PREMIER TRANSFORMING HEALTHCARE TOGETHER®

March 10, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
Submitted electronically to: http://www.regulations.gov

Re: Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P)

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its Notice of Proposed Rulemaking (NPRM) to advance interoperability and improve prior authorization processes across CMS-regulated health programs. The proposed rule seeks public comment on CMS' proposals to ensure timely access to care and improve data sharing among Medicare Advantage (MA) organizations, Medicaid managed care plans, the Children's Health Insurance Program (CHIP) and issuers of Qualified Health Plans (QHPs) on the federally-facilitated Exchanges.

Premier appreciates CMS' commitment to improving access to care and enabling better data exchange among providers, patients and payers. Specifically, Premier recommends the following:

- Require payers to disclose via Patient Access application programming interfaces (APIs) the specific coverage criteria that were and were not satisfied for prior authorization requests that result in denials;
- Finalize proposed requirements for payers to build and maintain Provider Access APIs, while ensuring that patient data collected by vertically-integrated, payer-owned providers and health services companies is included in the available data;
- Require that data received by payers through the payer-to-payer data exchange be shared on the Provider Access API so that providers have access to longitudinal data on patients' healthcare and can provide the most appropriate care;
- Finalize proposed requirements for affected payers to build and maintain Prior Authorization Requirements, Documentation, and Decision (PARDD) APIs, creating a single electronic point of entry for the payer's prior authorization processes that holds potential for integrating into the provider workflow;
- No later than 12 months following the publication of a final rule, require affected payers to deliver prior authorization responses within 72 calendar hours for standard, non-urgent services and within 24 calendar hours for urgent services; and
- In the longer term, develop programs to provide affected payers with additional flexibilities and/or financial rewards for implementing real-time prior authorization programs with contracted providers.

Premier welcomes the opportunity to provide feedback on the proposals included in this NPRM. Our detailed recommendations are included below.

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I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. PATIENT ACCESS API

Background

In May 2020, CMS issued the Interoperability and Patient Access final rule,[1] which required affected payers to build and maintain Fast Healthcare Interoperability Resources (FHIR) APIs to better enable patients' access to their own health information. Specifically, the Patient Access final rule required certain CMS-regulated payers to provide patients with access to adjudicated claims, encounter data (for visits with capitated providers) and a subset of clinical data and laboratory results via health apps.

In this NPRM, CMS proposes to further require that Patient Access APIs include information on prior authorization requests and decisions. As proposed, required prior authorization information for Patient Access APIs would include request status, date of approval or denial, date or circumstance under which the authorization ends, items and services approved, quantity used to date under the authorization and the specific reason for any denial(s). Patient Access APIs would also be required to include any documentation or other materials that the provider sends to the payer to support a decision – for example, structured or unstructured clinical data including laboratory results, scores or assessments, past medications or procedures, progress notes, or diagnostic reports.

CMS notes that a major goal of the newly proposed Patient Access API requirements is improving patients' visibility into decisions made about their care. CMS hypothesizes that making prior authorization information more transparent would enable patients to better participate in their care and more effectively navigate their plan's prior authorization requirements independently, which would in turn reduce burden on both providers

[1] "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, state Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges and Health Care Providers" (85 FR 25510)

and payers. To ensure timely access to data, CMS proposes to require affected payers to make prior authorization information available to patients not later than one business day after the payer receives the prior authorization request or the status of the request changes (e.g., approval or denial).

Premier's Recommendations for Improving Transparency and Empowering Patients

Premier supports CMS' proposed requirements to include information about prior authorizations in Patient Access API data. Premier is particularly supportive of the proposed requirements to disclose the specific reasons for denials of prior authorization requests, as this information is critical for patients - and their providers - in determining the most appropriate next steps for seeking covered services. It is important to note that some payers that would be subject to the proposals in this rule are already required under federal or state law to provide notice to patients or providers, or both, with the specific reasons for denial. CMS notes that the proposals in this NPRM build on those existing policies rather than modifying or replacing them. For example, QHP issuers on the federally-facilitated exchange (FFE) that offer individual health insurance are already required to provide the specific reason(s) for an adverse benefit determination, and MA program regulations already specify the form and content of the written notice to enrollees in the event of a plan's denial. Premier encourages CMS to continue to work to standardize and harmonize requirements across to the extent practicable to reduce potential burden for providers and confusion for consumers.

