AMERICAN PSYCHIATRIC ASSOCIATION

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September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Polices Under the Physician Payment Schedule and Medicare Shared Savings Program Requirements

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, would like to take the opportunity to comment on the CY 2023 payment policies under the physician payment schedule and other programs. We appreciate and support the Administration's commitment to supporting our nation's mental health through increasing the capacity of services, connecting more people to care and attending to an environment that supports health and mental health. Our comments focus on ensuring access to mental health and substance use disorder (SUD) treatment through continuing support for coverage and reimbursement of services via telehealth (including audio-only); reducing the barriers to care; support for new services (general behavioral health integration, Intensive Outpatient Programs); increasing access and quality of care through incentivizing the Collaborative Care Model and measurement-based care; and ensuring quality and health equity.

As has been widely reported, the United States is experiencing a crisis of mental health and well-being that has been compounded by the disruption, isolation, and loss experienced during the COVID-19 pandemic. As the impact of the pandemic continues to exacerbate mental health conditions, including substance use disorders (MH/SUD), the consequences are plain to see rising rates of suicide, record overdose deaths, and increased depression and anxiety across nearly all ages and demographics. Even beyond these sobering statistics, COVID-19 has impacted almost every single aspect of our lives, from job security to health equity, health outcomes, and beyond. Indeed, this is a crisis which has impacted not just individuals, or families, but entire communities.

Medicare Conversion Factor

As with primary care, the mental health and substance use disorder infrastructure is underfunded and under resourced. APA is concerned that further reductions to the Medicare conversion factor forecast for 2023 will have a negative impact on psychiatric practice and in turn access to care. It comes at a time when there is an increase in individuals seeking care and a limited supply of clinicians available to provide treatment. The continuing problem of emergency room boarding reflects both a lack of outpatient services as well as limited inpatient beds. There are not enough psychiatrists to treat all those needing care. Not only is the supply of child and adolescent psychiatrists in short supply, but the numbers of psychiatrists specializing in geriatric psychiatry are even lower; in part due to the difficulty of sustaining a practice serving a large number of Medicare beneficiaries. Of the 150 available geriatric fellowship slots only 48 filled in 2022. This exacerbates the challenges Medicare beneficiaries will face when trying to access psychiatric care**.** Ensuring easy and early access to care for mental health and substance use disorder treatment has a positive impact on long-term costs and improves the quality of life for individuals. **In addition, President Biden has stated that access to mental health and substance use is a priority for his administration, and without appropriate payment for services being able to find a psychiatrist will become even harder. APA urges CMS to work with Congress and the physician community to not only address the current constraints related to the Medicare Physician Fee Schedule methodology including addressing the limitations imposed by budget neutrality, but to develop strategies that support and incentivize access to evidence-based treatments and ensure practice sustainability.**

Practice Expense (PE) Relative Value Units (Section II.B.)
Rebasing and Revising the Medicare Economic Index (MEI) (Section II.M.)

The accuracy of any payment system is only as good as the data used to calculate a payment. As with the recent update to the clinical labor inputs, CMS has proposed updates to the current practice expense inputs using data from a new source, the US Census Bureau's Services Annual Survey (SAS). Additionally, CMS is signaling the potential for a future update of the weighting of the inputs to the Medicare Economic Index (MEI) that would substantially redistribute payments.

APA agrees that updates to the practice expense data from the 2006 AMA Physician Practice Information Survey (PPIS) are long overdue. It is unclear at this point what impact those changes will have on the overall practice expense component let alone the impact this will have on adjustments to the MEI. **APA urges CMS to proceed in a stepwise approach starting first with updates to the practice expense component.** It is our understanding that the American Medical Association (AMA) has field tested a survey that reflects the breadth of how physician practices are organized which is likely to yield meaningful results. **APA supports AMA's efforts and encourages CMS to delay any changes (both in terms of PE inputs as well as MEI weighting) until the AMA process is complete. This will provide additional information and allows for a better understanding of the magnitude of the PE changes and the cumulative impact when applied along with any adjustment to the MEI weights.**

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Section II.D.)

Requests To Add Services to the Medicare Telehealth Services List for CY 2023 (b)

Telephone E/M Services (2)

CMS's decision to amend coverage policies at the beginning of the pandemic to cover the existing telephone codes and aligning payments with outpatient E/M services provided reflects an understanding that there is a benefit to audio-only care. **We urge CMS to maintain coverage for the telephone E/M visits** beyond the end of the Public Health Emergency and the 151-day extension or until the AMA CPT/RUC Telemedicine Office Visits Workgroup completes their work.

- CMS should continue its current coverage and payment policies for telephone visits and audio-visual telehealth services until the joint CPT/RUC Telemedicine Office Visits Workgroup determines accurate coding and valuation, as needed, for office visits performed via audio-visual and audio-only modalities.

Emotional/Behavior Assessment, Psychological, or Neuropsychological Testing & Evaluation Services (5)

We support the addition of the following codes as Category 3 Telehealth codes which will allow for additional data collection:

- 97151 (Behavior identification assessment, administered by a physician or other qualified health care professional),
- 97152 (Behavior identification- supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional),
- 97153 (Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional),
- 97154 (Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional),
- 97155 (Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician),
- 97156 (Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present),
- 97157 (Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present),
- 97158 (Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional),
- 0362T (Behavior identification supporting assessment), and
- 0373T (Adaptive behavior treatment with protocol modification)

Other Services Proposed for Addition to the Medicare Telehealth Services List (c)

We support the addition of the following code as Category 3 codes to allow time for additional data:

- 90875 (Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy
- *96127 (Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/ hyperactivity disorder [ADHD] scale)*

We support the addition of the prolonged services codes as Category I codes once finalized. We encourage CMS to work with the CPT/RUC Workgroup on E/M to finalize a single set of prolonged services codes in lieu of implementing HCPCS codes that describe similar services. This will lead to confusion and miscoding.

