January 4, 2021

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9123-P
Submitted electronically to http://www.regulations.gov

Re: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications

Dear Administrator Verma,

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information proposed rule.

AMIA is the professional home for more than 5,500 informatics professionals, representing frontline clinicians, researchers and public health experts who bring meaning to data, manage information and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations.

AMIA strongly supports CMS in its effort to provide patients, providers, and payers improved access to certain data through modern application programming interface (API) standards and policies to enable such access. We view these data as important components to better define the picture of patient/beneficiary health and care, and we likewise appreciate CMS efforts to align standards with certain Implementation Guides (IGs) and the US Core Data for Interoperability (USCDI). We believe that specifying IGs and bringing these proposals into alignment with Medicare Blue Button policies is necessary to create a standardized environment whereby patients, payers, and providers can improve their access and exchange capabilities via APIs. However, we encourage CMS to consider additional aspects that will ensure long-term success of the proposed policies.

Namely, despite its proposals to require that the APIs be conformant with these IGs, we caution that the maturity of the proposed IGs vary. Inconsistent maturity will undoubtably complicate the exchange and use of these data, so we recommend CMS work closely with the impacted payers and the information system vendors upon which they rely. CMS should use every lever at its disposal to encourage the use of the referenced standards and IGs and should provide financial and human resource support for their ongoing adoption, evaluation, and refinement.

Chart a course towards adding prior authorization APIs as part of certification criteria

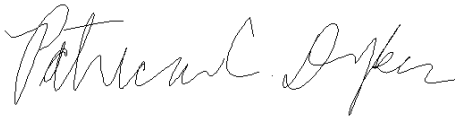
We are additionally pleased with CMS's willingness to address prior authorization workflow through APIs. We support CMS's intent to provide more specific guidance to implementers and agree that more consistent exchanges between payers and providers could reduce current burdens if implemented thoughtfully. However, while the goals are laudable, the proposals must also address the underlying causes of prior authorization burden. The text of the proposed rule considers whether new EHR certification criteria are needed, and we believe that they are. We have previously recommended that CMS re-assert its jurisdictional purview to establish industry adoption timelines for health IT, rather than cede this responsibility to ONC.[1] While we generally support the proposals in the interim, we also believe that CMS's goal to streamline the prior authorization process through FHIR-enabled APIs will only ultimately be successful if these requirements are built into certification and CMS is the agency determining these adoption requirements.

Reevaluate proposed compliance dates

In considering CMS's proposed timelines for adoption and deployment of six different APIs conformant to even greater number of standards, AMIA believes that the January 1, 2023 deadline will not provide sufficient time for impacted payers to comply. We thus recommend that the compliance date be delayed. Providing additional time to adopt these standards is especially important for the State Medicaid and CHIP agencies impacted by these proposals, given their resource limitations.

Below, we offer detailed responses to specific proposals in the proposed rule and questions from the various requests for information (RFI). Thank you for considering our comments. Should you have questions about these comments or require additional information, please contact Scott Weinberg, Public Policy Specialist at scott@amia.org or (240) 479-2134. We look forward to continued partnership and dialogue.

Sincerely,



Patricia C. Dykes, PhD, RN, FAAN, FACMI
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[1] https://www.amia.org/sites/default/files/AMIA-Response-to-CMS-Interop-and-Patient-Access-NPRM.pdf

Center for Patient Safety, Research, and Practice
Brigham and Women's Hospital

(Enclosed: AMIA Detailed Comments)

Patient Access API

CMS is proposing to finalize specific IGs through notice-and-comment rulemaking to ensure that all impacted payers are using these IGs in order to support true interoperability. Impacted payers would be required to ensure their APIs are conformant with these IGs (for Medicaid managed care plans and CHIP managed care entities, by the rating period beginning on or after January 1, 2023). The CARIN IG for Blue Button, the PDex IG, and the PDex US Drug Formulary IG are proposed for HHS use.

AMIA Comments: As stated above, AMIA supports specifying IGs, which effectively bring these proposals into alignment with existing Blue Button policies. We do, however, caution that some of the proposed IGs are not yet mature enough. We therefore recommend that CMS revise its proposed timeline.

We do not, however, support allowing parties to implement new versions of the IGs without clear and public advance notification and planned schedule for rollout. Such advanced notification should include providing the ability for API users to test the new version in advance.

