



A driving force for health equity

Submitted via [regulations.gov](https://www.regulations.gov)

March 13, 2023

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

Re: Proposed Rule on 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 (Proposed Rule on Interoperability and ePrior Authorization); and Request for Information on Accelerating the Adoption of Standards Related to Social Risk Factor Data (RFI on Social Risk Standards)

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, we appreciate the opportunity to comment on the Proposed Rule on Interoperability and ePrior authorization (Proposed Rule) as well as the Request for Information (RFI) on Accelerating the Adoption of Standards Related to Social Risk Factor Data (Social Risk Standards). OCHIN is a [national health information technology innovation and research network](#) of locally controlled, community-based providers with more than 1,000 care sites and 22,000 providers in 47 states, serving more than 6 million patients that have documented 1.8 million social risk screenings within their electronic health records. OCHIN supports the Centers for Medicare and Medicaid Services' (CMS) efforts to advance interoperability, ePrior authorization and policies to address patient level social risk drivers of health.

The OCHIN collaborative of community providers offers technology solutions, informatics, technical expertise, workforce development and training, evidence-based research, and policy insights. Members include federally qualified health centers (FQHCs) and other community clinics, including in rural areas, we support certified community behavioral health clinics (CCBHC), complex specialty mental health organizations, local public health agencies, corrections, school-based mental health programs, youth authorities and rural hospitals. OCHIN has been an ongoing advocate for national digital data and technical standards to support interoperability, reduction in complexity and cost of data collection and reporting, as well as efforts to advance digital solutions.

OCHIN provides the following broad recommendations related to interoperability, ePrior authorization and the RFI on Social Risk Standards. (We have also included a more detailed set of responses to the RFI on Social Risk Standards in the Appendix.)

1. OCHIN, a member of the [Health IT End Users Alliance](#) (the Alliance), strongly supports CMS efforts to advance automation of prior authorization and concurs with the recommendations advanced by the Alliance.

- We underscore the importance of federal funding for more robust real-world testing of the interoperability standards and implementation guides intended to facilitate automation. **Such testing should be prioritized in provider networks serving patients and providers in underserved communities.**
- OCHIN network members, despite very limited resources relative to other providers, have engaged in technical testing of important implementation guides and identified important operational needs of end users for digital data and technical standards for social drivers of risk, for example, that have benefited all providers. Similarly, the OCHIN network has been a leader in partnership with other organizations and the Centers for Disease Control and Prevention (CDC) in developing and then testing technical standards for electronic case reporting (eCR) and has led the nation in the number of eCRs triggered. In both cases, the OCHIN network has borne significant costs to help develop and test digital data and technical standards despite the fact that these activities benefit federal and state health programs and other providers throughout the nation.

2. OCHIN supports CMS’s requirement that applicable payers must build a Provider Access API for payers to share the following patient data with in-network providers with whom the patient has a treatment relationship beginning in 2026: (1) patient claims and encounter data, excluding cost information; (2) United States Core Data for Interoperability (USCDI) version 1 data elements, and (3) prior authorization requests and decision. However, OCHIN recommends the following modifications to this proposal:

- OCHIN urges CMS to require providers to share claims and encounter data **including cost information**. As CMS and State Medicaid agencies drive toward value-based payment targets, it is critical that providers understand the total cost of care because they will not have the same level of cost data that federal and state health programs and contracted plans have to negotiate effectively. In order to remain sustainable, providers must be able to calculate sustainable total cost of care for patients attributed to them as part of value-based payment models.
- OCHIN also urges CMS to consider whether CMS and state Medicaid agencies will need the exchange of at least USCDI version 3 since this proposed requirement for payers does not go into effect until 2026. Because USCDI version 1 does not have digital data standards for social determinant of health (SDOH), sexual orientation and gender identity (SOGI), nor other data standards important for public health capabilities, this could be a missed opportunity to drive national digital data standardization in this area. Such a requirement would create a business case and drive adoption of standards and a move by industry to align.

3. OCHIN strongly supports efforts to address the social drivers of health to improve patient health outcomes and move to sustainable delivery models. OCHIN offers a number of responses to the RFI but would like to underscore that policymakers and payers can best promote the collection and sharing of social risk data by creating and implementing quality measures and reimbursement, with clear conceptual groundings, that are portable across care settings. This portability will also promote consistency across care settings. Further, we highlight that simply screening/monitoring/documenting the social needs of the patient population is not enough and that we must prioritize promoting taking actions to address these social needs and their associated health impacts.

Please contact me at stollj@ochin.org as OCHIN welcomes the opportunity to advance efforts to

streamline prior authorization processes as well as addressing social drivers of health that adversely impact health outcomes.

Sincerely,

A handwritten signature in blue ink that reads "Jennifer Stoll". The signature is written in a cursive, flowing style.

