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Telebehavioral Health: An Effective Alternative to In-Person Care

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Policy Points

- Telehealth is just as effective as in-person care for certain behavioral health conditions
- States can cover telebehavioral health as as a separate benefit or as a treatment modality, meaning that certain services are covered regardless of how they are delivered

ABSTRACT

In recent years, many states have seen an increase in the prevalence of behavioral health diagnoses and challenges in treatment access. At the same time, the health care delivery system has increasingly relied on telehealth. Given the importance of behavioral health care and the desire of state policymakers to improve outcomes, leaders should consider the effectiveness of various behavioral health treatments delivered via synchronous telehealth.

While the COVID-19 pandemic has prompted numerous, often temporary, telehealth policy changes across the health care field, some states and health care organizations already had robust telehealth policies in place. As health care leaders and organizations consider extending or making these new telehealth policies permanent, they should consider the lessons learned from existing programs.

This brief provides summary findings from a 2019, pre-pandemic review of the evidence of telebehavioral health's effectiveness on key clinical outcomes. It also describes the programmatic structure and relevant telebehavioral health policies of three programs: Texas Medicaid, Massachusetts Medicaid, and the Portland Veterans Affairs Medical Center Rural Telemental Health Program (VA RTMH).

Key Evidence Findings:

- Telehealth is just as effective as in-person care for certain behavioral health conditions;
- Telehealth is not harmful compared with in-person behavioral health care; and,
- The cost of telebehavioral health can be lower than in-person visits, provided that patients have devices they can use.

Key Policy Findings:

- Permanent telebehavioral health policies can be implemented using various means, including treating telehealth as a modality or as a separate program; and
- Administrative or legislative mechanisms can be used to enact authorization for such policies.

BACKGROUND

More than 50% of Americans will be diagnosed with a mental health disorder such as anxiety or depression during their lifetime, with one in five US adults experiencing a mental illness in a given year.[3-5] Approximately 21 million Americans have a substance use disorder (SUD) related to alcohol, opioids, or other drugs.[6] Population-based surveys suggest one in six US children aged two to eight years has a mental, behavioral, or developmental disorder.[7]

> Telebehavioral health, also known as telemental health, is broadly defined as any telehealth services delivered by behavioral health professionals, such as psychiatrists, psychologists, and social workers.[1] Examples of behavioral health services delivered via telehealth include cognitive behavioral therapy, general psychotherapy, behavioral activation, problem-solving therapy, medication management, and training for parents of children with attention-deficit hyperactivity disorder. For the purposes of this brief, telebehavioral health services are limited to live audio-video connections (synchronous) in which patients receive health care at an originating site (e.g., clinical or home setting) from providers located at a distant site.[2]

Despite the ubiquity of mental and behavioral health conditions, access to treatment is often out of reach, particularly for children and adolescents. Sixty-five percent of nonmetropolitan counties in the US do not have a psychiatrist, and there are often shortages of both nonpsychiatric and psychiatric care professionals in rural geographic areas.[8] While primary care clinicians provide substantial amounts of behavioral health care, they often report difficulties obtaining specialist mental health referrals for rural and low-income patients.[9,10] Even with sufficient staffing, providers may be unable to deliver the right services, such as acute and crisis care. Furthermore, only a small proportion of individuals with SUD receive treatment, a reflection of the shortage of SUD treatment providers.[6] This treatment gap is particularly evident among vulnerable populations including racial and ethnic minorities, children, rural communities, and individuals with special health care needs.[7] Telehealth may have the ability to fill at least some of these gaps in access to care.

