# Telebehavioral Health in Response to the COVID-19 Pandemic:

## What Worked, What Didn't Work, and How Can This Shape Future Policy?

*Telehealth technology, a resource available to providers for more than 20 years, was not often used to deliver mental and behavioral health care services.[1] Despite the widespread growth of internet-enabled communication options,[2] there was limited reimbursement for many telehealth services, discouraging nationwide adoption.[3] This changed in March 2020, when the federal government recommended the use of telehealth services to mitigate public health risks associated with COVID-19 and the Centers for Medicare & Medicaid Services adjusted associated regulations and reimbursement requirements to further encourage use.[2]*

*In addition to federal efforts to support telehealth use, 30 states passed emergency orders to permit expansion of telehealth services.[2] These emergency orders allowed state agencies to temporarily ease certain restrictions and requirements around the provision of telehealth during the COVID-19 public health emergency (PHE) in an effort to reduce the risk of contracting and spreading the virus.*

*With the development and deployment of several COVID-19 vaccines, states are looking toward the health care policy landscape after the PHE ends. With respect to telehealth and telebehavioral health, states are considering which of the expanded policies and flexibilities to make permanent and which to roll back.*

*This telebehavioral health tool is based on research done by the Center for Evidence-based Policy for the Medicaid Evidence-based Decisions (MED) Project, "Telebehavioral Health in Response to the COVID-19 Pandemic: What Worked, What Didn't Work, and How Can This Shape Future Policy?"[4]*

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## Effectiveness and Safety

- There are currently few published studies comparing the provision of behavioral health services by synchronous telehealth modalities with in-person delivery during the COVID-19 PHE.
  - The few studies meeting our inclusion criteria focused on the delivery of telebehavioral health services for anxiety and depression, autism spectrum disorder, attention-deficit/hyperactivity disorder (ADHD), serious mental illness, and substance use disorder (SUD).
  - Studies generally enrolled few participants, were short in duration, and we assessed all as having a high risk of bias.
- Based on limited evidence of interventions delivered during the COVID-19 PHE, behavioral health services delivered by synchronous telehealth can improve clinical outcomes, lead to high patient and provider satisfaction, and reduce barriers to health care access.
  - Evidence from 1 randomized controlled trial of videoconferencing to deliver therapist-guided group teletherapy sessions to treat anxiety and depression indicated it may be just as effective as in-person service delivery, with respect to clinical outcomes.
  - This limited evidence is consistent with findings from the MED report, *Behavioral Health Treatment Delivered via Synchronous Telehealth: Effectiveness and Programmatic Structure*,[5] on telebehavioral health service provision before the pandemic, and also consistent with studies on telehealth at large.

## Policy Changes During COVID-19

- Policy flexibilities put forth by CMS, the Office of Civil Rights (OCR), the Drug Enforcement Administration (DEA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) led to a cascade of important policy changes in federal and state Medicaid programs, and those among private payers. Key policy flexibilities for telehealth include:
  - Allowing platforms not necessarily compliant with the Health Insurance Portability and Accountability Act (HIPAA)
  - Allowing audio-only telephone services
  - Prescription of controlled substances by telehealth modalities
  - Medical emergency flexibilities with regard to 42 CFR (Code of Federal Regulations) Part 2
- Key areas of policy change taken by interviewed state Medicaid programs (AL, NC, NV, SC, TN, WA) during the COVID-19 pandemic include allowing audio-only telehealth, use of specific codes and modifiers for tracking services, payment parity, and interstate provider allowances.
  - All interviewed states allowed for audio-only telehealth encounters.
  - Codes and modifiers: POS 02 was used by all interviewed states. Other modifiers were used by subsets of these states: GT modifier (NC, SC, WA), CR modifier (AL, NC, WA), KX modifier (NC).
  - Payment parity: All interviewed states allowed audio-video telehealth to be billed at the same rate as in-person services, while NC planned to allow audio-only telehealth services to be billed at 80% of in-person rates.
  - Interstate provider allowances: 3 states (AL, NC, NV, TN) have passed legislation allowing them to participate in PSYPACT,

the Psychology Interjurisdictional Compact, while 2 states (SC, WA) have pending legislation.

- States are currently gathering and reviewing data necessary for future policy decisions on telebehavorial health services. All states interviewed have not made formal decisions on which telebehavioral health policies will be made permanent. Reviews of state utilization and cost data, and subsequent published studies combined with feedback from clinicians, patients, caregivers, and other stakeholders will be important in informing their future telebehavioral health policy decisions.

## Considerations for Post-Pandemic Telebehavioral Health Policies

We offer a potential framework for designing and implementing postpandemic telebehavioral health policies, using the available evidence and state policymaker experiences with policy development during the COVID-19 PHE.

| Key Considerations When Developing Postpandemic Telebehavioral Health Policies: A Framework | | |
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| **Outcomes** | | |
| Goals | • Access<br>• Quality<br>• Utilization<br>• Cost<br>• Patient outcomes | Connect clients with the most highly trained clinician available, in a timely manner, with the highest quality service provided. |
| **Structure** | | |
| Regulation | • Risk management<br>• Privacy issues<br>• Quality standards<br>• Governance | Anticipate additional effort required to monitor, engage, and connect clients over telehealth when attempting to achieve treatment fidelity. |
| Payment | • Aligning efforts across payers<br>• Payment model<br>• Modifiers and codes | Develop specific codes and modifiers (e.g., POS 02, GT) to differentiate audio-video telehealth from audio-only telehealth in claims data. |
| **Process** | | |
| Technology and modality | • Digital divide<br>• Available technologies<br>• Appropriateness for client and condition | Consider how providing behavioral health services by telehealth may affect client satisfaction and perceived stigma (e.g., improved patient satisfaction with induction of buprenorphine for opioid use disorder clients through telehealth). |
| Clinical quality and delivery | • Infrastructure<br>• Provider training and education | Provide comprehensive technical assistance and guidance to clinicians and other providers to aid in participation, engagement, and satisfaction. |
| Equity, diversity, and inclusion | • Populations<br>• Settings | Consider how PHE flexibilities, including audio-only telehealth and use of HIPAA-noncompliant platforms, may affect access and continuity of care for clients in rural and underserved communities. |

## *References*


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5. Lazur B, Sobolik L, King V. *Behavioral health treatment delivered via synchronous telehealth: effectiveness and programmatic structure*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2020.


## *Interviews*

Program staff:

- Alabama Medicaid and Alabama Department of Mental Health
- North Carolina Medicaid and Department of Health and Human Services
- Nevada Division of Health Care Financing and Policy and Nevada Patient Protection Commission
- South Carolina Department of Health and Human Services
- TennCare
- Washington Health Care Authority

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