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Tele-Behavioral Health for Employees:

Pre-COVID Practices and Recommendations for a Post COVID Path Forward

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Executive Summary

Following the President's March 13th, 2020, proclamation of a national emergency concerning the COVID-19 pandemic, governors across the United States prohibited in-person commerce at non-essential businesses.^{i,ii} These prohibitions led to the "virtualization" of behavioral health services for which in-person care was not essential. Behavioral health providers, payers, employers, and regulators rapidly implemented a series of changes to facilitate tele-behavioral health (TBH) in an environment in which in-person care was no longer safe or feasible. Many changes were made to relax restrictions on the practice of TBH across state lines, to enable providers to prescribe controlled substances without having first met patients in person, and to facilitate broader reimbursement of TBH.

This brief examines the state of TBH in the United States before the COVID-19 pandemic, how TBH policies and practices changed in response to it, the opportunity TBH presents to improve access to care, and the barriers that TBH has faced. Since employers can use lessons learned from these rapid changes to inform the design of their behavioral health benefits during the crisis and in the future, this report concludes with a series of recommendations about specific steps employers and health plans can take to "lock-in" and further extend and enhance key elements of recently improved access to behavioral healthcare made possible by the expansion of TBH.

The brief concludes by recommending that employers and health plans do the following:

- Except in circumstances which dictate a different approach (e.g. electroconvulsive therapy, Applied Behavioral Analysis), (a) offer patients choice in the modalities through which they interact with providers when receiving behavioral healthcare, be it through telephonic, audiovisual, or in-person communication, and (b) pay behavioral health providers equivalently for all appropriate modalities so that they offer patients choice. It should not be assumed that every patient owns a laptop or smartphone, or that the device used is not shared.ⁱⁱⁱ There is evidence to support the effectiveness of both telephonic and audiovisual care.^{iv} The impact of modality on access and adherence to care should be considered in tandem with the impact of modality on the quality or effectiveness of care.^{v,vi} Access is essential, as more than half of people with behavioral health issues do not receive care.^{vii}
- Ensure and certify that your health plans comply with all applicable state telemedicine parity laws, which may require payers to reimburse telemedicine in the same manner as in-person care.
- Ensure and certify that your health plans offer parity in access to telehealth for physical and mental illness, and are compliant with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).^{viii}
- Cover the same TBH CPT codes as Medicare.
- Ensure that both telephonic and audiovisual care are delivered in a HIPAA-compliant manner.^{ix}
- Ensure that any vendors providing TBH group therapy take measures to assure patient privacy.
- Ensure that Measurement-Based Care is implemented by providers as a component of TBH offerings as applicable.
- In the event that intermediaries decline to implement the above recommendations, request that a detailed, evidence-based explanation be provided.
- Support the goals of the ERISA Industry Committee's (ERIC) national telemedicine initiative.^x

Introduction

While tele-behavioral (TBH) services have been in use at least since the 1960s, they were not in widespread use at the dawn of the 2020s.¹ Following the President's March 13th, 2020, proclamation of a national emergency concerning the COVID-19 pandemic, governors across the United States prohibited in-person commerce at non-essential businesses.^{2,3} These prohibitions led to the cancellation of elective medical and dental procedures, and the virtualization of behavioral health services for which in-person care was not essential. Behavioral health providers, payers, employers, and regulators rapidly implemented a series of changes to facilitate TBH in an environment in which in-person care was no longer safe or feasible.

This brief examines the state of TBH in the United States before the COVID-19 pandemic, how TBH policies and practices changed in response to it, how TBH has the potential to improve access to care, and the barriers that TBH has faced. Since employers and health plans can use lessons learned from these rapid changes to inform the design of their behavioral health benefits going forward, we conclude with a series of specific recommendations on actions that employers and health plans can take to foster TBH and improve access to mental healthcare in the immediate future.

