AMERICAN PSYCHIATRIC ASSOCIATION

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August 9, 2019

Seema Verma, Administrator,
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC, 20201

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

Dear Administrator Verma,

The American Psychiatric Association (APA), the national medical specialty society representing more than 37,800 psychiatrists who treat mental health disorders, including substance use disorders, appreciates the opportunity to submit feedback to the Department of Health and Human Services' (HHS) "Patients over Paperwork" initiative. The APA is fully supportive of the myriad ways in which the Centers for Medicare and Medicaid Services (CMS) has endeavored in recent years to attain the "Triple Aim" of enhancing the patient experience, improving population health, and reducing costs. We appreciate the move by CMS to include improving the work life of health care providers (the "Quadruple Aim") among its priorities. Unfortunately, many psychiatrists are still experiencing significant burdens with respect to CMS regulations around payment policy, quality measures, documentation requirements, and health IT.

The APA would like to use this opportunity to highlight some broad domains aligned with burden experienced by psychiatrists and offer recommendations on how CMS can help to ameliorate some of them via future rulemaking and/or sub-regulatory guidance.

**EHR/Health IT Use in the Merit-Based Incentive Payment System**

The enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Federal Health IT Strategic Plan (2015 – 2020) has been successful in driving the adoption of basic Electronic Health Record (EHR) systems as well as certified EHR technology among acute care hospitals, academic centers and large group practices. Nevertheless, uptake among psychiatric hospitals and solo and small group providers continues to lag behind. The time associated with purchasing and integrating an EHR system as well as upfront and ongoing costs remain barriers to EHR adoption by psychiatrists. Many psychiatrists also have found that there are too few certified EHR solutions geared toward mental health practices. Specifically, the EHRs that are targeted to most small group and solo practitioners (i.e., primary care providers) do not mirror the

workflows of psychiatric practices, whereas EHRs that are intended for smaller mental and behavioral health practices are not economically motivated to pursue ONC certification.

**The APA recommends that the CMS continue to explore opportunities to partner with standards organizations (e.g., using HL7's FHIR), in cooperation with the ONC, as outlined in the 21st Century Cures Act Interoperability and Information Blocking Proposed Rule.** Enhancing interoperability between CEHRT and non-CEHRT products would help to mitigate many of these issues.

**Quality Measurement & Electronic Clinical Quality Measures**

We appreciate the efforts of Congress and CMS to reduce the burden of Medicare quality reporting through creation of the Quality Payment Program, particularly MIPS. Many psychiatrists are likely to be exempt from MIPS under the changes to the low-volume threshold that began with the 2018 performance year. However, it remains to be seen whether (and to what extent) psychiatrists and other physicians who are subject to MIPS reporting requirements will actually experience less burden under MIPS than the previous programs that it replaced.

Guided by the APA strategic plan, the APA supports the development and implementation of quality measures that close gaps in mental health care and reduce variations in practice. Measurement should integrate evidence-based practice and help to facilitate achieving outcomes jointly identified by patients, psychiatrists, and other health care providers. It is also important to recognize that psychiatrists practice in a wide array of health care settings, including physician offices, large health systems, inpatient and outpatient hospital units, community health centers, and long-term care facilities—in urban and rural areas—and serve an extremely diverse population of every age, socio-economic stratum, culture, ethnicity, gender identification, and developmental level. The following outlines the most prevalent difficulties psychiatrists have associated with quality measurement:

1. Since its proliferation, quality measurement has led to undue burden for psychiatrists, and other physicians.

    - **Compliance burden**: This burden is particularly high and poses additional difficulties for psychiatrists, as they are often limited in the quality measure data they can report due to the limitations of EHRs that omit certain data elements included in psychiatric electronic-Clinical Quality Measures (e-CQMs). One particular difficulty is that psychiatrists are responsible for reporting e-CQMs, but by virtue of their contractual work, they do not own the patient data, and therefore cannot report provider-level quality measures through the facility's EHR system, nor can they import the data into their own practice's EHR system.