However, CMS has an opportunity to go further in encouraging payer transparency around reasons for denials. It is insufficient for payers to simply indicate that a prior authorization request was denied because it "does not meet medical necessity criteria," as this response does not help guide the patient toward what the payer would deem as medically appropriate (and thus covered) care. For example, notifying a patient that prior authorization for a spinal procedure is denied based on a lack of medical necessity provides far less information for care planning than notifying a patient that prior authorization for the procedure was denied because the patient has not yet exhausted non-surgical (e.g., physical therapy) treatment options. The former leaves patients and their providers with few clear options for next steps aside from appealing the decision. The latter clearly states the medical necessity criteria that the patient must meet to have their care covered by insurance. Patients and their providers must have sufficient feedback from payers to address deficits in denied prior authorization requests or formulate alternative courses of treatment, as necessary.

Premier recommends that CMS require affected payers to disclose via Patient Access APIs the specific coverage criteria that were and were not satisfied in the plan's assessment of prior authorization requests that result in denials. Premier believes that payers' coverage criteria must be more transparent to enrollees to improve access to care. In the context of this NPRM, CMS should require payers to make this information available with respect to individual decisions. In the broader context of payer transparency, Premier notes that the Improving Seniors' Timely Access to Care Act (H.R. 3173/S.3018, 117th Congress), which the proposals of this NPRM closely mirror, included requirements for plans to provide enrollees, providers and suppliers with access to any policies, procedures and criteria used by the plan for making determinations with respect to prior authorization requests. ***Premier will continue to work with our partners in Congress to ensure that CMS has sufficient statutory authority to require payers to comply with this broader level of transparency.*** As discussed in greater detail below, it is particularly critical to ensure that patients and their providers receive the same information at the same time to ensure that patients receive access to high quality, medically necessary care.

Required Reporting and Ongoing Analysis

In addition to building and maintaining Patient Access APIs, CMS proposes to require that payers report annual metrics to CMS on patient use of the API. Required reporting would include the number of unique patients whose data are transferred via the Patient Access API to a health app, and the total number of unique patients whose data are transferred more than once. Based on feedback received on its December 2020 proposed rule, CMS proposes to require reporting on an annual basis rather than quarterly. CMS does not plan to publicly report these metrics at the state, plan or issuer level but may reference or publish aggregated and de-identified data.

Premier supports annual reporting of patient use of the Patient Access API and urges CMS to publicly report aggregated data to the extent practicable. Monitoring for equitable access to Patient Access APIs will be critical to the policy's implementation, if finalized, and Premier encourages CMS to closely track potential disparities in access to Patient Access APIs due to social determinants of health and/or digital literacy gaps.

III. PROVIDER ACCESS API

In the May 2020 Patient Access final rule, CMS finalized policies that would allow patients to leverage the Patient Access API to potentially share that information with their provider during an appointment. At the time, CMS sought comment on the feasibility of implementing and maintaining a FHIR API for data exchange between payers and providers and comments strongly supported requiring payers to make data available through a Provider Access API, including information about prior authorization decisions. In this proposed rule, CMS continues to support providers' access to comprehensive patient data through a Provider Access API, while noting that such technology could also reduce burden on patients to recall and share specific information regarding prior care.

Specifically, CMS proposes to require that impacted payers implement and maintain a Provider Access API to enable the information of current patients to be exchanged from payers to providers that are in that payer's network,[2] at the provider's request. Both the Provider Access API and the Patient Access API would use FHIR-based exchange of claims and encounter data, as well as all data classes and data elements included in the content standard at 45 CFR §170.213, such as immunizations, procedures, and assessment and plan of treatment. Both would also require payers to share information on prior authorization requests and decisions for items and services (excluding drugs). Payers must also establish and maintain an option for a patient to opt-out of having their data made available for providers through the Provider Access API. In addition to a patient opt-out option, CMS encourages payers to implement processes for patients to select individual providers with whom the payer should not share data.

CMS describes a few notable differences between the Patient Access API and the Provider Access API. For the Patient Access API, patients are requesting their own information through a health app for their own use. For the Provider Access API, providers would receive access to the patient's information securely through their electronic health record (EHR) or other technology solution for treatment purposes (not through the provider's own health app). Unlike the Patient Access API, the proposed Provider Access API would not include provider remittances and enrollee cost sharing information, as CMS notes that those are considered by many payers to be proprietary and would have limited benefit for treatment or care coordination.