Pre-COVID-19 Policies Towards Tele-Behavioral Health

Payers

Commercial

Commercial payers have varied in their coverage of telehealth services. Self-insured ("administrative services only") health plans for multistate employers are regulated by the Employee Retirement Income Security Act of 1974 (ERISA), with provisions enforced by the Employee Benefits Security Administration within the U.S. Department of Labor. Thus, telehealth requirements for self-insured health plans are regulated federally. The ERISA Industry Committee (ERIC) has led a national telehealth initiative since 2015, with the goal of encouraging policies that:⁴

- *"Avoid imposing additional requirements on providers that offer telehealth services that are not imposed on in-person visits*
- *Avoid restrictions that require patients to visit specific locations (e.g., "originating sites") in order to access telehealth services*
- *Adopt technology-neutral requirements, permitting use of different types of technology platforms that are designed for telehealth*
- *Adopt licensing policies that facilitate inter-state practice so providers, located in or out of the state, who deliver high-quality care, can serve patients located in that state*
- *Consider the needs of patients to have better access to care that can be provided via telehealth, either through a telehealth visit or remote monitoring of health conditions"*

¹ Kelley T. "Telemental Health is Becoming the Norm." Managed Care. April 13, 2017.

<https://www.managedcaremag.com/archives/2017/4/telemental-health-becoming-norm> Accessed April 17, 2020.

² "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak." The White House. March 13, 2020. <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/> Accessed April 14, 2020.

³ "COVID-19 Projections." IHME. April 13, 2020. <https://covid19.healthdata.org/united-states-of-america> Accessed April 14, 2020.

⁴ "Telehealth." The ERISA Industry Committee. <https://www.eric.org/paid-leave-state-mandates/telehealth/> Accessed April 14, 2020.

ERIC advocated for these policies because they were not universally implemented across the country. Although not mentioned by ERIC's list, payment parity has been another issue. Some payers have not paid as much for a TBH visit as an in-person visit, which has reduced the willingness of providers to offer TBH services. Likewise, there have historically been payment differences between care delivered via audiovisual telemedicine versus telephonically. Although audiovisual care may provide additional insights into patients' states, it is an access barrier for patients without smartphones or laptops, and can also pose patient privacy challenges.

At a Federal level, there are no laws requiring commercial plans to offer parity in coverage for care provided via telemedicine versus in person. However, 29 states and the District of Columbia have implemented laws requiring health plans to have parity in coverage for telemedicine. Nonetheless, not all states require that telemedicine be covered if the patient is receiving care at home – in some states, the law only applies to telemedicine that patients receive in particular settings, like physicians' offices.⁵

Medicare

Before the pandemic, TBH had been covered by Medicare for patients that traveled to a qualifying "originating site" and saw a healthcare provider licensed in their state, using live videoconferencing. Patients could receive TBH at home in just a limited number of circumstances. Medicare only covered telehealth delivered via "communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication".⁶ Medicare did not cover telephone-based care (Current Procedural Terminology [CPT] codes 98966-98968 and 99441-99443), although codes were available for it and used by some payers other than Medicare.⁷

Medicaid

All 50 states provided some level of coverage for audiovisual TBH through their fee-for-service (non-managed) Medicaid programs. States were highly variable in their TBH coverage policies. As of 2019, 14 states allowed patients' homes to serve as the originating sites for telemental health services under certain circumstances. Furthermore, many states have had policies allowing non-physician providers to be reimbursed for TBH services provided to patients covered by Medicaid health plans.⁸

Employers

Employers were paying for TBH on a CPT basis, through direct contracts between the employer and the provider (administered by the third-party administrator [TPA]), and through EAP program fees. Not all employers were paying for TBH services, as it has not been required by law. Some employers have additionally contracted with digital intermediaries (e.g. Ginger, Meru Health, Spring Health, Total Brain) to provide services combining app-based assessments, self-care solutions, healthcare system navigation, and live treatment, which do not always bill employers using CPT codes.

Employees accessed TBH in multiple ways. In some instances, employees accessed TBH while receiving in-person care from another provider. For instance, some primary care physicians have used TBH services provided on-premises to increase access to behavioral healthcare in locations where a low level of demand would not warrant an on-site provider. In other cases, employees connected directly with a

⁵ "Private Payers & Telemedicine." eVisit. <https://evisit.com/resources/telemedicine-private-payers-issues/> Accessed April 18, 2020.