        - To alleviate this burden**, we recommend exemptions for physicians reporting into programs where provider-level eCQMs require data collection in cases where a) the facility's EHR system does not collect such information, and b) where the provider does not own the data, which ultimately prevents this information from being imported into the practice's own EHR system.**

    - **Administrative burden**: Not only are the voluminous amounts of quality programs and measures which psychiatrists and others are expected to participate in time exhaustive, but they increasingly impede on clinical encounter time. For instance, if an EHR does not capture the necessary data elements required to report the e-CQM (as noted in the above section on

burdens inherent to the PI category of MIPS), efforts are made to submit proxy data. This takes additional time and effort and may unintentionally alter the level of quality demonstrated by the measure.

    - **As mentioned above, we support the CMS and ONC's continued efforts toward increased interoperability between EHR technology.** This would help to alleviate administrative burden by capturing data elements frequently included in cross-cutting eCQMs and thus would allow such elements to be used by psychiatrists in reporting. We recognize that data elements specific to mental health specialty measures may not be included for mainstream implementation in general medical facilities, but certain data elements are more frequently collected and assessed by eCQMs appropriate for mental health providers' utilization. By leveraging common standards such as FHIR to potentiate interoperability, and by reducing the need for proxy data, eCQM results will be more robust and informative of the quality of care administered as well as help to mitigate related costs.

- **Implementation burden**: Given that psychiatrists have been slow adopters of EHR systems in practice, as noted above, there has likely been a similarly slow uptake and pace of modifications made to psychiatrists' workflow for the inclusion of e-CQMs in practice. Further tied into the other types of burden is that many psychiatrists—especially solo or small group providers—have limited or no support staff, depending on each particular practice. This limitation in practice often prevents the e-CQM from being implemented at the point of care, which invalidates the very benefit of using e-CQMs and making them "meaningful" to the patient encounter. Likewise, many psychiatrists also may not have a plan for data extraction and use after the information is collected.
    - As above, the APA remains supportive of the HHS' efforts to increase interoperability using existing standards. If successful, implementation burdens have the potential to be greatly reduced. For example, manual chart review is often still need to extract necessary information from progress notes or other sections of the chart. This task often falls to the clinician who lacks adequate support staff who might assist in this process. Better interoperability, including appropriate meta-data tagging of quality information within the progress note, would help to substantially alleviate this burden.

2. Unfortunately, most disease-specific, "check-the-box" process measures are often irrelevant to psychiatric practice, yielding little if any value to inform on the quality of patient care delivered. Many of these e-CQMs, required for the Quality program interfere with the implementation of patient-centered care in psychiatric practice as they are not truly meaningful or applicable. For instance, infectious disease specialists and geriatricians might ask their patients about obtaining the influenza vaccine (a popular e-CQM), which is relevant to the type of care delivered by these professionals; however, psychiatrists attempting to deliver high quality and appropriate care become occupied with addressing health factors that have no relation to the particular patient encounter (e.g., the pneumonia vaccine may be addressed, but the patient encounter should focus on the patient's psychotic symptoms). Indeed, asking such a question could interrupt the flow of psychotherapy, upset the patient, or create issues of distrust. Instead, the psychiatrist and patient should spend the encounter addressing issues pertinent to the behavioral health visit, and in this instance, administering quality care.

3. Actionable and practical quality measures that assess current or recent changes in patients' clinical symptoms and functioning should be automated to capture consequent treatment modifications. Clinical decision support included as part of the EHR system collecting these e-CQM data should provide information about recommended treatment modifications in real-time. However, the resources available across practice settings to utilize this type of e-CQM must be considered. For instance, just because a well specified and meaningful e-CQM has been developed, the expectation that all providers are able to use it in routine practice is unreasonable. Limitations inherent of practice settings (e.g., rural practices might not have be able refer patients to alternative settings for therapeutic intervention, recommended as part of the clinical decision support), patient characteristics (e.g., patients without reliable transportation or modes of communication might not attend), and other resource-reliant factors could prevent this e-CQM from improving patient care, no matter how feasible, valid, and reliable it is.

