



AMERICA'S ESSENTIAL HOSPITALS

March 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-0057-P: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals welcomes the Centers for Medicare & Medicaid Services' (CMS') work to promote interoperability and facilitate the access, exchange, and use of health information. We appreciate that the agency is prioritizing patient access to timely care and removing provider burden by streamlining current prior authorization processes. Essential hospitals are committed to using health information technology (IT) to improve their patients' lives through population health efforts, using telehealth to reach patients who face transportation and other barriers to care, and leveraging electronic health record (EHR) data to reduce unnecessary readmissions and improve outcomes. Despite these successes, burdensome regulatory requirements drain staff time and resources that hospitals could better spend on delivering high-quality, patient-centered care. As CMS develops policies to advance interoperability and streamline prior authorization, we encourage the agency to act in a way cognizant of the unique challenges essential hospitals and their patients face and that does not impose additional resource requirements on providers.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins less than half that of other hospitals—3.2 percent on average compared with 7.7 percent for all

hospitals nationwide.¹ These narrow operating margins result in minimal reserves and low cash on hand—circumstances exacerbated by recent financial pressures. As essential hospitals attempt to rebound from the COVID-19 pandemic, they face new challenges, such as rising workforce costs and shortages, rising supply costs, and supply shortages.

Essential hospitals' commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. This commitment begins early in our patients' lives—one in 10 U.S. residents are born at an essential hospital, and essential hospitals are uniquely situated to tackle structural inequities in maternal health care. A disproportionate number of their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. More than seven million people in essential hospital communities have limited access to healthy food, and nearly 16 million live below the poverty line.² Essential hospitals are uniquely situated to target these social determinants of health (SDOH) and are committed to serving these marginalized patients. These circumstances, however, compound our members' challenges and strain their resources, requiring flexibility to ensure essential hospitals are not unfairly disadvantaged for serving marginalized populations and can continue to provide vital services in their communities.

America's Essential Hospitals agrees with the need for the seamless flow of health information across providers, patients, and payers. Payer prior authorization policies cause unnecessary delays in accessing care, contradict the judgment of clinicians in the best position to assess the needs of their patients, add excessive burden on providers, and introduce inefficiencies across the health care system at large. Unfortunately, payer policies are only becoming more cumbersome, with an increase last year in wait times for procedures to be approved and a rise in prior authorization-related claim denials.³ We appreciate that CMS has put forth policies that attempt to improve prior authorization processes and increase payer transparency. In developing policies to streamline prior authorization, we urge the agency to consider carefully the readiness of existing health IT infrastructure for these requirements, as well as the potential for these policies to place additional regulatory burdens on providers. We generally support the proposals in the rule, such as the use of application programming interfaces (APIs) to hasten prior authorization decisions and payer reporting requirements. Below, we offer recommendations on areas for improvement that will help remove prior authorization barriers while reducing burden on providers.

- 1. CMS should work to develop consistent standards for electronic prior authorization that allow seamless integration of such processes into EHRs.**

America's Essential Hospitals encourages CMS to identify processes to improve care coordination and facilitate prior authorization, while preserving providers' ability to prescribe and deliver lifesaving medications and services expeditiously.

The proposed rule appropriately highlights some of the burdens associated with prior authorization, which still primarily takes place through traditional, paper-based means and is not fully automated. The delay in automatic prior authorization processes is largely the result of

¹ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed February 14, 2023.

² Ibid.