⁶ 42 C.F.R. §410.78(a)(3) available at <https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-78.pdf>

⁷ "Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19." Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf> Accessed April 14, 2020.

⁸ "Telemental Health Laws: Overview." Epstein Becker Green. <https://www.ebglaw.com/telemental-health-laws-overview/> Accessed April 14, 2020.

TBH provider while in the workplace or at home, enabling them to receive care without taking time off from work to attend an in-person appointment. Finally, app-based digital intermediaries helped triage the needs of employees, so that those that are in greatest need of in-person care could get the help they need, and those with needs amenable to self-help are provided with tools that they can use on their own.

Provider regulation

Licensing

Since licenses are issued at the state level, licensed TBH providers normally cannot offer care across state lines unless they are licensed in the state in which the patient resides, or of their state participates in a licensure compact with the state in which the patient resides and the TBH provider has performed the steps necessary to be licensed in the patient's state. Psychiatrists residing in states participating in the Interstate Medical Licensure Compact (IMLC) still need to obtain licensure in other participating states, although the Compact streamlines the process.⁹ Likewise, psychologists residing in states participating in the Psychology Interstate Compact (PSYPACT) may offer telepsychology, as well as temporary face-to-face care, to patients residing in other participating states.¹⁰ Regulations on the corporate practice of medicine further complicated matters, as in some states, physicians practicing in the state must be employed by a professional corporation that is owned by physicians licensed to practice medicine in the state in question. Physician licensing regulations and corporate practice of medicine regulations have complicated the process through which digital intermediaries deliver TBH services nationally.

Licensure issues pose continuity of care challenges for patients. Patients have not been able to maintain their provider relationship as they move to other states, since providers have had to be licensed in the state in which the patient is situated. This has posed challenges for college students that may spend their summers in a different state than where the college is located. Likewise, snowbirds with multiple homes have encountered this barrier in receiving care while out of the state in which their provider is based. While some providers have informally skirted these rules with established patients, there has been no clear safe harbor to protect healthcare providers that do so.

Reimbursement

Payment codes have long existed to support TBH services, delivered by both physicians (psychiatrists) and non-physicians. There were three main pathways for billing that were used within the CPT coding system: 1) billing an evaluation and management code, 2) billing an evaluation and management code in combination with an add-on code, and 3) billing a psychotherapy code only (typically done by non-physicians). In some states, reimbursement restrictions could exist; for instance, insurers could require patients to live in rural areas or to receive care at a particular site of service in order to qualify for reimbursement.¹¹ Health plan-level variation in coverage for TBH services has been a barrier for providers, as providers typically practice using an intent to treat approach, in which patients are all treated equally, regardless of the details of their health plan. When a critical mass of health plans are not providing coverage for a telehealth service, it becomes impractical for providers to offer it.

⁹ "Physician licensure." Interstate Medical Licensure Compact. <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/> Accessed April 14, 2020.

¹⁰ "PSYPACT FAQs." Association of State and Provincial Psychology Boards. https://cdn.ymaws.com/www.asppb.net/resource/resmgr/PSYPACT_Docs/PSYPACT_FAQs.pdf Accessed April 27, 2020.

¹¹ "Birgman IM. "Private insurance reimbursement." American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/private-insurance-reimbursement> Accessed April 16, 2020.

HIPAA Requirements

Until the COVID-19 pandemic, tele-behavioral health visits needed to be conducted in a HIPAA-compliant fashion, using HIPAA-compliant videoconferencing software or a HIPAA-compliant telephone connection.¹² While traditional copper landline and cellular service-based telephone calls do not require special technology to achieve compliance, as the telephone line or cellular connection is serving as a conduit unregulated by HIPAA, additional considerations arise with Voice Over Internet Protocol-based telephone systems with voice message storage capabilities or systems with text messaging capabilities.¹³ Consumer software, such as FaceTime and Skype are not compliant, and could not be used. As any third-party that has access to protected health information from a healthcare provider must sign a Business Associate Agreement (BAA) with the healthcare provider for its access to the information to be considered HIPAA-compliant, only videoconferencing solutions from videoconferencing companies willing to sign a BAA could achieve compliance.¹⁴

Modality Limitations

Many TBH providers have avoided providing Medication-Assisted Treatment (MAT), due to the requirements of the Ryan Haight Act. The Act requires healthcare providers prescribing controlled substances to patients to perform in-person examinations of patients before doing so, with some limited exceptions.¹⁵ Since many TBH services, particularly those organized by digital intermediaries, are premised on the assumption that the patient and provider will not meet in person, the most common way to remain compliant has been to not include the prescription of controlled substances in the service offering.