[2] That is, any provider or healthcare facility that is part of a specific health plan's network of providers with which it has a contract. For Medicaid and CHIP FFS programs, this means any providers or facilities enrolled with the state as Medicaid or CHIP providers.

Premier generally supports CMS' proposals to require payers to build and maintain Provider Access APIs to enable better access to patient data. Premier also notes that with increasing vertical integration among large, national payers, it becomes increasingly more likely that patients receive some items and/or services from payer-owned providers or provider groups. ***It is incredibly important that patient data collected by payer-owned providers and health services companies be included in the Provider Access API.*** This helps ensure that patients are not subjected to duplicative diagnostic testing or questions about their health that are already represented in payer-owned data, and that providers have the information they need to better manage care.

Further, Premier recommends that CMS specify that payers may not charge providers a user fee to access Provider Access APIs, and that CMS develop monitoring and enforcement strategies against such tactics. CMS should develop educational resources for providers to encourage broad usage of the payer systems as they become available, and to ensure that providers are aware of where to report observed noncompliance among health plans. Finally, Premier urges CMS to work closely with providers across healthcare settings to ensure that EHR integration for the Provider Access API tools is user-friendly and incorporated into the clinical workflow to avoid contributing to providers' administrative burden.

IV. PAYER-TO-PAYER DATA EXCHANGE ON FHIR

The 2020 Patient Access final rule required payer-to-payer exchange of patient data, effective Jan. 1, 2022, for MA organizations, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs. The final rule required that affected payers maintain a process for the electronic exchange of the data to ensure that patients switching coverage are able to request their records be sent to their new health plan. Although the final rule did not specify an API standard, CMS encouraged payers to consider using a FHIR API and signaled it could be a future requirement.

Since then, payers have continued to express concern over the lack of technical specifications for the payer-to-payer data exchange: implementation has been challenging, data quality has been poor and administrative burden has been substantial. CMS attempted to address these concerns about standards and specifications in the December 2020 proposed rule, which would have required use of a FHIR API. CMS is withdrawing that proposed rule and, for purposes of the payer-to-payer data exchange, proposes rescinding the applicable portions of the May 2020 final rule. CMS also has not been enforcing the payer-to-payer requirements of the May 2020 final rule, in accordance with the notice the agency published in a Federal Register notice (86 FR 70412, Dec. 20, 2021).

In this proposed rule, CMS again proposes to require affected payers to implement and maintain a payer-to-payer data exchange using a FHIR API and a patient opt-in policy. CMS notes that each payer would only be responsible for its own side of a transaction. For example, if an impacted payer is required to request patient data from another payer that is not an impacted payer, the impacted payer must make that request regardless of the other payer's status. CMS is hopeful non-impacted payers will implement the Payer-to-Payer API to better enable portability of patient health records when enrollees switch plans. CMS' ultimate goal is to create a longitudinal health record, maintained with an enrollee's current payer, that follows the enrollee throughout their healthcare journey.

Premier supports CMS' renewed proposal for a payer-to-payer data exchange for enrollees that are covered by multiple payers or are transitioning between payers. Premier agrees with the CMS assessment that such data sharing would improve the completeness and quality of patient data through a longitudinal record and support better care coordination for patients. Furthermore, Premier believes that

investments made in payer-to-payer data sharing would benefit broader multi-payer alignment efforts, which are a key priority for improving quality, access and value in healthcare. To this end, ***Premier recommends that CMS require that data received by payers through the payer-to-payer data exchange be shared on the Provider Access API as expeditiously as possible.*** Having a complete, longitudinal view of a patient's care to date is critical to ensure that providers have the information they need to make clinical decisions and that they are not providing duplicative or wasteful care.

V. IMPROVING PRIOR AUTHORIZATION PROCESSES

Background

Used by some health insurance companies and federal healthcare programs, prior authorization is intended to protect patient safety and lower costs by putting guardrails in place to avoid inappropriate care. However, too often it can also limit timely patient access to medically necessary services and be costly, time-consuming and burdensome for healthcare providers. The HHS Office of the Inspector General (OIG) issued an alarming report finding that MA plans often denied or delayed patients' access to medically necessary services and burdened physicians, even though the requests met Medicare coverage rules. These inappropriate denials were due in large part to human error during the manual claims processing reviews. ***A main culprit is a lack of standardization, transparency and automation of the prior authorization process.***

In this proposed rule, CMS seeks to improve prior authorization processes by requiring affected payers to build and maintain FHIR PARDD APIs to support fully-electronic prior authorizations. CMS notes that only 26 percent of prior authorization transactions were fully electronic in 2021; most transactions required providers to utilize manual processes via telephone, fax, and/or highly individualized separate online portals for each payer.