³ Devereaux M. Health systems see increasing claim denials as payer 'delay tactic.' *Modern Healthcare*. November 21, 2022. <https://www.modernhealthcare.com/insurance/insurance-claim-denial-rates-rising-health-systems-struggle>. Accessed February 14, 2023.

a lack of standards and the failure of developers to implement existing standards. The ability of a provider to expeditiously submit prior authorization documentation verifying the need for a particular medication or service will facilitate the provision of care and minimize unnecessary burden on clinical and support staff. The rule relies heavily on the use of APIs to facilitate electronic prior authorization. Electronic prior authorization has the potential to streamline the prior authorization process, but, as with any health IT advancement, there are multiple issues that CMS should consider before providers are ready to adopt electronic prior authorization and use these APIs. Requirements pertaining to electronic prior authorization should:

- Minimize burden on providers.
- Have clear, consistent, and mature standards to ensure seamless data interoperability across payers, providers, and patients.
- Protect patient privacy and security of sensitive health information.
- Integrate into existing mechanisms, such as EHR systems and e-prescribing capabilities.

As with other processes that require the use of health IT, it is imperative to have mature standards and requisite real-world testing of these standards. Mature standards also are critical to ensuring patient privacy and secure transmission of confidential patient health information. Recent cybersecurity threats in the health care space, including through ransomware attacks on providers and breaches of protected health information, are a reminder of the need to ensure the security of new capabilities before rushing into implementation. As HHS has highlighted, these threats increased in 2022 and are expected to continue to affect health care providers' operations in 2023.⁴ The implementation guides that CMS suggests could be used to standardize automated prior authorization procedures are a first step toward enabling seamless exchange and integrating into existing workflows. However, there is uneven uptake of these standards and implementation guides by EHR vendors, and this uptake will be critical to guaranteeing the success of electronic prior authorization.

CMS also should work with the Office of the National Coordinator (ONC) for Health IT to ensure rigorous certification criteria for and oversight of EHRs with built-in electronic prior authorization capabilities so software developers deliver functional, safe products. Currently, not all EHRs and EHR modules contain the required functionality for electronic prior authorization. While ONC certification criteria include electronic prior authorization for medications, there are no criteria for electronic prior authorization for other items and services. Including electronic prior authorization in certification criteria will incent EHR vendors to build these functionalities into their products. For providers to leverage their EHRs to produce information required to respond to payer prior authorization requests, the inclusion of these functionalities will be imperative.

In addition, HHS should explore the current landscape of electronic prior authorization to ensure all stakeholders—from prescribers to pharmacies—have the capabilities to benefit from this technology. This would include assessing the extent to which electronic prior authorization is built into electronic prescribing functionalities in EHRs. Hospitals are required to electronically submit prescriptions through their EHR as part of the Medicare and Medicaid Promoting Interoperability Programs. To minimize provider burden, electronic prior

⁴ Department of Health and Human Services, Health Sector Cybersecurity Coordination Center (HC3). 2022 Healthcare Cybersecurity Year in Review, and a 2023 Look-Ahead. February 9, 2023. <https://www.hhs.gov/sites/default/files/2022-retrospective-and-2023-look-ahead.pdf>. Accessed February 14, 2023.

authorization should integrate into e-prescribing functionalities to streamline staff workflows and minimize redundancy.

2. CMS should shorten the proposed timeframes for payers to submit a prior authorization determination to the provider.

For most impacted payers, CMS proposes shorter timeframes for payers to respond to prior authorization requests—seven calendar days for standard prior authorization requests and 72 hours for urgent requests. CMS seeks comment on an alternative policy of 48 hours for urgent request and five calendar days for standard requests. This is a positive step toward expediting prior authorization decisions and removing delays to care but CMS should shorten these timeframes further. **Specifically, we recommend that CMS finalize a requirement of 24 hours for urgent services and 72 hours for non-urgent services. Moreover, once CMS begins receiving data on average prior authorization timelines by payer and service, it should develop a list of routinely approved services (which have low denial rates) and require payers to make real-time decisions on these services.**

