AMERICAN PSYCHIATRIC ASSOCIATION

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March 13, 2023

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)
Attention: Administrator Brooks-LaSure

Re: Advancing Interoperability and Improving Prior Authorization Processes (File Code CMS-0057-P)

Dear Administrator Brooks-Lasure,

The American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the improvement of health information exchange through advancing interoperability and improving prior authorization processes. We applaud CMS's commitment to interoperability and prior authorization transparency in service of improved care coordination, health equity, and health outcomes. In particular, we are thankful for the emphasis that this proposed rule places on payer obligations to develop, maintain, support, and use interoperable technology. APA shares CMS's commitment to improving continuity and quality of care through standardized data shared within clinical and regulatory guidelines.

To support CMS in achieving these objectives, we suggest some revisions for the final rule focused on equity and effectiveness. Increased sophistication and standardization of technology only works for settings that are operating on an electronic data system, and on one where they can manage and afford upgrades. To effectively focus efforts on standardization and interoperability, the root causes of technological inequity in clinical mental health settings need to be addressed through financial incentives, technical assistance, and learning networks.

Value of data shared through APIs

While APA's members are optimistic about the value of shared data in improving continuity and quality of care, we urge CMS to consider the value of exchanging large quantities of claims data to achieve this objective. Clinicians that work in large systems with more advanced technology may have the data processing personnel and baseline capabilities to derive valuable insights from these data, but those personnel and capabilities require significant investment and may pull institutional resources away from other priorities. Meanwhile, clinicians practicing in smaller or independent settings and that serve lower-resourced communities may not have the infrastructure in place – a challenge that runs the risk of deepening inequities in

access to and quality of care. On the data production and management side of the equation, data quality and validation processes depend on personnel and technology in order for accurate data to be sent across systems. Further, while alignment to FHIR APIs is valuable, APA members remain concerned about the potential for development of distinct solutions across payers requiring unique configuration across EHRs and workflows.

We urge CMS to identify data analytics solutions that can produce insights relevant to transitions and delivery of care at scale that are configurable and consistent across technology platforms in clinical settings. Solutions that are payer-specific increase burden on clinicians and systems to accommodate multiple payers.

Data privacy and security

APA appreciates CMS's commitment to maintaining data security standards while developing interoperable capabilities. In particular, the balance of patient empowerment and data protection in the Patient Access API can be supported through programmatic efforts to support patients in understanding data protections and technology. We recognize the limits of CMS's regulatory authority in managing apps to which patients have their data sent or what those apps do with patient data, but many patients may erroneously assume that their data are HIPAA-covered when shared by their clinician. Evidence shows that most consumers do not read privacy policies. Access to and quality of apps is also not evenly distributed across the population.

We recommend that CMS incorporate patient protection including clinician and patient education to understand app privacy policies, including the implementation of "digital navigator" and peer support programs, and requiring that apps that are not HIPAA-covered entities to clearly state any privacy protections while using the app, in plain, brief, and prominent language actively accepted by the user. APA has developed a tool, App Advisor, to support clinicians and patients navigating these issues when selecting an app.

Data and technology capabilities

APA is supportive of policy efforts that drive the health IT market toward interoperability, including through FHIR-driven APIs. Given the significant technological challenges of attribution and person-level matching at scale, we note the potential for clinicians receiving data on patients that are not in their panel and not receiving data on patients with whom they do have a treatment relationship. The very patients that most need their data to follow them through clinicians, systems, and payers are those that are most likely to have data discontinuity (e.g., misattribution based on claims history). We are supportive of CMS's efforts to incorporate sharing of health-related social needs data via Z-codes and other modalities, and remind CMS that the personnel and technology to produce, manage, and use these data is not present in community-based organizations (CBOs). If data exchange with these organizations is codified, CBOs should be reimbursed for any infrastructural investment and the proportionate value that they bring to the health care system and beneficiaries of CMS services.

We recommend significant third-party user and validity testing throughout the development and deployment process to track and mitigate any risks associated with missing or incorrect data. If benchmarks of readiness are not met that can ensure effective, secure roll-out of these technologies, we suggest that the enforcement timeline be delayed to accommodate these critical prerequisites.