CPT-based coverage for both telephonic visits and videoconferencing visits existed, but the two types of visits were not paid at the same rate. The telephone codes (99441-3) are based upon the time spent, not the evaluation and management services delivered. Evaluation and management codes were not universally covered for care delivered via telemedicine. Furthermore, Medicare allowed evaluation and management codes to be billed only if real-time, audiovisual care was delivered, and would not pay for telephonic care.

Changes to Tele-Behavioral Health Policies in Response to COVID-19

Payer Changes

The COVID-19 pandemic led to a series of government changes to facilitate access to care. Temporary measures taken in response to COVID-19 have allowed patients to be seen via a live videoconference in their homes, without traveling to a qualifying “originating site” for Medicare telehealth encounters. Medicare is also reimbursing care provided across state lines, as long as providers are properly licensed in their home state. The Medicare requirement that providers have seen a patient within the last three years has been suspended. Telephonic care is temporarily being reimbursed along with audio/visual

¹² Semel M. “How to Avoid Multi-Million-Dollar HIPAA Phone & Data Penalties.” Healthcare IT Today. May 20, 2019. <https://www.healthcareittoday.com/2019/05/20/how-to-avoid-multi-million-dollar-hipaa-phone-data-penalties/> Accessed April 18, 2020.

¹³ McAlpen M. “Why You Need to Partner with a HIPAA Compliant VoIP Provider.” 8x8. January 28, 2020. <https://www.8x8.com/blog/why-your-voip-provider-really-does-need-to-support-your-hipaa-compliance> Accessed April 19, 2020.

¹⁴ “Is your videoconferencing HIPAA compliant?” VSee. <https://vsee.com/hipaa/> Accessed April 15, 2020.

¹⁵ “Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder.” U.S. Department of Health and Human Services. September 2018. <https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf> Accessed April 27, 2020.

telehealth care by Medicare, but separate codes are being used, and telephonic care is not being reimbursed equivalently.¹⁶

Several of the temporary measures are relevant to payments from commercial plans as well. For example, high-deductible health plans with health savings accounts may cover telehealth prior to the patient meeting the deductible. Some, but not all, payers are reimbursing telephonic care at rates equivalent to those provided for in-person visits.^{17,18} Optum implemented a policy for commercial, Medicare, and Medicaid plan members receiving behavioral health and EAP services, enabling healthcare providers to be reimbursed for virtual visits, regardless of whether they are telephonic or conducted through a consumer video chat service, such as FaceTime or Facebook Messenger. While Optum provided coverage for consumer services that are not HIPAA-compliant, it explicitly banned coverage for care delivered via public-facing video chat services, such as Facebook Live and TikTok.¹⁹ To encourage the use of telemedicine, Aetna temporarily offered a \$0 copay on telemedicine visits to people with fully-insured plans; self-insured plans could enable this benefit as well, at the employer's discretion.²⁰

Provider Changes

Regulatory changes were made to enable providers to more easily deliver services remotely in response to COVID-19. The Ryan Haight Act was waived, enabling physicians to prescribe controlled substances to patients that they have not previously met in person. HIPAA enforcement discretion was implemented to permit unsecured audio/visual tools to be used; providers could contact patients through consumer-friendly conduits, such as FaceTime, without worrying about their lack of a Business Associate Agreement with the videoconferencing provider. Nonetheless, payers reserve the right to enforce higher standards for the privacy of care, on top of those set by HIPAA. Furthermore, changes were made to enable Medicare payments for group therapy and psychological testing conducted via telehealth. The Food and Drug Administration worked to foster digital care (e.g. use of smartphone apps) by announcing that it would exercise discretion in enforcing the Food, Drug, and Cosmetic Act for digital tools performing a broad variety of functions deemed to be low-risk.²¹

When patients access behavioral healthcare virtually, many of the factors that lead to non-adherence and missed appointments disappear. Dr. Bruce Schwartz noted that at the Montefiore Medical Center, where he serves as deputy chair of psychiatry and behavioral sciences, the no-show rate at the outpatient psychiatry practice declined from 25-30% to nearly 0% after the practice converted to providing TBH in response to COVID-19.²² Transportation ceases to be an issue when care is delivered

¹⁶ Letter to Administrator Verma. April 8, 2020.