The proposed timelines are unnecessarily lengthy and would continue to inhibit timely patient access to care. Further, reducing the required timelines, as we recommend, would encourage payers to utilize fully the technologies and APIs that will be put in place to allow for real-time data exchange. CMS proposes to require payers to implement a prior authorization requirements, documentation, and decision (PARDD) API based on the Fast Healthcare Interoperability Resources (FHIR) data exchange standard. This API will provide a seamless way to respond electronically to prior authorization requests and would allow involved parties to use third-party applications to access payer and provider data. This will facilitate swift prior authorization decisions as it replaces antiquated, paper-based prior authorization processes. When payers fully implement this API, they will be able to produce prior authorization requests and send decisions to providers in near real-time, which will allow them to comply with the shorter timelines we recommend. **Therefore, we recommend that CMS finalize a requirement of 24 hours for urgent services and 72 hours for non-urgent services. Furthermore, for frequently performed services with high prior authorization acceptance rates, CMS should require that payers provide real-time decisions to providers.**

3. To ensure uniformity in its policies and to maximize their reach, CMS should finalize a policy that will include Medicare Advantage organizations and qualified health plans.

Most of the rule’s prior authorization provisions apply to Medicare Advantage (MA) organizations, Medicaid managed care plans and Children’s Health Insurance Program (CHIP) managed care entities, state Medicaid and CHIP fee-for-service (FFS) programs, and qualified health plan (QHP) issuers on the federally facilitated exchanges (these payers are referred to collectively as “impacted payers” by CMS). In an earlier version of the proposed rule issued in December 2020, CMS excluded MA organizations from the rule’s provisions. Given the increased prevalence of MA organizations and increased MA market penetration, it is important that the rule’s proposals apply to MA organizations as well. Nearly half of all Medicare beneficiaries are now insured through MA, and more than half of federal Medicare spending is attributed to MA, with MA expected to be the predominant source of coverage for Medicare

beneficiaries as early as 2023.⁵ While MA coverage and spending compared with FFS is increasing, MA prior authorization delays and denials also are increasing. Prior authorization has become increasingly prevalent in MA, with 99 percent of MA enrollees in plans that require prior authorization for select services. These prior authorization requirements extend to important services, such as Part B drugs, inpatient hospital stays, mental health services, and critical wraparound services for marginalized communities, such as transportation services.⁶ The Office of Inspector General has raised concerns about the effect of prior authorization in MA on beneficiary access to care.⁷ Other than in limited contexts, similar prior authorization requirements do not apply in Medicare FFS. The rule's proposed provisions on prior authorization processes and transparency for payers will be critical in ensuring prior authorization in MA does not unnecessarily delay patient care and burden providers. **To that end, we support the inclusion of MA in the rule's provisions and urge CMS to finalize MA as an impacted payer.**

While CMS includes issuers of QHPs in federally facilitated exchanges (FEEs) as impacted payers in the rule, the agency proposes to exclude QHPs from the proposed timeframes for responding to provider prior authorization requests. Instead of the proposed timeframes of no later than 72 hours for urgent requests and seven calendar days for standard requests, QHPs would default to their current regulatory standard of 72 hours for urgent requests and fifteen days for standard requests. While we recognize that many QHPs are smaller plans with fewer enrollees, and thus more limited resources, excluding QHPs from the timeframe requirements would delay access to care for patients insured through the FEEs. **To ensure alignment across payers and minimize delays in the provision of care to patients, we urge CMS to include QHPs in the proposed timeframe requirements (revised as we recommend above in section 2).**

4. CMS should finalize policies that will increase transparency of prior authorization decisions and trends.

CMS proposes to require payers to publicly report aggregated prior authorization metrics, either on the payer website or through publicly accessible hyperlinks. The level at which data would be reported differs by payer, with CMS proposing MA organizations report at the organization level, Medicaid and CHIP managed care report at the plan level, Medicaid and CHIP FFS be reported at the state level, and QHP metrics be reported at the issuer level. The data payers would report annually include a list of all items and services that require prior authorization, the percentage of standard and expedited requests that were approved and denied, and the average and median time it took the payer to make a determination on standard and expedited requests. These data points would be aggregated and thus reported across all items and services covered by the payer. **We strongly support public reporting of these metrics, which will be critical to ensuring payer transparency and allowing providers and patients to evaluate plan performance on prior authorization**

⁵ Kaiser Family Foundation. Medicare Advantage in 2022: Enrollment Update and Key Trends. August 25, 2022. August 25, 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>. Accessed February 14, 2023.

