

September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1736-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure,

We are writing to raise awareness of a gap in CMS's laudable effort to bolster behavioral health services in rural areas through new telehealth policy in the CY 2022 Medicare Physician Fee Schedule (PFS). **We agree that telehealth payment should be addressed for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), and also believe outpatient behavioral therapy services offered by Critical Access Hospitals (CAHs) are a key component of a comprehensive rural behavioral health strategy.** Without action to ensure these hospitals can bill tele-behavioral health as they do in-person services, access to CAH-provided outpatient will be lost for thousands of Americans in rural areas.

As CMS recognizes through the draft PFS rule, rural behavioral health challenges are both a moral and economic imperative for communities across the nation. Approximately 20 percent of the rural population experiences mental illness¹ and the rural community is disproportionately impacted by the opioid epidemic.² Approximately 48,000 people die by suicide every year – the 10th leading cause of death in the United States.³ These suicide rates were 40 percent higher in rural areas than in large urban areas (and are increasing at a faster rate).⁴ This is only made worse by the fact that there is a severe shortage of mental health professionals in rural areas. Over 80 percent of rural counties do not have a psychiatrist, compared to 27 percent of counties in metropolitan areas.⁵

These challenges are particularly acute for Medicare beneficiaries. Approximately 33 percent of widowers become depressed – and while elderly adults represent only 13 percent of the population, they represent approximately 20 percent of all suicide deaths.^{6,7} At the same time, approximately 68 percent of elderly adults have little awareness about how to recognize and be treated for depression.⁸

¹ Rural Health Reform Policy Research Center (2014). "The 2014 Update Of The Rural-Urban Chartbook." Retrieved from: <https://www.ruralhealthresearch.org/publications/940>

² Keyes KM, Cerdá M, Brady JE, Havens JR, Galea S. Understanding the rural-urban differences in nonmedical prescription opioid use and abuse in the United States. *Am J Public Health.* 2014;104(2):e52-e59.

³ National Vital Statistics System –Mortality Data (2018) via CDC www.cdc.gov/nchs/fastats/suicide.htm

⁴ National Advisory Committee on Rural Health and Human Services, "Understanding the Impact of Suicide in Rural America" <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-impact-of-suicide.pdf>

⁵ American Journal of Preventative Medicine, "Geographic Variation in the Supply of Selected Behavioral Health Providers." Retrieved from: [https://www.ajpmonline.org/article/S0749-3797\(18\)30005-9/fulltext](https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext)

⁶ National Institute of Mental Health, *The Many Dimensions of Depression in Women: Women at Risk.* (1999)

⁷ National Institute of Mental Health, *Older Adults: Depression and Suicide Fact Sheet.* (1999)

⁸ Depression In Older Adults: More Facts | Mental Health America. (n.d.). Retrieved from <http://www.mentalhealthamerica.net/conditions/depression-older-adults-more-facts>

These are exactly the issues that Congress intended CAHs to address when designating them providers of essential services in rural communities. As you know COVID has only exacerbated these challenges – with the Commonwealth Fund finding that after the pandemic started, monthly overdose deaths spiked 50 percent to more than 9,000 deaths in May.⁹

We appreciate the COVID flexibilities that have allowed CAHs to provide outpatient hospital services via telehealth during the PHE by leveraging the Center for Medicare and Medicaid Services (CMS) waiver of the provider-based regulations described in “*Hospitals: CMS Flexibilities to Fight COVID-19.*”¹⁰ This flexibility to leverage virtual care to its full potential has proven crucial to meeting surging behavioral health needs during the COVID-19 pandemic.

The response among patients to the provision of behavioral therapy services via telecommunications technology has been extremely positive as patients have expressed relief and appreciation that they can continue their behavioral health therapy notwithstanding the social distancing protocols that help prevent the spread of COVID-19. This flexibility has also brought relief to the patients’ caregivers, as many of these beneficiaries reside in nursing homes, which have been particularly and understandably cautious during the pandemic.

Even in the absence of COVID-19, the ability of CAHs to furnish outpatient behavioral therapy via telehealth has improved continuity of care by easing some of the often-challenging transportation requirements in rural settings, which can be exacerbated during the winter months. CAHs serve communities characterized by access to care barriers, and CMS’ flexibilities have enabled CAHs to not only maintain access to outpatient behavioral therapy during the COVID-19 PHE, but it has also driven CAHs to identify and implement more efficient and clinically appropriate delivery of care models that leverage telecommunications technology.

Given the enormity of the challenge ahead of us, we must leverage our entire rural safety net to address these surging behavioral health needs. We strongly believe that CMS should ensure CAHs, RHCs, FQHCs, and other providers are all equipped to fully leverage telehealth and that they are able to bill for clinically equivalent services the same way they would an in-person service.

Thank you for your attention to this matter. We look forward to working with you to ensure rural seniors continue to have access to the behavioral health services that they need.

Sincerely,

Alliance for Connected Care
American Association for Psychoanalysis in Clinical Social Work
Association for Ambulatory Behavioral Healthcare

⁹ Commonwealth Fund, “The Spike in Drug Overdose Deaths During the COVID-19 Pandemic and Policy Options to Move Forward.” Retrieved from: <https://www.commonwealthfund.org/blog/2021/spike-drug-overdose-deaths-during-covid-19-pandemic-and-policy-options-move-forward>

¹⁰ Centers for Medicare and Medicaid Services, “Hospitals: CMS Flexibilities to Fight COVID-19.” Retrieved from: <https://www.cms.gov/files/document/covid-hospitals.pdf>

American Association on Health and Disability
American Mental Health Counselors Association
American Psychiatric Association
American Psychiatric Nurses Association
College of Psychiatric and Neurologic Pharmacists
Gundersen Health System
Lakeshore Foundation
Illinois Critical Access Hospital Network
International OCD Foundation
Marshfield Clinic Health System
Maternal Mental Health Leadership Alliance
Montana Hospital Association
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Rural Health Clinics
National Association for Rural Mental Health
National Association of Social Workers
National Rural Health Association
Psychiatric Medical Care