- GXXX1 (Prolonged hospital inpatient or observation care evaluation and management service(s)
- GXXX2 (Prolonged nursing facility evaluation and management service(s)
- GXXX3 (Prolonged home or residence evaluation and management service(s)

Services Proposed for Removal from the Medicare Telehealth Services List After 151 Days Following the End of the PHE (d)

We urge CMS to retain as Category I codes the new patient/initial day codes for the observation (99234-99236), hospital (99221-99223), nursing facility (99304-99306), domiciliary/residential/home (99324-99328), to allow psychiatrists to provide telehealth consultations when needed in those settings. Given the workforce shortage and maldistribution of providers, psychiatric consultations through telehealth have become an integral part of clinical practice, especially for communities that lack local expertise. Data gathered over the course of the pandemic underscores the impact, reflecting improved outcomes for patients receiving care for mental health or substance use disorders.[1,2] A 2016 survey by the AMDA – The Society for Post-Acute and Long-Term Care Medicine, found that nursing home clinicians supported consultations by psychiatrists via telehealth. This was seen as one way to improve access and timeliness to care.[3]

Implementation of Telehealth Provisions of the CAA, 2021 & 2022 (e)

We commend CMS for their continuing efforts to ensure access to care for those with mental illness or substance use disorders. The changes made permanent in the Final Rule on the 2023 Physician Fee Schedule ensure a smoother transition to in-person care and increased access via telehealth, including audio-only, to necessary care. It is especially important for mental health and substance use care, where

[1] Gopalan P, Auster L, Brockman I, Shenai N. Consultation-Liaison Telepsychiatry on an Inpatient Obstetrical Labor and Delivery Unit. J Acad Consult Liaison Psychiatry. 2021;62(6):577-581. doi:10.1016/j.jaclp.2021.04.001

[2] Deng H, Raheemullah A, Fenno LE, Lembke A. A telehealth inpatient addiction consult service is both feasible and effective in reducing readmission rates [published online ahead of print, 2022 Jul 12]. J Addict Dis. 2022;1-8. doi:10.1080/10550887.2022.2090822

[3] Driessen J, Chang W, Patel P, Wright RM, Ernst K, Handler SM. Nursing Home Provider Perceptions of Telemedicine for Providing Specialty Consults. Telemed J E Health. 2018;24(7):510-516. doi:10.1089/tmj.2017.0076

the ability to establish and maintain a strong, uninterrupted therapeutic alliance with patients is critical to effective interventions. The changes also showed the potential and benefits of virtual care in meeting treatment needs, including reduced no-show rates for appointments, increasing continuity of care and increased patient satisfaction.

A recent public poll conducted by Morning Consult on behalf of APA found that 90 percent of respondents were either very or somewhat satisfied with their virtual mental health appointments. When asked about their preference for future appointments, 36 percent preferred either all virtual or mostly virtual, 24 percent had no preference, and 40 percent preferred all in-person or mostly in-person. The largest cohort preferring virtual visits were in the age groups of 18 to 44. Of those receiving virtual care, 12 percent received care by audio-only with the highest use of audio-only care by women over the age of 58. In response to an open-ended question about virtual appointments, adults who say they prefer in person appointments say it's because it makes them feel more comfortable and it improves the patient experience, while those who prefer a virtual appointment also say comfort is a main reason and because in-person care is too far away. Putting restrictions on virtual care will disproportionately affect the low income, elderly, and those living in areas that lack transportation. High and low-tech options need to be available as we work collaboratively with patients to reduce the digital divide.[4,5]

As finalized in November, CMS has included audio-only services for mental health and substance abuse treatment as part of the telehealth list. **CMS has directed psychiatrists to use the office/outpatient (O/O) evaluation and management (E/M) codes (99202-99215) when providing outpatient E/M services by audio-only, a decision we strongly support.** To ensure proper use of the codes, A**PA recommends that CMS develop educational tools through the Medicare Learning Network (MLN) for psychiatrists providing care to people with mental illness and substance use disorders.** APA is willing to partner in sharing the MLN education with its members. Psychiatrists provide both evaluation and management services as well as psychotherapy and a range of other treatments. While audio-only care comprises a small percentage of visits, the ability to bill an audio-only service is critical to ensure patients receive timely and necessary care.

APA appreciates that CMS has allowed some flexibilities regarding the in-person visit requirement, however we **remain concerned about any requirement for an in-person visit prior to a telehealth encounter, regardless of whether the telehealth encounter is conducted via synchronous video or via audio-only.** Requiring an initial or subsequent in-person visit for a patient to qualify for a telehealth encounter of any modality will be a barrier to care and disproportionately affect people with low income, the elderly and those in rural areas. As we note below in our comments regarding flexibilities in telehealth in the OPT setting, data is showing that telehealth, including audio-only is effective in starting care and

[4] Alkureishi MA, Choo ZY, Rahman A, et al. Digitally Disconnected: Qualitative Study of Patient Perspectives on the Digital Divide and Potential Solutions. JMIR Hum Factors. 2021;8(4):e33364. Published 2021 Dec 15. doi:10.2196/33364

[5] Sharma P, Patten CA. A Need for Digitally Inclusive Health Care Service in the United States: Recommendations for Clinicians and Health Care Systems [published online ahead of print, 2022 Jul 20]. Perm J. 2022;1-5. doi:10.7812/TPP/21.156

retaining patients in treatment. This decision should be based on the clinical decision making of the clinician.

Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID–19 (f)
APA does not support CMS's proposal to pay for telehealth rates to facility rate following 151 days after the Public Health Emergency. Section 1834(m)(2) of the Social Security Act requires that the Secretary pay the clinician furnishing a telehealth service to an eligible individual at the rate equal to the rate they would have received if providing that service without the use of telehealth. **We urge CMS to continue the long-standing payment policy and pay for services in the O/O setting at the non-facility rate.**

Valuation of Specific Codes (Section II.E.)

Caregiver Behavior Management Training (CPT codes 96X70 and 96X71) (29)

The APA supports the RUC recommendations for 96X70 and 96X71 and urges CMS to approve these services as a Medicare covered benefit. As with the proposal to remove coverage restrictions for family therapy without the patient present, the APA supports coverage for the Caregiver Behavioral Management Training. These programs are aimed to enhance the caregiver's ability to manage behavior problems and other deteriorations in function related to attending to a child, adolescent, or adult patient with a physical or mental health condition. This training has been shown to positively impact treatment for patients with conditions such as ADHD, Alzheimer's, and dementia,[6,7,8] reducing the need for medication, preventing hospitalizations and has the potential to delay the need for institutionalization.

Cognitive Behavioral Therapy Monitoring (CPT Code 989X6) (30)

See the Remote Therapeutic Monitoring (RTM) section II.I. of this proposed rule for a review of the new device code, CPT code 989X6.

Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS Codes G0442 and G0444) (31)

APA supports CMS's proposal to revise the descriptor to allow the billing of these services within a shorter timeframe.

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[6] Coles EK, Pelham WE, Fabiano GA, et al. Randomized Trial of First-Line Behavioral Intervention to Reduce Need for Medication in Children with ADHD. J Clin Child Adolesc Psychol. 2020;49(5):673-687. doi:10.1080/15374416.2019.1630835

[7] Sansoni J, Anderson KH, Varona LM, Varela G. Caregivers of Alzheimer's patients and factors influencing institutionalization of loved ones: some considerations on existing literature. Ann Ig. 2013;25(3):235-246. doi:10.7416/ai.2013.1926

[8] Sperling SA, Brown DS, Jensen C, Inker J, Mittelman MS, Manning CA. FAMILIES: an effective healthcare intervention for caregivers of community dwelling people living with dementia. Aging Ment Health. 2020;24(10):1700-1708. doi:10.1080/13607863.2019.1647141

Proposed Revisions to the ''Incident to' Physicians' Services Regulation for Behavioral Health Services (34)

We appreciate CMS's interest in expanding access to care for mental health and substance use disorder services. There are many ways to increase access (see discussion re CoCM) to necessary services. This proposal seeks to increase the workforce by proposing to classify marriage and family therapists and licensed profession counselors as auxiliary personnel, allowing their time to be billable under the supervising professional. Supervision, in this case general supervision, is a critical component of ensuring Medicare beneficiaries have access to safe and effective care. Scope of practice is determined by one's licensure in the state, supervision can ensure safe delivery of that care. **We encourage data collection and research on the care provided by these individuals (MFT, LPC) prior to expanding the policy to other providers to ensure patients are receiving the best quality care to meet their needs.**

New Coding and Payment for General Behavioral Health Integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs) (35)

APA supports CMS's proposal to provide coding and payment for general behavioral health integration services by clinical psychologists and clinical social workers. *Care management services for behavioral health conditions (GBHI1)* lays the foundation for implementing measurement-based care (MBC), which is defined as "repeated, validated measures to track symptoms and functional outcomes in clinical settings."[9] Assessing patients and providing follow-up monitoring through the use of validated rating scales to track progress and adjust treatment not only improves outcomes, but it also empowers patients, improves communication between the patient and clinician[10] and has been shown to reduce disparities by race and ethnicity in depression outcomes.[11,12] Referral and ongoing care coordination/collaboration with psychiatrists and primary care clinicians is also an important aspect of care.[13]

We also support the use of 90791 (Psychiatric diagnostic evaluation) as the initiating visit as psychologists and social workers are not medical providers and thus not able to bill E/M services. We agree with CMS's proposal to crosswalk the values to 99484 (Care management services for behavioral

[9] Alter, C.L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H.T., McLaughlin, R, & Sieger-Walls, J. (2021, January). Measurement Based Care in the Treatment of Behavioral Health Disorders. Dallas, TX: Meadows Mental Health Policy Institute. mmhpi.org

[10] Fortney, (J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services (Washington, D.C.), 68(2), 179–188. https://doi.org/10.1176/appi.ps.201500439

[11] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.

[12] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859

[13] Dickson KS, Sklar M, Chen SZ, Kim B. Characterization of multilevel influences of mental health care transitions: a comparative case study analysis. BMC Health Serv Res. 2022;22(1):437. Published 2022 Apr 2. doi:10.1186/s12913-022-07748-2

health conditions), which can be performed by physicians/QHPs or clinical staff. It is unclear if the current valuation is accurate; the 99484 will be reviewed by the RUC at their September 2022 meeting. **As we note in section 38 (below), these codes could be billed when providing measurement-based care (MBC) however, the current valuation of the 99484 is not enough to incentivize clinicians to make the changes required for this model of care.**

Request for Information: Medicare Potentially Underutilized Services (38)

Behavioral Health Integration Services

Incentivize the Adoption of The Collaborative Care Model

The Collaborative Care Model (CoCM) is currently being implemented in many large health care systems and independent primary care practices, and is also reimbursed by Medicare, many private insurers, and a growing number of state Medicaid programs. Despite its compelling evidence base (improves access, outcomes, patient and provider satisfaction, and reduces disparities in care and long-term costs) and availability of reimbursement, uptake of the CoCM by primary care physicians and practices remains lower than expected.[14,15]

The following are some of the barriers to implementation identified thus far:

- **Up-front costs incurred that are associated with implementation/practice transformation.** This includes costs associated with infrastructure (hiring of additional staff before caseloads are established), EHR/registry modifications, as well as uncompensated costs not associated with direct patient care but none the less important to ensuring positive outcomes (i.e., development and training on workflows and caseload reviews, ongoing education, quality improvement activities). Activities that benefit from having technical assistance.