⁶ Kaiser Family Foundation. Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. August 25, 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>. Accessed February 14, 2023.

⁷ HHS Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 27, 2022. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp?hero=mao-report-04-28-2022>. Accessed February 14, 2023.

metrics. We offer some additional suggestions that will increase the meaningfulness of this data to the public.

CMS should require that MA organizations report their metrics at the plan instead of the organization level. CMS proposes that MA organizations report metrics at the organizational level. MA organizations typically offer numerous plans across states, regions, and often nationwide. If the information for a large MA organization is reported at the organizational level, this data would have limited utility for a patient seeking information on the average prior authorization determination time and denial rate in their market. Similarly, providers seeking to contract with payers, including MA plans, could benefit from knowledge about specific plans in their region, as opposed to data on the entire MA organization.

Furthermore, CMS should require all payers to report information at a more granular level, such as by service category, instead of as aggregated data across all items and services. Detailed data for categories of services will be informative for patients seeking to better understand what the expected determination time and approval rate might be for a specific service. For example, for a patient expecting hip replacement surgery in the coming year who is evaluating plans during open enrollment, specific information on hip replacement surgery prior authorization requests would be more useful than aggregated data across all items and services.

Finally, CMS should ensure that payers present this data in a manner that is understandable by the average consumer, particularly limited English proficiency (LEP) communities and those with low health literacy. Given that more than 300 languages are commonly spoken in the United States, it is not uncommon for health care providers to encounter multiple spoken languages in their care settings and to find themselves ill-prepared to communicate effectively with their patients. Language barriers put the health of many LEP individuals, and that of their communities, at risk by affecting their ability to access care and communicate with their health care providers. This, in turn, increases the risk of life-threatening errors, wrong procedures, preventable readmissions, and other adverse events.⁸ Empowering patients to take charge of their own health and work collaboratively with their providers is critical to achieving high-quality health care, especially in settings that serve marginalized people. CMS should require payers to provide access to prior authorization data in multiple languages (based on the most common languages in a community) and in a format that is comprehensible to the average consumer. This information will be critical as America's Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance.

5. CMS should not finalize the addition of an electronic prior authorization measure as a mandatory measure until the agency has adequate standards and specifications to support electronic prior authorization.

CMS proposes a new measure that would be included in the health information exchange (HIE) objective of the Medicare Promoting Interoperability Program for eligible hospitals and the promoting interoperability performance category of the Merit-based Incentive Payment System (MIPS) for eligible physicians beginning with the calendar year 2026 performance period. This

⁸ Karliner LS, Jacobs EA, Chen AH, et al. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Services Research*. 2007;42(2):727-754. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955368/>. Accessed February 14, 2023.

measure would require eligible hospitals and eligible clinicians to make a prior authorization request through a PARDD API using data pulled from their certified EHR technology, as well as other data as necessary, to justify the request. **We urge CMS to delay mandating reporting for this measure until there are adequate standards and specifications to support electronic prior authorization.**

Essential hospitals are vested in automating prior authorization and leveraging their EHRs to expedite prior authorization requests. Integrating prior authorization workflows within the EHR has the potential to reduce provider burden and shorten prior authorization determination times. However, while the intent of incenting the use of EHRs for prior authorization by including a new measure is unobjectionable, it is premature to include it as a mandatory measure against which providers' performance will be assessed and to which their reimbursement will be tied. CMS could include the measure as a voluntary measure and award bonus points for reporting on the measure, which will encourage reporting while affording providers time to familiarize themselves with the measure and with new electronic prior authorization processes.