The telehealth policy and reimbursement landscape continue to evolve, particularly with changes occurring in the wake of the COVID-19 pandemic. Still, prior to COVID-19, Medicaid fee-for-service provided reimbursement for some forms of live video telehealth in 49 states and Washington, DC.[11]

Evidence on Telebehavioral Health

As Effective as In-Person Care for Common Behavioral Health Conditions

- Studies indicate that there are largely no significant differences between telehealth and in-person care for adults with anxiety,[12-18] depression,[13-22] substance use disorder,[23] and post-traumatic stress disorder[17,18] for the following outcomes:
  - Symptom improvement,
  - Patient satisfaction,
  - Quality of life, and
  - Medication and treatment adherence.
- Patients have reported that behavioral health treatment delivered by synchronous telehealth was convenient and reduced barriers to accessing treatment.[15,23]

Greater Improvements in Attention Deficit Hyperactivity Disorder (ADHD) Symptoms

- For children with ADHD, a study showed improvement in symptoms occurred in both synchronous telehealth—in which a patient and provider are connected in real time via teleconferencing—and in-person treatment groups, but the improvement was significantly greater for those participating in the telehealth intervention.[24]
- Telebehavioral health led to decreases in distress among caregivers of children with ADHD.[25]

Neither Worse Than Nor Harmful in Comparison to In-Person Care for Many Behavioral Health Conditions

- No study found behavioral health treatment delivered by synchronous telehealth to be worse than or harmful in comparison to behavioral health treatment delivered in-person.[12-36] However, no

studies evaluated the effects of long-term telebehavioral health treatment, and there were few studies in children.

Costs Vary Greatly by Program, Depending on Staffing, Services, and Technology

- Studies reported mixed findings pertaining to costs and health care utilization for participants in synchronous telehealth and comparison groups across all behavioral health populations studied.[12,13,18,26]
- Studies of people with depression noted direct telehealth costs were lower than costs for in-person care if patients provided their own technology rather than being provided with equipment by clinical providers or the government.[18]
- Telebehavioral health costs less as long as patients have devices that they can use.[18]

Telebehavioral Health Policy Implementation

Telebehavioral Health as a Treatment Modality or Separate Benefit

States can cover telebehavioral health as a treatment modality, meaning that they cover certain services regardless of how they are delivered, or as a separate benefit, where the state specifically defines its coverage of telehealth treatment (e.g., cover telehealth but only for particular conditions or under certain circumstances). Below, we describe examples of both approaches from three states: Texas, Massachusetts, and Oregon. In all three states, the major impetus for developing telebehavioral health programs was to address health professional shortages and reduce treatment barriers related to patient location.[40,41]

While Texas and Massachusetts's Medicaid policies were authorized using different mechanisms, Texas legislatively in 2005[37] and Massachusetts administratively in 2019,[38,39] both states treat telebehavioral health as a treatment modality, not as a distinct, separately covered service.[1*,2*] In contrast, the Portland Veterans Affairs Medical Center (Portland VA) created its telebehavioral health program, Rural Telemental Health (RTMH), in 2009 for patients living in rural areas of Oregon as a separate specialty program.[3*]

There are minimal differences between in-person and remotely delivered services, regardless of modality or separate benefit designation.[38,39,42]

The Texas and Massachusetts Medicaid programs both provide:

- Equal reimbursement;[37,38,43,44]
- Identical patient eligibility requirements;
- Identical prior authorization requirements;[37] and
- No start-up funding or equipment for providers or patients.

Implementation nuances remain for telebehavioral health services:

- Requirement of staff training programs (Mass.);[38,39]
- Presence of a health care professional in mental health emergencies (Texas);[45]
- Specific eligibility exclusions including severe SUD, high risk of suicide or homicide, and dementia (VA RTMH);[4*] and
- Special delivery and eligibility requirements for children (Texas).[45,46]

Minimal Restrictions to Allowed Services

All three programs (Texas, Mass., VA RTMH) permit a wide range of services to be delivered through telebehavioral health including:[4*,38,47-50]

- Diagnosis, evaluation, and treatment;
- Services for new patients; and
- Medication prescribing.

Considerations for prescribing of controlled substances include:

- Compliance with federal and state laws (Texas, Mass., VA RTMH); [4*,38,39,49,51]
- Required periodic in-person visits (Mass., VA RTMH); [4*,38,39]
- Particular restrictions for Schedule II controlled substances (Mass.);[38,39] and
- Exclusion of chronic pain conditions (Texas).[51]

*[1] Texas Medicaid staff, personal communication.
*[2] Massachusetts Medicaid staff, personal communication.
*[3] VA RTMH staff, personal communication.
*[4] VA RTMH staff, personal communication.