It is important to note that the consequences of inefficient prior authorization processes extend beyond administrative burden:

- ***Prior authorization can delay care and harm patients.*** Because of the prior authorization time lags, 93 percent of providers responding to a survey by the American Medical Association (AMA) report treatment delays, 82 percent reported that prior authorization can sometimes lead to treatment abandonment, 24 percent say these delays resulted in hospitalization and 18 percent say delays led to a life-threatening event or required intervention to prevent permanent impairment or damage.[3]
- ***The prior authorization process is burdensome to providers and patients and is disconnected from the clinical workflow.*** It is a manually-intensive process that requires healthcare professionals to take time away from caring for their patients to engage with payers. CMS notes in this proposed rule that recent studies show that physicians and physician group practices spend 12 hours per week on dedicated administrative time to handle prior authorizations.
- ***A lack of end-to-end real-time automation of prior authorization between payers and providers also creates tremendous inefficiencies and can further delay care.*** Without electronic prior authorization processes based on national standards, most EHRs, which providers use to record clinical data, have no way of communicating with payment systems run by insurers.

[3] 2021 AMA prior authorization (PA) physician survey: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Proposed PARDD API

In this rule, CMS proposes to require that affected payers build and maintain PARDD APIs with the following functionalities, at minimum:

- List the payer's covered items and services (excluding drugs) for which prior authorization is required
- List documentation requirements for providers who are submitting prior authorization requests
- Allow providers to ascertain the requirements for additional data, forms or medical record documentation required by the payer
- Ensure responses from the payer include information on approval (including duration) or denial (with specific reason)

CMS asserts that the PARDD API would make prior authorization requirements and documentation requirements more accessible and transparent to providers at the point of care. For example, providers could use the API to query the prior authorization requirements for specific items and services to identify documentation requirements and could use the API to complete electronic forms and templates or to link elsewhere to submit the documentation. CMS also notes that the API could improve electronic data exchange between impacted payers and providers once provider practice management systems or EHRs connect with the API. In addition, CMS sees benefits to payers because use of this API could reduce the number of unnecessary requests, minimize follow-up and reduce denials and appeals.

Premier supports CMS' proposal to require affected payers to build and maintain a PARDD API, creating a single electronic point of entry for the payer's prior authorization processes that holds potential for integrating into the provider workflow. As noted above, Premier believes it is critical for providers and patients to have transparency into payers' prior authorization criteria at the point of care to expediate care planning. To this end, Premier recommends that CMS work closely with provider and patient stakeholder groups to develop clear guidance to payers, ensuring that PARDD APIs provide granular enough information that patients and their care teams have clear insights into next steps to get access to covered care. ***To expedite the process of bringing electronic prior authorization tools to scale, Premier recommends that CMS require payers to make PARDD APIs available to providers by no later than 12 months following the publication of a final rule, in order to ensure that bi-directional flow of electronic prior authorization information is fully operational by Jan. 1, 2026***. This lead time is particularly important for providers facing potential financial impacts from performance on the proposed electronic prior authorization performance measures discussed in greater detail below.

Requirements for Prior Authorization Decision Timeframes and Communications

In this rule, CMS proposes specific deadlines for prior authorization decisions from affected payers, with the aim of ensuring more timely access to care. For "standard" requests, which CMS defines as non-expedited, non-urgent requests for prior authorization, CMS proposes that decisions by MA organizations and applicable integrated plans, Medicaid FFS programs and CHIP FFS programs must be provided as expeditiously as a patient's health conditions require, but no later than seven calendar days after the request is submitted. For "expedited" requests, CMS proposes that decisions by Medicaid FFS programs and CHIP FFS programs must be provided as expeditiously as a patient's health condition requires, but no later than 72 hours (unless a shorter timeframe is established under state law). CMS notes that current federal regulations already impose a 72-hour deadline for "expedited" decisions made by MA organizations, applicable integrated plans, Medicaid managed care plans and CHIP managed care entities. This proposed rule does not change those policies – rather, CMS simply proposes to align requirements for Medicaid and CHIP FFS programs with the existing 72-hour expedited deadline for other CMS-regulated programs.