<https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Federal/APA-Coalition-Letter-CMS-Telephone-Appt-Payments-COVID19-02082020.pdf> Accessed April 16, 2020.

¹⁷ "Telehealth Coding and Billing During COVID-19." American College of Physicians. April 14, 2020.

<https://www.acponline.org/practice-resources/covid-19-practice-management-resources/telehealth-coding-and-billing-during-covid-19> Accessed April 16, 2020.

¹⁸ Griswold B. "Insurance Coverage for Phone and Video Sessions in Response to COVID-19." Navigating the Insurance Maze. April 17, 2020. <https://navigatingtheinsurancemaze.com/telehealthpolicies/> Accessed April 18, 2020.

¹⁹ "Getting behavioral health support during COVID-19." Optum. <https://www.optum.com/covid-19/behaviorial-supports-covid-19.html> Accessed April 16, 2020.

²⁰ "Extra benefits for you." Aetna. <https://www.aetna.com/individuals-families/member-rights-resources/covid19/benefits.html> Accessed April 16, 2020.

²¹ "Enforcement Policy for Digital Health Devices For Treating Psychiatric Disorders During the Coronavirus Disease 2019 (COVID-19) Public Health Emergency." Food and Drug Administration. April 14, 2020. <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/enforcement-policy-digital-health-devices-treating-psychiatric-disorders-during-coronavirus-disease> Accessed April 16, 2020.

²² Petersen A. "Your Video Therapist Will See You Now." The Wall Street Journal. April 26, 2020.

<https://www.wsj.com/articles/your-video-therapist-will-see-you-now-11587906000> Accessed April 27, 2020.

via TBH. Relatedly, as transportation time no longer contributes to the time it takes patients to receive care, TBH takes less time out of a patient's day, and does not necessitate as much absence from work.

Employer Changes

State-based stay-at-home orders caused many non-essential businesses to close their offices. As a result, employer sponsored on-site health services were no longer available to employees. Employee access to behavioral health services has become a growing concern to employers due to the increased isolation and stress from uncertainty and the economic downturn that employees are facing.

Human resources departments within employers looked for ways to address the changing benefits needs of a suddenly distributed workforce. One global employer instituted a chatbot to handle basic human resources questions, increasing the capacity of the human staff. Meanwhile, an academic health system had its internal behavioral health team offer its employees a series of half-hour group TBH sessions. The sessions, which were scheduled to occur several times each day, offered employees the opportunity to discuss topics such as stress management, cognitive reframing, and managing anxiety.

The Future: Barriers to Tele-Behavioral Health Adoption

In addition to the licensing, regulatory, and reimbursement barriers previously described, there have been numerous practical barriers that have historically limited the use of TBH. Many patients have lacked TBH coverage, as employer-sponsored health plans are not required to provide it. When it is provided, there has been modest patient demand for TBH due to a combination of a lack of patient awareness, as well as a lack of patient comfort in using secure audiovisual tools. Low pre-COVID-19 TBH provider availability may also have contributed to the lack of utilization.

Building provider networks so that TBH can be offered to patients has likewise been a challenge. There is a limited supply of behavioral health providers in general, and thus few people that can potentially move to providing care virtually. Expanding the provider supply for TBH has been made more difficult by the fact that some payers are reimbursing providers less for TBH services. Digital intermediaries offering TBH services have reported that it is particularly challenging to get contracts to pay enough to cover the costs associated with telepsychiatry. Payer reimbursements (for both in-person behavioral care and TBH care) are often far below reimbursement for other medical providers and far below what behavioral health providers can earn from private pay patients.²³ Therefore, for example, up to 40% of psychiatrists choose to run private pay practices as the market will pay them substantially more generously than typical payer contracts.²⁴ When TBH providers are available, out-of-network coverage limitations on TBH add to the challenge that patients face in obtaining care.

