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## How the COVID-19 Pandemic Is Shaping the Future of Behavioral Telehealth

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## **Introduction**

For decades, telehealth has been explored as a potential solution to some of the barriers Americans face accessing health care, particularly behavioral health care. Behavioral telehealth is associated with its own barriers, which have limited its widespread use until recently. The COVID-19 pandemic forced the United States to deliver health care without the use of in-person services, as it became unsafe and impracticable to provide health care services in this traditional modality. As a result, federal and state governments endeavored to make telehealth services more widely available to the public via a series of executive and legislative actions. This paper proposes that most of these actions, which provide a roadmap to successful telehealth expansion, should survive the COVID-19 pandemic, at least with respect to behavioral telehealth.

Psychotherapy is particularly well suited for telehealth expansion because of the growing body of empirical evidence demonstrating that it is as effective as in-person services. Additional measures are warranted, however, to address telehealth-related barriers, some of which have the potential to exacerbate existing social inequities in health care.

Part I of this paper presents background on barriers to behavioral health care access and the historical development of telehealth in the United States. Part II considers the potential of behavioral telehealth to reduce some of these barriers and reviews clinical effectiveness research, as well as research on the impact telehealth on the cost of care. Part III addresses barriers to behavioral telehealth existing prior to the COVID-19 pandemic. Part IV reviews federal and state executive and legislative action taken during the pandemic to expand telehealth. Finally, Part V proposes recommendations for specific actions that should survive the pandemic and considerations for actions that may not be as well suited for continuation once the pandemic recedes. Recommendations will also be provided for further actions needed to address additional

behavioral telehealth barriers. Throughout the paper, the potential of behavioral telehealth to alleviate or, alternatively, exacerbate existing social inequities in health care access is considered.

## **I. Background**

### **A. Definitions**

According to the American Psychological Association (“APA”), telemental health or telepsychology, also known as behavioral telehealth, is defined as the “provision of behavioral and/or mental health care services using technological modalities in lieu of, or in addition to, traditional face-to-face methods.”<sup>1</sup> The Health Resources and Services Administration (“HRSA”) defines telehealth more generally “as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.”<sup>2</sup> Telehealth is typically categorized into three categories, including synchronous (i.e., live) telehealth, such as via audiovisual teleconferencing, asynchronous telehealth, also known as “store-and-forward” telehealth, and remote patient monitoring.<sup>3</sup> Store-and-forward telehealth involves transmitting recordings of patient data (e.g., patient interviews, imaging, reports) to providers for review at a later time than when the data is collected.<sup>4</sup> Remote patient monitoring involves remote collection and transmission of patient health data, such as vital signs or heart rate, to providers.<sup>5</sup> While definitions of telehealth vary, the focus of this paper is on behavioral telehealth delivered via

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<sup>1</sup> Am. Psychol. Ass’n, *What are Telehealth and Telepsychology?*, <https://www.apa.org/pi/disability/resources/publications/telepsychology> (last visited Mar. 20, 2021).

<sup>2</sup> Off. for Civil Rts., *What is Telehealth?*, [www.hhs.gov/hipaa/for-professionals/faq/3015/what-is-telehealth/index.html](http://www.hhs.gov/hipaa/for-professionals/faq/3015/what-is-telehealth/index.html) (last visited Mar. 20, 2021).

<sup>3</sup> See OREN J. MECHANIC ET AL., *TELEHEALTH SYSTEMS* (2020).

<sup>4</sup> *Id.*

<sup>5</sup> Ctr. for Connected Health Pol’y, *Remote Patient Monitoring (RPM)*, <https://www.cchpca.org/about/about-telehealth/remote-patient-monitoring-rpm> (last visited Mar. 20, 2021).

synchronous audiovisual videoconferencing. The APA describes synchronous service provision as “[c]ommunication in real time between a professional and a consumer.”<sup>6</sup> The HRSA further defines synchronous videoconferencing as “a two-way audiovisual link between a patient and a care provider.”<sup>7</sup>

## B. Barriers to Behavioral Health Care Access

Barriers to behavioral health care access include, but are not limited to, significant financial barriers, such as those faced by individuals who lack health insurance or are underinsured, compounded by a lack of providers who accept health insurance.<sup>8</sup> These barriers are exacerbated by very narrow behavioral health provider insurance networks.<sup>9</sup> Additionally, general provider shortages plague the entire behavioral health care industry.<sup>10</sup> These barriers make it difficult for the general population to access behavioral health care and disproportionately impact poor communities and people of color.<sup>11</sup> According to the American Psychiatric Association, only 43% of people with mental illness receive behavioral health treatment and White populations are more likely to receive treatment than minority populations.<sup>12</sup> For example, in 2015, approximately 48% of White individuals with mental illness received treatment, as compared to 31% of Black individuals and 31% of Hispanic individuals with mental illness.<sup>13</sup>

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<sup>6</sup> *Id.*

<sup>7</sup> Health Res. & Servs. Admin., *Telemedicine and Telehealth*, <https://www.healthit.gov/topic/health-it-health-care-settings/telemedicine-and-telehealth> (last visited Mar. 20, 2021).

<sup>8</sup> See Sarah Heath, *Key Barriers Limiting Patient Access to Mental Healthcare*, PATIENT ENGAGEMENT HIT (Aug. 7, 2009), <https://patientengagementhit.com/news/key-barriers-limiting-patient-access-to-mental-healthcare>.

<sup>9</sup> Jane M. Zhu et al., *Networks in ACA Marketplaces are Narrower for Mental Health Care Than for Primary Health Care*, 36 HEALTH AFF. 1624 (Sept. 1, 2017).

<sup>10</sup> See Heath, *supra* note 8.

<sup>11</sup> See Am. Psychiatric Ass’n, *Mental Health Disparities: Diverse Populations*, <https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts> (last visited Mar. 20, 2021).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

Many Americans simply cannot afford behavioral health care. Only half of the behavioral health care providers in the United States join insurance networks, with the remaining providers requiring patients to pay out of pocket for behavioral health care.<sup>14</sup> Non-physician behavioral health care providers are less likely to join insurance networks than their physician counterparts.<sup>15</sup> A 2017 study of Affordable Care Act (“ACA”) marketplace insurance networks found that only 42.7% of psychiatrists and 19.3% of non-physician behavioral health care providers participated in at least one insurance network.<sup>16</sup> Particularly narrow behavioral health provider insurance networks exacerbate this problem.<sup>17</sup> The same study reported these insurance networks typically include only 11.3% of mental health providers in a given market, as compared to 24.3% of primary care providers in that market.<sup>18</sup> According to a national survey conducted by the National Alliance on Mental Illness, approximately 27% of respondents reported receiving treatment from a behavioral health provider outside their insurance network and 32% reported difficulty finding a provider willing to accept their insurance.<sup>19</sup> Not surprisingly, respondents reported higher cost-sharing for behavioral health care relative to other types of health care,<sup>20</sup> likely due to the need to seek care outside their insurance networks. Against the backdrop of the large number of Americans who either lack insurance or are underinsured, these barriers to behavioral health care are significant. In 2019, 10.9% of people under the age of 65 in the United States were uninsured and a disproportionate number of the uninsured were people of color.<sup>21</sup>

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<sup>14</sup> See Heath, *supra* note 8.

<sup>15</sup> Heath, *supra* note 8.

<sup>16</sup> *Id.*

<sup>17</sup> See *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> Nat'l All. of Mental Health Illness, *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity* (Nov. 2016), [https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental\\_Health\\_Parity2016.pdf](https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf).

<sup>20</sup> See *Id.*

<sup>21</sup> See Jennifer Tolbert & Kendal Orgera, *Key Facts about the Uninsured Population*, KAISER HEALTH NEWS (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population>.

Less than 8% of the uninsured were White, while 20% were Hispanic and 11.4% were Black.<sup>22</sup> As to the underinsured, one-quarter of the adult American population with employer-sponsored insurance are underinsured, meaning they have a gap in health insurance coverage or high cost-sharing responsibilities in relation to their income.<sup>23</sup>

The general shortage of behavioral health care providers in the United States is another major barrier to behavioral health care.<sup>24</sup> The HRSA designates Health Professional Shortage Areas (“HPSA”) by calculating the number of professionals available to meet the health care need of populations throughout all regions of the United States.<sup>25</sup> According to federal regulations, if the number of available providers in a region relative to that region’s population falls below a certain threshold, the region is designated as an HPSA.<sup>26</sup> For behavioral health care, the required threshold is one provider per 30,000 people, although this ratio drops down to one provider per 20,000 people in areas identified as having high mental health need.<sup>27</sup> As of December 2020, only 29.51% of the national behavioral health care need was met, according to HPSA designations.<sup>28</sup> Comparably, 44.51% of the nation’s primary medical care need was met.<sup>29</sup>

Rural or partially rural geographic areas comprised 66.63% of areas with unmet behavioral health care need.<sup>30</sup> States with the lowest levels of met need included Missouri (3.7% met need), Arizona (11.1% met need), and South Dakota (11.2% met need).<sup>31</sup> States with the

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<sup>22</sup> *Id.*

<sup>23</sup> Samantha Liss, *A quarter of adults in employer plans are underinsured, Commonwealth Fund says*, HEALTHCARE DIVE (Sept. 9, 2020), <https://www.healthcaredive.com/news/a-quarter-of-adults-in-employer-plans-are-underinsured-commonwealth-fund-s/584918/>.