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In addition to enhancing the Patient Access API by proposing to require that the API be conformant with the specified IGs, CMS is proposing to require that information about prior authorization decisions be made available to patients through the Patient Access API conformant with the HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG no later than one (1) business day after a provider initiates a prior authorization request or there is a change of status for the prior authorization. This would include the date the prior authorization was approved, the date the authorization ends, the units and services approved, and those used to date.

AMIA Comments: We believe that including prior authorization information as part of the Patient Access API is ultimately essential. However, we note that considerable development by information technology providers would be required for all three groups of interested parties. Until patient-facing third-party apps are better able to consume data from prior authorization APIs, we believe that the gain will ultimately be minimal. Solving this problem will require patient-facing app developers, payers, and providers to coordinate.

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CMS is also requesting comment for possible future consideration on whether or not impacted payers should be required to include information about prescription drug and/or covered outpatient drug pending and active prior authorization decisions with the other items or services proposed via the Patient Access API, the Provider Access API, or the Payer-to-Payer API.

AMIA Comments: We recommend that CMS establish requirements for impacted plans to make available drug benefit data, including pharmacy directory information and formulary or preferred drug list data, through this and the other APIs proposed. These standards are well-established, but they are not consistently adopted and used. The information systems that exchange and use eRx transactions can be variable because not all stakeholders use certified

EHR technology (CEHRT) to generate those data. Further, pharmacy directory, and formulary data is often incomplete and non-standard, which complicates access, exchange, and use.

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Privacy Policy Attestation

CMS is proposing to make it a requirement that impacted payers request a privacy policy attestation from third party app developers when their app requests to connect to the payer's Patient Access API.

AMIA Comments: While we support the goals of the proposed privacy attestation requirement, we believe a more effective approach would be for CMS to coordinate with ONC to require conformance with the ONC Model Privacy Notice[2] and also seek conformance statements from app developers, which then could be accessed both by patients and by payers. This will aid the patient in considering whether to use the app, while also relieving payers from having to repeatedly seek the attestation. CMS should additionally coordinate with ONC on the creation of an app "clearing house," which would allow patients, payers, and providers to obtain information regarding any app attempting to access APIs in their environments. These apps should also be required to conform to the ONC Model Privacy Notice. If CMS finalizes this proposal, we recommend that the payer additionally be required to limit the length of the notice.

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Patient Access API Metrics

CMS is proposing to require impacted payers to report metrics about patient use of the Patient Access API to CMS.

AMIA Comments: AMIA supports this proposal. We note that it will be important for policymakers to closely monitor the effectiveness and uptake of this latest requirement.

Provider Access APIs

CMS is proposing a Provider Access API that allows providers to have access to an individual patient's information. Second, it is proposing that the Provider Access API allow access to multiple patients' information at the same time.

Additional Proposed Requirements for the Provider Access APIs

a. Attribution

CMS is proposing that each payer establish, implement, and maintain for itself, a process to facilitate generating each provider's current patient roster to enable proposed payer-to-provider data sharing via the Provider Access API.

[2] https://www.healthit.gov/topic/privacy-security-and-hipaa/model-privacy-notice-mpn

AMIA Comments: AMIA generally supports this proposal. However, we caution CMS about introducing further complexity into identification, authorization, and attribution workflows, especially if it allows each payer to design its own system for managing these workflows.

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b. Opt-In

CMS is proposing that impacted payers would be permitted to put a process in place for patients to opt-in to use of the Provider Access API for data sharing between their payer and their providers.

AMIA Comments: AMIA believes that patients should have maximum control over their own data, and thus supports a mild modification to this proposal. We note that similar opt-in policies for health information exchange, such as the one employed by the VA until 2020, have met with limited success in engaging patients. We recommend that CMS require minimum guidelines for payers putting in place an opt-in process. Specifically, payers should provide a specific request to the patient to opt-in to use of the Provider Access API. The request should also include a clear and succinct statement explaining the benefits of doing so. The patient should then have the opportunity to decline. We believe that this approach is more advantageous to either a blanket opt-in or opt-out process, as this seeks to obtain explicit patient permission and would better satisfy privacy concerns.

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c. Provider Resources

CMS is proposing that payers make educational resources available to providers that describe how a provider can request patient data using the payer's Provider Access APIs in nontechnical, simple, and easy-to-understand language.

