NATIONAL CENTER ON
DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH

September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Attn: CMS-1751-P

Submitted electronically

RE: Medicare Program: CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements (CMS-1751-P)

Dear Administrator Brooks-LaSure:

On behalf of the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH), I write to provide feedback on the telehealth provisions of the Centers for Medicare and Medicaid Services' (CMS) CY 2022 Payment Policies under the Medicare Physician Fee Schedule (MPFS) proposed rule.

NCDVTMH is one of four national Special Issue Resource Centers funded by the U.S. Department of Health and Human Services' Family Violence Prevention and Services Program. NCDVTMH is dedicated to addressing the intersection of domestic and sexual violence, trauma, substance use, and mental health through a comprehensive array of training and technical assistance services and resources. As part of its mission to support systems change, NCDVTMH provides training and consultation to a wide range of health, mental health, and substance use disorder treatment providers as well as to legal and child welfare professionals, state and federal policymakers, and to the domestic violence field.

<u>Utility of telehealth to expand access to services</u>

On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) issued guidance[1] that currently allows Medicare patients to receive health and mental health services via live videoconferencing in their homes without having to travel to a qualifying clinical "originating site." NCDVTMH recognizes the significant value of expanding telehealth services to extend access to a wide range of care that survivors

[1] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

of domestic violence (DV) need such as health, mental health, and substance use care.[2] At the same time it is important to recognize that accessing services from home when an abusive partner is present poses safety, security, and privacy risks to DV survivors and to other household members.

NCDVTMH wants to remind CMS that emerging research and widespread reports from the field have found that rates of DV have increased significantly during the COVID-19 pandemic, including rates of severe DV-related injury and coercive control. Mental health (MH) and substance use (SU) conditions such as depression, anxiety, PTSD suicide attempts, and drug overdoses have also increased during the pandemic - conditions that survivors of DV already experience at higher rates. Furthermore, DV survivors who have tried to access tele-mental health and substance use disorder (SUD) services during the Public Health Emergency (PHE) report consistent challenges due to interference from abusive partners (e.g., monitoring or listening-in to sessions, tracking phone or internet usage, trying to prevent or disrupt participation, threatening the treatment provider, trying to access electronic health records). At the same time telehealth services may be a survivor's only means of support. This paradox underscores the need to ensure that telehealth services are both widely accessible *and* safe.[3]

Given the widespread adoption of telehealth services and efforts to support expanded access, going forward **it is critical to ensure that policies and practices for addressing safety, privacy, and confidentiality for survivors of DV and sexual assault (SA) are incorporated into federal regulations regarding the provision of telehealth services.** Further, guidance to enhance survivor safety and support access to needed services should be developed for telehealth vendors and providers as well as health, mental health, and substance use disorder treatment systems, professional societies, and accrediting bodies. In this comment to the 2022 MPFS proposed rule, we aim to highlight the nexus of the value of utilizing telehealth to access care and the risk of the "coercive control" element of DV when an individual monitors and threatens a partner to prevent them from accessing needed MH/SUD services and/or uses information about their partner's treatment to further their own power and control.

<u>Risks faced by survivors of domestic violence</u>

While valuable, the expansion of access to care via telehealth also raises concerns about potential risks for survivors of DV and SA for whom in-home services may not be safe. Domestic violence is a pattern of power and control that extends beyond acts of physical and sexual violence. Intimidation, manipulation, threats, undermining, and other tactics used to instill fear and sustain domination are recognized as central elements of DV. As part of a broader pattern of abuse and control, many survivors are subject to efforts to undermine their sanity or sobriety, to control their medication and treatment, or to sabotage their recovery and access to resources and support—tactics known as "mental health and substance use coercion".[4]

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[2] NCDVTMH, "Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability: Implications for Policy, Research, and Practice", http://www.nationalcenterdvtraumamh.org/publications-products/su-coercion-reports/, pp39, accessed 9/8/2021

[3] Czeisler MÉ, Howard ME, Rajaratnam SMW. Mental Health During the COVID-19 Pandemic: Challenges, Populations at Risk, Implications, and Opportunities. Am J Health Promot. 2021 Feb;35(2):301-311. doi: 10.1177/0890117120983982b. PMID: 33554624.