Prior authorizations

APA also support CMS's non-technical proposals to improve prior authorization (PA) processes and transparency, including:

- Reducing the maximum time to approve prior authorization requests.
- Requiring payers to provide a specific reason for denials.
- Requiring payers to report metrics on how many procedures they authorize and deny.

We recommend CMS further reduce the maximum time to approve prior authorizations for urgent requests from the proposed 48 hours to 24 hours; and from the proposed 72 hours to 48 hours for non-urgent requests. We also recommend that CMS further strengthen PA reforms by extending the proposals to prescription drugs. Psychiatrists attempting to triage emergent patient issues require a faster PA review in order to appropriately care for patients. The use of electronic exchange of information should lend itself to these reduced response times from payers. The PA process currently serves as a barrier to care, impeding access to appropriate services and potentially increasing the cost of care. It should not be used routinely but rather selectively when needed to ensure quality care.

We urge CMS not to add a new MIPs measure for eligible clinicians, eligible hospitals, and critical access hospitals to report the number of PAs processed on an API from their EHI technology. EHRs do not have the ability to transmit data to an API and even if they did, psychiatrists have lagged behind other specialists in adopting full technology due to 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 and adolescents and those engaged in ECT/TMS treatments. These all contribute to the electronic divide observed between psychiatry and other specialties.

We oppose CMS's proposal of using a numerator denominator methodology for this measure. Calculating the total number of PAs for the denominator will require physicians or their staff to identify the number of PA transactions that used alternative methods such as mail, portal or fax and collecting this information will add even more administrative burden to clinicians and their staff. APA also opposes this measure because MIPS is intended to improve patient care and PA contributes to worse clinical outcomes.[1] **As an alternative, we recommend that CMS accept physician attestation to meet this measure.**

[1] 2021 AMA Prior Authorization Physician Study, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf, Accessed January 25, 2023

APA supports CMS's payer-to-payer API proposal. Encourage payers to consider PA information received from previous payers when making new prior authorization determinations could potentially eliminate the need for patients and clinicians to repeat the PA process with the new payer. 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 clinician, when warranted, without necessitating a duplicative PA process to be initiated between clinicians and payers. Prior PA decisions from previous claims can be used to limit these duplicative efforts, easing clinician burden and other barriers to patient care. However, we are concerned that without mandating this proposal, impacted payers will not consider PA information received from previous payers.

RFI: Accelerating the Adoption of Standards Related to Social Risk Factor Data

Unequal access to social resources perpetuates mental health disparities, particularly for patients and their families who belong to groups that are marginalized or under-resourced. Unequal allocation of resources (i.e., food, housing, transportation, access to clinical care) and application of institutional and public policies (i.e., lack of parity, flawed criminal justice system) worsen these disparities. Health equity is a public health paradigm and quality goal that aims to promote equitable access to health-related opportunities when needs are equal, provide enhanced opportunities when needs are greater, and address systemic issues that perpetuate inequalities.

These social determinants of health (SDOH) have an even more significant impact on mental health. In addition to being risk factors for mental illness including substance use disorders (e.g., discrimination, unemployment, housing instability, food insecurity, poor access to healthcare), these same exposures are frequent consequences of serious mental illnesses and substance use disorders. These are likewise the drivers of the comorbid medical conditions that produce early mortality and great morbidity for psychiatric patients.

We applaud CMS's investment in supporting healthcare systems to assess and improve their capabilities to screen, understand, and address the structural and social determinants not only of health but of mental health specifically (i.e., stigma against those with mental illness/substance use disorders, lack of mental health parity, social connection, loneliness, social media, immigration, social despair and hopelessness, Positive Psychosocial Determinants).[2] Most adults with serious mental illness and substance use disorders start experiencing symptoms by age 24, some as young as 14 years old; these individuals die 15-20 years younger and are more likely to be incarcerated.[3,4] Early intervention and prevention strategies – further

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[2] Social Determinants of Mental Health Task Force. Psychiatry.org - Social Determinants of Mental Health Task Force. https://www.psychiatry.org/psychiatrists/social-determinants-of-mental-health-task-force. Published October 1, 2021. Accessed February 25, 2023.

