February 15, 2022

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Humans Services
Attention: CMS-9906-P,
P.O. Box 8016 Baltimore, MD 21244-801

Dear Ms. Brooks-LaSure:

On behalf of the Maternal Mental Health Leadership Alliance, a national nonprofit focused on advancing public policy around maternal mental health, I'm writing to urge CMS to permanently extend Medicaid and Medicare coverage for telehealth to help improve access to mental health care for pregnant and postpartum mothers on Medicaid and SSDI under Medicare.

Maternal mental health (MMH) conditions are the most common complications of pregnancy and childbirth and affect 1 in 5 women during pregnancy or the first year following pregnancy, negatively impacting 800,000 families each year in the United States.[1] Recent studies show that suicide and overdose combined are the leading cause of postpartum death for new mothers, contributing to the distressingly high maternal mortality rate in the United States.[2,3] Sadly, 75% of those experiencing MMH conditions are never treated, increasing the risk of multigenerational, long-term impacts on both mother and child.[4,5] The cost of not treating MMH conditions is $32,000 per mother-infant pair, or $14.2 billion in 2017 in addressing poor health outcomes of mother and baby, and accounting for lost wages and productivity of the mother.[6] COVID-19 has fueled a three-fold increase in the number of pregnant and postpartum women experiencing anxiety and depression.[7,8] Women of color, low-income women, and other populations disproportionately served by Medicaid programs are also impacted at greater rates by both the pandemic[9] and MMH conditions, experiencing MMH and substance use disorders at rates as high as 28%.[10,11,12,13,14]

---

[1] Luca, D., et al (2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States. *Mathematica Policy Research.*
[2] Metz, T., et al (2016). Maternal Deaths From Suicide and Overdose in Colorado, 2004-2012. *Obstet Gynecol.*
[3] Davis N., et al (2019). Pregnancy-Related Deaths: Data From 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.
[4] Center for Disease Control and Prevention website. www.cdc.gov/reproductivehealth/depression/index.
[5] Luca, et al.
[6] Luca, et al.
[7] Berthelot N., et al (2020). Uptrend in Distress and Psychiatric Symptomatology in Pregnant Women During the Coronavirus Disease 2019 Pandemic. *Acta Obstetricia et Gynecologica Scandinavica*.
[8] Lebel, C., et al (2020). Elevated Depression and Anxiety Among Pregnant Individuals During COVID-19c. *Journal of Affective Disorders.*
[9] Society for Research in Women's Health website. https://swhr.org/the-disproportionate-impact-of-covid-19-on-women-of-color/
[10] Howell, E., et al. (2005). Racial and Ethnic Differences in Factors Associated With Early Postpartum Depressive Symptoms. *Obstet Gynecol.*
[11] Goldman-Mellor, S. and C.E. Margerison (2019). Maternal drug-related death and suicide are leading causes of postpartum death in California. *Am J Obstet Gynecol.*
[12] Lindahl, V., J.L. Pearson, and L. Colpe (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archive of Women's Mental Health*.
[13] Davis, et al.
[14] Gavin, N.I., et al. (2005). Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol.*

Given the negative impact of MMH conditions on the mother, baby, family, and society, there is a critical need to ensure mothers can access support and treatment as soon as possible. Moreover, data show that MMH conditions can be identified and treated before they become crises, and exciting research is underway that shows these conditions can even be predicted and prevented.

Telehealth:

The one silver lining of the pandemic – especially for individuals impacted by MMH conditions – has been the expansion of telehealth services, helping pregnant and postpartum patients overcome barriers to accessing care, including fear of exposure to the COVID-19 virus, transportation challenges, and lack of childcare. A recent study concluded that "telemedicine interventions significantly decreased postpartum depression symptoms and demonstrated feasibility and acceptability among mothers in the postnatal period." (*Midwifery,* March 2021). Thus, we have the following recommendations for CMS:

Extending telehealth services beyond the PHE. The flexibilities granted by the §1135 emergency telehealth waivers have provided critical stability for healthcare professionals, patients and families across the nation during this challenging time. We recommend extending these flexibilities for at least one year beyond the conclusion of the Public Health Emergency (PHE) will allow for additional time to evaluate questions associated with cost, utilization, efficacy, and compliance. If the evaluations show effective, we urge the full implementation of telehealth past the PHE to help mothers affected by maternal mental health conditions receive access to care.

Access to support has increased for mothers when virtual options, both free and those covered by insurance, have become available during the pandemic. Many organizations who provide support to new mothers experiencing MMH conditions have found telehealth usage has significantly increased attendance at virtual support groups for pregnant and postpartum people. Here are just two examples:

- Postpartum Support International, the nation's leading organization in assisting pregnant and postpartum parents experiencing MMH conditions, has increased the number of virtual support groups four-fold since the beginning of the pandemic to meet demand. In addition, PSI has launched specialized support for individuals at highest risk for experiencing MMH conditions, including parents with a baby in the neonatal intensive care unit, military parents, parents of color, and LGBTQ parents.
- Mary's Center, a federally qualified health center in Washington DC, offered in-person support groups for new parents in at-risk communities for the past five years, but attendance was often spotty, with parents citing lack of time, transportation, and childcare as reasons for not attending. These same parents are now able to attend virtual support groups as these barriers have been removed.

Removing the Six-Month Interval In-Person Requirement. We can attest to the rise in maternal mental health utilization throughout the pandemic and how access to telehealth has saved mothers' lives. Thus, we oppose the six month in-person requirement with the physician or practitioner to the initial telehealth service, and at least once every six months thereafter. This provision is discriminatory against individuals with mental health conditions as no in-person requirement is required for individuals seeking treatment for substance use disorder. This arbitrary requirement puts burdensome travel and safety concerns on mothers who are less likely to seek treatment for their maternal mental health condition in the first place. Although the Mental Health Parity and Addiction Equity Act (MHPAEA) does not apply to Medicare, devising policies that flout a federal law does a disservice for all Americans seeking treatment for mental health conditions and sets the tone for the continuation of commercial payers to remain incompliant. The in-person requirement has been sold as a way to mitigate fraud; however, fraud for mental health conditions provided via

telehealth has yet to surface. We urge you to re-evaluate this requirement, considering the data and benefits for mothers affected by maternal mental health conditions.

Extending the use of telephonic (audio only) services. We support the amendment to regulation § 410.789(a)(3) to define and expand "interactive telecommunications system" to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health patients provided to established patients when the originating site is the patient's home. Audio-only visits have been a lifeline for patients during the PHE, especially to those who have been hardest hit by COVID-19, including individuals in rural areas and communities of color.

According to the FCC, as many as 13% of Americans do not have access to broadband services, and many in racial / ethnic and low-income groups lack access to broadband or video-enabled devices. It is important to note that women facing racial or economic inequities are more likely to experience MMH conditions and less likely to get care. We recommend allowing audio and text check-ins for mental health care to help address these racial and health inequities.

We thank CMS for its ongoing attention to issues of mental health in our country, and especially for addressing MMH conditions. New mothers need support: they are the heart and soul of the family. When a mother thrives, so does her baby, her family, and her community. Should you need any additional information, please contact me at agriffen@mmhla.org or 571-643-2738.

Sincerely,

Adrienne Griffen, MPP
Executive Director