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Chiquita Brooks-LaSure

Administrator, Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,400 psychiatric physicians and their patients, would like to take the opportunity to comment on the FY 2022 Hospital Inpatient Prospective Payment System (PPS) proposed rule. Our comments focus primarily on Graduate Medical Education (GME) and measurement issues, particularly standards for health IT and interoperability. As has been widely reported, the COVID-19 pandemic has led to an increase in individuals seeking care for mental health (i.e., depression, anxiety) and substance use disorders, as well as an increase in suicide; trends we anticipate will continue for the foreseeable future. This increased need for care comes at a time when hospitals are straining under financial constraints due to the significant disruption of inpatient care and increasing costs associated with caring for patients during the pandemic. **We ask that CMS reduce the regulatory burdens that drive up costs and provide adequate funding for the full continuum of care inclusive of inpatient, community and residential options.**

*Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers*

In general, APA appreciates the efforts of Congress and CMS to reduce the burden of CMS quality reporting across the various quality programs. APA supports the development and implementation of quality measures that close gaps in mental health and substance use disorders care and reduce variation in practice. Measurement should integrate evidence-based practice and help facilitate achieving optimal outcomes that are jointly identified by patients, psychiatrists, and other health care providers. We appreciate the application of the Meaningful Measures Framework and welcome the benefits of reduced burden at the hospital level of quality measurement.

*Closing the Health Equity Gap in CMS Hospital Quality Programs*

APA would like to reiterate its support for stratification of quality measure results by dual-eligibility. As CMS notes in the proposed rule, dual eligibility is a powerful predictor of poor health outcomes, and stratification of results using dual eligibility

as an indicator of social risk will allow for more appropriate comparisons of performance across facilities and will also help those facilities assess their efforts to address and close health disparities.

#### *Proposed Changes to the Medicare Promoting Interoperability Program*

The APA appreciates the continued flexibility in reporting requirements under the Promoting Interoperability program for Eligible Hospitals and Critical Access Hospitals, including options surrounding measure choice, scoring, and opportunities for bonus points. Please find feedback regarding the proposed changes below.

CMS is proposing to continue the EHR reporting period of a minimum of any continuous 90-day period for new and returning eligible hospitals and CAHs for CY 2023 and to increase the EHR reporting period to a minimum of any continuous 180-day period for new and returning eligible hospitals and CAHs for CY 2024. APA appreciates that CMS has maintained the 90-day reporting period for these electronic measures since the inception of MACRA in 2015. **APA supports transitioning from a 90-day continuous reporting period to a 180-day continuous reporting period for 2024.** Revising the reporting period will help to improve interoperability and health information exchange by increasing the amount of comprehensive and reliable data available for patients and providers.

#### *Maintaining the Electronic Prescribing Objective's Query of PDMP*

**APA supports maintaining the PDMP measure as optional for CY2022, and also supports increasing the bonus for reporting on this measure from 5 points to 10.** As we have stated in previous letters to CMS, it is still premature to require the Query of PDMP measure and then include it in the Promoting Interoperability score. As CMS has acknowledged, there are still technical challenges associated with connecting PDMPs with various EHR systems. Our membership remains affected by these technical challenges, which include a) a lack of standards connecting PDMPs and EHRs, b) the policy (e.g., statutory) and other technical challenges around integrating state PDMPs with HIEs and hospitals, c) addressing the challenges in integrating PDMP queries seamlessly into physician workflows, d) the cost and time required for developers—and subsequent downstream financial impact on physicians/hospitals—to develop standards and technological solutions to better integrating PDMPs with other health IT software and finally, e) the burden in tracking and calculating numerator/denominator requirements for the PDMPs.

Moreover, not only do these challenges remain, but they were undoubtedly difficult to address during the COVID-19 public health emergency by healthcare organizations, as they shifted resources to mitigate the ongoing public health crisis. Additionally, as ONC and CMS' Final Rule around Interoperability and Information Blocking were released in 2020, with the revised Applicability Date of April 2021, hospitals' and vendors' priorities had to be adjusted to meet the expectations around complying with these regulations. Thus, waiting to require the Query PDMP measure under the Electronic Prescribing Objective would give hospitals and vendors more time to adapt their systems accordingly.

As the technology necessary to connect PDMPs with HIT systems matures, requiring this measure will become less burdensome. For example, the 2020 PFS outlined a transition to the updated CEHRT 2015 Edition standard and a transition for CEHRT to use the NCPDP SCRIPT 2017071 standard for electronic prescribing; the ONC, in its 21<sup>st</sup> Century Cures Final Rule, requires those vendors developing CEHRT for Promoting Interoperability will use FHIR open APIs to connect providers and other users of HIT. Given these advancements, APA is optimistic that, in time, the data captured by PDMPs will be able to flow through the HIT ecosystem without significant burden to hospitals and providers. We look forward to continuing to be part of the conversation regarding how the Query PDMP measure can be successfully implemented in both the IPPS and Medicare Promoting Interoperability Programs in the future.