<sup>24</sup> See Heath, *supra* note 8.

<sup>25</sup> *Mental Health Care Health Professional Shortage Areas (HPSAs)*, KAISER HEALTH NEWS (Sept. 30, 2020), <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas>.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

highest levels of met need included New Jersey (69.8% met need) and Rhode Island (69.5% met need).<sup>32</sup> Such provider shortages, even in states such as New Jersey and Rhode Island, make it difficult, if not impossible, for many individuals with behavioral health care needs to access providers. Moreover, communities lacking resources and social supports, such as reliable transportation, childcare, or paid time off work, are likely to be disproportionately impacted by these barriers.<sup>33</sup>

### C. Early Telehealth Efforts

The historical evolution of behavioral telehealth in the United States dates back to 1964 when a hospital used a “telemedicine link” for psychiatric consultation and group therapy.<sup>34</sup> Early telehealth efforts in the 1960s and 1970s endeavored to improve health care access for rural populations.<sup>35</sup> These efforts expanded in the 1970s to include patients with mobility issues, such as nursing homes residents, and patients such as astronauts and military members, who were stationed in areas where no providers were available.<sup>36</sup> In the 1990s, attention turned to the use of telehealth for prison populations to save costs and efforts associated with transporting providers to prisons or prisoners to providers.<sup>37</sup> In the mid-1990s, the National Library of Medicine commissioned the Institute of Medicine (“IOM”) to establish an evaluation framework for telehealth services.<sup>38</sup> IOM’s report highlights the potential of telehealth to improve health care access and save costs, but identifies technological barriers as a major obstacle to achieving these goals.<sup>39</sup> The report also underscores the dearth of available research supporting the clinical

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<sup>32</sup> *Id.*

<sup>33</sup> *See* Heath, *supra* note 8.

<sup>34</sup> *See* INST. OF MED. (U.S.) COMM. ON EVALUATING CLINICAL APPLICATIONS OF TELEMEDICINE, *TELEMEDICINE: A GUIDE TO TELECOMMUNICATIONS FOR HEALTH CARE* (1996).

<sup>35</sup> *See Id.*

<sup>36</sup> *See Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *See Id.*



effectiveness of telehealth.<sup>40</sup> Notably, however, this report was published in the mid-1990s, only a few years after the World Wide Web become publicly available.<sup>41</sup> Technological and research advances since that time have successfully addressed some of the IOM's concerns.

## **II. Telehealth as a Solution to Behavioral Health Care Access Barriers**

Telehealth can help address some barriers to behavioral health care access by providing treatment-seekers with access to a larger number of providers, as well as to more diverse providers. Telehealth may offer increased access to providers with specialized training in certain treatments, for example, or who offer multilingual services. Burdens related to provider shortages and narrow insurance networks may be partially alleviated by removing geographic restrictions when individuals seek telehealth providers. Access to providers in a larger geographical area offers individuals better opportunities to find providers who accept insurance and participate in specific insurance networks. Social resource burdens, such as lack of reliable transportation, inadequate childcare, or lack of paid time off work, may also be partially alleviated with telehealth. Additionally, telehealth can help patients can save costs by reducing travel and childcare expenses and decreasing the need to take time off work.

### **A. Clinical Effectiveness of Behavioral Telehealth**

The Agency for Healthcare Research and Quality (“AHRQ”), an agency of the United States Department of Health and Human Services (“HSS”), issued two comprehensive reports on telehealth outcomes in 2016 and 2019. The 2016 report is a description of 58 systematic reviews of telehealth outcomes, comprised of 950 research studies published between 2007 and 2015.<sup>42</sup>

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<sup>40</sup> *See Id.*

<sup>41</sup> World Wide Web Found., *History of the Web*, <https://webfoundation.org/about/vision/history-of-the-web/> (last visited Mar. 20, 2021).

<sup>42</sup> Agency for Healthcare Res. & Quality, *Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews* (June 30, 2016), <https://effectivehealthcare.ahrq.gov/products/telehealth/technical-brief>.

The 2019 report systemically reviews 233 telehealth studies, 110 based in the United States, published between 1996 and 2018, including studies carried out in inpatient, emergency, and outpatient health care settings.<sup>43</sup> AHRQ released a white paper in May 2020 based on the data and findings of these two reports for the purpose of presenting telehealth outcome data in the context of telehealth expansion during the COVID-19 pandemic.<sup>44</sup> Although the White Paper was released in 2020, the studies on which it was based were published pre-COVID-19.<sup>45</sup>

AHRQ’s white paper highlights two key findings. The first is that telehealth is “beneficial” when used with specific patient populations for specific purposes.<sup>46</sup> The second finding emphasizes the “evidence of benefit [is] concentrated in specific uses,”<sup>47</sup> wherein AHRQ cites “a large body of evidence” supporting telehealth use for specific purposes.<sup>48</sup> One such purpose is psychotherapy in behavioral health care.<sup>49</sup> An American Family Physicians research article corroborated this finding, noting evidence of effectiveness in certain medical subspecialties, including psychiatry and wound care, to the exclusion of other medical subspecialties.<sup>50</sup> Thus, while the effectiveness of telehealth across different medical specialties may not yet be established,<sup>51</sup> clinical efficacy research generally supports its use in behavioral health care, particularly as to psychotherapy services.

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<sup>43</sup> Agency for Healthcare Res. & Quality, *Telehealth for Acute and Chronic Care Consultations Evidence Summary* (Apr. 24, 2019), <https://effectivehealthcare.ahrq.gov/sites/default/files/cer-216-telehealth-evidence-summary.pdf>.

<sup>44</sup> See Agency for Healthcare Res. & Quality, *The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic* (May 2020), <https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/telehealth-commentary-white-paper.pdf>

<sup>45</sup> See *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* (identifying the other purposes as remote monitoring, counseling/communicating with patients suffering from chronic conditions, such as congestive heart failure)

<sup>49</sup> *Id.*

<sup>50</sup> See Dean A. Seehusen & Anne Azrak, *The Effectiveness of Outpatient Telehealth Consultations*, 100 AM. FAM. PHYSICIANS 575 (Nov. 2019).

<sup>51</sup> See generally *Id.*

Since the 1990s, likely due to the types of technological advances predicted by the IMO in its report,<sup>52</sup> a plethora of efficacy research on behavioral telehealth has been published. Reviews and meta-analyses consistently demonstrate telehealth to be generally as effective as in-person services<sup>53</sup> across a variety of clinical populations, including, but not limited to, adult, geriatric, civilian, military, and veteran populations.<sup>54</sup> In fact, since early telehealth efforts targeted rural and military populations, the Veterans Health Administration of the Department of Veteran Affairs (“VA”) has emerged as an international leader in telehealth.<sup>55</sup> Behavioral telehealth research has expanded beyond individual adult populations to pediatric populations with mental illness,<sup>56</sup> as well as to couples<sup>57</sup> and family<sup>58</sup> behavioral health treatments.

Moreover, numerous behavioral health professional organizations published best practice guidelines for behavioral telehealth over the past two decades. These organizations include the APA,<sup>59</sup> the American Psychiatric Association in collaboration with the American Telemedicine Association,<sup>60</sup> the National Association of Social Workers in Collaboration with the Association of Social Work Boards, the Council on Social Work Education, and the Clinical Social Work

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<sup>52</sup>See generally *Id.*

<sup>53</sup> See, e.g., Erin Shigekawa et al., *The Current State of Telehealth Evidence: A Rapid Review*, 37(12) HEALTH AFF. 1975 (Dec. 2018).

<sup>54</sup> See, e.g., Donald M. Hilty et al., *The Effectiveness of Telehealth: A 2013 Review*, 19 TELEMEDICINE & E-HEALTH 444 (June 2013).

<sup>55</sup> Peter W. Tuerk et al., *Towards the Development of National Telehealth Services: The Role of Veterans Health Administration and Future Directions for Research*, 16 TELEMEDICINE & E-HEALTH 117 (2010).

