August 9, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-6082-NC
Submitted electronically to: http://www.regulations.gov

Re: Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork

Dear Administrator Verma:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 165,000 other provider organizations, we appreciate the opportunity to submit comments on the *Reducing Administrative Burden to Put Patients Over Paperwork* Request for Information. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them.

Premier appreciates and supports CMS' efforts to reduce regulatory requirements that have limited clinical benefit or are not well-suited to support coordinated, patient-centered care. Premier believes that the *Patients Over Paperwork* initiative is alleviating barriers to care coordination and reducing regulatory overload. These efforts will help reduce clinician burnout and promote focus on patients. We appreciate the opportunity to submit comments on HHS' efforts to address provider administrative burden.

Access to Patient Data

Data are essential to achieve the vision of a consumer-centered and healthcare provider-driven healthcare system. Premier wholeheartedly supports expanding patients' access to their healthcare data. However, a simultaneous effort is needed to ensure that providers have unfettered access to patients' health data. Healthcare providers need data at the point of care and within workflow to deliver informed, high-quality, safe, coordinated and cost-effective care. Similar to Blue Button for patients, providers should have access to all claims for their patients, including via application programming interfaces (API). Premier applauds CMS for its efforts to advance innovation in this essential area through the *Data at the Point of Care and the Beneficiary Claims Data API* pilot programs that allow clinicians and accountable care organizations (ACOs), respectively, to access claims data. **CMS should focus additional attention and resources on the need for providers to have real time access to Medicare, Medicaid, and Medicare Advantage data at the point of care and within workflow as well as in bulk format to help them manage a population.**

42 C.F.R. Part 2 Reform

We note that 42 CFR Part 2 regulations continue to inhibit information flow. Access to a patient's entire medical record, including addiction records, ensures that certain providers and organizations, when medically necessary, have all the information necessary for safe, effective, high quality treatment and

care coordination that addresses patients' health needs. Premier has previously submitted comments about the need to align HIPAA and 42 CFR Part 2. This alignment is essential to advance and maximize the benefits of interoperability with behavioral health providers. **We again strongly recommend that Part 2 requirements should be aligned fully with the HIPAA requirements that allow the use and disclosure of patient information for treatment, payment, and healthcare operations**. The current Part 2 requirements focus on patient privacy but run counter to the goals of interoperability and care coordination. At a minimum, CMS should provide de-identified aggregate data on substance use claims to providers.

Alternative Payment Models

Providers have served as partners with CMS and the Center for Medicare & Medicaid Innovation (CMMI) in transitioning to value-based healthcare, making significant investments in infrastructure and personnel to support care redesign. The rollout of several alternative payment models (APMs) within a relatively short timeframe often results in provider confusion. The increasing number of APMs tested simultaneously by CMS elevates the need to ensure that models are complementary and can be easily interpreted by providers. Accordingly, CMS should:

- **Ensure there is a regular cycle for proposing changes, receiving feedback from participants, and finalizing changes to each APM.** The current process does not provide adequate opportunity to provide feedback to CMS on potential changes or participants to prepare for upcoming changes. CMS could employ process similar to the draft and final notices for Medicare Advantage (MA) rating setting.

- **Provide sufficient technical information when proposing new payment models to allow stakeholders to realistically evaluate payment impact.** Models often incorporate benchmarking and reconciliation processes that are both complicated and complex. Scarcity of detail discourages potential participants in voluntary payment models and imposes unfair expectations upon participants in mandatory models. Process step descriptions should be accompanied by examples using real data, allowing model participants to accurately forecast the economic consequences of such models to their institutions, clinicians and patients. **Data and examples should be made available online simultaneously with proposed models**. Further, CMS should allow organizations to apply for a national file to not only calculate individual participant performance, but also regional and national factors that often serve as benchmarks for performance.

- **Address the interaction of models, giving precedence to the total-cost-of-care (TCOC) APMs that may experience material financial harm in absence of protections.** Specifically, CMS should:
    - Provide attribution and financial reconciliation preference to longitudinal, total-cost-of-care models, which are at the greatest financial risk.
    - Allow TCOC APMs to choose if beneficiaries can be aligned to other models, for example if their beneficiaries can also be included in bundled payment APMs.
    - Reward APM entities participating in multiple risk-based models. CMS should explore options to reward providers who partner with the CMMI on multiple APMs (e.g. increased opportunity for shared savings in some models, additional flexibilities).
    - Study the impact of model overlap independently and as part of the evaluation of all CMMI models.

