

October 5, 2020

Administrator Seema Verma
The Centers for Medicare & Medicaid Services,
U.S. Department of Health and Human Services
7500 Security Boulevard
Box 8016
Baltimore, MD 21244-1850

RE: CMS-1734-P (Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021)

SUBMITTED ELECTRONICALLY

Dear Administrator Verma:

The Mental Health Liaison Group (MHLG), a coalition of national organizations representing consumers, families, mental health and substance use treatment providers, advocates, and other stakeholders committed to strengthening access to high quality mental and behavioral health care, greatly appreciates this opportunity to provide our comments on the permanent expansion of some telehealth services recently proposed by the Centers for Medicare and Medicaid Services (CMS) and to offer our recommendations for additional, critical areas of flexibility in telehealth. **We support the changes CMS is proposing to expand telehealth, but strongly urge further expansion by allowing telehealth through audio-only devices and the elimination of current geographic and site restrictions.**

First and foremost, we express our gratitude for CMS' broad lifting of prior telehealth restrictions in federally funded and subsidized health programs to meet access and treatment needs, particularly in the areas of mental health and substance use disorder (SUD) treatment, throughout the ongoing COVID-19 pandemic. MHLG's members, allies and providers in the mental illness and SUD prevention and treatment fields strongly supported and are utilizing telehealth extensively to help millions of individuals and families throughout the country.

We especially appreciate CMS' expansion of telehealth coverage in Medicare and Medicaid during the current crisis to include audio-only telehealth and for payment parity in telehealth.¹ The ability to reach patients wherever they are located, particularly at home, and with different

¹ On April 30, 2020, CMS announced the issuance of a waiver under section 1135(b)(8) of the Social Security Act, as amended by section 3703 of the CARES Act, of the requirements under section 1834(m) of the Act and regulation at §410.78, waiving its prior requirement that services be provided using video technology and allowing certain behavioral health counseling and education services to be furnished via telehealth using audio-only communications technology for the duration of the public health emergency. Available at: <https://www.federalregister.gov/d/2020-06990>.

modalities according to individual needs has proven crucial to ensuring continued mental health and SUD treatment throughout this public health emergency while keeping patients and providers safe from the risk of infection. The coverage of telehealth at parity with in-person care has helped sustain mental health and SUD treatment providers' ability to continue serving their clients throughout this difficult time. Anecdotal evidence from the field reported by providers and in the press indicates these flexibilities have facilitated access to and by behavioral health providers across all federally funded and subsidized programs under conditions that might otherwise have seen a much greater reduction in access.² Despite the social distancing measures required during the pandemic, behavioral health providers have been maintaining contact, communications, and therapeutic activities with their patients via landlines, smartphones, and computer-based applications, including in both rural/frontier remote areas and urban areas where communities of color have been hard-hit by the pandemic.

People living with behavioral health conditions need timely and safe access to mental health and SUD services now more than ever *and are likely to continue to need behavioral health care long after the official public health emergency declaration is over*. New research is showing that the pandemic is greatly exacerbating existing behavioral health issues and leading to substantial increases in anxiety, depression, and SUDs. A recent major study found that approximately 27 percent of people in the United States are suffering from symptoms of depression, representing a three-fold increase in the prevalence of depression before the pandemic began.³ Further, those with lower incomes, less savings, and those severely affected by the current crisis by, for example, job loss or the loss of a loved one, are more likely to suffer from depression symptoms. Moreover, although some increase in mental illness was expected consistent with prior research regarding reactions to traumatic experiences, such as major natural disasters, the current rise in mental illness attributable to the pandemic is far greater than expected, according to the study's authors. Another marker of increasing distress is evident in the surge of calls coming into mental distress hotlines, such as the Disaster Distress Helpline, a sub-network of the National Suicide Prevention Lifeline that offers emotional support to people in need after natural and human-caused disasters. The Distress Helpline saw an 890% spike in call volume in April 2020 compared with April 2019.

Anecdotal evidence from the current crisis is also showing that telehealth, particularly telemental health, is highly effective in addressing the public's needs for mental health care. In today's connected world, we must strive for a mental health and SUD treatment system free from unnecessary barriers to care, a system that meets individuals and families where they are and that

² [With Red Tape Lifted, Dr. Zoom Will See You Now](#), Paula Span, *New York Times*, The New Old Age, May 8; [Doctors and Patients Turn to TeleMedicine in the Coronavirus Outbreak](#), Reed Abelson, *New York Times*, May 11; [A Pandemic Benefit: The Expansion of Telemedicine](#), Jane E. Brody, *New York Times*, May 11; [5 Reasons Why Telehealth Is Here to Stay \(COVID19 and Beyond\)](#), Joe Harpaz, *Forbes*, May 4.

³ [Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic](#), Catherine Ettman et al., *JAMA*, Sept. 2, 2020.

provides access to care according to their needs and preferences. For these reasons, MHLG commends CMS on its proposal to expand some telehealth flexibilities on a permanent basis and urges CMS to implement additional expansions to improve access to essential behavioral health services. Specifically, we support CMS for proposing to expand Medicare-covered telehealth services permanently to include Group Psychotherapy (CPT code 90853) and the add-on code for the Neurobehavioral Status Examination (CPT code 96121).

Expansion of Medicare-covered health to include the above proposed changes is a step in the right direction to allowing Medicare beneficiaries access to the behavioral health services they need, but it is not enough. Without permanent telehealth expansion, the delivery of these services would still be greatly limited in scope to more rural areas and would continue to impose unnecessary barriers to care, such as the requirement of dual audio-visual communication.