[3] Jeste, Dilip V, and Vivian B Pender. "Social Determinants of Mental Health: Recommendations for Research, Training, Practice, and Policy." JAMA psychiatry vol. 79,4 (2022): 283-284. doi:10.1001/jamapsychiatry.2021.4385

[4] American Psychiatric Association, 2022, American Psychiatric Association/Report of the APA Presidential Task Force on Social Determinants of Mental Health 2022 APA Board of Trustees (March 2022): Task Force Report

upstream prior to a crisis services or a hospital admission - related to SDOH and SDoMH are critical to impacting the development and/or progression of disease and resource costs over the lifespan.[5,6,7] **The APA Resource Document – Social Determinants of Mental Health in Children & Youth highlights important domains of SDoMH in children and youth, provides information on screening tools and questions, and delineates practical actions at different levels: downstream, midstream and upstream interventions. We encourage CMS to review the information and recommendations put forward in this document. Additionally, we've included a list of Z codes, highlighting those that are considered a priority (Appendix 1) for your consideration.**

We urge CMS to consider what other segments of the larger healthcare community are currently collecting. A growing number of states and other entities (i.e., NY, CA, Survey of State MH Medical Directors) have been actively engaged in this topic and may be a good source of information as to how best to proceed as well as maximize and coordinate data collection. The National Committee for Quality Assurance (NCQA) has developed measures related to screening of social needs and corresponding interventions (implemented in HEDIS in 2023). CMS should monitor the implementation of these measures and build on existing efforts to measure screening and interventions for social needs; alignment of measurement activities will ease documentation and reporting burdens and promote collection of comparable data. CMS should also encourage stratification of quality measures by social risk factors to identify disparities and opportunities for improvement.

We also urge CMS to encourage health plans and health systems to assess and improve their capabilities to screen, understand, and address the structural and social determinants of mental health, not just in the inpatient setting, including emergency rooms, but in all settings where care is provided. Data collection and documentation should be streamlined; overly burdensome administrative requirements will discourage accurate reporting. Clinicians should be incentivized through increased reimbursement and streamlined processes, given the resources that will be required to comply. Adequate funding is necessary, not only to support the additional data collection process but also to support care delivery itself including community services to address identified needs and coordinate care. This will be particularly challenging for solo and small group practices with limited ability to provide services beyond direct clinical care.

Existing financing models such as Alternative Payment Models (APM) and Accountable Care Organizations (ACO), allow for the development of novel payment mechanisms that offer financial incentives for keeping patients' healthy and reducing patient need for costly interventions including hospital and emergency

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[5] Shim, Ruth S, and Steven M Starks. "COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic." Psychiatric services (Washington, D.C.) vol. 72,10 (2021): 1193-1198. doi:10.1176/appi.ps.202000725

[6] Shim, Ruth S, and Michael T Compton. "The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity." Focus (American Psychiatric Publishing) vol. 18,1 (2020): 25-30. doi:10.1176/appi.focus.20190035

[7] Compton, Michael T., and Ruth S. Shim. "The Social Determinants of Mental Health." FOCUS, vol. 13, no. 4, 2015, pp. 419–425., https://doi.org/10.1176/appi.focus.20150017.

department stays. A benefit of these models is that they offer an opportunity for flexibility in Medicare reimbursement to incentivize the use and interoperability of social risk factors and provide support for costs associated with implementation, which are not typically covered or otherwise funded. To combat adverse selection and the risk of disincentivizing clinicians from caring for vulnerable populations, clinicians should be reimbursed for the assessment of and intervention for modifiable SDOH. Additionally, more data is needed regarding the effect of SDOH on health outcomes and how to risk-adjust for SDOH.

We encourage CMS to increase funding for research not only in standardizing and validating the current tools and processes to collect information but also to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop and disseminate new evidence-based interventions to promote mental health equity. Collection of and integration of data as well as addressing identified needs takes resources that are not generally recognized within the current payment structure. This work is transformational and requires resources (i.e., human capital, technical assistance, financing) in order to be successful. Consideration should be given to innovation models including payment models and/or workflows for social determinants of mental health.