AMIA Comments: AMIA supports this proposal.

Documentation and Prior Authorization Burden Reduction through APIs

Proposed Requirement for Payers: Documentation Requirement Lookup Service (DRLS) API

CMS proposes to require that impacted payers implement and maintain a FHIR-based DRLS API conformant with the HL7 FHIR Da Vinci Coverage Requirements Discovery (CRD) IG: Version STU 1.0.044 and the HL7 FHIR Da Vinci Documentation Templates and Rules (DTR): Version STU 1.0.045 IG, populated with their list of covered items and services, not including prescription drugs and/or covered outpatient drugs, for which prior authorization is required, and with the organization's documentation requirements for submitting a prior authorization request, including a description of the required documentation.

Proposed Requirement for Payers: Implementation of a Prior Authorization Support API

CMS is proposing that impacted payers implement a Prior Authorization Support (PAS) API that facilitates a HIPAA compliant prior authorization request and response, including any forms or medical record documentation required by the payer for items or services for which the provider is seeking authorization. If this provision is finalized as proposed, the payer would be required to implement the API, and, when sending the response, include information regarding whether the organization approves (and for how long), denies, or requests more information for the prior authorization request, along with a reason for denial in the case of a denial.

AMIA Comments: AMIA supports the inclusion of both of these API requirements. Requiring the payer to publish what requires authorization and the minimum data requirement would be a helpful antecedent to trying to automate the request-assessment-approval process. We suggest that CMS look to its current requirements that certain orders for radiology procedures be submitted for electronic approval, as a way to assess how the prior authorization process might be automated.

Ultimately, however, we disagree with CMS that requiring the impacted payers to implement the FHIR-based APIs that would be available for providers might ultimately result in broader industry-wide changes to address the prior authorization issues. We strongly believe that the best way to leverage these APIs to streamline the prior authorization process is to eventually include these functions as certification criteria in the ONC Health IT Certification Program.

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a. Requirement to Provide a Reason for Denial

CMS is proposing that impacted payers send certain response information regarding the reason for denying a prior authorization request. Impacted payers must transmit, through the proposed PAS API, information regarding whether the payer approves (and for how long), denies, or requests more information related to the prior authorization request. In addition, it proposes that impacted payers include a specific reason for denial with all prior authorization decisions, regardless of the method used to send the prior authorization decision.

AMIA Comments: AMIA supports this proposal.

Public Reporting of Prior Authorization Metrics

CMS is proposing to require impacted payers to publicly report certain prior authorization metrics on their websites at the state-level for Medicaid and CHIP FFS, at the plan-level for Medicaid and CHIP managed care, and at the issuer-level for QHP issuers on the FFEs.

AMIA Comments: AMIA supports this requirement, but urges CMS to leverage this data to vigorously monitor the success of the potential prior authorization API requirements. While we do not foresee the average provider or beneficiary utilizing such data, we still believe that such data can potentially support ongoing program evaluation. To be most useful, the data would need to be able to be sorted or filtered by payer and/or pre-authorization carve-out manager, as well as by the item being authorized. Making such information more transparent could have significant benefits in demonstrating overly restrictive pre-authorization behaviors by insurers, or in

showing that pre-authorization almost always is approved (thus indicating that the main purpose is to erect delays and disincentives to appropriate care for patients and for providers).

Request for Comments on "Gold-Carding" Programs for Prior Authorization

CMS seeks comment for potential future rulemaking on the incorporation of gold-carding into star ratings for QHP issuers on the FFEs. We also considered proposing gold-carding as a requirement in payer's prior authorization policies and seek comment on how such programs could be structured to meet such a potential requirement.

AMIA Comments: AMIA supports the adoption of gold-carding approaches. We caution that any future policy that incorporates gold-carding programs have vigorous auditing procedures in place. Such procedures should ensure that providers are not disincentivized from ordering certain tests or medications to maintain their gold-card status with a payer.

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10. Additional Requests for Comment

CMS seeks comment on whether there should be certain restrictions regarding requirements for repeat prior authorizations for items and services for chronic conditions, or whether there can be approvals for long term authorizations. What alternative programs are in place or could be considered to provide long-term authorizations for terminal or chronic conditions?