[4] NCDVTMH "Mental Health and Substance Use Coercion Surveys Report" (March 2014), http://www.nationalcenterdvtraumamh.org/publications-products/mental-health-and-substance-use-coercion-surveys-report/, accessed 9/8/2021

A pair of studies by NCDVTMH and the National Domestic Violence Hotline on mental health and substance use coercion found disturbingly high rates of abuse specifically targeting a partner's mental health and/or substance use.[5] Callers reported that their abusive partners intentionally undermined their sanity; coerced them into using substances, prevented them from accessing treatment, controlled their medication; sabotaged their recovery efforts; and then used their mental health or substance use "condition" to discredit them with friends, family, helping professionals, and the courts. Callers also reported that abusive partners would try to insert themselves into the treatment process, control providers' perceptions, and gather information that could be used to jeopardize a survivor's employment, housing, and/or ability to maintain custody of their children and keep them trapped in the relationship. In other words, abusers often contributed to their partner's mental health or substance use condition, and then used that condition against their partners. Further, experiencing a mental health or substance use disorder places people at greater risk for being controlled by an abusive partner. Stigma associated with substance use and mental illness contributes to the effectiveness of these abusive tactics and can create additional barriers for survivors and their children when they try to seek help.

Safeguards should be installed to protect survivors of domestic violence

The COVID–19 PHE has hindered access to care for a significant portion of Americans. In the rush to expand access to telehealth during the Public Health Emergency (PHE), legislation passed in 2020 waived some privacy protections with the goal of minimizing logistical barriers for patients and providers. The use of technology to extend the reach of services has both pros and cons. The intent of those emergency provisions was laudable; however, for those who are survivors of domestic violence as well as those also grappling with the impacts of substance use or mental health disorders, simply easing restrictions to allow for access to care via telehealth is not just insufficient, but carries great risk. Survivors of domestic violence are in need of additional privacy protections and flexibilities to ensure that they are able to safely access their care via telehealth. **In order for services to be effective, safe, and accessible to survivors, it is crucial that practitioners and policy makers understand the ways that people who abuse their partners exploit the relaxation of privacy safeguards that has been paired with the expansion of mental health and substance use treatment options via telehealth**. Simply put, the goal of improving outcomes by easing access to care could backfire and result in terrifying outcomes for survivors and their children.

Perpetrators of domestic violence are known to install spyware or other monitoring software and tools upon the technology devices of those they seek to control. Therefore, it is crucial that CMS also institute regulations that require sensible and possibly life-saving limitations such as secure technology platforms to shield victims from a range of monitoring technologies that can put them risk. Recognizing and addressing these issues is essential to the safety and well-being of survivors and their children and also has important implications for the health, mental health, substance use, legal, child welfare, immigration, public benefits, and domestic violence advocacy systems. NCDVTMH calls upon CMS to make sure that safeguards and privacy protections are put into place in order to ensure that telehealth regulations provide protections for individuals who have been or are impacted by domestic violence, trauma, and mental health challenges. We take this opportunity to offer to provide expert advice and connections to our programming partners in order to support the Agency's efforts to achieve this goal.

[5] NCDVTMH "Mental Health and Substance Use Coercion Surveys Report" (March 2014), http://www.nationalcenterdvtraumamh.org/publications-products/mental-health-and-substance-use-coercion-surveys-report/, accessed 9/8/2021

Given the risks of telehealth services just described, key considerations for survivors of DV regarding **additional guardrails are needed to minimize program integrity and patient safety concerns. Based on the vast experience of the DV field with MH/SUD coercion and technology-specific risks, we strongly recommend that CMS require the following guardrails:**

