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March 20, 2023

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)
Attention: Gift Tee, Director, Division of Practitioner Services

Re: Telemental Health in the CMS 2024 Medicare Physician Fee Schedule

Dear Gift,

The American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians and their patients, appreciates the time the Centers for Medicare and Medicaid Services' (CMS) Hospital and Ambulatory Group took to speak with APA members and staff on Thursday, March 2, 2023 and the opportunity to continue to provide input on the coverage of telemental health in the Medicare program.

We applaud CMS's commitment to mental health equity and access through technology, demonstrated by key elements in the 2023 Medicare Physician Fee Schedule (MPFS). In particular, the permanent allowance of audio-only telemental health care; the allowance for the 12-month follow-up visit to be waived based on documented clinical decision-making in the best interests of the patient; and simplified coding structure are all clear demonstrations of CMS's commitment to the mental health and wellbeing of the Medicare population. Americans continue to rely heavily on telehealth for access to treatment for mental health conditions, with mental health representing 62.5 percent of all telehealth treatment in December 2022.¹ **There are some remaining areas of opportunity for supporting clinicians in delivering high-quality, technology-enabled mental health care to beneficiaries.** Below, we recommend components for inclusion in the 2024 MPFS and any additional pertinent rulemaking.

Standardized Coding and Reimbursement

The 2023 MPFS confirmed a straightforward coding framework that allows clinicians to use the same billing codes as those for an in-person service. APA supports this approach and recommends that it continue. Standardized coding reduces clinician confusion and burden and recognizes telehealth delivery – both video and audio-only – as a modality of care rather than a separate service. This approach reflects that most psychiatrists will be treating patients in a hybrid environment where patient need drives how care is provided. **APA does not support coding constructs that**

¹ Monthly Telehealth Regional Tracker, <https://www.fairhealth.org/states-by-the-numbers/telehealth>.

delineate CPT codes by modality, and instead supports the use of modifiers to identify telehealth delivery for the purposes of research and analysis.

In this hybrid care environment, APA notes that adjustment to the facility fee from the non-facility fee for telehealth services is a significant risk to the strides forward in equity and access that CMS has generated through telehealth policy throughout the COVID-19 public health emergency (PHE). Practice expenses are the same in a hybrid environment as they would be in an in-person environment, and most Americans (about 2/3) plan to maintain telehealth or hybrid care for mental health visits.² Negative implications of downward fee adjustments include reduction in clinicians delivering telehealth, reductions in clinicians' ability to get and maintain telehealth technology, and potential cherry-picking of patients with the ability to travel to an in-person visit, all of which constitute risks to health equity, access, and quality. Clinicians that are delivering online or hybrid care need the capital to purchase and maintain high-quality, secure technology platforms that can provide care to CMS beneficiaries. As discussed, APA recognizes the relevance to this issue of the breakdown of in-person, hybrid, and all-virtual care across the psychiatry workforce and will work with its membership to gather more data on the current landscape of the hybrid and virtual workplace. **APA does not support the adjustment of telehealth services to the facility fee and urges CMS to reimburse these services at parity with in-person care.**

In-person Visit Requirements

APA recognizes that CMS is assessing the landscape of in-person care prior to the resumption of in-person requirements for Medicare beneficiaries in 2025. We note that, in the 2023 MPFS, the 12-month follow-up requirement is subject to exemption, recognizing the role of clinical decision-making in determining the best course of action for the specific patient. We also note that the in-person initiation requirement does not apply to SUD services in recognition of the importance of removing barriers to accessing these services. Importantly, the Administration's work to address mental health and substance use disorder are closely linked, as 65 percent of all patients who had a substance use disorder or overdose diagnosis in 2021 had a preexisting mental health condition.³

Telehealth treatment has been found to be as safe and effective as in-person care even for high-acuity psychiatric concerns, and increases access to care in instances of stigma, rural location, mobility challenges, and other health-related social needs.⁴ **APA urges CMS to permanently remove a mandatory in-person visit requirement for Medicare beneficiaries prior to initiating or maintaining telemental health care with a psychiatrist, contributing to equitable access to crucial, safe, and effective telepsychiatry.**

² Telehealth and the future of Hybrid Care, <https://www.oliverwyman.com/our-expertise/perspectives/health/2020/oct/the-future-of-hybrid-care.html>.

³ A Comparison of Substance Use Disorders before and during the COVID-19 Pandemic: A Study of Private Healthcare Claims, <https://www.fairhealth.org/publications/whitepapers>.

⁴ Telehealth Treatment of Patients in an Intensive Acute Care Psychiatric Setting During the COVID-19 Pandemic: Comparative Safety and Effectiveness to In-Person Treatment, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8613935/>.

Residency Telehealth and Supervision Requirements

The allowance for residents to deliver telehealth services to Medicare beneficiaries under virtual supervision expires with the end of the PHE on May 11, 2023. APA notes that CMS's exception of patients and residents in non-metropolitan statistical areas, allowing the delivery of telehealth by residents in rural areas, recognizes that this flexibility is a tool to facilitate access to care in underserved settings.

Residents delivering telehealth has been demonstrated throughout the COVID-19 PHE to be a safe and effective strategy for maintaining access to care. Further, residents delivering telehealth with supervision from a teaching physician ensures that they are trained for telehealth service delivery when they enter the physician workforce. The teaching physician is ultimately responsible for the clinical outcomes of the care provided by residents, and the resident accordingly is held to the same clinical standard as the teaching physician providing care themselves.

Furthermore, guardrails exist through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations that have standards and systems that will ensure patient safety and oversight of residents when virtual supervision of residents occurs. ACGME sets forth extensive program requirements, including requirements related to supervision. ACGME recognizes that supervision may be exercised through a variety of methods, as appropriate to the situation, including through telecommunication technology. The program must demonstrate that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and ability guided by milestones, as well as patient complexity and acuity. The faculty must assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility, and each resident must also know the limits of their scope of authority. ACGME, other accrediting organizations, and the medical education community work hard to monitor, report, and address any issues related to workload, patient safety, medical error, resident well-being and burn-out, professionalism, and resident learning and outcomes.

In tandem, maintaining virtual direct supervision increases access to quality care. The American Association of Medical Colleges (AAMC) members have found that virtual supervision has been safe, effective, and improved access to care. For example, virtual supervision allows physicians to supervise clinical staff across multiple campuses, which increases patients' access to care. On a practical note, practices and clinicians are already scheduling several months out for appointments; if CMS waits to issue updated guidance, patient care will have to be rearranged and may be disrupted.

APA recommends that the ability for residents to deliver telehealth services under virtual supervision be applied permanently. At a minimum, APA urges CMS to extend the end date for this reversion to the end of 2024, consistent with other provisions in CAA 2023, and/or to extend virtual supervision capabilities to residents in metropolitan statistical areas when their patients are in rural areas.

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 Abby Worthen (aworthen@psych.org), Deputy Director, Digital Health.

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller letters to the right. There is a horizontal line under the name "Levin".

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