The measure is not ready for inclusion in these reporting programs because, as we note above, there is still work to be done for the adoption of standards and certification criteria. It would be premature to require providers to use their EHRs for a functionality that has not yet been uniformly integrated into EHRs due to the lack of certification requirements. Moreover, providers will require time to train their staff to become accustomed to the new workflows involved in electronic prior authorization requests throughs EHRs. CMS should work with other agencies, such as ONC and appropriate standards development organizations, to rectify this lack of standards and certification criteria, before requiring this measure. **Until CMS can confirm prior authorization standards and certification are available, it should not include the new measure for mandatory reporting.**

Requests for Information

In the proposed rule, CMS includes requests for information (RFIs) on multiple topics. Below, we provide recommendations and input on the RFIs on:

- Current barriers to adopting standards related to social risk factors, as well as opportunities to adopt such standards.
 - Advancing the electronic exchange of behavioral health information.
 - Advancing interoperability and improving prior authorization processes to improve maternal health outcomes.
- 1. Current barriers to adopting standards related to social risk factors, as well as opportunities to adopt such standards.**

CMS solicits feedback on barriers the health care industry faces to using industry standards and opportunities to accelerate adoption of data collection standards related to social risk factor data, including exchange of information with community-based organizations. Below, we provide feedback on topics related to the collection of social risk and social needs data that CMS should address to encourage the collection and use of this data for improving health outcomes and promoting health equity.

a. **Standardized Collection of Data on Social Determinants of Health (SDOH)**

America's Essential Hospitals supports CMS' efforts to gather accurate, standardized data on patient demographics. We believe collecting race, ethnicity, and language (REL) data supports hospitals' efforts to identify preferences and needs and to tailor a care plan to specific patient characteristics. For example, collecting preferred language helps identify appropriate interpreter services, as necessary. The ability to monitor and stratify data also helps front-line staff identify problems and standardize efforts across hospitals.

But the lack of consistently available and reliable race and ethnicity data in health care continues to be a barrier to measurement. Several components have been noted to improve the collection of race and ethnicity data at an organization, such as having leadership buy-in and support, streamlining data collection processes and structure, standardizing staff education, engaging patients in direct communication, and measuring and monitoring these activities.⁹

CMS currently does not consistently collect self-reported race and ethnicity information for the Medicare program; the agency largely relies on Social Security Administration data.¹⁰ The lack of consistent standards related to data collection—particularly for marginalized population subgroups—challenges adequately collecting, reporting, and tracking information on health disparities. There also is a potential benefit in standardizing when data is collected (e.g., upon admission or patient registration), as well as providing consistency in how hospitals respond to

⁹ Shapiro A, Meyer D, Riley L, et al. Building the Foundations for Equitable Care. *NEJM Catalyst*. September 1, 2021. <https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0256>. Accessed February 14, 2023.

¹⁰ Filice C, Joynt K. Examining Race and Ethnicity Information in Medicare Administrative Data. *Medical Care*. 2017;55(12):e170–e176. https://journals.lww.com/lww-medicalcare/Abstract/2017/12000/Examining_Race_and_Ethnicity_Information_in.26.aspx. Accessed February 14, 2023.

patient concerns about the ways in which that data will be used.¹¹ **We encourage CMS to raise awareness and develop resources to support REL data collection and sharing, with clear information about how the agency or others will use the data.**

America's Essential Hospitals also supports efforts to improve the collection of social risk factor information to understand better how these factors affect outcomes; this work is important to identifying the needs of our nation's underrepresented patients. **We support a consensus-building approach that brings interested stakeholders together to determine relevant social factors and how to capture them in a standardized, culturally sensitive way.** But there are challenges to collecting SDOH data, including the sensitive nature of these conversations, a lack of alignment across screening tools, and a need to link data from medical and nonmedical sources (i.e., community services).