1. Secure platforms

While we understand CMS' initial decision to loosen HIPAA restrictions[6] to increase access during the PHE, this decision resulted in an increased risk for DV survivors. We are pleased that the Office for Civil Rights (OCR) guidance[7] encourages telehealth providers to use more secure HIPAA compliant videoconferencing software when possible and is clear about the types of publicly facing platforms that are *not* permitted under the 1135 Waiver. At the same time, we must point out that under normal circumstances HIPAA compliant platforms are not necessarily protective enough to meet the stricter privacy and confidentiality standards required by the Violence Against Women Act (VAWA), the Victims of Crime Act (VOCA), and the Family Violence Prevention and Services Act (FVPSA) that are best practices for DV programs and the survivors they serve.[8] **NCDVTMH implores CMS to require providers serving DV survivors to use secure technology platforms that meet the stricter standards of VAWA, VOCA, and FVPSA in order to shield victims from a range of monitoring technologies that can put them risk**.

2. Hinder digital forms of abuse such as the installation of spyware and tracking devices on phones, tablets, computers, and cars by abusive partners (aka tech abuse)

NCDVTMH suggests that CMS require the incorporation of DV/SA safety, privacy, confidentiality concerns into an informed consent process which is centered on survivors' individual safety needs. Informed consent discussions should take place prior to the visit and include the following: developing strategies for optimizing safety from an abusive partner during the provision of in-home services; discussing the most secure methods for participating in telehealth visits but understanding that the optimal method might change as survivor's individual situation evolves; providing information about the technology being used and any potential risks associated with it, including ways an abusive partner could potentially gain access to information about the encounter; and learning about the survivor's concerns and potential strategies for addressing them (e.g., optimizing digital security; using alternate forms of communication if possible; stopping the session at any time).

If a survivor then decides to proceed with the visit, the consent process should also include a conversation about how they would like to handle any safety concerns that might arise; their preferred way(s) to be contacted; and what to do in the event of a privacy breach.

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[6] U.S. Dept. of Health and Human Services, Office for Civil Rights, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Mar. 17, 2020) available at www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

[7] OCR, *FAQs on Telehealth and HIPAA During the COVID-19 Nationwide Public Health Emergency,* available at www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf.

[8] For a comparison of privacy requirements under HIPAA, VAWA, FVPSA and VOCA, see NNEDV's privacy comparison chart and FAQs.

3. Required safety precautions and informed consent processes to ensure safety, privacy and confidentiality in the context of Domestic Violence

The premise that providers know best and should be able to refer someone for services without first having a conversation with them and receiving consent to share their information is paternalistic and particularly dangerous for survivors of DV and sexual assault. In situations where information sharing can lead to grave physical, financial, and emotional harm, and even death, the devaluing of privacy and choice is of particular concern to survivors of domestic violence, sexual assault, and their children.

The domestic violence field has worked hard to ensure that, under HIPAA, survivors have the right to request privacy restrictions and confidential communications to prevent abusive partners from accessing information about their health or mental health care. For survivors of domestic violence, safety often depends on robust informed consent and disclosure of the least amount of information possible. Patients are best equipped to decide what information is and isn't safe to be shared, and as such, should be consulted any time personal health information will be shared with social service organizations outside of the healthcare system. **As part of informed consent, HIPAA should require health care practitioners talk with patients about potential risks associated with disclosure of their personal health information**. These risks include the possibility that an abusive partner who works within the healthcare system, for an entity covered by the consent-to-treatment agreement, or who is otherwise able to access their record online (e.g., through spyware or coercing a partner to share passwords) might be able to access sensitive information about them and their treatment. Frank discussions about these and similar risks are particularly critical for providers who are not already sensitive to these issues.

Therefore, **NCDVTMH recommends that CMS provide guidance regarding the safe use of technology**. The Agency should **require that providers serving DV clients observe technology safety precautions such as checking phones, computers, tablets, and cars for tracking devices and spyware; ensuring that digital communications do not leave an online trail; enabling and rechecking privacy settings; using password protected devices and WiFi; and/or obtaining secure devices for patients to use during telehealth encounters**.