<sup>56</sup> See Rosmary Ros-DeMarize et al., *Pediatric behavioral telehealth in the age of COVID-19: Brief evidence review and practice consideration*, 51 CURRENT PROBS. IN PEDIATRIC & ADOLESCENT HEALTH CARE 1 (Jan. 2021).

<sup>57</sup> See Richard J. Bischoff, *Considerations in the Use of Telecommunications as a Primary Treatment Medium: The Application of Behavioral Telehealth to Marriage and Family Therapy*, 32 AM. J. OF FAM. THERAPY 173 (Aug. 2010).

<sup>58</sup> Sian A. McLean, *Exploring the Efficacy of Telehealth for Family Therapy Through Systematic, Meta-analytic, and Qualitative Evidence*, CLINICAL CHILD & FAM. PSYCHOL. REV. (January 25, 2021), <https://link.springer.com/content/pdf/10.1007/s10567-020-00340-2.pdf>.

<sup>59</sup> Joint Task Force for the Dev. of Telepsychology Guidelines for Psychologists, *American Psychological Association, Guidelines for the Practice of Telepsychology*, 68 AM. PSYCHOLOGIST 791 (Dec. 2013).

<sup>60</sup> Am. Psychiatric Ass’n & Am. Telemedicine Ass’n, *Best Practices in Videoconferencing-Based Telemental Health* (Apr. 2018), <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-and-ata-release-new-telemental-health-guide>.

Association,<sup>61</sup> the Association of Social Work Boards,<sup>62</sup> and the National Board for Certified Counselors.<sup>63</sup> Some professional organizations also incorporate ethical guidelines specific to telehealth practice in their general codes of ethics.<sup>64</sup>

Yet, it is feasible that telehealth may not be clinically appropriate for use with certain clinical populations. It has been suggested, for example, telehealth may exacerbate delusions of reference for psychotic patients, although research has demonstrated this to be the exception, not the rule.<sup>65</sup> Empirical evidence does not support the notion that telehealth is a contraindicated modality for psychotic individuals.<sup>66</sup> To the contrary, telehealth has been demonstrated to be an effective and even a preferred modality by many of these patients.<sup>67</sup> One study suggested that “there is evidence that [telehealth] affords some patients a higher degree of comfort in that the

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<sup>61</sup> Nat’l Ass’n of Soc. Workers et al., *NASW, ASWB, CSWE, & CSWA Standards for Technology in Social Work Practice* (2017), [https://www.socialworkers.org/includes/newincludes/homepage/PRA-BRO-33617.TechStandards\\_FINAL\\_POSTING.pdf](https://www.socialworkers.org/includes/newincludes/homepage/PRA-BRO-33617.TechStandards_FINAL_POSTING.pdf).

<sup>62</sup> Ass’n of Social Work Boards Int’l Tech. Task Force, *Model Regulatory Standards for Technology and Social Work Practice* (Mar. 2015), <https://www.aswb.org/wp-content/uploads/2015/03/ASWB-Model-Regulatory-Standards-for-Technology-and-Social-Work-Practice.pdf>.

<sup>63</sup> Nat’l Board for Certified Counselors *Policy Regarding the Provision of Distance Professional Services* (Feb. 2016), <https://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf>.

<sup>64</sup> See, E.g., Am. Ass’n of Marriage & Fam. Therapists (AAMFT), *Code of Ethics* (Jan. 1, 2015), [https://www.aamft.org/Legal\\_Ethics/Code\\_of\\_Ethics.aspx](https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx); Am. Counseling Ass’n, *2014 Code of Ethics* (2014), <https://www.counseling.org/Resources/aca-code-of-ethics.pdf>; Am. Mental Health Counselors Ass’n, *2020 Code of Ethics* (2020), <https://www.amhca.org/publications/ethics>; Nat’l Board for Certified Counselors, *Code of Ethics* (October 7, 2016), <https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf>.

<sup>65</sup> Amy Donahue, Jennifer Rodriguez, & Jay H. Shore, *Telemental Health and the Management of Psychosis*, 23 CURRENT PSYCHIATRY REP. (Mar. 24, 2021), <https://link.springer.com/article/10.1007/s11920-021-01242-y>. (“As it can be the nature of psychosis for individuals to have ideas of reference, it is an understandable concern that the use of videoconferencing could trigger an exacerbation of symptoms. Fortunately, with rare exception, this experience has not been borne out in the literature.”)

<sup>66</sup> See Olga Santesteban-Echarriet et al., *Telehealth Interventions for Schizophrenia-Spectrum Disorders and Clinical High-Risk for Psychosis Individuals: A Scoping Review*, J. OF TELEMEDICINE & TELE CARE (Aug. 22, 2018), <https://pubmed.ncbi.nlm.nih.gov/30134781/>; Ian R. Sharp, Kenneth A. Kobak & Douglas A. Osman, *The use of videoconferencing with patients with psychosis: a review of the literature*, 10 ANNALS OF GENERAL PSYCHIATRY, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101132/pdf/1744-859X-10-14.pdf>.

<sup>67</sup> See Donahue, *supra* note 65.

perceived distance of the interaction is less anxiety provoking and reduces overstimulation found in some in person interactions.”<sup>68</sup>

Concerns still exist, however, as to the use of telehealth with clinical populations who may have difficulty interpreting nuanced interpersonal communication cues via audiovisual technology.<sup>69</sup> Additionally, issues related to safety may arise when telehealth is provided to victims of abuse if patients are in proximity of abuse perpetrators while engaging in telehealth.<sup>70</sup> In addition to the risk of perpetrators intentionally or unintentionally overhearing the patient while speaking to a provider, some patients may be more inhibited via telehealth due to privacy and safety concerns associated with receiving behavioral health care at home.<sup>71</sup>

Moreover, an area with limited telehealth outcome research is the practice of psychological testing. Standardized psychological tests are statistically validated on populations using specific procedures and protocols, some of which may be difficult to replicate via telehealth. While telehealth-based psychological testing *may* be as effective as in-person testing, the lack of measures standardized using telehealth protocols render psychometricians cautious about administering psychological tests via telehealth.<sup>72</sup> Telehealth-related factors may impact the validity and reliability of these standardized measures.<sup>73</sup> For example, lack of physical

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<sup>68</sup> Ian R. Sharp, Kenneth A. Kobak & Douglas A. Osman, *The use of videoconferencing with patients with psychosis: a review of the literature*, 10 ANNALS OF GENERAL PSYCHIATRY, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101132/pdf/1744-859X-10-14.pdf>.

<sup>69</sup> Sage Breslin, *Telehealth Best Practices: Online Therapy and Domestic Violence*, GOODTHERAPY.ORG, <https://www.goodtherapy.org/for-professionals/software-technology/telehealth/article/telehealth-best-practices-online-therapy-and-domestic-violence> (last visited Apr. 14, 2021).

<sup>70</sup> *Id.*

<sup>71</sup> Lori Ahuja, *Telehealth Therapy Concerns for Clients Engaging in Treatment for Domestic Violence*, Societyforpsychotherapy.org, <https://societyforpsychotherapy.org/telehealth-therapy-concerns-for-clients-engaging-in-treatment-for-domestic-violence/> (last visited Apr. 14, 2021).

<sup>72</sup> See A. J. Wright et al., *Guidance on psychological tele-assessment during the COVID-19 crisis*, AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES (Apr. 3, 2020), <https://www.apaservices.org/practice/reimbursement/health-codes/testing/tele-assessment-covid-19>.

<sup>73</sup> See David D. Luxton et al., *Best Practices for Remote Psychological Assessment via Telehealth Technologies*, 45 PROF. PSYCHOL. RES. & PRACTICE 27 (Feb. 2014).

presence with the test administrators may reduce test-takers' engagement in the testing process, particularly if test-takers belong to cultures that significantly rely on interpersonal or nonverbal cues.<sup>74</sup> Moreover, tests that utilize verbal and visual cues and responses may be better suited for telehealth than those requiring motor cues and responses.<sup>75</sup> Telehealth validity and reliability studies are needed to address this key area of concern. The APA has provided guidelines for psychologists administering psychological tests via telehealth, given the reality that such testing was needed during the COVID-19 pandemic to meet the behavioral health care needs of some populations.<sup>76</sup>

Behavioral health assessment, which is frequently used in behavioral health care, is broader in scope than standardized psychological testing and may or may not involve the use of standardized measures.<sup>77</sup> This type of assessment commonly involves a clinical interview of the patient by the provider and may also include “informal tests and surveys, interview information, school or medical records, medical evaluation and observation data.”<sup>78</sup> Research has shown that when behavioral health assessment is conducted via telehealth for diagnostic and treatment purposes, it is as effective as when conducted in person.<sup>79</sup> Studies demonstrate high inter-rater reliability between different interviewers conducting clinical interviews of the same patient via telehealth versus in person, where telehealth interviewers tend to reach “identical or near

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<sup>74</sup> *Id.*

<sup>75</sup> Timothy W. Brearly et al., *Neuropsychological Test Administration by Videoconference: A Systematic Review and Meta-Analysis*, 27 *NEUROPSYCHOLOGY REV.* 174 (June 2017).