AMIA Comments: We believe that such restrictions can be a common-sense fix for patients with chronic conditions, as there was never a need for repeated authorizations for the overwhelming majority of items and services to begin with. We do not think an alternative program is necessary, but rather a policy change so that authorizations are ongoing by default for certain chronic conditions. There may be a small fraction of items/services that should still be subject to re-authorization, such as controlled substances or very expensive medications that would not be expected to be needed on a chronic basis. However, even in those circumstances, the re-authorization should be streamlined and should not put patients at risk by introducing delays in treatment. For items such as durable medical equipment and supplies, minor adjustments to the type of item should not require re-authorization, as long as the item's purpose is the same. For tests, imaging studies, etc. that are required for surveillance after specific procedures (e.g., after surgery or initial chemotherapy for cancer), we also believe that authorization for subsequent testing should also be automatic.

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CMS also seeks comment on whether a prior authorization decision should follow a patient when they change from one qualified health plan on the Exchange to another, or to another health plan impacted by this proposed rule, and under what circumstances that prior authorization could follow a patient from payer to payer.

AMIA Comments: AMIA believes that authorizations should always follow a patient when they change from one plan to the next and would be supportive of future policies that will enable this.

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CMS requests input on solutions to standardizing prior authorization forms, including the possibility of developing an HL7 FHIR based questionnaire for prior authorization requests. Input on requiring the use of a standardized questionnaire could inform future rulemaking.

AMIA Comments: As long as each payer can design their own questions, completing prior authorization forms will be burdensome for providers. This will hold true whether the questionnaire is paper, fax, or digital. We believe that the only way this state of affairs can improve is if the provider's system can automatically respond to a payer's request for data. This would require that payers limit requests to previously specified data elements that are already collected in the normal course of care delivery.

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CMS requests comments on how to potentially phase out the use of fax technology to request and send information for prior authorization decisions.

AMIA Comments: It should be possible to eventually eliminate fax machines if all providers were required to have a Direct Secure Messaging address and if Direct addresses could also be set up similar to messaging pools (for an entire office, to be addressed by office staff). Even for providers who do not have an EHR, having Direct Secure Messaging software (akin to email software) should be technically feasible without too much ramp up time. As an interim step, providers should be able to specify whether they want prior authorizations sent to fax or directly to their EHR. Similarly, they should be able to specify that insurers no longer send information via fax and that pharmacies turn off automated renewal requests altogether (both by fax and by electronic means).

Payer-to Payer Data Exchange on FHIR

CMS is proposing to extend the payer-to-payer data exchange to state Medicaid and CHIP FFS programs. It is also proposing to enhance this payer-to-payer data exchange by requiring a FHIR-based API for this data exchange. In addition, it proposes that this standards-based API must be conformant with specific IGs. It also proposes that this Payer-to-Payer API, at the patient's request, must make not just clinical data as defined in the USCDI available, but also claims and encounter data (not including cost information), and information about pending and active prior authorization decisions.

AMIA Comments: AMIA supports these proposals, caveated with our concerns about the compliance timeline and IG maturity that we mentioned above.

Adoption of Health IT Standards and Implementation Specifications

CMS is proposing to adopt the latest versions of several standards under a new paragraph (c), "Standards and Implementation Specifications for Health Care Operations."

AMIA Comments: AMIA supports HHS adoption or publication of standards recognized or adopted in CMS rules, based on recommendations from ONC.

Methods for Enabling Patients and Providers to Control Sharing of Health Information

Taking into consideration applicable federal, state, local, and tribal law, CMS is interested in stakeholder feedback on different methods that enable patients and providers to have more granular control over the sharing of patient health information.

AMIA Comments: We note that many patients may not understand the advantages and disadvantages of data sharing and segmentation. Many may have difficulty, for example, with configuring privacy related settings through a patient portal or other patient-facing apps. This should not be surprising, given the difficulties that most people have in understanding privacy implications and settings for commonly used technologies, such a social media. Such difficulties should not, however, de-emphasize the importance of patients being able to determine who has access to specific information about them. Providers may, by necessity, take on some role in helping patients control access to their information, based on patients' stated preferences for data segmentation and sharing. Consequently, software vendors should be required to have options for data segmentation and access restriction that could either be applied easily within provider workflows, or by patients. There are a number of contexts in which patients typically request restrictions on access to their information:

