years beginning in 2023, HHS proposes to reinstate time and distance standards. Time and distance standards would be calculated at the county level and vary by county designation to account for variations in population size and density. The standards would apply to the specialty lists outlined in the proposed rule. Issuers that are unable to meet the specified standards would be able to submit a justification to account for variances, which HHS would review to determine whether the variances are reasonable and if it would be in the interest of qualified individuals and enrollees to offer the plan through the federally facilitated exchanges (FFE).

The AAFP supports the proposal to reinstate time and distance standards. We appreciate that HHS has modified the proposals and specialty lists to account for unique considerations in the qualified health plan (QHP) market. The AAFP has long supported minimum federal network adequacy standards in order to facilitate timely, equitable access to comprehensive primary care and other services.

While we understand that HHS is using “behavioral health” to include both mental health and substance use disorder (SUD) treatment services, the AAFP is concerned that, without further specification, enrollees may experience challenges accessing in-network SUD treatment services. We note that many family physicians provide buprenorphine treatment in their practices, often serving as the only source of outpatient SUD treatment in their communities. Time and distance standards should recognize the availability of SUD treatment in primary care clinics and also acknowledge the limited capacity these practices have to take on new patients due to regulatory and other requirements. The AAFP recommends HHS separately monitor time and distance to both inpatient and outpatient SUD treatment services and consider implementing separate standards for SUD treatment in future rulemaking.

Appointment Wait Time Standards

HHS also proposes to adopt appointment wait time standards to assess whether QHPs offered through FFEs fulfill network adequacy standards. Appointment wait time standards would be assessed for behavioral health services, routine primary care services, and non-urgent specialty care services. The specific parameters for appointment wait times, if finalized, would be detailed in future guidance. Issuers applying for FFE QHP certification would need to attest that they meet the standards. HHS would conduct compliance reviews in response to access to care complaints or through random sampling. **The AAFP supports this proposal and agrees that appointment wait times are an important component of health care accessibility.**

Maintaining a robust network of primary care physicians and ensuring timely access to routine primary care are foundational components of comprehensive health coverage. Patients often first seek care for an acute or chronic issue with their primary care physician and most rely on them completely for recommended preventive services. Existing appointment wait time standards for routine primary care vary across plans and coverage types. We’ve found that a 10-day maximum standard wait time is relatively common and we believe an appropriate maximum wait time in many areas.

HHS should consider implementing different appointment wait time standards for SUD treatment services and other behavioral health services. The Department should, at a minimum, measure appointment wait time separately. Given the well documented lack of SUD treatment providers, the importance of care continuity throughout SUD treatment, and the potential harm that could be caused by long appointment wait times, we believe different standards may be needed to ensure equitable access to SUD care for QHP enrollees.

HHS seeks comments on other ideas and standards to strengthen network adequacy policy in future years and on possible methods to collect and analyze claims data to inform future network adequacy standards. The AAFP recommends HHS consider measuring the availability of integrated behavioral health services in primary care. Integrating behavioral health services into primary care can improve enrollees’ access to and utilization of needed behavioral health services, can help mitigate disparate access to behavioral health clinicians, and has shown significant cost-savings for payers and

physicians.^{3,4} In considering this for future standards and measurement, we note that integrated behavioral health services are not yet defined but can include consistent coordination of referrals and exchange of information, colocation of services in the primary care setting, or full integration of treatment plans shared between primary care and behavioral health clinicians. In order to effectively measure access to integrated behavioral health services or create a futures standard, HHS will need to work with stakeholders to outline what level of integration is required. The AAFP stands ready to work with HHS to advance access to and measurement of integrated behavioral health services.

Tiered Networks

HHS proposes that, for plans that use tiered networks, to count toward the issuer's satisfaction of the network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. The AAFP supports this proposal and agrees this will facilitate access to affordable care for QHP enrollees.