While Premier appreciates CMS' commitment to codifying required deadlines for prior authorization decisions, we note that a pathway to real-time prior authorization exists and urge CMS to develop incentives to move payers and providers closer to real-time processes. The failure to deploy end-to-end real-time automation of prior authorization between payers and providers perpetuates inefficiencies and negative impacts on clinical outcomes. ***Specifically, Premier recommends that CMS develop demonstration programs to provide affected payers with additional flexibilities and/or financial rewards for implementing real-time prior authorization programs with contracted providers.***

It is essential that CMS acknowledge that while standards and technology continue to evolve and mature, real-time prior authorization should be the goal, and the standards and technology currently exist to implement real-time prior authorization for certain used cases. For example, clear appropriate use criteria (AUC) exist for certain advanced diagnostic imaging services, as required by the Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b). Qualified Clinical Decision Support Mechanisms (CDSMs) can provide near-instant determinations of whether orders adhere to AUC. Incentivizing health plans to accept CDSM verification of a provider's compliance with AUC or other plan-determined criteria (i.e., using CDSMs as a "gold-carding" mechanism) would allow plans to retain control over prior authorization decisions while also reducing provider burden from prior authorization request submissions, improving beneficiary care experiences by expediting determinations so that they know the plan of care before leaving the provider's office and significantly reducing plan expenses associated with more manual prior authorization request review processes. While CMS develops incentives to expedite the move to real-time prior authorization processes, ***Premier recommends that no later than 12 months following the publication of a final rule, CMS should require affected payers to deliver prior authorization responses within 72 calendar hours for standard, non-urgent services and within 24 calendar hours for urgent services***, as stakeholder advocacy groups have long recommended. Further, ***CMS should commit to putting forward recommendations within 12 months following the publication of a final rule for incentives for moving the industry to real-time prior authorization.***

VI. ELECTRONIC PRIOR AUTHORIZATION MEASURES IN OTHER MEDICARE PROGRAMS

To encourage providers to use the PARDD APIs that payers would be required to build and maintain, CMS proposes a new measure related to electronic prior authorization for Merit Based Incentive Payment System (MIPS) eligible clinicians under the MIPS Promoting Interoperability (PI) performance category, and for eligible hospitals and critical access hospitals (CAHs) under the Medicare Promoting Interoperability Program (PIP). The new measure, "Electronic Prior Authorization," would be included in the Health Information Exchange (HIE) objective for the MIPS PI performance category and in the HIE objective for the Medicare PIP.

Under the proposal, MIPS eligible clinicians would report this measure beginning with the calendar year (CY) 2026 performance period/CY 2028 MIPS payment year, and eligible hospitals and CAHs would report the measure beginning with the CY 2026 EHR reporting period. However, the measure would not be scored in 2026. As proposed, the measure would essentially track the number of unique prior authorization requests made electronically through a PARDD API using data from certified electronic health record technology (CEHRT).

Premier generally supports incorporating the Electronic Prior Authorization measure into the MIPS PI performance category and the Medicare PIP. Premier urges CMS to work with hospitals, health systems and other provider stakeholders in the development of specific performance requirements for the measure to ensure that desired standards are achievable, and that CMS is not simply replacing one type of

administrative burden (manual prior authorization processes) with another (compliance with new Electronic Prior Authorization measure requirements).

VII. REQUESTS FOR INFORMATION

Request for Information: Accelerating the Adoption of Standards Related to Social Risk Factor Data

CMS seeks input on barriers the healthcare industry faces in the collection of social risk and social needs data, the difficulties in using industry standards to collect and share such data and opportunities to accelerate adoption of data collection standards related to social risk factor data. Premier does not, at the current time, have specific recommendations on the precise manner or tool of collecting such data but we would like to provide the insights we have gleaned through our on-going health equity work that outline some of the challenges the industry faces in this space.