RFI: Electronic Exchange of Behavioral Health Information

While the goals of this effort are laudable, the resource costs are not insignificant, especially for those in small and solo practice. Considering the effort it will take to effectively manage the data exchange, and assimilation of the information for a panel of thousands of patients, these efforts will not be possible without additional clinical staff within the practice to assist in managing the population of patients and their associated healthcare clinicians. Financial resources are needed in order to achieve the goals outlined in this proposed rule and any other programmatic objectives aligning behavioral health data across settings. In addition, technical assistance to behavioral health clinicians is critical to improve digital literacy among clinicians and their patients, understand the regulatory requirements (and capabilities) available to them to reduce anxiety around digitization, assist with start-up and maintenance, and perform any upgrades pursuant to new certification criteria or new policy.

It is not clear what technologies CMS envisions when considering alternatives to EHRs. The institutional cost and effort associated with selecting, adopting, and managing an EHR may not be greater than alternatives. If psychiatrists use a third-party app to collect and share data, the burden remains on the clinician to integrate and aggregate those data into any existing data management system or otherwise process the data in a manner compliant with the API requirements herein. EHR adoption should be encouraged to achieve interoperability. Unless significantly cheaper or easier alternatives become available that are a stepping stone – not a stumbling block – to workflow modernization, APA suggests that these partners focus efforts on helping clinicians and health systems adopt consistent, natively interoperable technology.

APA recommends that ONC focus certification efforts on ensuring that certified EHR technologies are available to clinicians across specialties and patient populations. In behavioral health settings it is critical that ONC and partners work to lower the barrier to participation in CEHRT, including start-up and maintenance costs and the cost of upgrades to maintain certification so that those costs are not borne by

clinicians. Additional care models that could support the expansion of access to and use of high-quality technology include the team-based Collaborative Care Model (CoCM) – a mechanism by which shared data can be operationalized and implemented to improve patient care and outcomes. With many more primary care practices than psychiatric practices using EHRs and other clinical technology, centering primary care as a hub for care coordination and data management could support the spectrum of specialty services in sharing and using data to improve outcomes.

As mentioned elsewhere in this response, the value and utility of data exchange and capacity to process and manage data are key considerations. When establishing data sharing expectations or requirements, the baseline capabilities of rural and community-based practitioners should be understood and, if possible, addressed to help those clinicians meet emerging expectations. Next, the ability to appropriately segregate and protect sensitive data (e.g., 42 CFR Part 2 records) needs to be recognized and maintained in regulatory and technical activities. Given the varying payers and contexts to which these data will be exchanged, managing appropriate data safeguards may be difficult or impossible for small practices.

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments further, please contact Becky Yowell (byowell@psych.org), Director, Reimbursement Policy.

Sincerely,

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

Appendix 1: Z Code Prioritization

Yellow highlight = recommended by APA as priority codes

ICD-10-CM Code	Description	ICD-10-CM Code	Description
Z55.0	Illiteracy and low-level literacy	Z57.39	Occupational exposure to other air contaminants
Z55.1	Schooling unavailable and unattainable	Z57.4	Occupational exposure to toxic agents in agriculture
Z55.2	Failed school examinations	Z57.5	Occupational exposure to toxic agents in other industries
Z55.3	Underachievement in school	Z57.6	Occupational exposure to extreme temperature
Z55.4	Educational maladjustment and discord with teachers and classmates	Z57.7	Occupational exposure to vibration
Z55.5	Less than a high school diploma	Z57.8	Occupational exposure to other risk factors
Z55.8	Other problems related to education and literacy	Z57.9	Occupational exposure to unspecified risk factor
Z55.9	Problems related to education and literacy, unspecified	Z58.6	Inadequate drinking-water supply
Z56.0	Unemployment, unspecified	Z59.00	Homelessness unspecified
Z56.1	Change of job	Z59.01	Sheltered homelessness
Z56.2	Threat of job loss	Z59.02	Unsheltered homelessness
Z56.3	Stressful work schedule	Z59.1	Inadequate housing
Z56.4	Discord with boss and workmates	Z59.2	Discord with neighbors, lodgers and landlord
Z56.5	Uncongenial work environment	Z59.3	Problems related to living in residential institution
Z56.6	Other physical and mental strain related to work	Z59.41	Food insecurity
Z56.81	Sexual harassment on the job	Z59.48	Other specified lack of adequate food
Z56.82	Military deployment status	Z59.5	Extreme poverty
Z56.89	Other problems related to employment	Z59.6	Low income
Z56.9	Unspecified problems related to employment	Z59.7	Insufficient social insurance and welfare support
Z57.0	Occupational exposure to noise	Z59.811	Housing instability, housed, with risk of homelessness
Z57.1	Occupational exposure to radiation	Z59.812	Housing instability, housed, homelessness in past 12 months
Z57.2	Occupational exposure to dust	Z59.819	Housing instability, housed unspecified
Z57.31	Occupational exposure to environmental tobacco smoke	Z59.89	Other problems related to housing and economic circumstances