<sup>76</sup> Am. Psychol. Ass'n, *How to do psychological testing via telehealth* (Apr. 3, 2020), <https://www.apaservices.org/practice/reimbursement/health-codes/testing/psychological-telehealth>.

<sup>77</sup> *See generally Id.*

<sup>78</sup> Am. Psychol. Ass'n, *Understanding psychological testing and assessment*, APA.ORG, <https://www.apa.org/topics/psychological-testing-assessment> (last visited Apr. 14, 2021).

<sup>79</sup> *See* Elizabeth L. Ciemins et al., *Telemedicine and the Mini-Mental State Examination: Assessment from a Distance*, 15 *TELEMEDICINE JOURNAL AND E-HEALTH* (June 2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2956527/pdf/tmj.2008.0144.pdf>; Calvin T. Schafer, Preeti Nakrani & Paul A. Pirraglia, *Telemental Health Care: A Review of Efficacy and Interventions*, 5 *TELEHEALTH & MED. TODAY* (2020), <https://telehealthandmedicinetoday.com/index.php/journal/article/view/218>.

identical” diagnostic conclusions as in-person interviewers.<sup>80</sup> Thus, there is empirical support for telehealth-based behavioral assessment, but more research is needed for the narrower practice of psychological testing.

### B. Impact of Telehealth on Costs of Behavioral Health Care

Cost savings attributable to telehealth use can be measured in different ways, including savings to patients, providers, or payers (e.g., insurance companies, public health systems). Early telehealth efforts focused on savings due to decreased transportation costs associated with providing health care to isolated populations (e.g., rural communities, prison populations).<sup>81</sup> Since that time, research has primarily attributed cost savings to patients’ reduced transportation and travel time.<sup>82</sup> In its 2019 report, AHRQ identified thirty-two outpatient, five emergency care, and seven inpatient telehealth studies assessing cost as a function of telehealth.<sup>83</sup> While some studies identified lower costs related to telehealth, “in most cases savings [were] attributable to reductions in transfers or less transportation.”<sup>84</sup> Moreover, AHRQ reported that “the rigor of the measurement, imprecision of estimates and inconsistency in the magnitude of the effects limits confidence in these finding [resulting in] low strength of evidence[.]”<sup>85</sup> Other studies confirm AHRQ’s findings that evidence regarding cost savings is equivocal due to methodological limitations.<sup>86</sup> The limited studies that have identified cost savings primarily attribute them to

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<sup>80</sup> Paul E. Ruskin et al., *Reliability and acceptability of psychiatric diagnosis via telecommunication and audiovisual technology*, 49 PSYCHIATRIC SERV. 1086 (Aug. 1998).

<sup>81</sup> See Nat’l Inst. of Just., *Telemedicine Can Reduce Correctional Health Care Costs: An Evaluation of a Prison Telemedicine Network* (Mar. 1999), <https://www.ojp.gov/pdffiles1/175040.pdf>.

<sup>82</sup> See Centaine L. Snoswell et al., *Determining if Telehealth Can Reduce Health System Costs: Scoping Review*, J. Med. Internet Res. (Oct. 2020), <https://www.jmir.org/2020/10/e17298/>.

<sup>83</sup> Agency for Healthcare Res. & Quality, note 43.

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> See, e.g., Hema Mistry, *Systematic review of studies of the cost-effectiveness of telemedicine and telecare. Changes in the economic evidence over twenty years*, 18 J. of TELEMEDICINE & TELE CARE 1 (Jan. 2012); Isabel de la Torre-Diez et al., *Cost-utility and cost-effectiveness studies of telemedicine, electronic, and mobile health systems in the literature: a systemic review*, 21 TELEMEDICINE & E-HEALTH 81 (Feb. 2015); Pamela S. Whitten, *Systemic review of cost effectiveness studies of telemedicine interventions*, 324 BRIT. MED. J. 1434 (June 15, 2002).

reduced patient transportation and travel time.<sup>87</sup> In systems such as the VA, where transportation costs are absorbed by the health care system, these savings may be realized by the system itself.<sup>88</sup> More likely, however, savings are realized by patients,<sup>89</sup> in the form of not needing to take unpaid time off work and reducing the need to tap into valuable social resources (e.g., childcare) to attend health care appointments.

Where providers are required to travel to patients' homes to provide health care, savings may be realized by the providers, particularly in the form of improved efficiency and productivity.<sup>90</sup> Providers who do not travel, however, are less likely to save costs by delivering health care via telehealth rather than in person.<sup>91</sup> Some research suggests providers may even experience increased administrative costs related to scheduling telehealth appointments, required technology infrastructure, and technology-related staff training.<sup>92</sup> While some commentators suggest that providers delivering services via telehealth may save material costs, such as "patient gowns, cleaning, disinfectants, and other supply expenses,"<sup>93</sup> the research does not evidence such savings. Moreover, these expenses are less applicable to behavioral health care setting, where patients do not undergo formal physical examinations or medical diagnostic testing. One unique cost-saving mechanism that may be associated with telehealth, however, is its potential to reduce unnecessary emergency care visits and hospitalizations.<sup>94</sup> Some research also suggests telehealth may save health systems costs by decreasing use of secondary care, such specialist or procedural

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<sup>87</sup> *E.g.*, Agency for Healthcare Res. & Quality, note 43.

<sup>88</sup> *See Id.*

<sup>89</sup> *See Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *See Id.*

<sup>92</sup> *See Id.*

<sup>93</sup> Jacqueline LaPointe, *CMS to Assess Telehealth Reimbursement Rates Post-Pandemic*, RevCycleIntelligence.com (July 21, 2020), <https://revcycleintelligence.com/news/cms-to-assess-telehealth-reimbursement-rates-post-pandemic>.

<sup>94</sup> David C. Grabowski & A. J. O'Malley, *Use of telemedicine can reduce hospitalizations of nursing home residents and generate savings for Medicare*, 33 HEALTH AFF. 244 (Feb. 2014).



follow-up visits.<sup>95</sup> This evidence is not specific to behavioral health care, however, and may not apply to this specialty.

### **III. Pre-COVID Barriers to Behavioral Telehealth**

Barriers to behavioral telehealth identified over the past few decades include technological (e.g. technology access, literacy, and accessibility) and reimbursement barriers. Providers also experience barriers related how and when they are permitted to provide telehealth services, particularly with respect to establishing treatment relationships, prescribing, and interjurisdictional practice. Some of these barriers may disproportionately impact poor, minority, rural, disabled, and elderly populations, as well as individuals with limited English proficiency.

#### **A. Technological Barriers**

Patient access to technology is a major barrier to behavioral telehealth, disproportionately impacting rural, poor, and minority communities. The Telecommunications Act of 1996 called for improved access to telecommunications and high-speed internet for all Americans, with a focus on underserved communities, especially rural and low-income communities.<sup>96</sup> This statute requires the Federal Communications Commission (“FCC”) to report annually on the extent to which broadband<sup>97</sup> “is being deployed to all Americans in a reasonable and timely fashion.”<sup>98</sup> According to the FCC, approximately 19 million Americans (6% of the population) still lack physical access to fixed broadband internet.<sup>99</sup> Even those with physical access may not adopt

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<sup>95</sup> Centaine, *supra* note 82.

<sup>96</sup> Telecommunications Act of 1996, Pub. LA. No. 104-104, 110 Stat. 56.

<sup>97</sup>FED. COMM. COMM’N, 2020 BROADBAND DEPLOYMENT REPORT (Apr. 24, 2020) (defining broadband as “technology with the capacity to transmit data to enable a subscriber to the service to originate and receive high-quality voice, data, graphics and video”).

<sup>98</sup> Heath, *supra* note 8.