Jennifer Stoll
Executive Vice President
External Affairs

APPENDIX

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

- Because of the range of social risk domains needed and varied patient populations served, the frequency of social risk screening within our own network of members reflects a wide-range of practices and patient population needs. This also reflects the need for resources, including reimbursement and quality measures, to establish this as a priority area. Providers in underserved communities have frequently had to resort to seeking outside funding to support such screening because of the lack of payment and quality measure incentives to support this work. In addition, there is variability in the chronicity of certain domains that influences the ideal frequency of screening. Some social risks will be short-term and are likely to change more rapidly (e.g., economic needs), while others will be more immutable due to greater structural barriers (e.g., neighborhood environment). **Importantly, there will be additional variability in the best practice based on population served, screener/tool, staffing resources, and funder requirements.**
- **While the variety of screening tools in use may be a perceived barrier to documenting and exchanging social risk data, we believe that a universal screening tool is *not* the best path forward.** While it is critical to ensure equity in the ability to access and implement any screener, it is equally important to allow community-based health centers and other clinical practices to use the screening tool that is most appropriate and sensitive for the specific population they serve. However, it would be important to have a common conceptual understanding of how the domains, that these individual tools are mapped to, are defined. For example, “housing” needs represent a wide variety of needs and vary across rural and urban contexts. Importantly, the definition of “homeless” varies across federal programs as well. The recent expansion of Z-codes for homelessness (Oct 2022) acknowledged this variation by implementing more granular codes. **A similar conceptual map of the most common social need domains, and clarity in the definition of these needs, would allow for greater exchanging and portability of the results from various screeners.**
- There are numerous provider- and system-level barriers to capturing, exchanging, and using social risk data. These barriers begin with screening due to limited staff time and resources and continue through to receiving outside (i.e., closed loop) social risk data. One of the biggest barriers are that these efforts that often require staff time and technology. Systems that serve populations with the highest social needs often have the fewest resources, both staff and technology, that would support the implementation of robust datasets of closed-loop systems. **Greater federal investment and funding in establishing and testing secure, reliable, and automated closed-loop referral systems for community-based health centers would greatly improve the sharing of information on our nation’s most underserved populations.**
- We also acknowledge the power and potential of Z-codes but note the substantial provider barriers to using these codes. Safety net providers have several competing demands and are facing high rates of workforce burnout. This is one of the many reasons that non-billable codes, such as Z-codes, despite being helpful for population health purposes tend to be de-prioritized. There is a need to identify mechanisms that would compensate for this additional coding burden *or* recommend best practices to accurately automate.
- OCHIN is undertaking several promising initiatives around developing, piloting, and implementing EHR-based tools that would support our community-based health center members in routinely screening and documenting social needs data. These tools will be further extended to supporting efforts to establish closed-loop referral systems with providers.

- The patient-level privacy issues that accompany promoting exchanging social risk data cannot be understated. First, we recognize that the health care system has not been exempt to a history of the same societal structures that have created a maldistribution of health promoting resources. The communities with the highest social needs are those that have been historically disadvantaged and the process of rebuilding trust between these communities and the health care system is an ongoing process. Given this foundation, we first emphasize that *all* social needs must be considered with a high level of privacy. These are aspects of a patient’s life that they may wish, for any number of reasons, to not share with other individuals. Importantly, there may be certain domains of social risk data that – if shared non-securely, inappropriately, and out of context – may present a greater risk to the patient (e.g., reporting relationship safety issues). Ultimately, ensuring that social risk data for services can be shared in a manner consistent with privacy protections of private health data is critical. OCHIN urges CMS to work with sister agencies such as the Office of Civil Rights to exercise maximum regulatory discretion to expand the entities that could be covered under the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA) while also urging action by Congress.
- Prioritizing data – through quality measures and reimbursement – that focus on referral to social services and resolution of social needs will promote exchange of social risk data. If measures focus solely on actions within the walls of the health care system (i.e., screening) there may be a lack of focus on interoperable tools and data sharing. Continuing to advance measures and incorporating them across CMS programs such as through the Universal Foundation, and subsequently **providing funding for under-resourced health care settings to build the necessary tools and systems to allow for interoperability will greatly advance the pace of this work.**
- **There is a strong need to identify a regulatory pathway to advance adoption of USCDI version 3 and future versions.** Currently, USCDI version 1 does not include social determinant of health data domains or elements. As a result, certified health IT developers are not required to adopt these national digital data and technical standards. **OCHIN strongly urges investment by CMS and sister agencies, such as ONC, in partnerships with state Medicaid programs to accelerate testing of the USCDI version 3 and beyond SDOH digital data and technical standards.** Resources should be directed to providers in underserved communities and their networks to test and drive national scaling.