<u>Accommodations necessary for persons with co-occurring mental health disorders</u>

In the proposed rule, CMS notes that "The requirement that the physician or practitioner must furnish an item or service in person, without the use of telehealth, within a specified time frame shall not apply to telehealth services furnished for treatment of a diagnosed substance use disorder or co-occurring mental health disorder…"[9] NCDVTMH applauds CMS for the flexibility to enable expanded access to mental health telehealth services. However, in the context of ongoing DV, the utility and value of care via telehealth is not universal.

For some survivors of DV, an in-person visit is safer because accessing services in the home is not private or safe. At the same time—particularly when MH or SU coercion is involved—requiring an in-person visit may create undue risks and thus preclude or prevent survivors from receiving or being able to access needed care. **For survivors of DV, having the ability to choose the safest option is critical. We would thereby recommend that receiving services via telehealth be maintained as a valuable option, but not the sole way to access necessary services**.

[9] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39146

NCDVTMH would also like to point out that many individuals (including survivors of DV) in need of services are not yet established patients; therefore, requiring an in-person visit as an entry-point could be an insurmountable barrier. Examples include: individuals living in rural areas where their abusive partner controls their transportation or child care; individuals living in a DV shelter or staying with someone who isn't able to provide transportation; situations where local services do not exist; or local services which are thought to be available are not sufficient because they are not culturally relevant, gender responsive, LGBTQ-affirming, linguistically accessible, or attuned to the needs of someone experiencing DV and/or other trauma.

CMS requested comments "regarding the extent to which a patient routinely receiving mental health services from one practitioner in a group might have occasion to see a different practitioner of the same specialty in that group for treatment of the same condition."[10] and thereby streamlining their access to care for a substance use disorder and/or mental health disorder. NCDVTMH notes that allowing practitioners in the same group to be covered under the required 6-month in-person visit would be clearly helpful and necessary to anyone seeking MH/SUD services. However, **for survivors of DV and other trauma, it is crucial that this flexibility would be paired with a robust informed consent process**. It is of the utmost importance that prior to utilizing this flexibility, patients would have to opt-in to the information sharing of any personal health information in addition to other confidential, sensitive information between members of a given practice.

<u>DV survivor safety requires expanding definition of originating site</u>

CMS has also proposed to "identify the home of a beneficiary as an originating site for telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the first day after the end of the PHE".[11] However, it is crucial that DV survivors have a range of safe ways to access telehealth, mental health and SUD treatment services that is based on their particular situation and knowledge about their abusive partner. Protective policies should emphasize the importance of employing DV/SA-informed strategies in all aspects of patient/client care. Therefore, we'd be remiss if we didn't suggest a modification. **NCDVTMH recommends that for individuals seeking telehealth services for the diagnosis, evaluation, or treatment of a diagnosed substance use disorder or co-occurring mental health disorder that additional locations other that the office of their provider be treated as the equivalent of "in their home"—such locations could include potentially safer, more private locations such as inside a car, outside on a walk, in a stairwell, at another site, inside a bathroom with water running, or in another room with music or TV playing**. This minor modification will enable survivors of domestic violence to receive the care they need from a location in which they feel safe from an abusive partner, and where their privacy can be protected.

<u>Permitting audio-only communications for mental health telehealth services</u>

NCDVTMH agrees with CMS' reasoning that "mental health services are different from most other services on the Medicare telehealth services list in that many of the services primarily involve verbal conversation where visualization between the patient and furnishing physician or practitioner may be less critical to provision of the service."[12] Survivors of domestic violence will benefit greatly from being

[10] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39146
[11] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39147
[12] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39148

able to access mental health services using audio-only technologies; voice-only communications can be more secure and more private—a factor of significant concern to us and those we serve. NCDVTMH applauds CMS' proposal to revise its regulatory definition of ''interactive telecommunications system'' to permit use of audio-only communications technology for mental health telehealth services under certain conditions.