<sup>99</sup>FED. COMM. COMM’N, EIGHT BROADBAND PROGRESS REPORT (Aug. 21, 2012).

broadband internet services for a variety of reasons, such as cost.<sup>100</sup> Twenty-five percent of individuals residing in rural communities and approximately one-third of those residing in tribal areas lack such access.<sup>101</sup>

The United States Census Bureau reported in 2017 that 36.4% of Black respondents and 30.3% of Hispanic respondents did not have broadband internet or a computer, as compared to 21.2% of White respondents.<sup>102</sup> In recognition of the lack of reliable internet access in many communities of color, the National Telecommunications and Information Administration of the United States Department of Commerce established the Minority Broadband Initiative, in collaboration with Historically Black Colleges, to address these gaps.<sup>103</sup> According to a 2019 Pew Research Center survey, only 57% to 58% of Black and Hispanic respondents owned a desktop or laptop computer, as compared to 82% of White respondents.<sup>104</sup> Black and Hispanic respondents reported owning smartphones at similar rates as White respondents (80%, 79% and 82%, respectively).<sup>105</sup> Only 69% of Hispanic respondents born outside the United States owned smartphones, however, as compared to 87% of Hispanic respondents born in the United States. Moreover, while four-fifths of survey respondents owned smartphones, 29% of households with annual incomes under \$30,000 did not own smartphones and 46% of these low-income households did not own computers.<sup>106</sup> Lack of access to the technology necessary for telehealth,

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<sup>100</sup> John B. Horrigan & Maeve Duggan, Barriers to broadband adoption: Cost is now a substantial challenge for many non-users, PEW RESEARCH CENTER (Dec. 21, 2015), <https://www.pewresearch.org/internet/2015/12/21/3-barriers-to-broadband-adoption-cost-is-now-a-substantial-challenge-for-many-non-users/>.

<sup>101</sup> *Id.*

<sup>102</sup> U.S. Census Bureau, *The Digital Divide: Percentage of Households by Broadband Internet Subscription, Computer Type, Race and Hispanic Origin* (Sept. 11, 2017), <https://www.census.gov/library/visualizations/2017/comm/internet.html>.

<sup>103</sup> See NAT'L TELECOMM. & INFO. ADMIN., NTIA MINORITY BROADBAND INITIATIVE (Nov. 15, 2019).

<sup>104</sup> Andrew Perrin & Erica Turner, *Smartphones help blacks, Hispanics bridge some – but not all – digital gaps with whites*, PEW RESEARCH CENTER (Aug. 20, 2019), <https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/>.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

including high-speed internet and technological equipment with audio-visual conferencing capacity, is a major barrier for these populations. Successful efforts to expand behavioral telehealth must address these obstacles to avoid exacerbating existing inequities in access to health care.

As to providers, access to the necessary technology for delivery of telehealth is a potential barrier. The Health Insurance Portability and Accountability Act (“HIPAA”), which applies to healthcare providers transmitting personal health information in electronic form, is implicated in telehealth delivery.<sup>107</sup> The HIPAA Security Rule limits access of electronic Protected Health Information (“PHI”) to authorized users.<sup>108</sup> Providers are required to use a secure system for communication of PHI.<sup>109</sup> Additionally, providers must monitor communications using PHI to prevent breaches.<sup>110</sup> Providers are also required to obtain Business Associate Agreements (“BAA”) from technology vendors under the HIPAA Privacy Rule.<sup>111</sup> The need to utilize HIPAA-compliant secure technology, monitor for breaches, and obtain Business Associate Agreements from third-party vendors may increase telehealth-related administrative costs and burdens for providers.<sup>112</sup> Additionally, these requirements make it less likely that patients will be familiar with the technology providers are required to use for telehealth, since the technology must be specialized to ensure compliance with HIPAA.

Lack of technological literacy is another barrier to behavioral telehealth that disproportionately impacts certain populations. The American Institute for Research has

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<sup>107</sup> See The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936.

<sup>108</sup> HIPAA J., *HIPAA Guidelines on Telemedicine*, <https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/> (last visited Mar. 20, 2021).

<sup>109</sup> See Centaine, *supra* note 82.

<sup>110</sup> See *Id.*

<sup>111</sup> See *Id.*

<sup>112</sup> See *Id.*

described approximately 16% of American adults as technologically illiterate.<sup>113</sup> Adults identified as technologically illiterate included those who reported no computer use and those unwilling or unable to pass a computer test consisting of basic tasks, such as using a mouse or highlighting text on a computer screen.<sup>114</sup> These adults tended to be less educated, older, and more likely to have been born outside the United States.<sup>115</sup> They were also more likely to be Black or Hispanic.<sup>116</sup> Additional research has corroborated the finding that older Black patients are less likely to use telehealth than White and younger patients.<sup>117</sup>

Moreover, the technology used for telehealth not be accessible to some disabled and elderly populations. Disabilities and impairments including, but not limited to, physical, motor, visual, audio, and cognitive impairments may inhibit their use of the technology required for behavioral telehealth.<sup>118</sup> Videoconference technology inaccessibility for individuals with disabilities related to sight, hearing, speech, or cognitive impairments is an area of particular concern.<sup>119</sup> Telehealth technologies often lack features required by these individuals for proper use.<sup>120</sup> Patients with hearing disabilities, for example, may require captioning and those with

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<sup>113</sup> Madedova, Saida & Pawlowski, Emily. *Stats in Brief A Description of Adults Who Are Not Digitally Literate, U.S. DEP'T OF EDUC.* (May 2018), <https://nces.ed.gov/pubs2018/2018161.pdf>.

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> See, e.g., Rumi Chunara et al., *Telemedicine and healthcare disparities: a cohort study in a large healthcare system in New York City during COVID-19*, 28 J. OF THE AM. MED. INFORMATICS ASS'N 33, (Jan. 2021); Robert R. Pierce & James J. Stevermer, *Disparities in the use of telehealth at the onset of the COVID-19 public health emergency*, J. OF TELEMEDICINE AND TELECare (Oct. 21, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7578842/>; David Velasquez & Ateev Mehrota, *Ensuring the Growth of Telehealth During COVID-19 Does Not Exacerbate Disparities in Care*, HEALTH AFF. (May 8, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200505.591306/full/>; Kara Wegermann et al., *Racial and Socioeconomic Disparities in Utilization of Telehealth in Patients with Liver Disease During COVID-19*, DIGESTIVE DISEASES AND SCI. (Jan. 28, 2021), <https://link.springer.com/content/pdf/10.1007/s10620-021-06842-5.pdf>.

<sup>118</sup> Alex Kuerbis et al., *Older adults and mobile technology: Factors that enhance and inhibit utilization in the context of behavioral health*, 2 MENTAL HEALTH ADDICTION RES. 1, (2017).

<sup>119</sup> Rupa S. Valdez et al., *Ensuring full participation of people with disabilities in an era of telehealth*, 28 J. OF THE AM. MED. INFORMATICS ASS'N 389, (Nov. 18, 2020).

<sup>120</sup> Bureau of Internet, *Accessibility, Rising to Meet the Telehealth Accessibility Challenge in the Time of COVID-19*, BOIA.ORG (Aug. 11, 2020), <https://www.boia.org/blog/rising-to-meet-the-telehealth-accessibility-challenge-in-the-time-of-covid-19>.

visual impairments may require screen readers or similar assistive devices.<sup>121</sup> Individuals with speech impairments may require voice synthesizers or features that generate speech from text.<sup>122</sup> Many telehealth technologies do not offer these features or may otherwise be incompatible with assistive devices.<sup>123</sup>

#### B. Reimbursement Barriers

Medicare reimbursement for telehealth services is addressed under §1834(m) of the Social Security Act.<sup>124</sup> This provision permits payment to physicians and practitioners who provide telehealth to an “eligible telehealth individual.”<sup>125</sup> An eligible telehealth individual is defined as a beneficiary who receives telehealth at an originating site (i.e., patient’s location when receiving telehealth) that is located in:

an area that is designated as a rural health professional shortage area [or] in a county that is not included in a Metropolitan Statistical Area [or] from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.<sup>126</sup>

While these limitations stopped applying to patients treated for substance abuse or comorbid mental health disorders in July 2019,<sup>127</sup> all originating sites must still be located at specific health clinics, hospitals, physician offices, skilled nursing facilities, or renal dialysis facilities.<sup>128</sup> The originating site is only permitted to be the patient’s home when the patient is undergoing dialysis at home due to end stage renal disease.<sup>129</sup>

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<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> 42 U.S.C. § 1834(m)

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> 42 U.S.C. § 1881(b)(3)(B)

While the federal government regulates Medicare reimbursement for telehealth, states determine Medicaid coverage of telehealth services.<sup>130</sup> By 2016, all but two states (Massachusetts and Rhode Island) provided for some form of telehealth reimbursement under Medicaid.<sup>131</sup> Massachusetts was the last state to add telehealth reimbursement in 2019, specifically targeting behavioral telehealth and requiring payment parity, so that providers are reimbursed for telehealth services at the same rate as for in-person services.<sup>132</sup> As with Medicare, some states require that certain geographic restrictions be met as a condition of Medicaid coverage.<sup>133</sup> These restrictions vary and often include maximum distance requirements between provider and patient sites.<sup>134</sup> More commonly, states restrict the originating site (i.e., patient’s location) to physician offices, hospitals, and sometimes rural health clinics.<sup>135</sup> In 2019, 22 states had such restrictions,<sup>136</sup> but by 2020, 27 states and the District of Columbia permitted Medicaid reimbursement for telehealth delivered to the patient’s home,<sup>137</sup> as compared to only seven states in 2013.<sup>138</sup> States also vary as to the *type* of telehealth services authorized for Medicaid

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<sup>130</sup> Ctr. for Connected Health Pol’y, *State Telehealth Medicaid Fee For Service Policy: A Historical Analysis of Telehealth: 2013 – 2019*, THE NAT’L TELEHEALTHPOL’Y RESOURCE CTR. (Jan. 2020), <https://www.cchpca.org/sites/default/files/2020-01/Historical%20State%20Telehealth%20Medicaid%20Fee%20For%20Service%20Policy%20Report%20FINAL.pdf>.

