AMERICAN PSYCHIATRIC ASSOCIATION

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November 14, 2022

U.S. Department of Health and Human Services
Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care (BPHC)
Health Center Program
Attention: James Macrae, Associate Administrator

Re: Scope of Project and Telehealth Policy Information Notice (PIN)

Dear Mr. Macrae,

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the HRSA Scope of Project and Telehealth Policy Information Notice (PIN). We applaud HRSA's work to maintain and expand access to care through technology, especially as the COVID-19 Public Health Emergency (PHE) has underscored gaps in health equity and outcomes for historically underserved groups.

In particular, access to high-quality mental health care has emerged from the pandemic as a key population health and health equity priority, and we appreciate HRSA's commitment to allowing the maintenance of virtual care relationships post-PHE. In this letter, we will note additional opportunities for HRSA to strengthen access to mental health care through technology:

1. **Revising the requirement that "The individual receiving services is physically located** (e.g., is at their home or at another location where the provider is not located) within the health center's service area." There are several key benefits to relaxing or removing this requirement:
    - First, if a patient is traveling or recently moved, maintaining a virtual relationship with their mental health clinician would facilitate critical continuity of care. At minimum, this requirement should have exceptions for the timeframe of the patient's location out of the service area – a 6-month exception would accommodate temporary patient relocation or allow them to establish a new provider if they move and mirror CMS's in-person requirements for mental health services.
    - Next, if there is not an accessible clinic in the patient's service area, patients should be able to establish a virtual relationship at another clinic in their state to ensure and maintain access to care.

2. **Maintaining parity in reimbursement for telemental health services** to ensure that clinicians are able to continue to provide services in the modality and setting most appropriate to the patient's needs and preferences per clinical decision-making. This will also allow health centers to appropriately plan for staffing and infrastructure needs to properly meet the needs of patients and the well-being of staff.

3. Considering HRSA's unique position supporting communities with limited access to in-person care, **coordinating with other federal agencies to maintain key flexibilities around virtual and flexible care provision that improve access to care,** particularly concerning substance use disorders and given significant racial and ethnic disparities in treatment access and outcomes[1]:
    - Working with DEA to **remove the requirement of direct administration of methadone,** distinct from other medications to treat OUD (e.g., buprenorphine) that can be prescribed. Per the George Washington University Regulatory Studies Center, "This [restriction] goes well beyond the restrictions for other controlled substances, which can be prescribed by individual practitioners for pickup at pharmacies registered with DEA to dispense controlled substances[2]." The virtual and take-home landscape of medications for opioid use disorder should be determined by clinicians and in accordance with achieving desirable clinical outcomes.

4. **Coordinating with FCC and NTIA to expand grant-making** around access to broadband and internet-capable devices to increase equitable access to digital care and digital literacy among patients and providers; and

5. **Coordinating with CMS to continue exploring reimbursement for remote patient monitoring,** remote therapeutic monitoring, and store-and-forward technologies to maximize access to effective 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 Abby Worthen (aworthen@psych.org), Deputy Director, Digital Health.

Sincerely,

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

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[1] Dong, H.; Stringfellow, E; Russell, W.; *JAMA Psychiatry.* Nov. 9 2022. Racial and Ethnic Disparities in Buprenorphine treatment Duration in the US. doi:10.1001/jamapsychiatry.2022.3673

[2] Dooling, B. and Stanley, L. (Aug. 2022) A Vast and Discretionary Regime, Federal Regulation of Methadone as a Treatment for Opioid Use Disorder. https://regulatorystudies.columbian.gwu.edu/sites/g/files/zaxdzs4751/files/2022-08/gw-reg-studies_report_federal-methadone-regulations_bdooling-and-lstanley.pdf