Additionally, screening for health-related social needs (HRSNs) often is labor- and time-intensive, adding an additional resource burden on essential hospitals, which operate with low margins and disproportionately serve marginalized people who often face one or more HRSNs. The mode of data collection can heavily impact patient care workflows. For example, some essential hospitals administer screening electronically, via an application provided to all inpatients, while others might have health care workers use paper screening that requires subsequent data entry, which can consume considerable time and seem intrusive or unnecessary from the viewpoint of patients and families. Other essential hospitals use a standard, self-reported questionnaire provided through a patient portal, which has the potential benefit of more accurate answers to sensitive questions but requires that the application used be interoperable with existing EHRs to allow data to be transferred seamlessly into a patient's record. **We encourage CMS to recognize the time and resources required to implement screening of all patients for HRSNs and train staff to collect this data.**

As CMS compiles resources and identifies standards and best practices for the collection of SDOH data, we encourage the agency to leverage the Network of Quality Improvement and Innovation Contractors (NQIIC) program. The existing NQIIC infrastructure would be a logical and efficient way to support and promote this work. Established in 2018, the NQIIC program is designed as a potential 10-year, \$25 billion contract vehicle to support health care improvement initiatives. It allows preselected contractors to work with the health care field to target public health, behavioral health, patient safety, care coordination, and chronic disease self-management—issues that are critical to advancing health equity and are focus areas for essential hospitals. The NQIIC statement of work envisions leveraging contractors to provide technical assistance to participants on the use of health information technology, with a vulnerable populations and disparities focus. **Therefore, CMS can leverage the NQIIC program to help in the important work of identifying and disseminating best practices to capture, record, and exchange SDOH data.**

Building the infrastructure to leverage equity data (e.g., stratification to identify inequities) can be a substantial investment. Further, all health care professionals and others working in the delivery system must be trained in collecting accurate socioeconomic and sociodemographic data and educating patients on why such data are being collected. **Providers need time to become familiar with the data and the data collection processes, as well as how**

¹¹ Pittman MA, Pierce D, Hasnain-Wynia R. Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals. *The Commonwealth Fund*. May 1, 2004. <https://www.commonwealthfund.org/publications/fund-reports/2004/may/who-when-and-how-current-state-race-ethnicity-and-primary>. Accessed February 14, 2023.

equity data might help set priorities and drive outcomes. The magnitude of the issue—health equity—demands a thoughtful, phased approach that accommodates providers at various stages along the path to health equity.

b. Use of ICD-10 Z Codes to Capture Standardized SDOH Data

CMS references the availability of International Statistical Classification of Diseases, 10th revision (ICD-10) Z codes to capture SDOH data, as well as the low utilization of Z codes on Medicare claims. The ICD-10 provides codes (Z00-Z99) to specify other factors that influence a patient's health status. Providers since 2015 have used Z codes to capture SDOH information for Medicare FFS beneficiaries. However, an analysis from CMS found less than 2 percent of Medicare FFS beneficiaries in 2019 had a Z code associated with a claim.¹² Limited documentation of SDOH data hinders our capacity to understand and adequately address social barriers to positive health outcomes. By encouraging the collection of this data in a standardized manner, CMS can better understand the severity of illness and resources necessary to treat adverse health outcomes caused by social barriers to care, while also improving the data sources and methodology to account for social indicators. **We urge CMS to address barriers to adopting and provide education on the importance of reporting Z codes.**

2. Advancing the electronic exchange of behavioral health information.

CMS seeks feedback on how to better facilitate the uptake of EHRs and the exchange of health information through non-EHR means, such as APIs, by behavioral health providers. CMS also references the regulations promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA) on improved care coordination among providers that treat substance use disorders, as well as protecting those patients' records (42 CFR Part 2). CMS can take steps to lift barriers to technical integration of systems and to facilitate the secure electronic exchange of health information, including sensitive health information.

Documenting consent to use, disclose, and redisclose Part 2 records, as well as limiting and revoking consent, depends highly on EHR technology and a system's ability to identify and segment certain parts of a medical record. Current rules require an EHR to segment Part 2 records from the rest of the patient's medical record, but the proposed patient protections will require EHRs to further segment individual Part 2 records or sections in a single record. Not all EHR systems have this capability or lend themselves to be upgraded to do so. Switching EHR systems or making significant functionality changes to existing systems can cost millions of dollars and require extensive planning.