1. Specific diagnoses/problems that they feel would be damaging to them if others were aware, typically related to mental health or reproductive health topics;
2. Sex, gender, and sexual orientation, depending on whether their individual orientation has been shared with others;
3. Specific individuals who they do not wish to have accessing their information (e.g., family members, ex-partners/spouses, other employees). This is particularly true when family members, friends, or others they know work within the health system and when individuals are employed by the organization where they are receiving care;
4. Less often, individuals will not want anyone except treating clinicians to have access to their information. This is most often when individuals have public roles (e.g., politicians, entertainers), but can also occur with professionals who fear job loss or public disapproval if mental illnesses – including substance use – come to light.

The primary unintended consequence of segmenting and restricting data access is that the data would not be available to other providers who are providing care to the patient. Depending on whether access to payers could also be limited, payment denials might be another unanticipated consequence. However, if an interoperable approach to data segmentation and privacy tagging was adopted, then these unintended consequences would be reduced because patients would not have to choose between sharing all information and sharing no information, as is frequently the case.

The other use case for data segmentation and added privacy protections relates to information that is problematic for the patient or more commonly, the patient's parent or guardian to be able to access. In mental health settings, for example, it is not uncommon for family members to express concern and provide important details about the patient's mental health, yet the individual who is providing the information does not wish the patient to know what was said out of fear of damaging the relationship or fear that the patient might harm them. When treating

adolescents, it is also common for them to express information that is confidential and may even be protected under state law from disclosure to parents or guardians. Providers need to have easy ways of documenting such information for clinical and medicolegal purposes that also keeps it from being inappropriately released. In most such situations, the harms of release do not rise to the level of harm that would create an exception under the Information Blocking rules, yet the emotional and long-term harms on relationships can still be devastating to individuals and result in future mistrust of healthcare, with associated negative consequences.

Data tagging would place additional demands on providers, but the number of instances where providers feel compelled to tag/segment data or notes will likely be small. Particularly with the advent of the interoperability provisions and the movement to OpenNotes,[3] providers themselves can also experience psychological distress and moral injury if they are forced to release notes and other information that they feel will be harmful to the patient. When such experiences occur due to limitations in EHRs to easily segment data, it will worsen already negative feeling of providers towards EHRs.

Most current consent practices are not effective in engaging patients to document their preferences for data segmentation and sharing or allowing provider discretion in responding to patient requests. In fact, the only option that it typically available for patients with concerns about their informational privacy is to have them seek care elsewhere, which may or may not be a realistic option. Existing standards such as Consent2Share and Data Segmentation for Privacy[4] were reasonable when initially developed, but never received sufficient adoption to learn their benefits or pitfalls. If a patient believes that their information is protected or if a provider believes that they have protected information on behalf of a patient, then those provisions should be respected. If entities are able to avoid implementing data segmentation and avoid adhering to patient/provider requests, they will likely do so, which will reduce or eliminate any benefits of segmentation.

Electronic Exchange of Behavioral Health Information

CMS interested in public comments on how it might best support electronic data exchange of behavioral health information between and among behavioral health providers, other health care providers, and patients, as well as how it might best inform and support the movement of health data (and its consistency) to behavioral health providers for their use to inform care and treatment of behavioral health services.

AMIA Comments: There are a number of reasons that behavioral health providers have not adopted EHRs in greater numbers and these same issues would apply to FHIR-based APIs.

For behavioral health providers who are engaged primarily in providing psychotherapy, the multiple features of EHRs bring limited added value over traditional charting. Behavioral health providers other than psychiatrists and psychiatric nurse practitioners do not have medical training, cannot prescribe medications, and are not familiar with the implications of much of the information that would be conveyed on a problem list or other aspects of the medical record. For

[3] https://www.opennotes.org/
[4] https://www.healthit.gov/topic/health-it-health-care-settings/behavioral-health-consent-management

these individuals, interoperability is of limited value and the costs of an EHR do not offset the benefits.

Many behavioral health providers also have significant concerns about patient privacy. Use of APIs would likely be of even greater concern to behavioral health providers than an EHR, particularly if they involved third-party intermediaries or apps with unclear privacy protections.