- **Current reimbursement rates.** Primary Care Practitioner (PCP) concerns that reimbursement rates for billable services are insufficient to cover costs, creating a disincentive to implement the model.

- **Patient attrition due to copays/cost-sharing requirements**, which can occur with any type of plan and is especially true in high-deductible plans.

- **Burdensome documentation requirements and billing challenges** related to tracking of minutes over the course of a calendar month, limitations on the number of minutes billed per month (i.e.

[14] Marcotte LM, Reddy A, Zhou L, et al. Provision of Collaborative Care Model and General Behavioral Health Integration Services in Medicare. Psychiatr Serv. 2021;72(7):822-825. doi:10.1176/appi.ps.202000265

[15] Newton H, Busch SH, Brunette M, Maust DT, O'Malley J, Meara ER. Implementation of collaborative care for depressive disorder treatment among accountable care organizations. Medicine (Baltimore). 2021;100(27):e26539. doi:10.1097/MD.0000000000026539

MUE billing limitations), patient consent, and different time requirements in FQHCs and RHCs that result in no payment or underpaying for the time spent to provide care, creating a disincentive.

Acting now to reduce the barriers would maximize efforts currently underway by medical organizations (AMA BHI Collaborative), and private payers in collaboration with community organizations (i.e., BCBS MI and IHA Health Services Corp) to support the implementation of CoCM.

In an effort to support this high-value model consideration should be given to:

- **Implementing funding and reimbursement mechanisms for CoCM to incent practices to implement the model including technical assistance.** In a recent RFI, HHS acknowledged the need to strengthen primary care practices stating, "our nation's primary health care foundation is weakening and in need of support: primary health care is under-resourced; the workforce is shrinking; workforce well-being is in peril; and many practices face reimbursement challenges that may result in financial instability." CoCM provides an opportunity to increase access to care and improve outcomes but requires changes in the way care is being provided which requires both financial and human capital. This type of practice transformation requires support that can help mitigate barriers to implementation and patient engagement and capitalize on lessons learned.[16] This is difficult to do in isolation, especially given the current demands on practices already on shaky ground.

  One possible solution is to provide financial support and technical assistance to primary care practices. Recommendation 14 from a 2021 report from Rand, supports the launch of a National Care Coordination Initiative,[17] including financial support to defray capital costs incurred to implement the CoCM model and higher reimbursement rates over a period of time to ensure practices maintain the model. This would include covering costs not typically addressed within a fee for service payment methodology (i.e., workflow development, training, registry costs, quality improvement activities). The report also suggests modeling the Initiative after CMS's Transforming Clinical Practice Initiative (TCPI) through regional learning networks to provide technical assistance for those that want to implement the model.

- **Designating CoCM services as preventive services by the Secretary, thus eliminating cost-sharing requirements for these services.** A recent study[18] confirms reports from the field that cite cost-sharing/copay as one of the reasons patients chose not to engage in or continue to receive care through the model. The purpose of cost-sharing is to help deter the over-use of

[16] Fu E, Carroll AJ, Rosenthal LJ, et al. Implementation Barriers and Experiences of Eligible Patients Who Failed to Enroll in Collaborative Care for Depression and Anxiety [published online ahead of print, 2022 Aug 5]. J Gen Intern Med. 2022;1-9. doi:10.1007/s11606-022-07750-8

[17] McBain RK., Eberhart N, Breslau J, Frank L, Burnam A, Kareddy V, and Simmons MM. How to Transform the U.S. Mental Health System: Evidence-Based Recommendations. Santa Monica, CA. RAND Corporation. 2021. https://www.rand.org/pubs/research_reports/RRA889-1.html.

[18] Blackmore MA, Patel UB, Stein D, et al. Collaborative Care for Low-Income Patients From Racial-Ethnic Minority Groups in Primary Care: Engagement and Clinical Outcomes. Psychiatr Serv. 2022;73(8):842-848. doi:10.1176/appi.ps.202000924

services, CoCM is something that the care system specifically wants patients to receive.

The United States Preventive Services Task Force (USPSTF) has given the Depression Screening in Adults and in Children and Adolescents B ratings (an evidence-based service whose net benefits are moderate to substantial[19]), meeting one of four categories identified by statute as a preventive service. Screening for depression is a core function of the CoCM. In fact, the USPSTF notes in their 2016 recommendation statement that the "Community Preventive Services Task Force recommends the collaborative care model for the management of depressive disorders based on the model's robust evidence of effectiveness in improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression. This collaboration is designed to improve the routine screening and diagnosis of depressive disorders, as well as the management of diagnosed depression."

A recent report from Assistant Secretary for Planning and Evaluation (ASPE) reported that millions of Americans have benefited from ACA coverage and the lack of cost-sharing associated with preventive services. The report noted the value of preventive care/screening for chronic conditions to prevent or reduce impacts on long-term health. It is widely understood that depression has been linked to increasing mortality and morbidity for individuals with chronic conditions (i.e., cardiovascular disease, diabetes). Identifying and treating depression and other mental health conditions sooner could modify the trajectory of disease and save overall health care costs not to mention improve the quality of life for patients.

- **Identifying ways to increase efficiency and reduce uncompensated care**
    - Allow clinical staff to obtain consent under general supervision of the treating physician. Once consented there should be no need to re-consent a patient during that episode of care. Consent should be tied to inclusion in the program within the practice and not to the identified treating clinician.