Telehealth

HHS proposes to require all issuers seeking certification of plans to submit information about whether network providers offer telehealth services, beginning in the 2023 plan year. HHS notes issuers should not construe this proposal to mean that telehealth services could be counted in place of in-person service access for the purpose of network adequacy standards. HHS seeks comments on how to incorporate telehealth availability into network adequacy standards in future plan years. Specifically, HHS seeks comments on whether it should align with the Medicare Advantage telehealth approach, in which issuers are offered a credit towards meeting time and distance standards.

The AAFP supports the proposal to require issuers to report whether network providers offer telehealth services. We agree this information would be beneficial to HHS and other stakeholders and could be helpful in developing future network adequacy policies. For example, HHS may want to monitor the availability of in-network telehealth services that are provided by or integrated with enrollees' usual source of care to ensure equitable access within the Exchanges.

The AAFP strongly recommends against providing issuers with credit toward time and distance standards for direct-to-consumer telehealth services. These types of telehealth providers cannot serve as a substitute for comprehensive, longitudinal, person-centered primary care. Clinicians providing telehealth services should only be included in network adequacy calculations if the clinician is also providing in-person care in the network.

Network Adequacy in State Exchanges

³ Ross, K.M., Klein, B., Ferro, K. *et al.* The Cost Effectiveness of Embedding a Behavioral Health Clinician into an Existing Primary Care Practice to Facilitate the Integration of Care: A Prospective, Case–Control Program Evaluation. *J Clin Psychol Med Settings* **26**, 59–67 (2019). <https://doi.org/10.1007/s10880-018-9564-9>

⁴ SY, L.-T., J, E., D, C., & PY, C. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. *Psychiatric Services (Washington, D.C.)*, 69(6), 628–647. <https://doi.org/10.1176/APPI.PS.201700382>

HHS seeks comments on network adequacy in states with State Exchanges. These Exchanges are regulated by the state and would not have to comply with the aforementioned network adequacy standards for FFEs. HHS notes that in 2022 there will be 21 State Exchanges with differing network adequacy standards and policies and wonders whether, given the proliferation of narrow networks, a more coordinated, national approach is needed. The AAFP shares HHS' concerns regarding variation of network adequacy standards and policies across Exchanges. We believe it may be appropriate to provide State Exchanges with flexibility to address unique needs among their enrollee populations while also increasing standardization across Exchanges.

Essential Community Providers

Essential community providers (ECPs) include those that serve predominantly low-income and medically underserved individuals. These include family planning providers, Indian health care providers, Federally Qualified Health Centers, hospitals, Ryan White providers, and others. Regulations require QHP issuers to include a sufficient number and geographic distribution of ECPs in their networks, where available. HHS proposes to raise the ECP provider participation threshold from 20 to 35 percent of available ECPs beginning in 2023. The available ECPs are based on an HHS ECP list for each plan year, including approved ECP write-ins. HHS also proposes that, for plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standard, ECPs must be contracted within the network tier that results in the lowest cost sharing obligation. HHS seeks comment on whether and how issuers should increase the use of telehealth services as part of their contingency planning to ensure access to adequate care for enrollees who might otherwise be cared for by ECP types missing from the issuer's provider network.

The AAFP is strongly supportive of the proposal to raise the ECP threshold. We believe raising the ECP threshold will increase the number of ECPs issuers contract with is needed in light of new policies facilitating enrollment of low-income enrollees. Ensuring low-income enrollees can access high-quality services at little or no cost will help improve health outcomes and advance health equity. The AAFP also agrees that for plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standard, ECPs must be contracted within the network tier that results in the lowest cost sharing obligation.

The AAFP believes that low-income consumers seeking care from ECPs should have equitable access to telehealth services. The AAFP has supported [Medicare](#) coverage and payment for tele-mental health services and believe a telehealth-only approach to mental health may improve access without jeopardizing quality in many situations. However, we are concerned that allowing issuers to meet ECP thresholds by replacing in-person primary care services with telehealth services could create a two-tiered system for low-income enrollees and ultimately exacerbate health inequities. We urge HHS to examine alternative options for accessible, affordable in-network services for low-income enrollees while also advancing policies to increase the number of ECPs across the country.