ICD-10-CM Code	Description	ICD-10-CM Code	Description
Z59.9	Problem related to housing and economic circumstances, unspecified	Z62.9	Problem related to upbringing, unspecified
Z60.0	Problems of adjustment to life-cycle transitions	Z63.0	Problems in relationship with spouse or partner
Z60.2	Problems related to living alone	Z63.1	Problems in relationship with in-laws
Z60.3	Acculturation difficulty	Z63.31	Absence of family member due to military deployment
Z60.4	Social exclusion and rejection	Z63.32	Other absence of family member
Z60.5	Target of (perceived) adverse discrimination and persecution	Z63.4	Disappearance and death of family member
Z60.8	Other problems related to social environment	Z63.5	Disruption of family by separation and divorce
Z60.9	Problem related to social environment, unspecified	Z63.6	Dependent relative needing care at home
Z62.0	Inadequate parental supervision and control	Z63.71	Stress on family due to return of family member from military deployment
Z62.1	Parental overprotection	Z63.72	Alcoholism and drug addiction in family
Z62.21	Child in welfare custody	Z63.79	Other stressful life events affecting family and household
Z62.22	Institutional upbringing	Z63.8	Other specified problems related to primary support group
Z62.29	Other upbringing away from parents	Z63.9	Problem related to primary support group, unspecified
Z62.3	Hostility towards and scapegoating of child	Z64.0	Problems related to unwanted pregnancy
Z62.6	Inappropriate (excessive) parental pressure	Z64.1	Problems related to multiparity
Z62.810	Personal history of physical and sexual abuse in childhood	Z64.4	Discord with counselors
Z62.811	Personal history of psychological abuse in childhood	Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z62.812	Personal history of neglect in childhood	Z65.1	Imprisonment and other incarceration
Z62.813	Personal history of forced labor or sexual exploitation in childhood	Z65.2	Problems related to release from prison
Z62.819	Personal history of unspecified abuse in childhood	Z65.3	Problems related to other legal circumstances
Z62.820	Parent-biological child conflict	Z65.4	Victim of crime and terrorism
Z62.821	Parent-adopted child conflict	Z65.5	Exposure to disaster, war and other hostilities
Z62.822	Parent-foster child conflict	Z65.8	Other specified problems related to psychosocial circumstances
Z62.890	Parent-child estrangement NEC	Z65.9	Problem related to unspecified psychosocial circumstances
Z62.891	Sibling rivalry	Z91.410	Personal history (past history) of spouse or partner violence, Physical
Z62.898	Other specified problems related to upbringing	Z91.410	Personal history (past history) of spouse or partner violence, Sexual

ICD-10-CM Code	Description
Z91.411	Personal history (past history) of spouse or partner psychological abuse
Z91.412	Personal history (past history) of spouse or partner neglect
Z69.81	Encounter for mental health services for victim of nonspousal/nonpartner adult abuse
Z69.81	Encounter for mental health services for victim of spouse/partner violence, Sexual
Z91.83	Wandering associated with a mental disorder
Z75.3	Unavailability or inaccessibility of health care facilities
Z75.4	Unavailability or inaccessibility of other helping agencies
Z91.198	Patient's noncompliance with other medical treatment and regimen for other reason
Z91.199	Patient's noncompliance with other medical treatment and regimen due to unspecified reason
Z91.51	History of suicidal behavior
Z91.52	History of nonsuicidal self-injury