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June 1, 2020

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Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1744 IFC

Bruce J. Schwartz, M.D.
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Dear Administrator Verma,

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The American Psychiatric Association (APA) applauds the Administration for the rapid decisive government action to make needed regulatory changes during the COVID 19 public health emergency. We appreciate the work CMS has done thus far to ensure access to vital psychiatric services. We are pleased to have the opportunity to comment on regulatory flexibilities being issued to allow healthcare providers to meet patient needs during this difficult time as outlined in the *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* interim final rule (CMS-1744-IFC).

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2020-2021

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Our country is facing an unprecedented crisis. The days, weeks, and months ahead are at best uncertain and for many crippling. We appreciate the work of CMS to reduce barriers to care throughout this crisis, especially through the use of telehealth. As some areas of the country begin to explore what the new normal will be and are lifting shelter-in-place restrictions and allowing non-essential businesses to resume in-person operations, there will continue to be an increased need for mental and behavioral health care services. Due to the scope and severity of the pandemic, we anticipate that mental health impacts will continue well after the public health emergency (PHE) period. The telehealth expansion has enabled millions of Americans to receive much-needed mental health and substance abuse care, some of them for the first time. It is also critical to ensure continuity of care. In mid-May, about two months into the PHE we conducted a survey of APA members and found that prior to the national emergency, 62 percent of respondents were seeing zero percent of their patients via telehealth. However, between the time their state issued a state of emergency and mid-May, 86 percent of respondents are seeing 75 percent or more of their patient load via telehealth. The survey also indicated that the use of telehealth during the national health emergency decreased the rate of no-show appointments for psychiatric patients, and results suggest that this is due to its

Administration

Saul Levin, M.D., M.P.A.
CEO and Medical Director

convenience, as well as increased patient satisfaction, numbers which are in line with research on telehealth. Higher patient satisfaction typically results in patients continuing their course of care.

We urge CMS to maintain a number of the recently implemented telehealth flexibilities permanently.

These changes would ensure a smooth transition to in-person care and increase access via telehealth and telephone to necessary care. It is especially important for mental health and substance use care, where the ability to establish and maintain a strong, uninterrupted therapeutic alliance with patients is crucial to effective interventions. To ensure continuity of care and continued improved access we recommend that CMS permanently:

- **remove limitations around originating site and geographical restrictions for mental health services.** This was done for patients with substance use disorders under the SUPPORT ACT and has proven to improve access to care for this population.
- **include all services on the expanded Medicare approved telehealth list including group psychotherapy (90853 and G0410).** This addition affords an opportunity to provide individuals in a variety of settings necessary and effective services.
- **maintain coverage and the increased payment for the telephone evaluation and management services that matches rates of the traditional outpatient evaluation and management services that may be provided in-person or via telehealth.** We also ask that CMS **remove the frequency limitations that are imposed** under those codes to allow those patients who receive all their care via the telephone alone (and not in-person or via telehealth) as often as is medically necessary which could be more frequently than once every seven days.
- **allow for the use of telephone (audio) only communications for evaluation and management and behavioral health services, including care for opioid use disorders, when it is in the patient's best interest,** such as when a patient has a lack of access to pertinent technology or broad band access, or in the event a medical or behavioral health condition of a patient (e.g., specific diagnosis) precludes the use of live video conferencing (i.e. a patient with schizophrenia who is paranoid). In addition, **payment rates for audio-only care should be at no less than what was established during the emergency.** According to our survey, about 60 percent of respondents stated between 1-25% of their patients cannot access care via audio and video platforms due to technical issues, such as the lack of broadband access, not able to afford video technology, and unable to work the technology. Flexibility is needed to continue to ensure this population, often the most vulnerable, has access to care.
- **remove frequency limitations for existing telehealth services in inpatient settings and nursing facilities.** Prior to the public health emergency some CPT codes for inpatient settings could only be used every 3 days; and for certain CPT codes used within skilled nursing facilities, only every 30 days. Care should be based on clinical judgement and medical necessity rather than influenced

by arbitrary restrictions that create a barrier to care, particularly given the higher level of acuity of patients in these settings.

- **allow teaching physicians to provide direct supervision of medical residents remotely through telehealth.** This will maximize the workforce and ensure the continuity of training of residents.

While instrumental to ensuring continuity of care during the COVID-19 public health emergency, after the emergency declaration is lifted, **we recommend that the Office of Civil Rights resume enforcing its authority around the HIPAA Privacy and Security Rules with respect to appropriate standards around live videoconferencing for telehealth.** Under the Security Rule, the Administrative, Technical, and Physical standards ensure that providers are engaging in activities that protect patient information from potential breaches of privacy. While we acknowledge that purchasing software and entering into business associate agreements (BAAs) with vendors may create some barriers to care, these requirements under the Security Rule ensure basic patient protections such as encryption standards and audit trails are met. However, we still underscore the need for telephone-only telehealth, when necessary and appropriate, and, just as traditional landlines (e.g., copper wires) do not fall under the HIPAA Security Rule, neither should the use of cellular phones relying on WiFi or voiceover internet protocol (VOIP) connections.

In addition, we recognize the importance of allowing temporary flexibility for clinicians to meet the demand for treatment needs, especially in communities experiencing a high rate of COVID-19 patients that strains the health system. Although we fully support nurse practitioners and physician assistants involvement in the treatment of psychiatric inpatients, including completing psychiatric evaluations and progress notes, the advanced medical training of physicians is necessary to oversee the treatment of these most psychiatrically ill patients, and therefore **a physician should have overall responsibility for the care of every psychiatric inpatient.** We also urge CMS, post the COVID pandemic, **to resume current regulations that require general supervision of nurse practitioners and physician assistants by a physician** and implement policies to advance the use of physician-led, team-based care, such as evidence-based integrated care models and telehealth, to improve access to quality care. The complex interactions between mental and physical health conditions and the medications used to treat them require advanced medical training in order to ensure high-quality clinical care through adherence to best practices, which typically leads to highly positive health outcomes.

Thank you again for your work to ensure healthcare providers can meet the increasing needs of patients. If you have any questions please contact Kristin Kroeger, Chief of Policy, Programs, and Partnerships at kkroeger@psych.org.

Sincerely,



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