We understand CMS' rationale for wanting to "limit payment for audio-only services to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology."[13] We agree that this flexibility will facilitate "access to care that would be unlikely to occur otherwise, given the patient's technological limitations or preferences".[14] However, we **suggest that the agency not strictly limit the provision of audio-only services to practitioners who have two-way audio/video capacity given that practitioners in rural areas and/or on Tribal lands may also have limited broadband access which thereby hinders their ability to use two-way audio/visual technology. Instead, these invaluable providers could offer audio-only services for those who are not able to access in-person services. We also suggest that the Agency incorporate the same location flexibilities that we suggested above so that survivors of domestic violence are able to access care from a location in which they feel safe**. We further suggest that CMS consider allowing for communications which utilize headphones as well as secure apps to text or chat so that a DV survivor can seek treatment but also prevent being overheard by their coercive partner.

Additional documentation regarding the patient's location at the time of service as well as the clinical appropriateness of providing audio-only telehealth services for mental health may be helpful for providers, but regulatory guidance should include cautions and waivers regarding information that could put survivors at risk if accessed by an abusive partner and/or others in their orbit. **It is imperative that the interests of protecting the safety of the survivor of DV outweigh the Agency's interest in record-keeping such that a survivor has protections to shield sensitive information and engages informed consent in order to minimize the risk of retaliation for disclosing abuse**. Therefore, NCDVTMH suggests that regulations require that potential safety risks associated with documentation of DV are discussed with the patient (such as implications of access to records by abusive partner), and a protocol of limiting access to information related to DV clients is instituted. Should CMS determine that this flexibility is outside of its regulatory authority, NCDVTMH would appreciate the Agency stating that in the 2022 MPFS final rule and then working with Members of Congress who are seeking technical assistance when crafting future legislation intended to provide CMS with the requisite authority to allow for this flexibility.

Limiting the flexibility and additional access point for services via telehealth to only established patients would prevent those people who develop a need for mental health and/or substance use services from accessing services at the time they are in greatest need. CMS has clearly stated it sees value in ensuring access to care via audio-only methods. Similarly, it is not uncommon for emergency services such as suicide prevention crisis lines to be audio-only. Therefore, **NCDVTMH suggests that new patients also be granted access to these types of services via audio-only technologies**. Given the high rates of

[13] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39148
[14] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39148

depression, PTSD, SU and suicidality among survivors of DV and increased risk for overdose, providing initial access to services via audio-only technologies may turn out to be lifesaving.

Finally, NCDVTMH strongly encourages CMS to extend its proposed audio-only mental health telehealth services exception to include certain higher-level services, such as level 4 or 5 E/M visit codes, when furnished alongside add-on codes for psychotherapy, or psychotherapy with crisis CPT codes. The full scope of service elements for these codes should also be available via audio-only communication technology because doing so will give domestic violence survivors access to care that is "needed to address their higher level or acute mental health needs in instances where they are unable to access two-way, audio/video communication technology" or when doing so in person or utilizing audio-visual technologies would place them at greater risk from an abusive partner.[15]

Conclusion

Research has consistently documented that exposure to abuse is a significant factor in the development and exacerbation of mental health and substance use conditions. Both random population studies and studies conducted in clinical settings indicate that abuse by an intimate partner places individuals at significantly higher risk for depression, anxiety, PTSD, eating disorders, chronic pain, insomnia, substance use disorders, suicide attempts, and experiencing greater unmet mental health and substance use-related needs. Experiencing multiple forms of abuse significantly increases this risk.

Thank you for the opportunity to comment on the CY 2022 Medicare Physician Fee Schedule proposed rule. We hope our insight and perspective will prompt CMS to reconsider some of its proposals because reductions in privacy protections are accompanied by an increased risk of harm to survivors of domestic violence. The National Center on Domestic Violence, Trauma, and Mental Health welcomes the opportunity to work with CMS to identify solutions that will result in a balance of improving access to care via telehealth while simultaneously protecting patients from coercive interference.

Sincerely,

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[15] CMS, 2022 MPFS proposed rule (CMS-1751-P), pp.39149