AMERICAN PSYCHIATRIC ASSOCIATION

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December 22, 2020

Secretary Alex M. Azar, II
United States Department of Health and Human Services
200 Independence Ave
Washington, DC 20201

Re: Executive Order 13924, *Regulatory Relief To Support Economic Recovery*, 85 FR 31353

On behalf of the American Psychiatric Association (APA), the medical specialty society representing over 38,800 physicians who specialize in the treatment of mental illnesses, including substance use disorders, we thank you for considering our comments in response to the Department of Health and Human Services' *Request for Information on Regulatory Relief to Support Economic Recovery*. APA applauds the Administration for its rapid response and action to make needed regulatory changes during the COVID-19 Public Health Emergency (PHE). Several of these regulatory changes have been beneficial to healthcare providers while others, if continued, would be detrimental to mental healthcare, absent the exigencies of the PHE.

APA urges CMS to maintain a number of its recently implemented telehealth flexibilities which have been beneficial to providing mental and behavioral healthcare to psychiatric patients. We have appreciated the work of CMS to reduce barriers to care throughout this crisis, especially through the use of telehealth. As the country continues to navigate COVID-19, we will see an increased need for mental and behavioral health care services continuing long after the PHE period. A survey of APA members, conducted in mid-May, showed that 86 percent of respondents have been seeing 75 percent or more of their patients via telehealth since their states issued a state of emergency. The survey also indicated that the use of telehealth during the PHE has decreased the rate of no-show appointments for psychiatric patients, suggesting a level of convenience and satisfaction among patients. Higher patient satisfaction typically translates to patients continuing their course of care. **The following telehealth flexibilities currently in place have been beneficial and should be made permanent once the PHE ends:**

- Removing limitations around originating site and geographical restrictions for mental health services. Under the SUPPORT Act, these limitations were removed for patients with substance use disorders and has proven to improve access to care to this vulnerable population.

- Including all services on the expanded Medicare approved telehealth list, including group psychotherapy (90853 and G0410). This addition affords physicians the opportunity to provide effective care to individuals in an array of settings.
- Allowing for the use of telephone (audio) only communications for evaluation and behavioral health services, including care for opioid use disorders, when it is in the patient's best interest (i.e. when a patient lacks access to necessary technology, broadband services) or in the event that a medical or behavioral health condition precludes them from live video conferencing (i.e. a patient with schizophrenia who is paranoid). In addition, payment for audio-only care should be at no less than what was established during the PHE. According to APA's survey, about 60 percent of respondents stated that up to 25 percent of their patients cannot access care via video platforms. Continuing audio only communication service flexibilities would ensure access to care to the most vulnerable patients.
- Maintaining coverage and increased payment for telephone evaluation and management services that match rates of the traditional outpatient evaluation and management services that may be provided in-person or via telehealth. Furthermore, in order for patients receiving their care via telephone (as opposed to in-person or via telehealth) to receive it as often as medically necessary, we would ask CMS to remove the frequency limitations that are imposed under these evaluation and management codes. The frequency limitations currently allow for telephone evaluation and management services to occur once every seven days, which may not be medically sufficient for some patients.
- Removing frequency limitations for existing telehealth services in inpatient settings and nursing facilities. Prior to the PHE, some CPT codes for inpatient settings could only be used every three days; and for certain CPT codes within skilled nursing facilities, only every 30 days. It is critical that frequency of care be determined by medical necessity based on clinical judgement, rather than any arbitrary restrictions and barriers to care.
- Allowing teaching physicians to provide direct supervision of medical residents remotely through telehealth. This will maximize the workforce and ensure continuity of training.

Although the aforementioned regulatory changes have been beneficial, several, if continued, could affect the overall quality of care of patients:

- While instrumental to ensuring continuity of care during the COVID-19 PHE, 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. The administrative, technical, and physical standards under the Privacy and Security Rules ensure that providers are engaging in activities that protect patient information from potential breaches of privacy. Although purchasing software and entering business association agreements with vendors may create some temporary barriers to care, these requirements ensure basic patient protections, including encryption standards and audit trails. APA still emphasizes the need for telephone-only care, when necessary and appropriate, and, just as traditional landlines do not fall under the HIPAA Security Rule, neither should the use of cellular phones relying on WiFi or voiceover internet protocol (VOIP) connections.
- Recognizing the importance of allowing temporary flexibility for clinicians to meet the demand for treatment needs while COVID-19 strains health systems, it is important that a physician has the overall responsibility for the care of every psychiatric patient. Interactions between physical and mental health conditions and the medications used to treat them are complex and require advanced medical training in order to ensure high quality clinical care and adherence to best practices. Access to mental health and substance use treatment is more vital now, than ever.

Research shows that survivors of COVID-19 appear to be at increased risk of psychiatric sequelae, and that a psychiatric diagnosis might be an independent risk factor for COVID-19. Nurse practitioners and physician assistants are an integral part of the treatment team. However, the advanced medical and psychosocial training of psychiatrists is necessary to oversee the overall treatment of our patients. Once the PHE ends, we urge CMS to resume current regulations that require general supervision of nurse practitioners and physician assistants by a physician and instead implement policies to advance the use of physician-led, team-based care, such as evidence-based integrated care models, such as the collaborative care model (CoCM), to improve access to quality care for patients. The CoCM is the only evidenced-based model of integrated care, that demonstrates effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes, and increasing patient satisfaction in a variety of primary care settings – rural, urban, and among veterans. APA recommends CMS provide incentives and technical assistance to primary care practices across the country to encourage nation-wide implementation.

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,

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