Behavioral health providers have typically received low levels of reimbursement from payers including CMS. This, in addition to the administrative burdens of being a participating provider leads many behavioral health providers to choose not to participate at all. Psychiatrists, for example, participate at lower rates than providers in other specialties.[5] For those providers who do participate, the added burdens of participation can be overwhelming. The CMS Conditions of Participation (CoP) for behavioral health are particularly challenging to address for many organizations, since they differ from the CoP for the rest of the institution and add complex requirements, such as formal Interdisciplinary Treatment Plans that are challenging to implement in an EHR, yet do not bring added value to patient care.

Although many behavioral health providers were excluded from initial EHR incentives, those who were included (typically as part of a large organization or academic health center) found may requirements of Meaningful Use and now MIPS to be irrelevant to behavioral health care. The financial benefits of participating in these programs additionally did not offset the total costs of EHR purchase and implementation or the additional burdens of compliance. For these reasons, CMS may wish to explore efforts to reduce the already sizeable compliance burdens on facilities that provide behavioral health care.[6]

Unlike other specialties that receive higher reimbursement rates, behavioral health providers lack sufficient funds to hire support staff to deal with administrative and billing issues, nursing staff to assist with tasks such as vital signs or medication histories, or information technology staff to support EHRs or other uses of information technology. Given the existing shortage of mental health providers, which is made worse by the increasing mental health needs due to COVID-19, the country cannot afford to burden individuals with costly new requirements, possibly pushing them into early retirement. Indeed, as of 2017, 61% of psychiatrists were age 55 and older[7] and data for psychologists also show a sizeable fraction who are approaching retirement age.[8]

To support greater information exchange to and from behavioral health providers who lack an EHR, a free or very low-cost solution is needed that would allow secure exchange of information between individual providers, while supporting data segmentation and other privacy protective features as they become available. In the initial phase, such an approach could function similarly to an electronic version of a fax machine, perhaps using Direct Secure Messaging for routing of documents or other information. Since not all individuals would have an EHR, it would need to support transmission of information in pdf or other document types. Such an approach would

[5] https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program
[6] https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf
[7] https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-age-and-specialty-2017
[8] https://www.apa.org/workforce/publications/13-demographics/report.pdf

also be relatively low bandwidth and could be used by rural behavioral health providers, as well as other community-based providers.

Reducing Burden and Improving Electronic Information Exchange of Prior Authorizations

CMS is interested in learning what barriers exist for hospitals (and other providers and suppliers) to electronically transmit prior authorization requests and receive prior authorization decisions for patients receiving care and services by the applicable provider.

AMIA Comments: Current barriers to electronic transmission of prior authorization requests and receipts include a lack of standardization of the elements and information required in such requests across different types of prior authorizations and workflows of providers and insurers that would currently make such authorizations challenging. Due to the current burdens associated with prior authorizations, most providers delegate these tasks to other staff members who focus only on such issues. However, most EHRs are designed in a patient-focused fashion that requires tasks to be completed by the provider for an individual patient. For these processes to work efficiently, vendors would need to have a way for orders that require prior authorization to be transferred to a message pool or task list that could be managed by prior authorization staff with electronic communications from insurers returning to the same pool or task list to facilitate further scheduling or follow-up with the patient, pharmacy, or others. Electronic communication with pharmacies, companies providing durable medical equipment, and providers of imaging or other tests would also need to be able to receive such communications.

We do not believe that addition of further elements to CMS CoP would be appropriate or helpful, as these are already quite burdensome. If prior authorizations can be switched to an electronic format without additional software, costs, or maintenance fees for users, the increase in efficiency will be more than sufficient to drive adoption.

Future Electronic Prior Authorization Use in the Merit-Based Incentive Payment System (MIPS)

CMS believes that MIPS eligible clinicians would also benefit from the PAS API, and is seeking comment on whether it should add a MIPS improvement activity to its Inventory that would utilize this PAS API to facilitate submitting and receiving electronic prior authorization requests and decisions to reduce burden, improve efficiency, and ultimately ensure patients receive the items and services they need in a timely fashion.

AMIA Comments: As noted above, if prior authorizations can be switched to an electronic format without additional software costs or maintenance fees for users, the increase in efficiency will be more than sufficient to drive adoption. If prior authorization requirements and workflows remain burdensome, incorporation into MIPS will not provide significant incentive. As long as prior authorization is primarily used as a way to delay or erect barriers to care, as it is at present, it seems unlikely that increased use of standards will improvement outcomes. On the other hand, if use of technology can reduce burdens for providers and patients and streamline access to needed care, then quality might improve and clinician burnout might be reduced. These efforts

would be greatly enhanced by a thorough review of all current pre-authorization requirements and elimination of pre-authorizations that do not serve to enhance care.