**Administrative Burdens**

1. *Documentation in the EHR*: EHRs possess features that potentially can make the practice of medicine easier (e.g., electronic prescribing, electronically sending patients messages and educational materials) and help physicians to measure the patient encounter at the point of care. Unfortunately, physicians are spending more time documenting the encounter in the EHR relative to the amount of time spent face-to-face with patients. According to a recent article in the *New England Journal of Medicine*, summarizing several studies, "for every hour physicians spend with patients, they spend one to two more hours finishing notes, documenting phone calls, ordering tests, reviewing results, responding to patient requests, prescribing medication, and communicating with staff." This is at least one factor in "burnout rates…twice as high in medicine as in other fields."

These burdens are certainly applicable to psychiatrists. Here are some examples highlighted by our membership as particularly burdensome:

a. *The CMS Documentation Guidelines for Evaluation and Management (E/M) services*: We would like to thank CMS for the steps they have already taken to ease documentation associated with outpatient services (focusing documentation on what has changed or pertinent items that have not changed, and allowing ancillary staff or the patient to record medical information, which is then reviewed and verified by the physician). We courage CMS to extend these changes to E/M services in other settings.

However, adhering to CMS' E/M Documentation Guidelines still requires a significant amount of physician time in the documentation of the patient encounter. Prior to the adoption of E/M Guidelines, a succinct progress note summarizing all pertinent clinical information and decision-making would have been sufficient documentation for record-keeping and billing purposes. Under the E/M structure, however, psychiatrists must now document specific numbers of clinical elements under the Guidelines in order to bill and be reimbursed at a certain level. ***Thus, under the E/M coding system, documentation becomes arbitrarily complex and litters the note with superfluous information without improving patient care in any useful or measurable respect.***

Similarly, the APA suggests that CMS eliminate the requirement that attending physicians working with nurse practitioners must also rewrite most elements of the note to conform to CMS requirements (especially the history of illness and mental status exam). This redundancy in documentation makes working with Nurse Practitioners more time-consuming than is necessary and does not improve patient

care. This issue is highly relevant in an era where more psychiatrists are working within integrated care settings.

b. *Patient admissions and continued hospitalization*: In the past, when a physician determined a patient's need for admission to the hospital, the physician's order (or an order by a resident or nurse practitioner, if employed by the hospital) was sufficient justification and documentation for the admission. Presently, however, CMS requires an attending physician to write the order to admit using CMS prescriptive language. This places an arbitrary restriction on the admission process and burden on attending physicians whose time is already allocated to other clinical and administrative obligations. Compounding this burden is CMS' requirement that physicians must document continued justification for a patient's inpatient stay, at regular intervals. One way that some practices have adapted to this requirement is by generating additional documentation *outside of the regular progress note*, to ensure that the required documentation is clearly identifiable to CMS for justification purposes. In conjunction with managing multiple patients simultaneously—and not always knowing whether said patients are Medicare/Medicaid beneficiaries at the time of admission—this time-consuming documentation process is increasingly burdensome to psychiatrists operating within a healthcare system in which there are limited professionals with their expertise. ***The APA contends that the admission history alone should provide sufficient evidence for an initial order to admit and that subsequent progress notes should provide sufficient justification of a continued need for hospitalization.***

c. *Interdisciplinary Treatment Plans (ITP).* Presently, CMS surveying requirements under the Condition of Participation: Special Provisions Applying to Psychiatric Hospitals ("B Tags") dictate that psychiatrists complete a patient-centered multidisciplinary treatment plan for the patient. While this is required, to some extent, by CMS in other settings (e.g., the patient centered medical home, general medical-surgical, long-term care) the specific details required by psychiatrists are more burdensome than in other treatment settings[1]. For instance, some requirements of the multidisciplinary treatment plan (e.g., long-term goals, short term goals, treatment interventions, etc.) are more onerous and duplicative than those required for patients in other settings. Further, most of what is required of psychiatrists within the MTP are already captured in the psychiatric progress note and other sections of the medical record. Part of the confusion and redundancy in the MTP is an outgrowth of the various levels of multi-entity, institutional oversight that monitor its implementation and documentation—i.e., different entities (the Joint Commission; State health agencies) are interpreting and implementing these CMS standards in different ways. Moreover, as these various entities attempt to implement these particular CMS requirements, EHR vendors struggle to link all of this information within their systems reliably, which results in a more convoluted documentation and treatment process for providers and patients. While the APA appreciates that this has been an attempt by CMS to make treatment more patient-centered, this approach was developed in the 1960's and is no longer clinically applicable in 2019. If the focus is to be on patient-centered care, it might make more sense for this requirement to be

[1] National Association for Behavioral Healthcare (2019). *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities*. [online] Washington, DC: National Association for Behavioral Healthcare, pp.9-14. Available at: https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf [Accessed 26 Jul. 2019].

replaced with an appropriate outcome measure (see the Quality Measurement section above on how measures could be more meaningful for psychiatrists' participation in Medicare) rather than just encumbering the physician with additional process documentation. **APA recommends that the Condition of Participation: Special Provisions Applying to Psychiatric Hospitals ("B Tags") and particularly the interpretive guidance, be reviewed and revised to eliminate redundancies and extraneous information that is no longer relevant to clinical care.**

2. *Prior Authorization:* According to a recent report by the American Medical Association, 92 percent of physicians report that "prior authorizations programs have a negative impact on patient clinical outcomes." Indeed, the AMA study revealed that "every week a medical practice completes an average of 29.1 prior authorization requirements per physician, which takes an average of 14.6 hours to process—the equivalent of nearly two business days." The APA echoes these results, noting that prior authorization requirements to insurers generally result in an extensive amount of required paperwork to be submitted, multiple phone calls back-and-forth to insurance companies, and significant wait times for prior authorization, resulting in delayed or disrupted medical care for patients.

For instance, phone-based peer-to-peer reviews conducted via phone are typically scheduled on short notice at the convenience of the payer and can require significant amounts of time to complete. Other utilization reviews are also time-consuming for administrative staff and require providing significant amounts of information on a frequent basis. ***The APA asks CMS to spearhead development of a streamlined asynchronous process for such reviews that could be done electronically without frequent and lengthy phone conversations. The content of required information should be standardized for all payers to facilitate integration into electronic documentation workflows.***

For prior authorizations for prescription medications, a single form should also be developed to be used by all payers. EHR certification criteria should include the ability to handle prior authorizations efficiently within the e-prescribing workflow. ***Prescribers should be able to request that prescription related information from payers and pharmacies be transmitted electronically rather than via mail or fax***, to reduce confusing (and potentially unsafe) duplications in communication. Additionally, ***payers should be prohibited from requiring repeated prior authorizations of the same medication, for individuals with chronic conditions who have been stabilized but need ongoing pharmacological treatment.*** For individuals with psychiatric disorders, including those with serious mental illness or substance use disorders, gaps in treatment due to pre-authorization denials can lead to relapse, with increased health care costs and devastating effects for individuals and their families.

***Ultimately, the APA urges greater transparency and streamlining of all prior authorization processes with an option for clinicians to have all such processes occur electronically. Prior authorization determinations should be made available to the prescribing physician rapidly and at the point of care, especially in the case of denials, with a clearly delineated process for real-time appeals***

The APA appreciates the opportunity to offer feedback to the ONC and CMS from the perspective of the psychiatric physician community on the myriad burdens encountered every day during routine practice. The APA looks forward to working with both entities in helping to put "patients over paperwork" and addressing not only improved patient outcomes, lower cost, and higher patient satisfaction, but also the "burden-to-burnout" phenomenon experienced among clinicians of all specialties. As you consider ways to reduce physician burden, please use the APA as a resource.

If you have any questions, please feel free to contact Nathan Tatro, Associate Director of Digital Health, at (202) 559-3680 or ntatro@psych.org.

Sincerely,

Saul Levin, MD, MPH, FRCP-E