<sup>131</sup> *Id.*

<sup>132</sup> Press Release, Executive Office of Health & Human Servs. Mass Health, *MassHealth Expands Access to Behavioral Health Care for Members through Telehealth*, MASS.GOV (Feb. 8, 2019), <https://www.mass.gov/news/masshealth-expands-access-to-behavioral-health-care-for-members-through-telehealth>.

<sup>133</sup> Ctr. for Connected Health Pol’y, *supra* note 130.

<sup>134</sup> *Id.* (reporting “one of the most common [geographic restriction] is to deny reimbursement for telehealth services when the originating and distant sites are within a specified distance from each other (typically five miles)”).

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> Ctr. for Connected Health Pol’y, *State Telehealth Laws and Reimbursement Policies At a Glance*, THE NAT’L TELEHEALTHPOL’Y RESOURCE CTR. (Fall 2019), <https://www.cchpca.org/sites/default/files/2020-10/StateTelehealthLawsandReimbursementPolicies%20FALL%202020%20.pdf>.

<sup>138</sup> *Id.*

coverage, with restrictions applying to certain medical specialties and to specific services within specialties.<sup>139</sup> Behavioral telehealth services, however, consistently make the cut.<sup>140</sup>

In 2020, 43 states and the District of Columbia had private payer telehealth statutes, as compared to only 14 states in 2012.<sup>141</sup> Most of these statutes mandated telehealth coverage parity, with a couple of exceptions. Prior to passing a statute in 2021 mandating parity, for example, Massachusetts prohibited insurance companies from charging patients higher cost-sharing for telehealth than for the same in-person services, but the statute did not mandate telehealth coverage as a general matter.<sup>142</sup> In April 2019, Florida passed a statute requiring contracts between insurers and telehealth providers be “voluntary” and “establish mutually acceptable payment rates or payment methodologies for services provided through telehealth,” but it does not provide for telehealth coverage parity.<sup>143</sup>

Florida’s statute mandating voluntary agreements as to telehealth reimbursement rates addresses a concern that payers tend to unilaterally pay providers lower reimbursement rates for telehealth services than for same in-person services, disincentivizing providers from offering telehealth.<sup>144</sup> Prior to the COVID-19 pandemic, ten state statutes more directly addressed this concern by mandating payment (reimbursement) parity, requiring payers to pay providers the same reimbursement rates for telehealth as for the same services provided in person.<sup>145</sup>

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<sup>139</sup> *Id.*

<sup>140</sup> *Id.*

<sup>141</sup> Ctr. for Connected Health Pol’y, *State Telehealth Laws and Reimbursement Policies*, THE NAT’L TELEHEALTH POL’Y RESOURCE CTR. (Fall 2020), <https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report>.

<sup>142</sup> MASS. GEN. LAW. ch. 175 § 47BB (2020).

<sup>143</sup> Fla. Stat. § 627.42396 (2020).

<sup>144</sup> Eric Wickland, Will Telehealth Payment Parity Be Permanent or a Passing Fancy? mHealthIntelligence.com (February 22, 2021), <https://mhealthintelligence.com/news/will-telehealth-payment-parity-be-permanent-or-a-passing-fancy>.

<sup>145</sup> Ctr. for Connected Health Pol’y, *supra* note 141. (reporting California, Delaware, Georgia, Hawaii, Minnesota, New Mexico, Arkansas, Colorado, Kentucky, and New Jersey mandated payment parity)

Washington was the last state to pass payment parity legislation a few months prior to the onset of the COVID-19 pandemic.<sup>146</sup> The statute was originally scheduled to take effect January 2021,<sup>147</sup> but took effect sooner, in March 2020.<sup>148</sup> State statutes vary as to whether coverage and payment parity provisions apply to all providers or are limited to providers in the insurance company's network. For example, Massachusetts only requires payment parity for in-network providers, in addition to specifically limiting payment parity to behavioral health providers.<sup>149</sup> Some private payer statutes also include a member cost-shifting provision prohibiting insurance companies from requiring patients to pay higher cost-sharing (e.g., deductible, copayment, coinsurance) for telehealth than for the same in-person services.

State private payer statutes only govern “fully insured” insurance plans, where the employer has a contract with an insurer to take on the financial risk of its employees’ health care costs in return for employer-paid premiums.<sup>150</sup> The Employee Retirement Income Security Act of 1974 (ERISA), a federal law governing employee benefit plans, has been interpreted as exempting self-funded plans from state insurance statutes.<sup>151</sup> Self-funded health insurance plans are those for which employers take on the financial risk of their employees’ health care cost and typically utilize third party administrators to manage benefits and pay claims.<sup>152</sup> In 2019, approximately 61% of American workers were insured by self-funded plans, most working for

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<sup>146</sup> WASH. REV. CODE § 41.05.700 (2020).

<sup>147</sup> *Id.*

<sup>148</sup> WASH. REV. CODE § 48.43.735 (2020).

<sup>149</sup> *See* Ctr. for Connected Health Pol’y *supra* note 141.

<sup>150</sup> Furrow et al., *Health Law: Cases, Materials, and Problems* (8th Ed.). Chapter 8: Employee Retirement Income Security Act. West Academic Publishing: 2018.

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*



large companies.<sup>153</sup> Significantly, ERISA does not mandate telehealth coverage, so self-funded plans are not required to provide their consumers any telehealth benefits.

### C. Limitations on Establishing Treatment Relationships

In 2019, the American Medical Association released the following practice guidelines on establishing patient-physician relationship relationships via telehealth:

The AMA believes that a valid patient-physician relationship must be established before the provision of telemedicine services, through: A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or (ii) A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or (iii) Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care.<sup>154</sup>

Some state statutes similarly require that treatment be initiated in person prior to the provision of telehealth,<sup>155</sup> although exceptions often apply.<sup>156</sup> Other states permit providers to initiate treatment via telehealth if the provider can provide the same standard of treatment as would be provided in person.<sup>157</sup> State statutes sometimes explicitly prohibit insurance companies from requiring providers to initiate treatment relationships in person as a condition of reimbursement.<sup>158</sup> Many states do not address the matter at all. Restrictions requiring the initiation of treatment relationships in person may disproportionately impact communities with

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<sup>153</sup> Kaiser Fam. Found. & NORC at the U. of Chicago, *Employer Health Benefits 2019 Annual Survey*, (2019) <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019> (reporting 80% of workers working for employers with 200 or more employees are covered by fully or partially self-funded plans).

<sup>154</sup> Am. Med. Ass'n, *Coverage of and Payment for Telemedicine H-480-946*, (2019) <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>.

<sup>155</sup> Nat'l Governors Ass'n Ctr. for Best Practices, *The Future of State Telehealth Policy*, (Nov. 2020) <https://www.nga.org/wp-content/uploads/2020/11/The-Future-of-State-Telehealth-Policy.pdf>.

<sup>156</sup> Am. Med. Ass'n, *50-state survey: Establishment of a patient-physician relationship via telemedicine*, (2018), <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>.

<sup>157</sup> Nat'l Governors Ass'n Ctr. for Best Practices, note 155.

<sup>158</sup> *Id.*

provider shortages, such as those in rural areas, where long travel distances may be required to establish treatment relationships. Issues related to lack of transportation, inability to take paid time off work, or lack of other social resources (e.g., childcare) may deter patients in these communities from seeking telehealth if they must first establish treatment in person.

