Increasing Reliance on Telebehavioral Health – Beyond COVID-19

Insights 10.28.22

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The COVID-19 pandemic has taken its toll on the nation's mental health, with rates of depression and anxiety disorders spiking since April 2020. Many individuals turned to telehealth (in this context, also known as telebehavioral or telemental health) to initiate or continue therapy and counseling during the pandemic, which played a critical role in allowing patients to access behavioral health and substance use disorder (SUD) treatment from their homes with more options for safety, privacy, and convenience. Moreover, telehealth allowed patient access to behavioral health providers at a time when there were (and still are) unprecedented shortages of behavioral health providers in many geographic areas.[1]

Notably, a study by the U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that the "share of Medicare visits conducted through telehealth in 2020 increased 63-fold, from approximately 840,000 in 2019 to 52.7 million," with visits to behavioral health specialists showing the largest increase of all types of telehealth services. The study highlights how the various regulatory flexibilities in response to the COVID-19 Public Health Emergency (PHE) enabled patient access to their providers through the use of telehealth, one of the significant benefits of telehealth overall. For example, these flexibilities included waiving statutory limitations such as geographic restrictions and allowing Medicare beneficiaries to receive telehealth in their home. Additionally, the HHS Office for Civil Rights relaxed enforcement of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy requirements for the duration of the PHE, allowing the use of everyday technology (e.g., Zoom, Google Hangouts) for virtual mental health visits. The U.S. Drug Enforcement Agency also acted by providing more flexibility for practitioners to prescribe controlled substances via telehealth, without the need for an in-person medical evaluation (see our article for the latest update on the status of the DEA waivers at the conclusion of the PHE).

Despite the benefits, including broadening access and equity in health care, barriers still remain to the utilization of telebehavioral health care. In particular, disparities in patients' access to technology or technical support – particularly for certain vulnerable populations, including individuals with lower incomes or with limited digital proficiency – and the ability to have quality telebehavioral health visits in the face of these challenges. In the midst of these challenges, behavioral health providers must continue treating patients and ensure continuity of care while navigating a complex and ever-shifting regulatory landscape. This article outlines the current regulatory landscape surrounding provision of telebehavioral health care, and what we expect to see going forward.

Federal Momentum to Expand Medicare Access to Virtual Behavioral Health

At the federal level, CMS in its 2022 Behavioral Health Strategy, pledged to "improve access to high quality, affordable, person-centered behavioral health care, and ensure parity in access, coverage, and quality for physical and mental health services, including care enabled through telehealth and technology." Reflecting these objectives, the proposed 2023 Medicare Physician Fee Schedule (PFS) rule, released by CMS on July 7, 2022, contains multiple provisions expanding access to behavioral health services, including:

Incident to Supervision for LMFTs and LPCs

The rule, as proposed, seeks to reduce existing barriers and make greater use of the services of licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) by allowing for general rather than direct supervision for these practitioners. Specifically, CMS is proposing to make an exception to the direct supervision requirement under the "incident to" supervision, meaning that the supervising physician or other practitioner need not be physically present while the services are performed, including via telehealth, incident to the services of a physician (or non-physician practitioner). However, the behavioral health providers must still be under the supervisory practitioner's "overall direction and control," and meet other applicable regulatory requirements. CMS notes that this proposed change is intended to facilitate utilization and extend the reach of behavioral health services for Medicare beneficiaries, particularly given the existing workforce shortages impeding access to behavioral health services.

Extended and New Reimbursement Opportunities for Behavioral Health Services

The proposed rule includes the addition of over 50 services to the Medicare Telehealth Services List on a "Category 3" basis, meaning that such codes are available through the end of 2023 regardless of the PHE status. Many of the services listed relate to behavioral health, such as adaptive behavior treatment and behavior identification assessment and cognitive therapies. Designating these codes as Category 3 allows CMS additional time for data analysis and consideration before making a decision whether to add these services to the list permanently.

CMS also proposes to create a new code for behavioral health integration (BHI) services (GBHI1), which would authorize reimbursement for "at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems…" Like other behavioral health services, GBHI1 services could be billed as incident to under general supervision. This change accounts for monthly care integration where the mental health services furnished by a CP or CSW serve as the main point of care integration. Further, the agency is proposing to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.

Continuation of Flexibilities for RHCs and FQHCs and Delay of In-Person Requirement for Behavioral Health Visits

CMS also proposes to implement the telehealth provisions in the Consolidated Appropriations Act, 2022 by extending certain flexibilities in place during the PHE for 151 days after the PHE ends, including waiving of geographic and site of service requirements, covering audio-only services, the revised payment methodology for rural health centers (RHCs) and federally qualified health centers (FQHCs), and waiving in-person initial visit requirements for mental health visits furnished via telecommunications technology.

For context, beginning in calendar year 2022, CMS implemented the telehealth provisions from the Consolidated Appropriations Act, 2021 and began covering telehealth services furnished for purposes of diagnosis, evaluation, and treatment of mental health disorders, including via audio-only communications technology, to a beneficiary located in the home where the practitioner has examined the patient in-person (and Medicare has covered that episode of care) in the 6 months preceding the telehealth visit furnished to the patient at home, and the practitioner treats the patient in-person at least once in the 12 month period following the telehealth service furnished to the patient in the home, excepting in certain

situations. (For example, the prior in-person examination requirement does not apply where the practitioner and patient agree that the benefits of an in-person examination within 12 months of the mental health service are outweighed by the risks and burdens associated with an in-person visit, which will help to ensure that underserved individuals, including elderly, minority populations and individuals in rural areas, are not unintentionally excluded from care.[2])

Proposed Federal Legislation?

While Congress has already contemplated some telehealth changes post-pandemic, many are not permanent and do not focus specifically on behavioral health or SUD treatments. In particular, there is still great uncertainty of what will happen post-pandemic with prescribing of controlled substances and the current telehealth flexibilities. This is a key area of provider concern given that important medications in behavioral health are controlled substances (for example, buprenorphine, which is used in addiction treatment). As noted in our colleague's article, the passage of telehealth bills currently introduced in Congress remains uncertain and may only provide a short-term extension of existing waivers.

However, the Senate Finance Committee has released a bipartisan discussion draft of legislation aimed at improving mental health care using telehealth services. The draft includes telehealth policies that would, among other initiatives: remove Medicare's in-person visit requirements discussed above for telebehavioral health services; preserve access for Medicare beneficiaries to "necessary and appropriate" audio-only mental health services; increase Medicare beneficiaries' understanding of coverage for telebehavioral health services; and, direct and incentivize Medicare, Medicaid and CHIP programs to support provider use of telehealth, including in school settings. Providers should monitor the progress of this bill, as it would have a significant impact on the ability to continue to provide telehealth services following the end of the current Medicare flexibilities and has the potential to be passed separate from other telehealth legislation.

State Efforts to Increase and Improve Access to Behavioral Health Services

There has been considerable movement at the state level in terms of flexibilities for providers furnishing behavioral health services remotely, reflecting progressive evolution in attitudes toward telebehavioral health services. States have also taken advantage of new federal policy options to address behavioral health issues in Medicaid programs. Some examples of state action in this area include:

- Many states expanded telehealth to increase access to behavioral health care during the COVID-19 pandemic, and plan to continue this coverage post-pandemic. California recently passed into law a trailer bill, Senate Bill 184, that permanently extends and expands upon many of the temporary Medi-Cal policies adopted by the Department of Health Care Services during the state's public health emergency – such as continuing coverage of synchronous video and audio-only telehealth for non-specialty and specialty mental health and SUD services. A number of states also have Medicaid initiatives in the works to promote the co-location of both physical and behavioral health services. In Colorado, for instance, Senate Bill 22-181 creates the primary care and behavioral health statewide integration grant program in the department of health care policy and financing to provide grants to primary care clinics for implementation of evidence-based clinical integration care models. It also requires the division of professions and occupations in the department of regulatory agencies (DORA) to make recommendations to expand the portability of existing credentialing requirements and behavioral healthcare practice through telehealth.
- A number of states are also focused on statutory and regulatory efforts designed to encourage and make it easier for behavioral health professionals to practice virtually – even across state lines – thereby expanding access for patients to care, particularly in underserved and/or rural areas. For example, while all states require health care professionals to hold a valid license issued by the state's relevant professional board to practice in the state, a number of states adopted various interstate compacts allowing out-of-state practice by providers who hold a license in good standing in their home state. Delaware recently passed S.B. 257, entering the state into the Multistate Professional Counselor Licensure Compact which will allow for the use of telehealth to facilitate professional counseling services across state lines. (Though Counseling Compact is not expected to go live late 2023, 17 states have already joined.) Other states, like Arizona, have created in-state licensure exceptions for out-of-state psychologists and behavior analysts.

- Another state trend is the growing number of states that now permit providers to prescribe non-controlled and controlled substances via telehealth based on a good faith examination of the patient via telehealth. Florida, for instance, passed Senate Bill 312 in April of this year, which removes prior restrictions on telemedicine prescribing of most controlled substances. Such changes make it easier for behavioral health providers to treat patients for behavioral health and substance use disorders that require controlled substances as part of the treatment regimen (though providers should still be mindful of the applicable prescribing requirements under federal law).

Conclusion and Takeaways

Ultimately, as telebehavioral health care utilization continues to soar, the regulatory landscape will evolve as federal and state public health emergencies expire, while at the same time patients expect continued access to the many benefits of remote behavioral health care services. Given the persistent and long-standing challenges with access and disparities in behavioral health care, it is clear that leveraging telebehavioral health care will be critical meet the public's behavioral health needs.

HLB's Digital Health Practice actively monitors digital health regulatory developments, including around virtual behavioral health care at the federal and state levels. If you have any questions, please contact Alicia Macklin in Los Angeles, Andrea Frey in San Francisco, or any other member of our Hooper, Lundy & Bookman team.

[1] See, e.g., S.Weiner, AAMC, A growing psychiatrist shortage and an enormous demand for mental health services (Aug. 9, 2022), available here; J.Wiener, CalMatters, Unanswered cries: Why California faces a shortage of mental health workers (Sept. 8, 2022), available here.

[2] 42 C.F.R. § 410.78(b).

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