In addition to there being a shortage of providers willing to offer TBH services, building a network is complicated by the variation that exists between provider groups. Different TBH provider groups are properly licensed to serve different geographies, and in many cases are optimized to serve different age groups. Thus, payers must rely upon multiple vendors in order to offer a comprehensive TBH offering.

²³ Melek S, Davenport S, Gray TJ. "Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement." Milliman. November 19, 2019. http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf Accessed April 19, 2020.

²⁴ Parks. J. "Crisis in psychiatry: Top 5 problems, many solutions." MDedge. August 7, 2017. <https://www.mdedge.com/psychiatry/article/144105/practice-management/crisis-psychiatry-top-5-problems-many-solutions> Accessed April 9, 2020.

Employers have in some cases been reluctant to offer TBH services due to a perception that they are an additive cost. In fact, offering telemedicine services to employees has been shown to be cost-effective: one observational study of care delivered to 650 patients found that net cost savings per telemedicine visit ranged from \$19 to \$121 per visit, that 74% of patients had their care needs resolved by the telemedicine visit, and that 84% would have sought care elsewhere had telemedicine been unavailable.²⁵ An analysis of 59,945 visit claims from a commercially-insured population found that the rate at which telemedicine visits led to follow-up outpatient visits, 28.1%, was not significantly different from the rate at which in-person primary care visits or retail health clinic visits led to follow-up outpatient visits; 28.1% and 28.5% respectively. Patients receiving care via telemedicine were significantly less likely to have laboratory tests than patients receiving in-person care, and had similar or significantly reduced rates of imaging, depending on the in-person care location. After medical and pharmacy costs were considered, the savings resulting from a virtual visit ranged from \$36 if a retail care visit was replaced, to \$1,735 if an emergency department visit was replaced.²⁶

Although the direct cost of TBH can be perceived as a barrier, offering employees enhanced access to TBH services makes economic sense for employers. First, employees with mental health or substance use issues are less productive at work and use more sick days. Second, behavioral health diagnoses are associated with increased medical expenditures that dwarf the cost of additional behavioral healthcare. As is shown in Figure 1, an analysis of 2017 commercial claims found that while people without any behavioral health diagnoses had expenditures averaging \$426 per member per month, people with behavioral health diagnoses had monthly expenditures averaging \$1,109 or more. Ongoing behavioral health issues lead to both higher medical costs and higher medical prescription costs. Therefore, there is a strong economic incentive to offer full and consistent behavioral health treatment to employees.

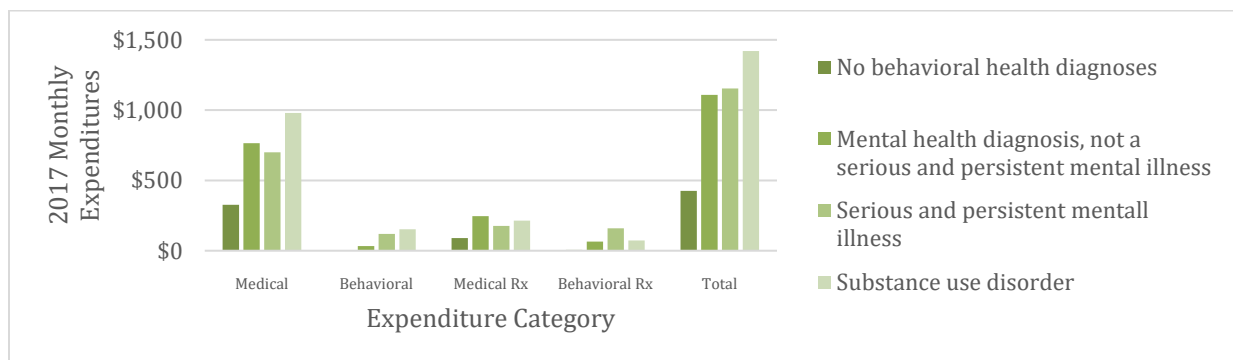


Figure 1: Commercial Insurance Per Member Per Month (PMPM) Expenditures by Behavioral Health Diagnosis²⁷

²⁵ Nord G, Rising KL, Band RA, Carr BG, Hollander JE. On-demand synchronous audio video telemedicine visits are cost effective. *The American journal of emergency medicine*. 2019 May 1;37(5):890-4.