#### D. Limitations on Prescribing

The federal government limits telehealth prescribing under the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (“Ryan Haight Act”),<sup>159</sup> making it illegal to “deliver, distribute, or dispense a controlled substance by means of the Internet.”<sup>160</sup> Under the Ryan Haight Act, named after an adolescent who died due to an overdose of controlled substances he purchased online,<sup>161</sup> “[n]o controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act 26 may be delivered, distributed, or dispensed by means of the Internet without a valid prescription.”<sup>162</sup> Valid prescriptions require that a patient first undergo an in-person medical evaluation by the prescribing provider or a covering provider.<sup>163</sup>

The Diversion Control Division of the Drug Enforcement Administration (DEA) interprets 21 U.S.C. § 829 (e)(3)(A) as providing an exception for a subset of providers who prescribe Schedule III-V controlled substances to treat opioid addiction.<sup>164</sup> Some states limit

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<sup>159</sup> 110 P.L. 425, 122 Stat. 4820

<sup>160</sup> 21 U.S.C. § 841(h)(1)

<sup>161</sup> *Implementation of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008*, 74 Fed. Reg. 15,596 (Apr. 6, 2009).

<sup>162</sup> 21 U.S.C. § 829(e)(1)

<sup>163</sup> *Id.*

<sup>164</sup> Drug Enforcement Admin. Drug Control Div. *Use of Telemedicine While Providing Medication Assisted Treatment (MAT)*, U.S. DEP’T OF JUST. (May 18, 2018), [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/medication\\_assisted/telemedicine-dea-guidance.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf).

these providers from utilizing the 21 U.S.C. § 829 (e)(3)(A) exception.<sup>165</sup> For example, to qualify for Medicaid reimbursement in Massachusetts, an in-person assessment of the patient by the prescribing provider or by a primary care physician who communicates with the prescriber is required.<sup>166</sup>

#### E. Limitations on Interjurisdictional Practice

Licensing of health care providers, including behavioral health providers, is governed by states under their police power.<sup>167</sup> No federal licensure exists for health care providers. Behavioral health providers may only provide behavioral telehealth services in the state that issues their license.<sup>168</sup> As a result, telehealth services are limited geographically to patients physically located in the state where a provider is licensed, thus prohibiting telehealth delivery across state lines.<sup>169</sup> One approach some states has taken to address this barrier to telehealth is to form interstate compacts, which are “contract[s] between two or more states . . . carr[ying] the force of statutory law and allow[ing] states to perform a certain action, observe a certain standard or cooperate in a critical policy area.”<sup>170</sup> Such compacts typically:

Establish a formal, legal relationship among states to address common problems or promote a common agenda; [c]reate independent, multistate governmental authorities (such as commissions) that can address issues more effectively than a state agency acting independently, or when no state has the authority to act unilaterally; and [e]stablish uniform guidelines, standards or procedures for agencies in the compact’s member states.<sup>171</sup>

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<sup>165</sup> Centers for Medicare and Medicaid Services, *Reducing Barriers To Furnishing Substance Use Disorders (SUD) Services Using Telehealth and Remote Patient Monitoring For Pediatric Populations Under Medicaid: Final Report* (May 15, 2020), <https://www.medicare.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf>.

<sup>166</sup> Commonwealth of Mass. Office of Medicaid, *Access To Behavioral Health Services Through Use of Telehealth Options*, 281 MASSHEALTH ALL PROVIDER BULLETIN (May 15, 2020), <https://www.mass.gov/files/documents/2019/01/23/all-provider-bulletin-281.pdf>.

<sup>167</sup> BARROW R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 33 (8th ed. 2018).

<sup>168</sup> Am. Psychol. Ass’n, *COVID-19: It is legal to treat clients in another state?* (October 15, 2020), <https://www.apaservices.org/practice/clinic/covid-19-treating-clients>.

<sup>169</sup> *Id.*

<sup>170</sup> PSYPACT, *PSYPACT Legislative Resource Kit*, (Feb. 2016) [https://cdn.ymaws.com/asppb.site-ym.com/resource/resmgr/PSYPACT\\_Docs/PSYPACT\\_Resource\\_Kit\\_2.11.20.pdf](https://cdn.ymaws.com/asppb.site-ym.com/resource/resmgr/PSYPACT_Docs/PSYPACT_Resource_Kit_2.11.20.pdf).

<sup>171</sup> *Id.*

Interstate license compacts are formed when states enact legislation to create discipline-specific compacts permitting providers to practice in the states participating in the compact. Some compacts simply facilitate a provider's licensure in all member states, so that the provider receives a separate license to practice in each state.<sup>172</sup> Others issue a separate license that specifically permits certain types of interstate practice.<sup>173</sup>

Prior to the COVID-19 pandemic, the Federation of State Medical Boards (FSMB) established the Interstate Medical Licensure Compact (IMLC), an interstate license compact for physicians with the goal of improving health care access, especially to medical specialties and rural geographical areas, via the use of new technologies.<sup>174</sup> The FSMB worked with state medical boards to draft a model compact act, which was first enacted in 2015 by numerous states.<sup>175</sup> The IMLC works by coordinating a centralized physician application that is distributed to member state medical licensing boards, which then individually issue separate state licenses to applicants.<sup>176</sup> Thus, applicants receive medical licenses in each state that participates in the compact.<sup>177</sup> This approach is referred to as a “streamlined application process” and the IMLC explicitly denies issuing a national or compact license to providers.<sup>178</sup> Members of participating states' licensing boards comprise the Interstate Medical Licensure Commission, which administers IMLC for participating states.<sup>179</sup> States must adopt the IMLC's model act via

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<sup>172</sup> *See Id.*

<sup>173</sup> Interstate Med. Licensure Compact, *A Faster Pathway to Physician Licensure*, <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/> (last visited Mar. 20, 2020).

<sup>174</sup> *Id.*

<sup>175</sup> Interstate Med. Licensure Compact, *Participating States*, <https://www.imlcc.org/participating-states/> (last visited Mar. 20, 2020) (reporting that states enacting the statute in 2015 included Idaho, Montana, Nevada, Utah, Wyoming, South Dakota, Minnesota, Iowa, Wisconsin, Illinois, Alabama, and West Virginia).

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> Interstate Med. Licensure Compact, *supra* note 173.

<sup>179</sup> *Id.*

legislation to become a participating state in the compact.<sup>180</sup> By 2019, 27 states, the District of Columbia, and Guam had joined IMLC, with Michigan being the most recent state to join in June 2019.<sup>181</sup>

Some states collaborate to permit clinical psychologists to provide telehealth services across state lines under the Interstate Compact Legislation.<sup>182</sup> The goal of this interstate legislative compact, PSYPACT, is to enable psychologists to provide telehealth and temporary in-person services to patients located in other states without requiring a license in those states.<sup>183</sup> PSYPACT's purpose is to provide greater access to behavioral health care, particularly in communities that are "underserved, geographically isolated or lack specialty care."<sup>184</sup> In addition, PSYPACT facilitates continuity of care for patients who move, temporarily or permanently, to other states<sup>185</sup> or who otherwise travel frequently, such as for work. PSYPACT explicitly does not apply to telehealth services delivered by a provider to a patient located in the state where the provider is licensed, the provision of permanent in-person behavioral health care, or intrastate telehealth.<sup>186</sup> Similar to IMLC, PSYPACT established a model act that states must enact to participate in the compact.<sup>187</sup> Colorado was first state to enact PSYPACT in April 2018, with three additional states enacting legislation that year.<sup>188</sup> Prior to the COVID-19 pandemic, 12 states had enacted PSYPACT legislation, most recently New Hampshire in July 2019.<sup>189</sup>

#### F. Telehealth Fraud and Abuse

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<sup>180</sup> *Id.*

<sup>181</sup> Fed'n of State Med. Boards, *Michigan Joins Interstate Medical Licensure Compact*, (Jan. 8, 2019) <https://www.fsmb.org/advocacy/news-releases/michigan-joins-interstate-medical-licensure-compact/>.

<sup>182</sup> PSYPACT, note 170.

<sup>183</sup> PSYPACT, *Legislative Frequently Asked Questions*, <https://psypact.org/page/faq> (last visited Mar. 20, 2021).

<sup>184</sup> *Id.*

<sup>185</sup> *Id.*

<sup>186</sup> PSYPACT, *supra* note 170.

<sup>187</sup> *Id.*

<sup>188</sup> PSYPACT, *PSYPACT Map/States*, <https://psypact.site-ym.com/page/psypactmap> (last visited Mar. 20, 2021).

<sup>189</sup> *Id.*

The Office of Inspector General (OIG) of HHS recently expressed concerns about the potential for financial exploitation of telehealth in the form of health care fraud and abuse.<sup>190</sup> In 2016, the first telehealth-related False Claims Act (FCA) claim was filed against a physician and mental health practice.<sup>191</sup> The defendants allegedly violated the FCA by providing telehealth services via phone rather than audiovisual communication technology, as required by Medicare, to patients who did not reside in rural health professional shortage areas.<sup>192</sup> The defendants entered a civil settlement, agreeing to pay \$36,704 to settle the claim.<sup>193</sup> Since then indictments related to fraudulent telehealth claims, while infrequent, have implicated billions of dollars worth of alleged false claims.