Further, upgrading and updating EHRs is costly and time-consuming, and providers lose access to EHR systems during updates. This requires that they work offline, which means they could lose access to their patient's medical records and their ability to transmit prescriptions to pharmacies and make referrals. They also must capture patient visit information offline and document it in the EHR later, a time-consuming task. When EHR systems are upgraded with new capabilities, such as documenting consent and segmenting records to share, it requires not only staff training on the new capabilities but also time to design, test, modify, and fix the new

¹² Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019. CMS Office of Minority Health. September 2021. <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>. Accessed February 14, 2023.

function. Each new function has an attached cost, so upgrades to EHR systems require planning, funding, and discretion.

We recognize that addressing technological barriers in EHRs is not fully within the agency's scope, but **CMS must work with other federal agencies, especially ONC, to improve EHR standards and create requirements** so EHR systems can implement privacy rules and better meet the needs of essential hospitals, as well as adapt to future needs. Updates, upgrades, and switching EHR systems require long-term planning, budgeting, and coordination to decide what and when to upgrade. With narrow operating margins, essential hospitals do not have the luxury of updating their EHR every time there is a new requirement or needed functionality or the ability to switch EHRs when their current system no longer meets their needs. The lack of required standards or functionality has led to some EHRs having limited capabilities, such as segmenting records for privacy reasons. This forces health systems to manage with a subpar EHR system or purchase a new system. Further, **we encourage federal financial support for essential hospitals to upgrade their EHRs as necessary to comply with new Part 2 rules.**

3. Advancing interoperability and improving prior authorization processes to improve maternal health outcomes.

Our members are adept at caring for new mothers and their babies at this critical time in their lives. This requires special attention to the unique circumstances faced by new mothers, particularly those who might experience additional social risk factors, such as food insecurity or housing instability. Providing comprehensive benefits for pregnant and postpartum patients should reach beyond the provision of traditional health care services and include addressing SDOH that often influence health outcomes (e.g., access to child care, support for feeding infants, testing for lead, etc.).

Essential hospitals are at the forefront of seeking to eliminate health disparities in maternal care. An essential hospital in California has created a prenatal and postpartum care known as BElovedBIRTH Black Centering. Through this no-cost program, patients attend sessions with other pregnant people and gain resources that can ease their pregnancies and prepare them for childbirth and the postpartum period. In Massachusetts, researchers at another essential hospital created a computer program called the Gabby Preconception Care System, which is designed to improve patients' health before pregnancy begins by increasing access to preconception care, providing relevant information, and building a health record. The program, Gabby, walks women through risk assessment activities in 13 health areas, including environmental risks, social factors, sexual health, infectious diseases, and genetic issues. This step helps inform women prior to appointments so they can ask questions and the provider can better understand what factors need to be considered moving forward.

Given the importance of prenatal and perinatal care to eliminating health inequities and to improving the health of marginalized communities, it is particularly important that prior authorization not serve as an obstacle to timely care. One purpose of prior authorization in maternal care is to decrease overutilization of certain procedures, such as ultrasounds. However, prior authorization has shown to lead to unanticipated circumstances, such as delaying access to obstetric imaging.¹³ For at-risk populations (like those essential hospitals

¹³ Jain v., et al. Prior authorization and its impact on access to obstetric ultrasound. *American Journal of Obstetrics and Gynecology*. 2020 Apr;222(4):338.e1–338.e5. <https://pubmed.ncbi.nlm.nih.gov/31962106/>. Accessed February 16, 2023.

serve) lack of access is an existing issue that has led to inequities in maternal health—prior authorizations must not exacerbate this issue. By adopting the recommendations we include throughout our letter, such as shorter prior authorization timeframe requirements for payers, CMS can ensure it removes obstacles to maternal care and improves maternal health outcomes.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO