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Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)

Attention: Gift Tee, Director, Division of Practitioner Services

Re: Coverage of Psychiatric Care in the CMS 2025 Medicare Physician Fee Schedule

Dear Gift,

The American Psychiatric Association (APA), the national medical specialty society representing over 38,900 psychiatric physicians and their patients, values the discussions held with Centers for Medicare and Medicaid Services' (CMS) Hospital and Ambulatory Group in January and February 2024. We appreciate the opportunity to contribute to the ongoing dialogue regarding psychiatric coverage under Medicare.

We applaud CMS's commitment to mental health equity and access through technology, demonstrated by key elements in the 2024 Medicare Physician Fee Schedule (MPFS). The continuation of outpatient telehealth reimbursement, coverage for telehealth services provided by virtually supervised residents, enhancements in payments for psychotherapy, and the inclusion of substance use treatment and crisis services exemplify CMS's commitment to the mental health of Medicare beneficiaries. These policies are pivotal for the care and outcomes of beneficiaries in 2025 and beyond.

We recognize that the policies set in 2024 will have significant influence on the care and outcomes of Medicare beneficiaries in 2025 and beyond and that federal partners are contending with multiple regulatory and legislative priorities in the upcoming year. In light of the importance of these initiatives, we propose the following recommendations for the 2025 MPFS and related rulemaking:

Telehealth coverage

The expansion of telehealth has been a cornerstone in improving access to psychiatric care, demonstrating efficacy comparable to in-person visits even for high-acuity concerns.¹ The flexibility in scheduling and the reduction of stigma associated with seeking mental health services have significantly contributed to patient engagement and long-term recovery, especially for those with substance use disorders (SUDs). This is particularly important given the ongoing Opioid Public Health Emergency.

Telehealth provides options for patients, including removing barriers like transportation to and from appointments. It reduces time away from family or work and makes it easier for patients to engage in their care. Psychiatric patients report that with telehealth as an option they are able to attend appointments they weren't able to attend before. Patients with motivation problems associated with depression, or anxiety about navigating transportation and being around other people have benefited from connecting to care through telehealth. Receiving treatment in one's home is not only more convenient for patients but can reduce the stigma associated with seeking help for mental health or OUD and other SUDs, making individuals more likely to engage in and adhere to treatment. Increased engagement and retention in care is critically important for long-term recovery for patients with mental health disorders but especially those with SUD. The convenience and privacy of receiving treatment at home can encourage individuals to seek and continue care they might otherwise avoid.

Payment parity

The literature demonstrates that Telehealth is as effective as in-person care. The work and the cost of providing care in a hybrid environment is the same as in-person only, only the modality used to communicate with the patient is different. As of December 2023, twenty-nine states have implemented some form of payment parity.² CMS outlined the argument for parity in CY 2024 final rule³ in their rationale for supporting payment parity for behavioral telehealth services (emphasis added):

Now that behavioral health telehealth services may be furnished in a patient's home, which now may serve as an originating site, **we believe these behavioral health services are most accurately valued the way they would have been valued without the use of telecommunications technology, namely in an office setting.** There was an increase in utilization of these mental

¹ Abraham A, Jithesh A, Doraiswamy S, Al-Khawaga N, Mamtani R, Cheema S. Telemental Health Use in the COVID-19 Pandemic: A Scoping Review and Evidence Gap Mapping. *Front Psychiatry*. 2021 Nov 8;12:748069. doi: 10.3389/fpsy.2021.748069. PMID: 34819885; PMCID: PMC8606591.

² Augustin J, Smith JM. Executive summary: tracking telehealth changes state-by-state in response to COVID-19. Accessed January 24, 2024.

<https://manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat>

³ Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, Vol. 88,F.R., 78875, (Finalized Nov 16, 2023) <https://www.federalregister.gov/d/2023-24184>

health services during the PHE that has persisted throughout and after expiration of the PHE for COVID–19. It appears that practice patterns for many mental health practitioners have evolved, and they are now seeing patients in office settings, as well as via telehealth. **As a result, these practitioners continue to maintain their office presence even as a significant proportion of their practice's utilization may be comprised of telehealth visits. As such, we stated that we believe their practice expense (PE) costs are more accurately reflected by the non-facility rate.**