Immediate Jeopardy

The Immediate Jeopardy (IJ) citations of the Medicare Conditions of Participation are reserved for situations where there is an immediate threat or potential for serious injury or harm to patients. However, current IJ guidelines provide significant latitude to surveyors in interpreting the potential and likelihood of harm, leading to inconsistency among surveyors seeking to implement the guidelines. **CMS should consider revising the current IJ guidelines to provide clarity to providers and surveyors in assessing necessity for an IJ determination.**

Fraud and Abuse Waivers

CMS and CMMI have sought to promote coordination and care integration in order to improve both the quality of patient care and the efficiency with which services are delivered through quality-driven, value-based care delivery and payment models. Yet, the federal fraud and abuse legal framework and certain Medicare payment policies currently in place pose major barriers to achieving this result for patients. Moreover, APMs require provider arrangements that implicate federal fraud and abuse laws or regulatory requirements. **Premier commends HHS on current efforts to provide regulatory guidance on fraud and abuse laws that reflects the transition to value-based care**. As these efforts are advanced, Premier continues to encourage HHS to:

- Use their regulatory authority to create additional exceptions to the Stark Physician Self-Referral law, Civil Monetary Penalties (CMPs) and safe harbors under the Anti-Kickback Statute (AKS) for all APMs
- Extend existing waivers of the AKS and the Stark Law applicable under certain Medicare programs (such as ACOs, bundled payment initiatives, and other Medicare APMs) to activities or initiatives that involve the integration of care and meet established value-based healthcare criteria that are designed to improve patient outcomes and reduce the overall cost of providing care. This protection should be made available to providers who are engaging in population health programs that may not be a Medicare APM; for example, contributing to a value-based purchasing model or participating in private-sector APMs.
- Establish good faith exemptions and safe harbors for when providers mistakenly apply waivers to patients who may not align with a Medicare APM.

Quality Reporting

Streamlining and Unifying Quality Reporting Requirements

Measuring interoperability across settings will provide valuable insight into providers' ability to share information that supports care coordination. A holistic approach is needed for data standards whereby standards are developed for use across care settings. **We urge CMS to enhance its efforts to develop cross-continuum standards and measures for data exchange and sharing across all care settings (including post-acute care),** rather than continued standards development for siloed settings of care.

Hospital Star Ratings

The hospital Star Ratings continue to suffer from a lack of transparency in methodology, inconsistent and disproportionate weighting of measures within groups, and a lack of stability within results. Stability is critical as these measures are leveraged by providers who desire to use the star rating to drive quality improvement and for patients who make important healthcare choices based on these ratings. **CMS must adopt a transparent overall hospital quality star rating that can be easily interpreted by**

consumers and replicated by hospitals. Premier believes the program would benefit from a simplified methodology using an explicit approach to enable hospital and patient understanding. **CMS should consider modeling the star rating after a program such as the Hospital Value Based Purchasing (HVBP) program that incorporates both achievement and improvement, allowing low-performers to rise rather than stagnate at the bottom**. HVBP has proved to be an effective vehicle because it is a well understood, tested method that addresses many of the flaws in the other programs. Converting HVBP performance to a star rating could ensure comprehension for hospitals and patients.

Documentation and Prior Authorization

Electronic Prior Authorization (ePA)

The current manual approach to prior authorization results in delays in access to necessary care and creates enormous burden on clinicians. The current process is largely done via phone or standalone, unique portals. These processes are not integrated with EHRs and often require additional and redundant effort by clinicians. **Premier strongly supports the advancement and adoption of data and interoperability standards (i.e., CDS hooks, in addition to transactions standards) to implement ePA and improve efficiencies in the prior authorization process, improve patient outcomes and care delivery. HHS should increase its focus on advancing the CDS hooks standard.** Embedding ePA within the clinical workflow will promote access to evidence-based clinically validated guidelines and minimize interruptions to clinical workflow.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, senior director, payment and quality policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance