AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

December 31, 2020

Honorable Seema Verma, Administrator
Center for Medicaid and Medicare Services
Department of Health and Suman Services
P.O. Box 8016
Baltimore, MD 21244-8016

ATTN: CMS-9123-P; RIN 0938-AT99

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing more than 38,800 psychiatric physicians, appreciates the opportunity to submit comments on the Department of Health and Human Services' (the Department or HHS) Center for Medicare and Medicaid Services' proposed rule on Reducing Provider and Patient Burden by Improving Prior Authorization Process while streamlining access to electronic health information, and the accompanying Requests for Information (RFI). We have frequently advocated reducing provider burden and improving patient outcomes by streamlining the electronic prior authorization (ePA) processes and improving interoperability between providers and patients who use electronic systems to facilitate care. Modernizing data standards and expectations for the specific payers identified in this proposed rule provides an opportunity to take a step toward that; although future rulemaking needs to address how Medicare FFS and Medicare Advantage (and therefore, private payers) will also incorporate these changes into the broader healthcare landscape. Below are our comments on specific components of the proposed rule, as well as the RFIs.

Provider Access Application Programming Interfaces

APA supports CMS in requiring payers affected by this rule to build and maintain a Provider Access API for payer-to-provider data sharing of claims and encounter data, as well as pending and active prior authorization decisions for individual patient requests, starting January 1, 2023. This would facilitate coordination of care and increase transparency in data sharing, cut down on phone calls by providers to payers, and will support API data exchange as outlined in the Interoperability and Information Blocking Final Rule.

Payer-to-Payer Application Program Interfaces

As a part of CMS' Interoperability and Patient Access final rule, CMS finalized a requirement that, at a patient's request, CMS-regulated payers must exchange certain patient health information, and maintain that information, thus creating a longitudinal health record for the patient that is maintained with their current payer. **APA supports CMS' proposal to enhance this payer-to-payer data exchange by requiring that it uses a FHIR-based API including the exchange of claims and encounter data, and information about pending and active prior authorization decisions, at a patient's request.**

Similarly, **APA is supportive of Payer-to-Payer data exchange at enrollment,** for similar reasons. This would enable payers to efficiently exchange information for one or more patients at one time using the HL7 FHIR Bulk specification, allowing patients to take their health information with them as they move from one payer to another.

Leveraging Information about Prior Authorization Decisions

As part of the payer-to-payer API proposal in this rule, CMS would encourage impacted payers to consider ePA information received from previous payers when making new prior authorization determinations. This could potentially eliminate the need for patients and providers to repeat the prior authorization process with the new payer. **APA supports this proposal. Many patients with serious mental illness require long-term care in the form of** long**-acting injectables and other forms of medication management that often do not require repeat testing or evaluation. An established course of care should be available between a patient and provider, when warranted, without necessitating a duplicative electronic prior authorization process to be initiated between providers and payers.** Prior ePA decisions from previous claims can be used to limit these duplicative efforts, easing provider burden and other barriers to patient care.

Prior Authorization Application Programming Interfaces

In this proposed rule, CMS proposes to require affected payers to build and maintain a Document Requirement Lookup Service (DRLS) API using FHIR that could be integrated with a provider's electronic health record (EHR), to allow providers to electronically locate prior authorization requirements for each specific payer from within the provider's workflow. CMS also proposes to require Prior Authorization Support (PAS) API using FHIR, that would also better integrate PA requests/responses within workflows, while maintaining HIPAA standards integrity. **APA is supportive of these initiatives.**

Prior Authorization Proposals

With respect to other proposals in this rule around Prior Authorization, APA is **supportive of requiring** payers to include a specific reason for a denial when denying a prior authorization request, regardless of the method used to send the prior authorization decision. However, with respect to the proposal around timelines and deadlines, the APA requests that CMS amend its proposal from requiring payers to send prior authorization deadlines within 72 hours for urgent requests and 7 calendar days for standard requests to **24 hours for urgent requests and 48 hours for standard requests**. Oftentimes, psychiatrists

attempting to triage emergent issues with a patient require a faster turnaround from payers around ePA in order to address such patients who are in acute crisis.

General Comments on Electronic Prior Authorization and API Proposals

While APA is supportive of efforts listed above to streamline ePA data from payer-to-payer, from provider-to-payer, and from provider-to-provider, the current proposal, as written, includes a limited number/type of payers. Because of this limitation, it is unclear as to the benefits to or improvements of the ePA process for providers and patients. For example, having claims data available via an API might prove useful to a patient, but if the patient is unable to appropriately and usefully interpret those data, there may be little-to-no benefit in patient outcomes. If and when CMS decides to broaden the scope of these requirements to Medicare, including Medicare Advantage (and thus private industry, which CMS "invites" in the rule to join in this effort), it might be helpful to coordinate with other entities to ensure pertinent educational information is available to patients so that they are equipped to interpret their claims data. This is especially pertinent to patients with serious mental illness or other conditions that preclude them from accurately and usefully reviewing their data.

Requests for Information (RFIs)

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

As APA has noted in previous letters to the Administration, and has CMS has acknowledged hearing from other groups, that providers and patients frequently indicate that they want and need additional options for controlling their and their patients' health information beyond what is currently in place under current federal and state laws and regulations. While APA wishes to express continued support for HHS' interoperability efforts—enabling patients' greater control over their healthcare records and ensuring that the record follows the patient—**we continue to hear from our members and their concerns about their privacy rights.**

To that end, providers and patients alike would like the ability to granularly select which elements from their record are shared with certain providers and payers. For instance, some providers may want to segment a part of their clinical notes before sharing with the patient or another provider, if they believe that sharing this part of the note could be detrimental to the patient's care. For instance, if the patient has a certain diagnosis that another provider does not need to know, a provider may wish to redact that from the clinical note; or, if the same note could lead to a disruption in the therapeutic alliance and negatively affect future treatment, the clinician might wish to segment that part of the record.

APA understands that certain state laws and regulations, as well as Exceptions built into the 21st Century Cures Interoperability and Information Blocking Final Rule allows for some of these preferences to be employed in practice; **however, these do not account for all use-cases within psychiatry**, and the APA offers the following responses to the prompts within this RFI:

Patient Engagement and Provider Discretion: As the goal of various ONC and CMS rules around interoperability focus on "placing the patient at the center of care," it makes sense, at one level, to given the patient agency over how they wish their record to be shared with other members of their care team. For instance, perhaps they do not wish their chiropractor to see their psychiatry record. As more open APIs begin to be integrated into the care continuum under 21st Century Cures, the ONC should encourage developers to use FHIR to create apps that will offer this degree of data segmentation when transmitting data into the patient's record.

Technical Considerations. While there are some current data segmentation strategies relying on standards like the Substance Abuse and Mental Health Services Administration's (SAMSHA) Consent2Share and HL7 Data Segmentation for Privacy (DS4P), these have, unfortunately, not gained adequate momentum from developers when it comes to implementation. While APA recognizes that there is some cost on the developer side to implement these data modeling strategies, and that there is a concern that these might be passed downstream to the broader healthcare community, there must be a framework for adopting these tools in a cost-effective, easily implemented way. **The developer and provider community needs to be brought together to address this head-on, especially as more providers and patients begin to rely on open APIs as the provisions of 21st Century Cures come online in 2023**.

Electronic Exchange of Behavioral Health Information

In the rule, CMS notes that behavioral health providers have lagged behind other specialties in adopting full EHR technology. One reason cited by CMS is that these providers were not included under the incentive payments provided by HITECH and Meaningful Use. While this is true of non-physicians, psychiatrists, as physicians, were included in these incentive payments and, as a result, some were early adopters of EHR technology, including CEHRT.

However, there are other barriers to adoption experienced by psychiatrists that play a role in adopting the technology and therefore the electronic disconnect observed between psychiatrists and other providers. These include a) the cost of implementation, b) the administrative burden related to implementation, as psychiatrists in solo practice often do not have support staff to aid them in bringing the new system online, and c) poor integration of the available EHR technology into many unique psychiatric workflows. Specifically, many systems do not reflect the unique nature of psychiatrists' practice, including those working with children/adolescents, those engaged in ECT/TMS treatments, and so on. These all contribute to the electronic divide observed between psychiatry and other specialties. The APA recommends that the ONC moves forward with the recommendations provided by the APA and other mental health professional societies via roundtables conducted for the ONC by the Urban Institute for the ONC's EHR Reporting Program. Involving mental health professionals in assessing the usability of EHR systems via the Reporting Program will help to bridge this digital divide.

In this proposed rule, CMS requests information on whether API technology, independent of a full EHR system, could be used to bridge this divide. While there is certainly potential for it to do so, at this point in time there are more questions than answers. For instance: if a psychiatrist uses a third-party app to

collect patient data, how will those data be modeled and to where will the data be sent if the psychiatrist is not using an EHR? What is the benefit of using multiple apps and multiple APIs if the provider can only send those data to another provider, but not aggregate them on their own personal system? Moreover, would these apps and their APIs still fail to integrate into psychiatric workflows, thereby retaining the burden that psychiatrists already face when assimilating new technology? While APA does not have the answers to these questions, **its members are willing to work with CMS and the ONC on collaborative activities that could possibly find solutions**. **These could include conversations with rulemaking staff, engagement with other stakeholders who also have a vested interested in finding solutions (e.g., vendors/developers, other specialties, etc.), and so on.** This collaborative process might look similar to the multi-stakeholder engagement work that occurred around developing the ONC EHR Reporting Program.

Reducing the Use of Fax Machines for Health Care Data Exchange

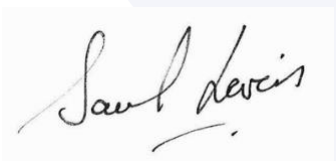
APA, like CMS, understands that fax machines provide a unique obstacle for health data interoperability. Sending patient records and other data via fax from provider-to-provider can lead to a discontinuity of care, fragmented records, lost data, and other issues. Moreover, even if a patient record sent via fax and then scanned and uploaded to an EHR, the .pdf file is often not readable by the record, which also perpetuates fragmented patient records.

However, APA would like to underscore that fax machines are still ubiquitous among providers for many reasons—namely some of those listed above: adopting EHR systems and other technology tends to be burdensome, both financially and administratively, for solo providers with little support. To these providers, fax machines are the tried-and-true method of sending claims data and patient records to other clinicians.

Also, many providers who live in rural areas that lack sufficient broadband access cannot send large files via the internet, and so they must rely on fax machines to conduct their business. The best way to address this issue to is to fund broadband infrastructure nationwide, which would facilitate interoperability in myriad ways—not just by replacing the fax machine with better, faster, more reliable technology.

Thank you for this opportunity to respond to this rule. If you have any questions, please contact Nathan Tatro, MA, Deputy Director of Digital Health, ntatro@psych.org.

Sincerely,



Saul Levin, MD, MPA, FRCP-E, FRCPsych