Therefore, we proposed that, beginning in CY 2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the non-facility PFS rate. When considering certain practice situations (such as in behavioral health settings, **where practitioners have been seeing greater numbers of patients via telehealth), practitioners will typically need to maintain both an in-person practice setting and a robust telehealth setting. We expect that these practitioners will be functionally maintaining all of their PEs, while furnishing services via telehealth.** When valuing services, we believe that there are few differences in PE when behavioral health services are furnished to a patient at home via telehealth as opposed to services furnished in-person (that is, behavioral health settings require few supplies relative to other healthcare services). Claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the PFS facility rate beginning on January 1, 2024, as we believe those services will be furnished in originating sites that were typical prior to the PHE for COVID–19, and we continue to believe that, as discussed in the CY 2017 PFS final rule ([81 FR 80199](#) through [80201](#)), the facility rate more accurately reflects the PE of these telehealth services; this applies to non-home originating sites such as physician's offices and hospitals

APA's own data supports the hybrid nature of psychiatric practice. A 2023 survey of APA members found that 94% of respondents had at least one physical practice location. Across all settings 82% of respondents deliver telehealth via audio/ video. Clinicians will continue to use the same medical decision-making table for code selection, with billing based on the level of work performed that day, regardless of whether they see the patient in-person or via telehealth.

Physician work

We have also heard overwhelmingly from our members that the work of seeing patients via telemedicine is equivalent to the work of seeing patients in-person; medical decision making is the same irrespective of modality and the time it takes to review records, take a history, formulate a plan, communicate next steps and write a note is the same whether that work is done for an in-person visit or a telemedicine visit. Psychiatrists will continue to use the same medical decision-making table for code selection, with billing based on the level of work performed that day, regardless of whether they see the patient in-person or via telehealth.

CPT coding

We fully support use of existing codes (99202-99215) for billing all telehealth services, including audio-only. We strongly urge CMS not to adopt the new CPT telehealth codes, but rather continue to pay for care as they have done historically with the addition of audio-only care. The existing codes have been

shown to work well for telehealth, which now includes providing care in a new site of service (the home) using telehealth modalities to communication. Adding a new series of CPT codes increases confusion, unnecessary complexity, and goes against the long-standing guidelines established by CPT and CMS – if existing codes adequately describe the service they should be used, and new codes should not be created. Existing POS codes (i.e., POS 10) and modifiers can be adopted to provide CMS with information as to where and how care was provided.

In-person visit requirement

APA's 2023 telehealth survey further indicates that most clinicians are using telehealth as a clinical modality based on the needs of patients and that regulatory flexibilities can support continuity of care, equitable access to care, and improved outcomes. APA continues to believe that the decision as to whether the patient needs to be seen in-person should rest with the treating provider rather than a mandated requirement. We appreciate the steps CMS took in the CY 2022 Final Rule when they finalized a policy establishing a requirement to see telehealth patients in-person at least once every twelve months with limited exceptions – "Specifically, if the patient and practitioner agree that the benefits of an in-person, non-telehealth service within 12-months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient's medical record, the in-person visit requirement will not apply for that particular 12-month period."⁴ Recognizing CMS cannot change the statutory requirement for the initial in-person visit for new patients (prior to the start of telehealth), we ask CMS to explore extending these same exceptions to new patients. This patient-centered approach considers the patient's condition and individual circumstances and removes a barrier to care.

Supervision of resident physicians

APA recommends that the ability for residents to deliver telehealth services under virtual supervision be applied permanently. We also urge CMS to reinstate and make permanent the allowance for virtual supervision in cases where the resident is delivering in-person care to the patient, regardless of geographic location. Residents delivering care via telehealth has been demonstrated throughout the COVID-19 PHE to be a safe and effective strategy for maintaining access to care.

Departments of psychiatry use multiple configurations of care delivery and supervision to ensure appropriate care by the resident and supervision by the teaching physician, and these additional options create no additional quality or effectiveness concerns for the patient. The most common of these configurations is the resident and patient collocated in a physical site with the teaching physician offsite, which allows: (1) supervision by the most appropriate teaching physician (e.g., a subspecialist in geriatric or addiction psychiatry) when that teaching physician may not be able to have a physical presence in the

⁴ Medicare and Medicaid Programs; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, Vol. 86,F.R., 65058, (Finalized Nov 19, 2021) <https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf>

facility; (2) the accommodation of patient preference if patients would prefer to receive their care in-person but the most appropriate supervising physician is offsite; and (3) the development of an authentic, trusted physician-patient relationship with the attending maintaining an unobtrusive virtual presence for oversight and teaching. As with all such policies, allowing residency training programs to mimic the reality of care delivery to the greatest extent possible – including both virtual and in-person care supervised by the most appropriate teaching physician – equips the resident with the most useful training for caring for patients independently.