MHLG therefore urges CMS to proceed further to expand Medicare-covered behavioral health services provided through telehealth on a permanent basis to match the new flexibilities it allowed during the current public health emergency. **Specifically, MHLG strongly supports having Medicare continue to pay for a broad range of mental and behavioral health services furnished through audio-only telephones.**⁴ Older adults and younger individuals with disabilities who rely on Medicare for essential behavioral health care will lose access to critically needed services if they are limited to using devices with both audio and visual communication technology.

Requiring dual audio-video communication is particularly a problem in rural and urban areas of the country that lack sufficient broadband coverage, among sizeable groups of older adults and people with disabilities who may lack the ability or comfort level to use these devices due to cognitive or visual impairments, and among racial/ethnic and lower income communities, who may not even own such devices. In 2019, the Federal Communications Commission reported that between 21.3 and 42 million Americans lack access to broadband. The ability to communicate between patients and behavioral health providers according to individuals' own needs is crucial to eliminating artificial barriers to care. **MHLG further believes that CMS has the authority to proceed with this change in Medicare policy without specific congressional authorization.** We believe that the current statutory authority under Section 1834m of the Social Security Act allows CMS to make this change now without further direction from or action by Congress.

⁴ This would include not only the ability to evaluate patients by audio-only communications, but also the ability to use audio-only devices to provide psychotherapy services and psychotherapy with evaluation and management (E/M) services covered by Medicare under CPT codes: 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90853, 90845, 90839, 90840, 90846, 90847, 90849. In addition, we urge the inclusion of health behavior assessment and interventions services, which help Medicare patients cope with or manage one or more physical conditions, covered by Medicare under the following CPT codes: 96156, 96158, 96159, 96164, 96165, 96167, 96178, 96170, and 96171, and medical evaluation and management for inpatient and outpatient services in a variety of facilities covered under: 99212-99214, 99231-99233, 99307-99310, 99334-99337.

Some services can easily be provided through telehealth and should be among the first services to be covered. Accordingly, we urge that:

- CMS permanently add Psychological and Neuropsychological Testing evaluation services (CPT codes 96130-96133 and 96135-96139) to Medicare's telehealth list, and Psychological and Neuropsychological Testing administration services (CPT codes 96136-96139); and
- CMS add to the interim telehealth list Developmental Testing (CPT codes 96112 & 96113) and the Adaptive Behavior & Treatment Codes (CPT codes 97151, 97152, 0362T, 97153, 97154, 97155, 97156, 97157, 97158 and 0373T) to the interim telehealth list.

In addition to allowing a broad range of behavioral health services to be provided through telehealth, **MHLG urges CMS to support the elimination of Medicare's originating and geographic site restrictions** so that patients can receive essential behavioral health services regardless where they are located including at home. Eliminating these restrictions is absolutely key to meeting individuals and families where they are. Although the pandemic has so clearly demonstrated the tremendous value of providing telehealth to individuals and families in their homes during this crisis, the benefits transcend the goal of reducing the spread of COVID-19. Allowing telehealth from homes is enabling millions of people to receive care who, due to barriers to care such as transportation and scheduling difficulties, previously were unable to access services. Accordingly, we urge CMS to support the elimination of Medicare's current originating and geographic site restrictions.

Thank you in advance for considering these comments. If you require additional information, please contact MHLG Chair Laurel Stine, Senior Director, Congressional & Federal Affairs and Partnerships with the American Psychological Association at lstine@apa.org, or MHLG Health Policy Committee Co-Chair Elizabeth Cullen, Counsel for Health Policy, The Jewish Federations of North America, at Elizabeth.cullen@jewishfederations.org.

Sincerely,

2020 Mom

American Academy of Child and Adolescent Psychiatry

American Art Therapy Association

American Association for Geriatric Psychiatry

American Association for Marriage and Family Therapy

American Association for Psychoanalysis in Clinical Social Work

American Association of Suicidology

American Association on Health and Disability

American Counseling Association

American Foundation for Suicide Prevention/SPAN USA

American Group Therapy Association

American Occupational Therapy Association

American Psychiatric Association

American Psychoanalytic Association

American Psychological Association

Anxiety and Depression Association of America

Association for Ambulatory Behavioral Healthcare

Center for Law and Social Policy

Centerstone

Children and Adults with Attention-Deficit/Hyperactivity Disorder

Clinical Social Work Association

College of Psychiatric and Neurologic Pharmacists

Depression and Bipolar Support Alliance

Eating Disorders Coalition for Research, Policy, and Action

Eye Movement Desensitization and Reprocessing

Global Alliance for Behavioral Health and Social Justice

International OCD Foundation

The Jewish Federations of North America

The Kennedy Forum

Lakeshore Foundation

Maternal Mental Health Leadership Alliance

Mental Health America

NAADAC, The Association for Addiction Professionals

National Alliance on Mental Illness

National Alliance to Advance Adolescent Health

National Association for Rural Health

National Association of Social Workers

National Association of State Mental Health Program Directors

The National Council for Behavioral Health

National Eating Disorders Association

National Federation of Families for Children's Mental Health

National League for Nursing

National Register of Health Service Psychologists

Psychotherapy Action Network

Residential Eating Disorders Consortium

SMART Recovery

Treatment Communities of America

Well Being Trust