    - Eliminate limitations on billing the 99494 related to Medically Unlikely Edit (MUE) policies. The current limit of two results in uncompensated time in those instances where more time is required.

- **Aligning of Medicare and other payer coding, payment and documentation requirements, and processes related to "high value" services**
    - Allow FQHCs and RHCs to bill the existing CPT codes (99492 - 99494, G2214) as defined in CPT. Most payers, including many Medicaid plans, use the CPT codes to bill for CoCM services. Consistency across payers will reduce the administrative burdens and potential errors that occur when required to do something differently for what is likely a small subset of patients.

[19] The Patient Protection and Affordable Care Act, Sec. 2713 (a)(1)

- Address barriers to billing the CoCM codes (99492-99494, G2214) related to the inability to bill incident-to services in a ProviderBased Clinic POS 19/22.

Reducing barriers and incentivizing adoption of CoCM will improve access, clinical outcomes and quality of life for patients and will reduce long-term health care costs over time.

Incentivize the Adoption of Measurement-Based Care (MBC)

Consideration should be given to providing financial support and technical assistance to implement measurement-based care (MBC) to both primary care clinicians (either within the context of a collaborative care implementation or as a stand-alone activity), as well as mental health clinicians. MBC, a core component of the Collaborative Care Model, has been shown to be effective in improving outcomes and patient and provider satisfaction in both primary and specialty care.[20,21,22,23] In their recent (2022) report to Congress, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) highlighted the positive effects of MBC; accrediting organizations and payers have also begun to recognize its value. MBC increases screening and can improve early identification and prevention and is more effective in improving outcomes than screening alone.

As with CoCM, clinicians in both primary care and specialty care have been slow to adopt this model of care. A 2020 JAMA Psychiatry article (Lewis et al) summarized several barriers faced by individual clinicians and organizations including concerns about patient response burden, patient confidentiality, the time and effort it takes to collect the information and track over time, lack of an electronic medical record or one that can facilitate MBC and the increase administrative burden on staff or individual clinicians.[24] Implementation will require stakeholder buy-in and adapting to change.[25]

CMS's coverage of *99484 and GBHI1 (Care management services for behavioral health conditions*) provides a starting point however does not fully account for the costs to implement measurement-based care. The current valuation does little to incentivize MBC. **As with CoCM, providing funding to implement reimbursement mechanisms that incentivize change, and support through technical assistance could**

[20] Fortney, (J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services (Washington, D.C.), 68(2), 179–188.
[21] Alter, C.L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H.T., McLaughlin, R, & Sieger-Walls, J. (2021, January). Measurement Based Care in the Treatment of Behavioral Health Disorders. Dallas, TX: Meadows Mental Health Policy Institute. mmhpi.org
[22] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.
[23] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859
[24] Lewis CC, Boyd M, Puspitasari A, et al. Implementing Measurement-Based Care in Behavioral Health: A Review. JAMA Psychiatry. 2019;76(3):324-335. doi:10.1001/jamapsychiatry.2018.3329
[25] Fortney, (J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services (Washington, D.C.), 68(2), 179–188.

reduce the barriers to adoption. This is one way for those primary care practices that may not choose to implement CoCM to improve outcomes for their patients suffering from mental health and substance use disorders.

Change in Procedure Status for Family Psychotherapy (39)

APA supports CMS's proposal to change the procedure status indicator for the family therapy codes (90847, 90849) from R (restricted) status to A (active) status. This modality of care has been shown to improve outcomes for individuals with mental illness and substance use disorders.[26,27] The change in status will remove a barrier to care.

Comment Solicitation on Intensive Outpatient Mental Health Treatment, including Substance Use Disorder (SUD) Treatment, Furnished by Intensive Outpatient Programs (IOPs) (40)

We applaud CMS's interest in Intensive Outpatient Programs (IOPs). IOPs have been shown to be an effective model of care for individuals with mental health and/or substance use disorders who either require a higher level of care than standard outpatient services or a lower level of care than partial hospitalization services.[28,29, 30] IOP services were maintained through the COVID 19 pandemic by telehealth, including some hybrid models. While still early, initial studies report that telehealth has been an effective form of treatment.[31,32] **APA supports Medicare coverage of IOPs (both in-person and virtual), as it is an important component in the continuum of care for patients with mental health or substance use disorders, including the ability to provide care via telehealth.**

The following is in response to CMS's questions around IOP services, and staffing. The APA would be interested in working with CMS as policies are developed, should coverage be finalized.

[26] Gorrell S, Loeb KL, Le Grange D. Family-based Treatment of Eating Disorders: A Narrative Review. Psychiatr Clin North Am. 2019;42(2):193-204. doi:10.1016/j.psc.2019.01.004

[27] Stahl ST, Rodakowski J, Saghafi EM, Park M, Reynolds CF, Dew MA. Systematic review of dyadic and family-oriented interventions for late-life depression. Int J Geriatr Psychiatry. 2016;31(9):963-973. doi:10.1002/gps.4434

[28] McCarty D, Braude L, Lyman DR, et al. Substance abuse intensive outpatient programs: assessing the evidence. Psychiatr Serv. 2014;65(6):718-726. doi:10.1176/appi.ps.201300249

[29] Burton MS, Rothbaum BO, Rauch SAM. The role of depression in the maintenance of gains after a prolonged exposure intensive outpatient program for posttraumatic stress disorder. *Depress Anxiety*. 2022;39(4):315-322. doi:10.1002/da.23240

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[31] Bean CAL, Aurora P, Maddox CJ, Mekota R, Updegraff A. A comparison of telehealth versus in-person group therapy: Results from a DBT-based dual diagnosis IOP [published online ahead of print, 2022 May 9]. J Clin Psychol. 2022;10.1002/jclp.23374. doi:10.1002/jclp.23374

[32] Levinson CA, Spoor SP, Keshishian AC, Pruitt A. Pilot outcomes from a multidisciplinary telehealth versus in-person intensive outpatient program for eating disorders during versus before the Covid-19 pandemic. Int J Eat Disord. 2021;54(9):1672-1679. doi:10.1002/eat.23579

In general, the types of services provided to patients with mental health disorders versus substance use disorders are similar. They include counseling, case management, psychosocial rehabilitation, individual and family work delivered in individual and group-based sessions. The typical practitioner types include licensed therapists, certified counselors, psychologists, nurses and an increasing number of peer recovery specialists to assist with housing needs or connect to other community services/supports.