Virtual supervision of residents providing care in-person or via telehealth enhances access to quality care by allowing supervision across multiple locations, facilitating access to patient data for more informed supervision, and improving continuity of care for patients. The teaching physician remains responsible for the clinical outcomes of care provided by residents, holding residents to the same clinical standards as if the teaching physician were providing the care directly. The ability to provide virtual supervision also serves as a retention tool for attending physicians and addresses the workforce shortage in psychiatry. It reduces commuting burdens to other sites and enables specialists to focus on populations in greatest need. The current policy distinction between rural and non-rural settings in those instances where the resident is providing in-person care, and the supervisor is virtual creates an inequity in access as well as training and educational opportunities for residents. Virtual supervision has the potential to offer more timely and diverse expertise, especially in those instances where specific expertise is required. If CMS continues to wish to remove this flexibility after 2024, CMS should provide data and a rationale to justify this decision.

Reporting of home address by Medicare practitioners

During the COVID-19 PHE, CMS allowed practitioners to list their practice address instead of their home address when providing telehealth services. APA recommends making this flexibility permanent. CMS's preexisting requirement that practitioners report their physical location at the time the prescription is written – even if that is their home address during a telehealth encounter – is unnecessary and poses unnecessary safety risks. APA members have reported safety incidents stemming from the disclosure of personal information. We urge CMS to allow practitioners to continue listing their practice address instead of their home address to mitigate safety risks and encourage continued Medicare participation among psychiatrists.

Suicide Safety Planning

The APA appreciates CMS's interest and ongoing support for suicide safety planning. We strongly recommend the incorporation of suicide safety planning and follow-up contacts into the billing and payment policies of the 2025 MPFS. Suicide safety planning is a crucial intervention for individuals at risk of suicide, offering a structured plan that they can follow to prevent the act. This intervention involves identifying warning signs, internal coping strategies, social settings and people who can provide distraction, people whom the individual can ask for help, professional agencies to contact during a crisis, and methods to make the environment safe. Pairing the safety planning intervention with follow-up

contacts stimulates patient engagement and offers an opportunity for psychosocial support and together have been shown to reduce suicide attempts and deaths compared to current usual care.⁵

Given the rising rates of suicide and mental health crises in the United States, ensuring payment for suicide safety planning and follow-up contacts is essential in settings where patients seek care (i.e., Emergency Departments, ambulatory care settings - including primary and specialty care, crisis services). The interventions can be done either by licensed clinicians or by a member of the clinical staff working under general supervision of the billing practitioner. These services can also be done via telehealth. Designated billing mechanisms would help track where and for whom these services are being furnished helping to inform quality improvement efforts given suicide safety planning is not yet standard care.⁶ The goal is to ensure and support wider dissemination of this evidence-based service which has shown to significantly reduce the risk of suicide among patients.

In summary, the APA's recommendations for the 2025 MPFS focus on maintaining and enhancing access to psychiatric care through telehealth, ensuring the quality of training for future psychiatrists, protecting the safety and privacy of practitioners, and improving patient outcomes through suicide safety planning. We believe that these recommendations are in line with CMS's commitment to mental health equity and access and will significantly contribute to the mental well-being of the Medicare population.

We look forward to your response and the opportunity to discuss these recommendations further. Thank you for considering our input. Please contact Becky Yowell (byowell@psych.org) for further information.

Sincerely,

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

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

⁵ Miller IW, Camargo CA Jr, Arias SA, Sullivan AF, Allen MH, Goldstein AB, Manton AP, Espinola JA, Jones R, Hasegawa K, Boudreaux ED; ED-SAFE Investigators. Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. JAMA Psychiatry. 2017 Jun 1;74(6):563-570. doi: 10.1001/jamapsychiatry.2017.0678. PMID: 28456130; PMCID: PMC5539839.

⁶ Melhem N, Moutier CY, Brent DA. Implementing Evidence-Based Suicide Prevention Strategies for Greatest Impact. Focus (Am Psychiatr Publ). 2023 Apr;21(2):117-128. doi: 10.1176/appi.focus.20220078. Epub 2023 Apr 14. PMID: 37201145; PMCID: PMC10172552.