Reducing the Use of Fax Machines

CMS seeks comment on how it can reduce or completely eliminate the use of fax technology across programs, including both hospitals and post-acute care facilities, so that information can be shared electronically in real time without extensive follow-up to determine if the information was received.

AMIA Comments: Several approaches can be taken to reduce reliance on fax machines, several of which have been highlighted in prior questions relating to information exchange with behavioral health providers or other providers who have not implemented EHRs. Greater use of Direct Secure Messaging and an updated accessible directory of such addresses would allow exchange of information that is currently sent by fax for exchanging health information and also for referrals to social services, long-term care facilities, and other organizations or agencies. Eliminating faxing of prior-authorization information, other insurance information, and pharmacy refill requests would go a long way to reducing needs for faxes. Similarly, requiring that laboratories and imaging centers be able to send results directly without complex and costly interface links to individual EHRs would lead to further reductions in faxes. Family members, school personnel, or others with information about patients will sometimes use faxes to get essential information to health care providers. Such information can be crucial to patient care, but cannot be sent electronically because patient portal accounts are not consistent in offering proxy access and typically do not allow communication between outside parties and the care team.

Electronic fax solutions can help in getting faxed information into EHRs without use of an actual paper fax, but would not eliminate the need to be able to send outbound faxes to individuals or facilities that are still using ordinary fax machines. It would also not eliminate the need to be able to send scanned or paper information that is not coming directly from the EHR, such as requests for forms, consents, and other paperwork that is not specific to an individual patient or that is unavailable in an electronic format. Better options for electronic signatures, without a need for additional costly software would be helpful in reducing some of these uses of fax machines.

Accelerating the Adoption of Standards Related to Social Risk Data

CMS seeks input on barriers the health care industry faces to using industry standards and opportunities to accelerate adoption of standards related to social risk data.

AMIA Comments: We currently lack consistency in documentation of social needs or risks. Although some factors associated with social determinants of health (SDOH) can be coded in SNOMED, most information on these factors is only available in portions of free text notes. One way to accelerate adoption of SDOH data is by including them in the USCDI, Version 2, as recently suggested by the Gravity Project.[9]

[9] https://www.healthit.gov/isa/sites/isa/files/2020-12/Gravity%20Project%20to%20ONC%20on%20SDOH%20Data%20Class%20for%20USCDI%20v2.pdf

In addition to barriers that exist for exchange of any information within the health system, additional barriers exist for those with significant social risk factors. For example, frequent changes in address, gaps in health insurance coverage, lack of primary care, and fragmented access to health care all result in difficulties in matching records between systems. Lack of access to technology or internet access makes it more challenging for those with social risk factors to use features, such as patient portals, to keep track of their own health information.

The PSYCKES initiative of the New York State Office of Mental Health is one approach that has leveraged information from Medicaid data to help enhance continuity of care and emergency decision making for those with mental health issues, many of whom also have social risk factors.[10] This initiative has benefitted from an underlying focus on improving the quality of care to individuals with mental health needs, but also has challenges due to gaps in some of the data that is outside the Office of Mental Health purview. PSYCKES has always attempted to enhance utility of information for clinicians by summarizing the available data. Privacy considerations and patient consent have also been integral to the process. Such elements are important if social risk data are to be collected and used in a fashion that is beneficial to patients.

By its very nature social risk data can actually create adverse biases in care, particularly if used in algorithms or machine learning applications without careful review of the outputs. Just as these approaches can perpetuate racial biases,[11,12,13] they can also perpetuate or even worsen biases against those with social risk factors. Such considerations must be kept in mind in pursuing data-related initiatives on social needs and risk factors to avoid negative unintended consequences.

[10] https://omh.ny.gov/omhweb/psyckes_medicaid/about/
[11] https://pubmed.ncbi.nlm.nih.gov/31649194/
[12] https://www.nejm.org/doi/full/10.1056/NEJMms2004740
[13] https://www.medrxiv.org/content/10.1101/2020.05.07.20094250v1