Currently, there is significant variation in the way social risk data is collected across different healthcare organizations and systems. This inconsistency can result in incomplete or inaccurate data, which can ultimately hinder efforts to address social risk factors and promote health equity. Premier has been working with our members and various coalitions to gain insights into health disparities and effective methods of tackling them, including the collection and sharing of social risk factor data. The barriers to health equity have several components that need to be addressed and Premier believes there are three key issues that are paramount:

1. There are numerous data collection, data sharing and outcome measurement standards that confound insights into health disparities. This inhibits collaboration across organizations and sectors.
2. There is a lack of sustainable funding for health equity endeavors, including better collection of social risk data. Currently there are very few payment mechanisms that support and incentivize care transformation that addresses medical and social needs to advance health equity.
3. There is a shortage of strong forums for the sharing of data, insights and best practices across organizations and sectors.

We provide additional detail regarding each of these issues below.

Data Collection and Reporting

The Agency for Healthcare Research and Quality (AHRQ) has found that one of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations and monitoring improvements over time. [4] AHRQ further found that the principal challenges in obtaining race, ethnicity and language data for use in quality improvement assessments include a lack of standardization and understanding of why the data are being collected.

In our work with our members, Premier has identified that there is substantial difference in the way that data is collected. Screening practices and tools are not standardized, and the type of social risk data that is collected varies depending on the tool used. Premier recognizes that each entity needs the flexibility to create and implement the tool that best fits their needs, but Premier recommends a standard of clearly identified core data elements that should be collected so that all entities can use these elements to compare and analyze with the option to add data elements and questions as needed. Absent standardized data

[4]Internet Citation: 1. Introduction. Content last reviewed April 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata1.html

collection methods and recognized agreement regarding health equity definitions and measurement, each sector of healthcare risks speaking its own language, resulting in a siloed and fragmented approach to a problem that requires a holistic and cohesive approach. A lack of standardized data impedes consistent decision making across the healthcare continuum and unfortunately can result in further harm to the goal of addressing health equity.

Additionally, the lack of standardization in screening practices and tools makes data exchange among healthcare organizations and between the healthcare and social service sectors challenging. For example, a recent survey of Medicaid managed care plans[5] found that plans reported using multiple social determinants of health (SDOH) screening tools, with half noting they used an internally developed or adapted tool. Without smooth data exchange, healthcare organizations are limited in their ability to refer people for interventions that address identified social needs.

Further, limitations on the ability to share social risk data and social needs data is an additional, massive barrier to leveraging the data to improve patient outcomes. There is no common platform or electronic health record to share risk and social needs data between healthcare providers and community-based organizations. The inability to share this data accurately and quickly across the providers involved in that person's care may result in missed opportunities to address a concern before it becomes a more critical situation.

Premier recommends that all efforts to stratify measures by race, ethnicity and social factors begin with confidential reporting and appropriate risk adjustment to account for factors associated with outcomes that cannot be addressed by providers. We must avoid a perverse cycle, wherein certain policies – such as public reporting of stratified quality data – discourages beneficiaries from visiting providers that care for patients in marginalized communities, subsequently leading to unequal care for those patients due to a lack of equal resources to treat them. It is critical that information publicly shared on disparities in care is accurate and can be understood by consumers.

Further, Premier recommends that collection and updating of social risk data be done as often possible. People may lose and gain jobs and change circumstances every day, which can adversely affect their health status. Currently there is no standardized way for social data to be updated as people's circumstances change. This would also need to be done in a manner that is not overly burdensome to the provider or the person seeking care so as not to create barriers to care.

Finally, we urge CMS to make a concerted effort to advance standards for the collection of social risk data, using existing tools such as the United States Core Data for Interoperability (USCDI), Z-codes, HL7 and Fast Healthcare Interoperability Resources (FHIR) standards. As we note above, CMS needs a coordinated approach for using social risk data for numerous purposes including payment and quality. This coordinated approach requires significant input from providers across the continuum, vendors, payers and suppliers. Premier recommends that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of social risk data and social risk factors.

Payment Reform that Supports and Incentivizes Care Transformation

As we have detailed above, a multitude of factors contribute to the lack of comprehensive social risk data collection. Lack of clear standard definitions, technological barriers, and lack of shared learnings all inhibit progress in the collection and sharing of these important data elements. But it would be disingenuous to

[5] Moore JE, Adams C, Bakst C, DePriest K, Kolenic GE. Medicaid Access & Coverage in 2019. Institute for Medicaid Innovation; 2020:74. https://www.medicaidinnovation.org/_images/content/2020- IMI-Medicaid_MCO_Survey-Report.pd

not mention the absence of financial support and incentives to transform behaviors that advance collection of these data and the overarching goal of health equity.

