ABHW

ISSUE BRIEF

Tele-behavioral Health

Updated July 2023

Background

In 2021, an estimated 57.8 million people in the United States (U.S.) experienced mental illness, and an estimated 46.3 million people (age 12 and over) had a substance use disorder (SUD); yet less than half of those people received treatment.[i] Telehealth can create a more equitable treatment pathway for individuals with limited or no access to in-person behavioral health services. While significant advancements have been made in telehealth, many spurred by the enhanced flexibilities during the COVID-19 pandemic, numerous barriers still face tele-behavioral health care. Additionally, barriers to services remain by requiring a prior in-person visit to establish a patient and provider relationship, restrictions on telehealth across state lines, and limitations on prescribing medications, such as those imposed by the Ryan Haight Act.[1]

While telehealth creates opportunities for many individuals to receive the treatment they need, advancements in telehealth must continue to promote equity and not exacerbate healthcare disparities. Access to telehealth services is challenging for rural and urban populations, older adults, low-income residents, and those with limited health, digital, or English literacy. More than one in three households in the U.S., led by someone aged 65 or older, do not have a desktop or laptop, and more than half do not have a smartphone device.[ii] A lack of broadband internet is another problem that magnifies obstacles to telehealth access.[iii]

[1] The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was created to regulate online internet prescriptions, is enforced by the Drug Enforcement Agency (DEA), and imposes rules around prescribing controlled substances through telepsychiatry.

The coronavirus pandemic increased the utilization of telehealth, given social distancing and stay-at-home orders.[iv] Approximately 45 percent of adults in the U.S. reported that their mental health had been negatively impacted due to stress and concern over COVID-19.[v] The impacts on mental health (MH) and SUDs have exacerbated the increasing need for access to behavioral health services.

During the COVID-19 Public Health Emergency (PHE), federal legislative and regulatory actions and those taken by insurers quickly expanded access to telehealth services. Medicare behavioral health services rose from 17 percent of telehealth spending for all evaluation and management services to 23 percent from 2020 to 2021.[vi] Tele-behavioral health services continued to grow in 2021, even as the use of other telehealth services declined from their peak in 2020.[vii] The increased utilization of telehealth and satisfaction by many patients and providers, particularly behavioral telehealth, is critical to making many changes permanent. While telemedicine has expanded, it is delivered unevenly across the United States, depending on different state-level telehealth policies.[viii] The PHE ended on May 11, 2023, but Congress has extended many of Medicare's telehealth flexibilities through December 31, 2024.

The literature on telehealth has grown since the onset of the PHE, but it is still lacking. The impact of telehealth on quality, access, and costs is limited because of the time lag in claims data, and some studies have methodological and data challenges.[ix] Some studies have shown that telehealth services can expand access to underserved communities.[xxi]

Recommendations

Overall, ABHW supports the expansion of coverage for evidence-based telehealth services and removing unnecessary barriers to telehealth care delivery. While expanding appropriate telehealth services has the potential to coordinate and improve care and outcomes, additional steps are needed to support evidence-based, safe, effective, and equitable enhancements and implementation of tele-behavioral health services.

- **Remove the In-Person Visit Requirement for Mental Health-Only**

Services in Medicare. Recent changes in Medicare to remove geographic and originating site restrictions for mental health services allow beneficiaries across the country to receive virtual care from their chosen location. However, these changes were accompanied by a new requirement, mandating that an individual must have an in-person visit no less than six months before they can receive mental health services via telehealth. ABHW recommends that Congress remove this inequitable requirement.

- **Address State Licensure Issues to Allow Providers to Deliver Telehealth Services Across State Lines.** ABHW encourages state and federal efforts that foster state licensure reciprocity to improve access to treatment through telehealth services.
- **Eliminate the In-Person Visit Requirement for the Prescribing of Buprenorphine.** The in-person evaluation required before prescribing buprenorphine via telemedicine only results in reduced access to care. During the COVID-19 PHE, the Drug Enforcement Agency (DEA) waived the in-person requirement, enabling providers to prescribe controlled substances using telemedicine safely. Removing the in-person requirement during the COVID-19 pandemic was not associated with increased overdose deaths. It showed improved access to care and alleviated health inequities in primary care programs.
- **Urge the DEA to Develop a Special Registration Pathway for Telehealth Prescribing of Controlled Substances.** Congress directed the DEA to create a special registration first in 2008 as a part of the Ryan Haight Act. Congress again directed the DEA to create this registration as a part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) in 2018. The DEA has declined to develop the special registration. ABHW urges the DEA to perform as directed by Congress.
- **Telehealth Credits for Network Adequacy.** Telehealth should count toward meeting time and distance standards for network adequacy purposes. This will allow health plans to apply virtual telehealth providers, who may be outside designated geographic areas, to satisfy behavioral health network adequacy standards. It will also improve access to services in mental health professional shortage areas.

- **The In-Person Visit Requirement for Prescribing Other Controlled Substances Besides Buprenorphine Should Be Based on Clinical Decision-Making**. ABHW believes it should be up to clinical decision-makers whether specific data is needed to prescribe controlled substances. Clinical decisions vary based on the prescribed medication, and no unified standard of care describes prerequisites for all controlled substances.
- **Telehealth Coverage in High Deductible Plans**. Under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), health savings accounts paired with high-deductible health plans (HSAs/HDHPs) were able to cover telehealth pre-deductibles. ABHW supports making this flexibility permanent to help employers continue supporting individuals leveraging virtual care.
- **ABHW Recommends that the Appropriate Regulatory Agencies Conduct Research to Determine How Best to Leverage Audio-Only Technology.** In 2022, the Centers for Medicare & Medicaid Services (CMS) permanently allowed audio-only services to be provided for diagnosing, evaluating, and treating mental health conditions and substance use disorders. In 2023, clinicians must indicate audio-only services on Medicare claims, which helps measure audio-only outcomes. ABHW supports additional considerations to addressing areas with limited broadband, populations without telehealth-capable devices, or other necessary situations as critical to improving access and reducing health disparities.
- **Regulatory Agencies Should Also Evaluate Quality Standards and Protections Against Fraud, Waste, and Abuse.** Some Medicare findings suggest that greater telehealth use was associated with little change in measured quality, somewhat improved access to care for some beneficiaries, and slightly increased costs during the pandemic. Still, more data needs to be collected and analyzed.

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[i] https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf

[ii] https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/full/

[iii] https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/full/

[iv] JAMA Health Forum, Mental Health Service Utilization Rates Among Commercially Insured Adults in the US During the First Year of the COVID-19 Pandemic, January 2023.

[v] https://webappa.cdc.gov/sasweb/ncipc/leadcause.html

[vi] Medicaid and CHIP Payment and Access Commission, June 2023 Report to Congress on Medicaid and CHIP

[vii] *Id.*

viii The American Journal of Managed Care, Provision of Telemental Health Before and After COVID-19 Onset, March 2023

[ix] Medicare and the Health Care Delivery System, Report to Congress June 2023: Mandated report: Telehealth in Medicare, June 2023

[x] https://www.healthcaredive.com/news/study-throws-claims-telehealth-savings-into-doubt-kaiser-family-foundation/640666/

[xi] https://www.healthcaredive.com/news/telemedicine-disadvantaged-communities-pandemic-study-health-affairs/623150/