Minimal Restrictions to Allowed Sites

All three programs permitted a patient's home to serve as an originating site for telemedicine, ensuring patients did not have to travel to a practitioner's office or medical facility.[37-39,49,50] The Texas and Massachusetts Medicaid programs had very few, if any, restrictions on patient site location.

Policy considerations for allowed sites include:

- Evaluating a patient's access to emergency services (VA RTMH);
- Requiring a clinical originating site for patients with certain controlled substance prescriptions, like Suboxone (VA RTMH); and
- Contingency planning for technical issues and health crises (Mass., VA RTMH). [4*,38,39]

Minimal Technical Specifications

All three programs provided limited direction on technological requirements and did not provide funding for equipment or technology for patients or providers.[4*,38,39,49]

The broad guidance for providers includes:[4*,38,39,49]

- Compliance with the Health Insurance Portability and Accountability Act of 1996; and
- Secure authentication.

> The US Department of Veterans Affairs (US VA) has an encrypted, web-based app, VA Video Connect, which is a web link that creates a virtual medical room.[52] Additionally, the US VA has recently piloted partnerships with public and private organizations, e.g., American Legion, Veterans of Foreign Wars, and Walmart, that will provide on-site access at five to 10 locations nationally to technology and private space for telehealth visits.[53-55]

Considerations for States Thinking About Continuing New Telebehavioral Health Policies Established During COVID

The establishment of permanent telebehavioral health policies, developed prior to COVID-19 by the Texas and Massachusetts Medicaid programs and Portland VA RTMH program, provides important lessons for states and health care organizations to consider when planning for their own long-term implementation of similar policies. States should consider these findings in the context of their unique regulatory environments.

Program Reporting

Texas and Massachusetts Medicaid staff emphasized that the assessment of remotely delivered services is critical, and both programs have a modifier code to denote remote delivery of services.[38,39,49] In Texas, the first external evaluation is underway and will report cost savings; recommend future data collection elements; and develop a methodology to evaluate the cost-effectiveness, clinical efficacy, and utilization of remotely delivered services.

Texas Medicaid regularly administers stakeholder surveys and has regular, standardized legislative reporting on its remote delivery services, which includes:[37]

- Number and type of health care providers using remotely delivered services;
- Provider geographic and demographic makeup;
- Provider expenditures;
- Common primary diagnoses for services; and
- Patient utilization.

Texas Medicaid staff noted some current data collection limitations and suggested states consider the following program improvements:

- Mandating the use of modifier codes (i.e., additional information to payers related to the specific service provided) to ensure consistency and
- Implementing codes for the place of treatment to track patient location.

Oversight Requirements

Among all three programs, there were no differences in audit or oversight requirements for remotely delivered and in-person services.[38,39] Remotely delivered services were simply included in any regular audit activities and were not overseen separately.

Staffing Requirements

Staffing requirements among the three programs depended on the scope and type of service included in the telebehavioral health program. Policies that treated telebehavioral health as a delivery modality were usually implemented with existing staffing. However, separate telebehavioral health programs required distinct staffing.

Key Takeaways

In light of the restrictions on in-person access to health care resulting from COVID-19, many states and health care organizations may consider making temporary telebehavioral health policies permanent. A pre-pandemic review of the evidence and policies from three existing programs provides key considerations for policymakers:

- Telehealth is just as effective as in-person care for certain behavioral health conditions, and
- Telebehavioral health policies can be implemented permanently using different structures, including treating it as a modality or as a separate program.

These findings are promising for the adoption of permanent policies. In addition to the evidence on effectiveness, policymakers should consider implementation nuances and the underlying motivations and expectations behind such policies. Cost savings and increased service utilization are of particular interest, however, the evidence in these two areas is unclear and requires additional research. A large expansion of telebehavioral health services could provide the needed impetus, and volume, to properly explore their impact on costs and service utilization.

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The authors would like to acknowledge the contributions of interviewees who provided their experience and knowledge to the development of the Center for Evidence-based Policy's report.

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The Center for Evidence-based Policy (Center) is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.

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Using evidence to improve population health

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