Risk Adjustment Issuer Data Requirements

HHS proposes that issuers collect and make available for HHS' extraction five new data elements: zip code, race, ethnicity, individual coverage health reimbursement (ICHRA) indicator, and a subsidy indicator. These elements would be required as part of the risk adjustment data issuers must make

accessible to HHS in states where HHS operates the risk adjustment program, beginning with the 2023 benefit year. Submission of the ICHRA indicator would be optional for the 2023 and 2024 benefit years. For race and ethnicity, HHS proposes to require issuers to report race and ethnicity data in accordance with the October 30, 2011, HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status (2011 HHS Data Standards). Issuers would have the option of selecting “unknown” for the race and ethnicity data element.

HHS would use the data to further assess and analyze actuarial risk and risk patterns in the individual, small group, and merged markets, and determine if any refinements to the HHS risk adjustment methodology, AV Calculator, or other HHS individual or small group market programs should be proposed through notice-and-comment rulemaking. HHS believes the collections and extractions would serve the government interest of promoting equity in health coverage and care, as well as the ACA’s goal of making high-quality health care accessible and affordable to all individuals.

The AAFP supports the proposal to require issuers to report these five new data elements. We agree with HHS that this additional data is needed to understand the full impact of policies, including changes risk adjustment methodologies, as well as identify and address disparities. We support improved collection and standardization of race and ethnicity data across health programs, particularly self-reported race and ethnicity data. We agree it is appropriate to provide issuers the option to report race or ethnicity as “unknown” in the 2023 plan year, but the AAFP encourages HHS to work with other stakeholders to improve data completeness in the future, including by potentially phasing out the option to report race and ethnicity as “unknown.” We strongly recommend HHS work with patient groups and other stakeholders throughout this process.

Encouraging the Use of Z Codes

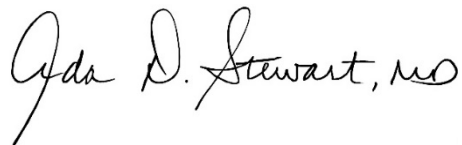
HHS seeks comments on the collection and extraction of ICD-10 z codes, particularly Z55-Z65. HHS is aware that there is inconsistent use of the codes by clinicians and is interested in ways they could encourage their use to help further assess risk in the individual, small group, and merged market risk pools. HHS also seeks comment about other data elements they should consider collecting and extracting to support the HHS-operated risk adjustment program.

The AAFP acknowledges the need for additional data on health-related social needs and social determinants of health and agrees this data could help improve risk adjustment policies on the Exchanges. We also believe that improving data collection and reporting on health-related social needs could similarly advance robust risk adjustment for physician payments, which is essential for advancing value-based care models and whole-person care. However, we are mindful that the collection of additional data, particularly via diagnosis coding and documentation, also introduces additional burden on physician practices. The AAFP suggests HHS explore ways to provide additional payment for reporting Z codes that is equitable and does not exacerbate existing disparities. For example, HHS could examine the feasibility of providing payment for screening for social determinants of health when a standardized screening tool is used in alternative payment models being tested by CMMI. While we believe it is important to provide adequate payment for collecting and reporting this information, we caution against any policy or program that would penalize physicians for not reporting Z codes.

Some family physicians report that their electronic health records (EHRs) do not support the reporting of more than a certain number of diagnosis codes, which precludes physicians from reporting z codes. HHS should develop EHR certification standards for capturing Z codes and other data related to social determinants of health. EHRs should be required to implement these standards in a manner that does not increase burden or impose additional expenses on physician practices.

Thank you for the opportunity to provide comments on the proposed rule. The AAFP looks forward to working with HHS to continue to improve health care coverage and access for all. Should you have any questions, please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aafp.org or 202-235-5126.

Sincerely,

A handwritten signature in black ink that reads "Ada D. Stewart, MD". The signature is written in a cursive, flowing style.

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

Cc: Department of Treasury
Department of Labor