#### Modify the Provide Patient's Electronic Access to Their Health Information

APA appreciates CMS' intent to align the Provide Patient Electronic Access to Their Health Information measure with the look-back period finalized in the Patient Access and Interoperability final rule. While the January 1, 2016 date seems reasonable for CAHs and EHs, the **APA recommends that CMS delay enforcement discretion from July 1, 2021, to the end of CY 2021, to account for the ongoing COVID-19 PHE.**

#### New Health Information Bi- Directional Exchange measure

The **APA supports the need for adding the HIE Bi-Directional Exchange measure as an optional alternative to the two existing measures under the Provider to Patient Exchange Objective.** Not only would this increase flexibility in reporting requirements, but incentivizing participation in HIEs will further support bidirectional exchange of information, better allowing for longitudinal care for patients who present to EHs and CAHs. We also appreciate CMS' statement within this proposed rule that "none of the actions required to attest to this measure are intended to conflict with a patient's rights or covered entities'...requirements/responsibilities under the HPA Privacy Rule." However, we do **urge CMS to work in coordination with ONC when implementing this measure to offer clear guidance/education for EHs and CAHs on how patients can opt-in/opt-out of having their information included in bidirectional HIE exchange,** should those entities choose to attest to this optional measure instead of the two existing measures under the Provider to Patient Exchange Objective.

#### New measure to the Protect Patient Health Information

The APA supports the use of the Safety Assurance Factors for EHR Resilience (SAFER) Guides as a part of the Protect Patient Health Information Objective within PI. Requiring EHs and CAHs to attest to completing these guides has the potential to help healthcare organizations enhance and optimize health IT, ensuring that they are "responsible operators of technology tools," as stated in this proposed rule. This attestation is reminiscent of the existing Security Risk Assessment measure in its utility to safeguard patient information, and in that it will not be scored for PI. While we appreciate CMS' acknowledgement that CAHs and EHs vary in terms of resources with respect being able to complete the SAFER attestation annually (especially for small or rural hospitals), APA recommends that, for the 2022 RY, **CMS conduct an**

**audit of those entities that attest “no,” in order to ascertain why they did not complete a SAFER attestation, to see if additional resources might support them in doing so for future reporting years.**

*GME: Consolidated Appropriations Act of 2021 (CAA) section 126 increase of additional residence slots*

The CAA provided 1,000 new Medicare-supported GME positions – the first such increase in nearly 25 years. These positions are meant to address an estimated shortage of between 37,800 to 124,000 doctors by 2034. Under the law, CMS is tasked with distributing 200 slots per year for five years, with slot awards effective July 1, 2023. The law also states that at least 10 percent of the slots must be distributed to each of the following categories: hospitals that are located in a rural area or treated as being located in a rural area; hospitals training over their Medicare cap; hospitals in a state with a new medical school or branch campus; and hospitals that serve areas designated as health professional shortage areas (HPSAs).

APA appreciates these new GME positions and encourages CMS to consider how the pandemic has affected the health and mental health of American’s and what those future healthcare needs will be. There is currently a severe shortage of psychiatrists in the United States. HRSA estimates that by the year 2030 the supply of psychiatrists is expected to decrease by approximately 27%, however the demand for psychiatrists is expected to increase by 6%. This will result in a shortage of approximately 18,000-21,000 psychiatrists. With over half of active psychiatrists at least age 55, and the process to fully train and license a physician requiring at least 10 years of study and practice (undergraduate school through residency and licensing). These workforce needs will likely be exacerbated following the pandemic given the devastating mental health and economic impact many people are experiencing. If early reports on mental health issues continue to rise as expected, we will have even more Americans in need of critical psychiatric care.

Psychiatrists have specific expertise looking at the biological and psychosocial aspects of a patients care. They provide desperately needed behavioral health treatment throughout our county by working in settings ranging from inpatient care, long-term care facilities and community services, to homeless programs, to jails, and prisons. Many of these systems were overburdened by unmet mental health and substance use disorder needs prior to the COVID-9 pandemic and with the onslaught of COVID-19 related illness, it is even more evident how under-resourced our health care system has been in providing mental health care.

CMS seeks stakeholder feedback on two proposed methodologies for distributing the new slots. Alternative 1 would distribute slots based on a hospital’s HPSA score only and would apply for all five years of the distribution process. Alternative 2 would award slots to hospitals that meet all four categories delineated by the CAA, with subsequent distribution for hospitals that meet three categories, two categories, and then one category until all 200 slots are allocated. This methodology would be for FY 2023 only, and the proposed rule states that it would allow “additional time to work with stakeholders to develop a more refined approach for future years.” Both proposals only allow for a maximum of 1.0 full time equivalent (FTE) to be awarded per hospital.

Because the CAA specifies that the slots should go to four categories of “Qualified Hospital,” **APA recommends that Alternative 2 be adopted, with modification, in the final rule.** As CMS noted in the proposed rule, “a more refined approach” to the distribution can be achieved with additional time and stakeholder input. **We also recommend that the number of FTEs per hospital be increased to allow for meaningful program expansion.** While we recognize that the need for additional GME support far outpaces the 1,000 new GME slots, 1.0 FTE per hospital is simply not practical.

With almost 25 years gone by and no increases in GME slots, these new slots are just a first step. APA supports additional funding for GME slots, especially for those specialties who have been filling their programs. We must also consider the severity of the physician shortages in areas of greatest health and mental health needs of the population.

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments, please contact Andrew Lyzenga ([alyzenga@psych.org](mailto:alyzenga@psych.org)), Deputy Director, Quality.

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller letters to the right.

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych  
CEO and Medical Director