Treatments for substance use disorders should be based on evidence and empirical studies whenever possible. Effective behavior therapies and medications are needed to address the multiple needs of the individual, and no single treatment is appropriate for everyone. In addition to its availability to outpatients, IOP services should also be available to those in residential settings – halfway houses, group homes, etc.

IOP treatment should be tied to scheduling a minimum of 9 hours per week for adults or 6 hours per week for adolescents with the ability to bill for a partial week. Patients with SUD requiring IOP treatment are by definition struggling with stability and ongoing drug use and are more likely to miss scheduled sessions. It is up to the provider to help incentivize adherence, and address barriers, however the program does not have control over whether the person attends. Programs must have the ability to bill for services provided even if the minimum number of scheduled hours for the week goes unmet. Bundled payments should be structured to allow some flexibility. Medical services provided by physicians, including psychiatrists, should be billed outside the bundle using the appropriate CPT codes; medications can be dealt with in the same way

Members have reported that Medicare rates for partial hospitalization services are inadequate to cover the cost of care. **We strongly recommend, if coverage is finalized, that CMS value the services at a rate that is comparable to other rates in the marketplace. This is an important component in the continuum of care that has been shown to be effective in improving outcomes.**

APA recently completed a two-year effort to look into the dynamics of the mental healthcare system, with a look at the relationship between multiple levels of care availability and the impact on needed inpatient beds. CMS may find this document, and the underlying methodology, useful in examining the potential impact of funding IOP services on the entire system of care.[33]

Comment Solicitation on Payment for Behavioral Health Services under the PFS (41)
We appreciate CMS's interest in addressing payment policies in an effort to ensure beneficiary access to behavioral health care. There have been significant shifts in payment over the last several years in large part due to the redistribution of relative value units as a result of modifications and revaluation of the evaluation and management services, and updates to clinical labor. These changes have had a significant impact on payments through reductions to the conversion factor, which impacts payments to psychiatrists and other behavioral health care providers. This trend will likely continue with updates to the practice

[33] McCarty D, Braude L, Lyman DR, et al. Substance abuse intensive outpatient programs: assessing the evidence. Psychiatr Serv. 2014;65(6):718-726. doi:10.1176/appi.ps.201300249

expense inputs, the proposed changes to the MEI weighting and shifts in PLI inputs put forward in this rule.

We are interested in insuring access to high quality care and thus recommend identifying ways to incentivize evidence-based models of care. Two were highlighted above, CoCM and MBC, and there are others (ECT, TMS, Sparano, crisis services, Coordinated Specialty Care) currently in use and more in development.

We welcome the opportunity to begin a dialogue to address the challenges of the current methodology and explore ways to ensure access to evidence-based treatment and practice sustainability, encourage participation in Medicare, and improve quality without incurring additional administrative burden. All the while ensuring there is adequate funding for services across the continuum of care.

Evaluation and Management (E/M) Visits (Section II.F)

APA appreciates CMS's accepting the recommendations for the facility (hospital inpatient or observation codes, nursing facility, emergency codes), home or residence visit codes, and prolonged services codes. This marks the end of a process that began with the modification and revaluation of the outpatient E/M codes. Harmonizing the code selection and documentation guidelines across all sites of service will ease administrative burdens for all physicians.

Prolonged Services (C)

APA strongly encourages CMS to work collaboratively with the AMA CPT/RUC E/M Workgroup to review and revise if appropriate the coding framework for prolonged services. This allows for multistakeholder input and would alleviate the need for clinicians to have to understand and pick between two different code sets describing similar work.

Split (or Shared) Services (E)

APA appreciates CMS's proposal to delay (January 1, 2024) implementation of the requirement that split (or shared) visits be billed on the basis of who spends the more than half of the total time with the patient during the split/shared visit rather than medical decision making. **We support the AMA's efforts to provide further clarification through the convening of the CPT/RUC Workgroup on E/M.**

Determination of Malpractice Relative Value Units (RVUs) (Section II.H.)

APA appreciates the work CMS has undertaken to identify data sources and propose premium amounts that more closely reflect the costs incurred by all clinicians, both physician and non-physician.

Non-Face-to-Face Services/Remote Therapeutic Monitoring (RTM) Services (Section II.I.)

There has been an expansion of available digital technologies offering interesting possibilities for mental health with the potential to help monitor symptoms and even deliver adjunctive treatments. Currently, there are apps targeting all major psychiatric illness and therapeutic modalities. While Apps can be appropriate and useful in care, clinicians should be thoughtful, working with their individual patient to identify the app that best meets their needs. Given the lack of oversight by the FDA, the APA developed the APP Advisor program to help clinicians and patients make an informed choice.

APA supports the use of digital technologies and the development of a funding mechanism that appropriately reflects the work and practice expenses required. **We urge CMS to work collaboratively with specialty societies and the American Medical Association, through the CPT and RUC process to devise a framework that will ensure safety, privacy, is based on a clinical foundation and addresses therapeutic goals**

Review of New RTM Device Code: Cognitive Behavioral Therapy Monitoring (CPT Code 989X6)

As one of the specialty societies requesting CMS contractor price 989X6, we support CMS' proposal to accept the RUC recommendation. We look forward to working collaboratively with CMS and others to identify and develop payment mechanisms for these emerging technologies.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (Section III.F.)