Alternative payment models that allow for greater flexibility to spend resources on social related services and have greater accountability for outcomes that encourage more substantial practice change may provide a space for providers to invest in standard data collection practices. Premier believes a critical component to improving quality, creating a more equitable healthcare system and reducing healthcare costs is to allow providers to develop innovative approaches for delivering care in value-based arrangements. Through large-scale data-driven collaboratives, the Premier healthcare alliance has for years worked with hundreds of hospitals, health systems and physician groups across the country to actively test and scale new models of care and build coordinated, population health capabilities through education, best practice sharing, measurement, and benchmarking.

To succeed with value-based arrangements, it is important for initiatives to be able to identify those people who will need future services and intervene early. A few states have undertaken this work under various waiver structures, allowing them to collect and share critical data elements with all participating providers in a standardized and actionable manner.

These nascent projects allow for financial investment in tools, technology and organizational training to create structures that allow for more efficient and effective collection, sharing, analysis and operational interventions based on social risk data. At the same time, we would note that providers who work disproportionately with higher-risk populations may also be the most financially limited from making these investments, so consideration of how-to best target incentives may be key.

Shared Learning Leads to Best Practices

As part of this request for information, CMS is requesting best practices that are currently addressing challenges such as integration of social risk and social needs data into clinical workflow and adoption and use of commonly used screening tools with associated health IT standards.

In CY 2023, Premier's Strategic Collaboratives team anticipates launching a health equity collaborative to support members in meeting and exceeding new regulatory, payer and accreditation requirements that are designed to reduce health disparities. Through this new collaborative, efforts will focus on providing data our members need to address the health equity issues pertinent to the communities they serve. Premier's role will be to act as a convener to provide solutions, many of them addressing the issues outlined in this request for information, including:

- Supporting collection of accurate equity-related drivers of health data
- Developing dashboards to access and analyze data quickly and efficiently
- Studying what works and sharing insights on strategies that advance equity that are scalable and sustainable, including creating best practices regarding collection of social risk data
- Improving delivery of care using real-world and community-informed evidence, which will include standardized social risk factor data

Premier is committed to continuing our health equity work and assisting in our common goal of creating a more accessible and equitable healthcare system. We look forward to sharing our learnings and best practices with CMS in the future.

Request for Information: Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health

CMS seeks information on evidence-based policies that leverage information technology to improve such outcomes, how current initiatives can be leveraged to harmonize maternal health data and whether there should be any special considerations for the prior authorization process in maternal healthcare.

Collection and Harmonization of Maternal Data

As noted above, the collection of social-related data is segmented and disparate and the same is true in relation to the maternal health data that is currently collected. Through our extensive maternal health work, Premier has identified numerous aspects of collection that we believe are critical to providing better maternal health outcomes.

Maternal health data should be collected such that:

1. **There is a simple way to track a maternal patient through the system.** Health systems have a lot of data that cannot be tied together because there is no "Universal Patient Identifier".
2. **Information is accurately available regarding the patient's Race, Ethnicity and Language (REaL), Social Drivers of Health (SDOH) and Sexual Orientation and Gender Identity (SOGI).** It is critical that information is accurately collected at the point of care, including standardized approaches for patient self-identification of REaL, SDOH and SOGI. Today, there is no such standard for collection of information as hospitals follow a variety of practices, including for many, making assumptions about the patient and documenting accordingly. This reduces the accuracy of our data, and the ability for us to understand the scope of maternal morbidity and mortality on our most vulnerable populations.
3. **Data is collected to allow for linking of maternal and infant patients.** Through the HHS Perinatal Improvement Collaborative, which we detail below, hospitals submit data with the maternal and infant patient records linked – allowing the collaborative to link the records together and begin exploring the complex inter-relationship between the dyad, including how the complications and risk factors of one patient is related to the other.
4. **Ambulatory data is linked to inpatient data to provide for a full and comprehensive view of the patient.**

CMS could help support the collection of this data through:

1. Setting standards and incentives for collection of REaL, SDOH and SOGI data which include patient self-identification.
2. Funding initiatives, such as the HHS Perinatal Improvement Collaborative, which allow for collection and analysis of maternal and infant linked data.
3. Funding initiatives to encourage interoperability between ambulatory and acute care data, to show the true patient continuum, as evidence indicates that mortality for this patient population continues to rise. In addition, Premier analyses indicate that mortality within the in-hospital delivery encounter is declining.
4. Encouraging the use of telehealth in maternal and post-partum care. Being able to attend healthcare visits remotely, collect routine health data at home or communicate with providers digitally could increase access to care for many patients.