²⁶ Gordon AS, Adamson WC, DeVries AR. Virtual visits for acute, nonurgent care: a claims analysis of episode-level utilization. *Journal of medical Internet research*. 2017;19(2):e35.

²⁷ Melek SP et al. "Potential economic impact of integrated medical-behavioral healthcare." *Milliman*. January 2018.

Recommended Changes that Employers and Health Plans Should Promote

To facilitate TBH and improve access to behavioral healthcare, employers and health plans should do the following:

- Except in circumstances which dictate a different approach (e.g. electroconvulsive therapy, Applied Behavioral Analysis), (a) offer patients choice in the modalities through which they interact with providers when receiving behavioral healthcare, be it through telephonic, audiovisual, or in-person communication, and (b) pay behavioral health providers equivalently for all appropriate modalities so that they offer patients choice. It should not be assumed that every patient owns a laptop or smartphone, or that the device used is not shared.²⁸ There is evidence to support the effectiveness of both telephonic and audiovisual care.²⁹ The impact of modality on access and adherence to care should be considered in tandem with the impact of modality on the quality or effectiveness of care.^{30,31} Access is essential, as more than half of people with behavioral health issues do not receive care.³²
- Ensure and certify that your health plans comply with all applicable state telemedicine parity laws, which may require payers to reimburse telemedicine in the same manner as in-person care.
- Ensure and certify that your health plans offer parity in access to telehealth for physical and mental illness, and are compliant with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).³³
- Cover the same TBH CPT codes as Medicare.
- Ensure that both telephonic and audiovisual care are delivered in a HIPAA-compliant manner.³⁴
- Ensure that any vendors providing TBH group therapy take measures to assure patient privacy.
- Ensure that Measurement-Based Care is implemented by providers as a component of TBH offerings as applicable.
- In the event that intermediaries decline to implement the above recommendations, request that a detailed, evidence-based explanation be provided.
- Support the goals of the ERISA Industry Committee's (ERIC) national telemedicine initiative.³⁵

²⁸ Torous J, Myrick KJ, Rauseo-Ricupero N, Firth J. Digital Mental Health and COVID-19: Using Technology Today to Accelerate the Curve on Access and Quality Tomorrow. *JMIR Mental Health*. 2020;7(3):e18848.

²⁹ Varker T, Brand RM, Ward J, Terhaag S, Phelps A. Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: A rapid evidence assessment. *Psychological services*. 2019 Nov;16(4):621.

³⁰ "APA Urges Additional Access to Mental Health Services Over Phone During COVID-19 Pandemic." American Psychiatric Association. April 2, 2020. <https://www.psychiatry.org/newsroom/news-releases/apa-urges-additional-access-to-mental-health-services-over-phone-during-covid-19-pandemic> Accessed April 16, 2020.

³¹ Mohr DC, Ho J, Duffecy J, Reifler D, Sokol L, Burns MN, Jin L, Siddique J. Effect of telephone-administered vs face-to-face cognitive behavioral therapy on adherence to therapy and depression outcomes among primary care patients: a randomized trial. *Jama*. 2012 Jun 6;307(21):2278-85.

³² "Mental Illness." National Institute of Mental Health. <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> Accessed April 27, 2020.

³³ "The Mental Health Parity and Addiction Equity Act (MHPAEA)." Centers for Medicare & Medicaid Services. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet Accessed April 18, 2020.

³⁴ McAlpen M. "Why You Need to Partner with a HIPAA Compliant VoIP Provider." 8x8. January 28, 2020. <https://www.8x8.com/blog/why-your-voip-provider-really-does-need-to-support-your-hipaa-compliance> Accessed April 19, 2020.

³⁵ "Telehealth." The ERISA Industry Committee. <https://www.eric.org/paid-leave-state-mandates/telehealth/> Accessed April 14, 2020.

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