APA supports the proposals put forward by CMS to ensure access to medically necessary care for those suffering from substance use disorders. This includes adjustments in payments to ensure costs of care are covered, ensuring practice sustainability; and the audio and audio/visual options for intake into Opioid Treatment Programs and for periodic assessments. Keeping beneficiaries engaged in treatment through the platforms that best meet their needs can be done using complementary risk mitigation to secure labs such as urine toxicology. APA supports clinicians in determining when virtual platforms can be used and when in-person visits are advised.

A new study published in JAMA Psychiatry found that the Federal telehealth waivers in place to increase access to substance use disorder care had a positive impact on patients receiving medications for opioid use disorders. A review of Medicare beneficiary data before and during the public health emergency showed "use of telehealth during the pandemic was associated with improved retention in care and reduced odds of medically treated overdose, providing support for permanent adoption [of the flexibilities]."[34] The study included care provided to new and established patients.

[34] Jones CM, Shoff C, Hodges K, et al. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic [published online ahead of print, 2022 Aug 31]. JAMA Psychiatry. 2022;10.1001/jamapsychiatry.2022.2284. doi:10.1001/jamapsychiatry.2022.2284

Medicare Shared Savings Program (MSSP) (Section III.G.)

APA encourages CMS to incentivize the implementation of the Collaborative Care Model (CoCM) in Accountable Care Organizations (ACO). CoCM is an evidence-based model that integrates behavioral health care within the primary care setting through a team-based approach that includes a primary care clinician, a psychiatric consultant, and a care manager. The model is a population-based approach, that includes care management activities, and the use of validated rating scales to access progress and make adjustments in treatment when patients are not improving. CoCM is supported by more than 90 randomized controlled trials and has been shown to double the number of patients with meaningful clinical improvement relative to usual care. It is effective in reducing disparities by race and ethnicity in depression outcomes.[35,36] In addition to demonstrated clinical efficacy, CoCM's population-based approach helps to alleviate the psychiatric workforce shortage by leveraging the expertise of the psychiatric consultant. One psychiatric consultant can help guide the treatment of many more patients within a CoCM model than if that same clinician was treating patients on a one-to-one basis. Providing effective treatment within primary care frees up specialty care capacity for patients needing that level of care. Additionally, the CoCM has tremendous potential to produce significant cost savings. For example, one cost/benefit analysis demonstrated that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults.[37] Furthermore, the virtual nature of CoCM enabled care to continue throughout the public health emergency.[38] Finally, primary care physicians have reported an increased sense of well-being and feel better prepared to provide care to patients with mental health and SUD. All of these feature's function to improve both mental and physical health and prevent downstream hospitalizations, or emergency room visits (not only for mental health or SUD conditions but physical health conditions as well) ultimately reducing overall-costs to our healthcare system.[39] All attributes that should be attractive to accountable care organizations.

Despite what would appear to be a natural synergy, there has not been wide-spread uptake of the model within the ACO setting. A 2021 article found that only 17% of ACOs reported full implementation of CoCM within their system. The study found that while many employed care managers, and some psychiatric

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[35] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.

[36] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859

[37] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=8

[38] Carlo AD, Barnett BS, Unützer J. Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. JAMA Psychiatry. 2021;78(4):355-356. doi:10.1001/jamapsychiatry.2020.3216

[39] Melek SP, Norris DT, Paulus J, Matthews K, Weaver A, Davenport S. Milliman Research Report potential economic impact of integrated ... Milliman. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf. Published February 12, 2018. Accessed July 27, 2022.

consultants, and were engaged in quality reporting, a large percentage were unable to track patient progress, a core component in improving patient outcomes. Measurement-based care, the act of regularly tracking the patient's progress and adjusting treatment if clinically indicated, means that practices can easily identify patients that are getting better and patients who may need to access more intensive services, strategically allocating resources so that each patient is able to receive just the right amount of care. Prioritizing that component, that includes the development and use of a registry in combination with other quality improvement activities is a way to improve outcomes.[40]

Updates to the Quality Payment Program (Section IV.)

MIPS Quality Performance Category Health Equity Request for Information (Section IV.10.c (1)(d))

APA continues to support efforts to improve collection of data on social risk factors and health disparities; we appreciate CMS's commitment to addressing health equity in its quality and measurement programs. Identifying health disparities and addressing gaps in care are vitally important goals, and we support efforts to find the most useful and appropriate methods for collecting data on disparities and social determinants of health.

Many Americans lack the nutritional, health care, housing, educational and occupational opportunities they need to be secure and thrive, with significant impact on their overall health and mortality, as well as their mental health. The prevalence of COVID-19, which disproportionately impacts individuals from marginalized communities and those with serious mental illnesses (SMI) or substance use disorder (SUD) who are at greater risk of infection due to social determinants of health (SDOH) factors,[41] has exacerbated these same determinants,[42] and worsened in populations where racism is endemic.[43] 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 SUD, as well as an increase in suicide; trends we anticipate will continue for the foreseeable future.