Current Initiatives Can be Leveraged to Harmonize Maternal Health Data

An April 2021 Premier analysis that leveraged data representing about 25 percent of all U.S. hospital births found:

- A 55 percent decrease in maternal deaths during hospital delivery for Black women from 2008-2019, which suggests the disparity gap between Black and white women for delivery-related in-hospital deaths has substantially narrowed. U.S. hospitals showed a 17 percent decrease in delivery-related maternal deaths for *all* races between 2008-2019, indicating hospitals are making progress at the time of delivery.
- While this is a positive development, severe maternal morbidity (SMM) continues to rise and disproportionately affects Black women, who have an 84 percent higher SMM rate than white women. The greater instances of SMM are a likely indicator of post-discharge maternal mortality, with CDC data showing that the mortality rate within 42 days of pregnancy increased 15 percent between 2018 and 2019.
- Black women have higher rates for heart failure, acute respiratory distress syndrome, eclampsia, acute renal failure, sepsis and blood transfusions.

These findings underscore the need for a standardized method to collect maternal-infant data, measure outcomes, adjust care and scale proven practices across hospitals nationwide. Maternal care improvement must start with reliable data that identifies the root causes. The lack of standardized outcome measurement and collection of complete, actionable data on maternal mortality and morbidity has been a persistent obstacle to reversing poor maternal-infant health trends and inequity in the US.

To address this problem head-on, the Department of Health and Human Services (HHS) Office of Women's Health (OWH) through the Maternal Morbidity and Mortality Data and Analysis Initiative has tapped into Premier's extensive data to understand why the disparate maternal outcomes occur. The HHS Perinatal Improvement Collaborative, a multi-year collaborative comprised of more than 225 hospitals from all 50 states and the District of Columbia, leverages standardized data and proven performance improvement methodology to scientifically identify root causes of maternal-infant mortality and morbidity. With these resources, the collaborative will implement and analyze evidence-based interventions to drive clinical quality improvement, advance health equity and help make America the safest place to have a baby.

In addition, in August of 2022, Premier responded to CMS's Maternity Care Action Plan with a commitment to collect population specific data across the continuum of care to understand the scope of maternal and infant harm. Premier will conduct follow-up research to measure progress in maternal and infant SDOH data collection and publish outcomes to advance health equity and assist organizations in the reduction of healthcare associated disparities.

Special Considerations for the Prior Authorization Process in Maternal Healthcare

In section II.D of this proposed rule, CMS outlines its proposals to improve prior authorizations. In addition to the impacts on patient care discussed in that section, there is recognition of the possible effects of inefficient prior authorizations on maternal health and whether there should be special considerations for the prior authorization process in maternal healthcare; for example, expedited prior authorization in cases where the prior authorization is related to prenatal and perinatal care.

In response to this inquiry, Premier echoes our comments related to the broader proposals around prior authorization; a special and unique prior authorization pathway for maternal health is not necessary if CMS adopts Premier's recommendations and focuses on the implementation of real-time prior authorization.

Immediate responses for maternal health related prior authorizations would greatly improve the care women, and their children, receive and help reduce disparities in care while improving outcomes. In maternal health, as with many other conditions, every second counts and unnecessary prior authorization burdens should be removed in favor of real-time prior authorization.
It also is important to note that the maternal healthcare space has a large percentage of Medicaid patients, and their payers can literally change daily. Any prior authorizations should carry over from one payer to another and should continue for the duration of the pregnancy and as appropriate clinically throughout the post-natal (1 year) period as well.

VIII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on CMS' Notice of Proposed Rulemaking to advance interoperability and improve prior authorization processes. If you have any questions regarding our comments, or if Premier can serve as a resource on these issues to the agency in its policy development, please contact Mason Ingram, Director of Payer Policy, at Mason_Ingram@premierinc.com or 334.318.5016.

Sincerely,

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Premier Inc.