In addition to traditional SDOH, consideration should be given to the impact of Social Determinants of Mental Health (SDoMH). Factors such as stigma, lack of parity (access and payment), the flawed criminal justice system, and the impact of social media, all of which disproportionately impact individuals with SMI and SUD. Most adults with SMI and SUD start experiencing symptoms by age 24, some as young as 14

[40] Newton H, Busch SH, Brunette M, Maust DT, O'Malley J, Meara ER. Implementation of collaborative care for depressive disorder treatment among accountable care organizations. Medicine (Baltimore). 2021;100(27):e26539. doi:10.1097/MD.0000000000026539

[41] 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

[42] Bernardini, Francesco et al. "Social Determinants of Mental Health As Mediators and Moderators of the Mental Health Impacts of the COVID-19 Pandemic." Psychiatric services (Washington, D.C.) vol. 72,5 (2021): 598-601. doi:10.1176/appi.ps.202000393

[43] 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

years old; these individuals die 15-20 years younger and are more likely to be incarcerated.[44,45] Too many children experience adverse childhood experiences (ACEs). - These are potentially traumatic events that occur in childhood (0-17 years) including: experiencing violence, abuse, or neglect, witnessing violence in the home or community, having a family member attempt or die by suicide. In addition, aspects of a child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use problems, mental health problems, or instability due to parental separation or household members being in jail or prison. It is widely known that these experiences have an impact on future health and mental health needs.[46] Early intervention and prevention strategies – further upstream prior to 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.[47,48,49]

Under current funding mechanisms, organizations are reluctant to implement novel approaches to address SDOH that go beyond what healthcare systems have traditionally focused on, especially when funding is not covering the costs of care now. Patients impacted by SDOH already require additional resources during their inpatient stay that may not be captured in the current funding mechanisms. Those experiencing homelessness not only require assistance in finding housing prior to discharge, but treatment plan modifications and discharge planning may be made more complex depending on housing options and outpatient clinical resources readily available and near one another. These patients are at an increased risk for non-compliance with their medication, relapse/readmission, and suicide. This can be further compounded by a lack of social safety nets and an insufficient continuum of care in the community.

The need for adequate funding extends across all care settings. Ensuring the full continuum of care is readily available and appropriately financed is critical to ensuring improved outcomes. This is in line with the comments made by President Biden in his 2022 state of the Union Address where he stated that the administration's focus is on supporting our nation's mental health by increasing the capacity of services, connecting more people to care, and attending to an environment that supports health and mental health.

APA urges CMS to support increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop and

[44] 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

[45] American Psychiatric Association, 2022, American Psychiatric Association/Report of the APA Presidential Task Force on Social Determinants of Mental Health, https://www.psychiatry.org/APA TF SDOMH March-Report.pdf. Accessed 6 June 2022.

[46] American Psychiatric Association, 2022, Social Determinants in Mental Health in Children & Youth

[47] 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

[48] 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

[49] 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.

disseminate evidence-based and interventions to promote mental health equity and improve the social and mental health needs of patients and their families. This includes identifying and testing screening tools/assessments used for data collection and further refining the list of SDOH.

Data collection and documentation should be streamlined with only the minimum necessary information relevant to the patient's condition or ongoing treatment documented. Overly burdensome administrative requirements will discourage reporting. Incentivizing through increased reimbursement should be done, given the resources that will be required to comply. The potential benefits to the patient will be improved outcomes. Adequate funding, not only to support the additional data collection process but also to support care delivery itself, including care coordination for transitions between levels of care, is required.

Promoting Interoperability performance category (c.4)

Proposal to require and modify the Electronic Prescribing Objective's Query of Prescription Drug Monitoring (PDMP) measure while maintaining the associated points at 10

APA encourages CMS to keep the PDMP measure as optional for 2023 at the associated 10 points, with the goal of including it as a requirement in the future. PDMPs are most effective when they have the broadest implementation to support patient care, privacy, and safety. In the October 2020 GAO report, *Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs,* it was that PDMPs are not routinely integrated within EHR systems, therefore continued challenges and burdens remained on physicians, especially in situations where time could be limited. The report also highlights that States were working to better integrate the PDMPs with EHRs, but we can assume that the COVID-19 pandemic may have delayed that work. Before mandating this measure, CMS should determine where states are with integration and create incentives to ensure all prescribing clinicians are using EHRs that can integrate with the states PDMPs. When used properly, PDMPs can improve clinical decision making, reduce controlled substance medication misuse, and identify controlled substance medication diversion.
Proposal for Public Reporting/Physician Compare: In an effort to expand the information available to patients and caregivers when choosing a doctor or clinician, we propose publicly reporting on individual clinician and group profile pages: (1) A telehealth indicator, as applicable, and technically feasible, for those clinicians furnishing covered telehealth services. (2) utilization data related to applicable conditions treated and procedures performed by each clinician or group respectively.

APA supports CMS to expand the information available to beneficiaries and caregivers when choosing a clinician. CMS can safely provide a telehealth indicator for clinicians who are furnishing covered telehealth services. We would encourage that with all information that CMS shares of this nature to be sure to create a process that allows clinicians to report misinformation with a quick review period following the initial report. We hope that if CMS is sharing this information, it may limit bad faith actors from sharing misinformation with the public.

APM Incentives (Section IV.10.)

We understand that CMS would like to encourage and promote participation in alternative payment models (APMs), especially Advanced APMs. APA supports the concept of APMs, which hold the potential to increase access and improve quality of care for individuals with mental health and substance use disorders. Integration of primary and mental health care is a significant need, and APMs may facilitate that process. However, many specialty physicians have struggled to determine how their services fit within the APM framework, and do not yet see a pathway to meaningful APM participation in the current environment. This is particularly true in psychiatry; mental health care has historically been under-funded and undervalued, and current payments for psychiatric services do not cover the costs of providing necessary services. As one of the primary goals of APMs is to reduce costs, there is the potential for this goal to conflict with the need for increased resources for treatment of patients with mental health and substance use disorders. We would encourage CMS to provide more details on how psychiatrists and other behavioral health specialists may participate in APMs in a way that best leverages their knowledge and expertise and provides adequate resources for this essential aspect of patient care.

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 Rebecca Yowell (byowell@psych.org), Director, Reimbursement Policy and Quality.

Sincerely,

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