In September 2019, thirty-five defendants, including individuals associated with telehealth companies and ten medical professionals, were charged with fraudulent Medicare billing of over two billion dollars.<sup>194</sup> The fraud scheme involved telemarketing unnecessary genetic tests to Medicare beneficiaries, where the tests were not carried out or results were never provided to the beneficiaries' physicians (or were otherwise not medically useful).<sup>195</sup> Previously, in April 2019, numerous telehealth company executives, medical professionals, and owners of medical durable equipment companies were indicted in a fraud scheme resulting in over one billion dollars of fraudulent Medicare billing for unnecessary medical equipment.<sup>196</sup> According

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<sup>190</sup> Dep't of Just. Off. of Pub. Aff., *Federal Law Enforcement Action Involving Fraudulent Genetic Testing Results in Charges Against 35 Individuals Responsible for Over \$2.1 Billion in Losses in One of the Largest Health Care Fraud Schemes Ever Charged*, JUSTICE NEWS (Sept. 27, 2019), <https://www.justice.gov/opa/pr/federal-law-enforcement-action-involving-fraudulent-genetic-testing-results-charges-against>.

<sup>191</sup> Dep't of Just., *Danbury Physician and Mental Health Practice Pay \$36,000 to Settle False Claim Act Allegations*, JUSTICE NEWS (JULY 27, 2016), [HTTPS://WWW.JUSTICE.GOV/USAO-CT/PR/DANBURY-PHYSICIAN-AND-MENTAL-HEALTH-PRACTICE-PAY-36000-SETTLE-FALSE-CLAIMS-ACT](https://www.justice.gov/USAO-CT/PR/DANBURY-PHYSICIAN-AND-MENTAL-HEALTH-PRACTICE-PAY-36000-SETTLE-FALSE-CLAIMS-ACT).

<sup>192</sup> *Id.*

<sup>193</sup> *Id.*

<sup>194</sup> *Id.*

<sup>195</sup> *Id.*

<sup>196</sup> Dep't of Just. Off. of Pub. Aff., *Federal Indictments & Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over \$1.2 Billion in Losses*, JUSTICE NEWS (Apr. 9, 2019),

to the Assistant Attorney General, “[t]hese defendants[,] rang[ing] from corporate executives to medical professionals[,] allegedly participated in an expansive and sophisticated fraud to exploit telemedicine technology meant for patients otherwise unable to access health care.”<sup>197</sup> Finally, in September 2020, 345 defendants, including 100 medical professionals, across fifty-one federal districts were charged with six billion dollars worth of fraudulent claims, over two-thirds related to telehealth services.<sup>198</sup> A large portion of these claims were for services provided in substance abuse treatment programs and related to illegal opioid distribution.<sup>199</sup> Telehealth company executives allegedly paid medical professionals to order unnecessary services, where the medical professionals never met the patients, or had only a brief phone conversation with them, prior to ordering services.<sup>200</sup>

These cross-jurisdictional schemes may have wide reach due to their use of telehealth companies.<sup>201</sup> In some of these schemes, Medicare beneficiaries were contacted via telephone and asked to provide their beneficiary ID numbers, which were then used for fraudulent billing.<sup>202</sup> According to Kaiser Health News, “[t]hese fraudulent activities can become massive because phone rooms operating anywhere in the world can target thousands of patients and Medicare may have difficulty differentiating improper bills from those submitted by a legitimate

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<https://www.justice.gov/opa/pr/federal-indictments-and-law-enforcement-actions-one-largest-health-care-fraud-schemes>.

<sup>197</sup> *Id.*

<sup>198</sup> Dep’t of Just. Off. of Pub. Aff., *National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More than \$6 Billion in Alleged Fraud Losses*, JUSTICE NEWS (Sept. 30, 2020), <https://www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants>.

<sup>199</sup> *Id.*

<sup>200</sup> *Id.*

<sup>201</sup> Lathrop GPM, *Just What the DOJ Ordered: Telehealth Enforcement Actions Are Here To Stay*, JDSUPRA (Dec. 2, 2020), <https://www.jdsupra.com/legalnews/telehealth-enforcement-actions-48714/>.

<sup>202</sup> Fred Schulte, *Coronavirus Fuels Explosive Growth In Telehealth – And Concern About Fraud*, KAISER HEALTH NEWS (Apr. 22, 2020), <https://khn.org/news/coronavirus-fuels-explosive-growth-in-telehealth-%E2%80%95-and-concern-about-fraud/>.

telehealth operation.”<sup>203</sup> The Centers for Medicare and Medicaid Services (CMS) consequently implemented audits on claims related to “waivers and flexibilities” by government agencies, including those related to telehealth.<sup>204</sup> While these concerns are not specific to behavioral telehealth, they give federal agencies concern about expanding telehealth.<sup>205</sup>

Fraudulent practices executed via telehealth include kickback schemes where Medicare beneficiaries are contacted via telemarketers and offered kickbacks to refer them for unnecessary services or to prescribe them unnecessary products (e.g., medications, durable medical equipment).<sup>206</sup> Additionally, CMS is monitoring claims where providers may bill for more time than actually spent providing telehealth services or for more complex services than are actually rendered.<sup>207</sup> There is also concern that providers may bill for services not rendered effectively, or at all, due to technical obstacles (e.g., poor internet) interfering with service provision.<sup>208</sup>

#### **IV. BEHAVIORAL TELEHEALTH DURING THE COVID-19 PANDEMIC**

##### **A. Behavioral Telehealth Utilization**

On January 31, 2020, the Secretary of HHS declared a Public Health Emergency under § 319 of the Public Health Services Act.<sup>209</sup> On March 13, 2020, President Trump designated the COVID-19 outbreak a National Emergency.<sup>210</sup> As a result of the pandemic, behavioral telehealth utilization skyrocketed. According to Fair Health, a nonprofit organization that tracks medical

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<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

<sup>206</sup> Sharon Klein et al., *The Compliance Monthly: Fraud Emerges as Telemedicine Surges – Compliance Guidance For Telemedicine Providers*, Temple University Beasley School of Law Center for Compliance and Ethics (Oct. 14, 2020), <https://www2.law.temple.edu/10q/the-compliance-monthly-fraud-emerges-as-telemedicine-surges-compliance-guidance-for-telemedicine-providers/>.

<sup>207</sup> *Id.*

<sup>208</sup> *Id.*

<sup>209</sup> U.S. Dep’t of Health & Human Servs., *Determination that a Public Health Emergency Exists*, PHE.GOV (Jan. 31, 2020), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

<sup>210</sup> *Proclamation 9994 of March 13, 2020. Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, 85 Fed. Reg. 15,337 (Mar. 18, 2020).



claims submitted to private payers, the total volume of medical telehealth claims increased by 8,3335% in April 2020 relative to April 2019.<sup>211</sup> By October 2020 the telehealth claim volume was 3,060% higher than the same month in 2019.<sup>212</sup> The two primary Current Procedural Terminology (CPT) <sup>213</sup> claims codes submitted by behavioral health providers for psychotherapy services ranked as the third and fourth most utilized claim codes across all medical fields in April 2020.<sup>214</sup> That same month, mental health diagnoses accounted for 34.10% of all telehealth claims submitted to payers.<sup>215</sup> Six months later, in October 2020, the 60-minute psychotherapy CPT code was the second-highest utilized claim code across all medical specialties,<sup>216</sup> with mental health diagnoses accounting for 51.81% of all telehealth claims.<sup>217</sup>

Blue Cross Blue Shield (BCBS) organizations across the nation reported record highs in behavioral telehealth utilization.<sup>218</sup> In May 2020, BCBS of Massachusetts announced, “[w]e’re experiencing a revolution when it comes to telehealth use, both for medical and mental health care...[i]t’s likely that this kind of growth would otherwise have taken years, based on the trends we saw before the COVID-19 crisis.”<sup>219</sup> The organization stated that, pre-COVID, it received approximately 200 telehealth claims daily, but it started receiving over 38,000 telehealth claims

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<sup>211</sup> Fair Health, *Monthly Telehealth Regional Tracker*, <https://www.fairhealth.org/states-by-the-numbers/telehealth> (last visited Mar. 21, 2021).

<sup>212</sup> *Id.*

<sup>213</sup> Am. Med. Ass’n, *Current Procedural Terminology 2021 Professional Edition*, (4<sup>th</sup> ed. 2020).

<sup>214</sup> *Id.*

<sup>215</sup> *Id.*

<sup>216</sup> Fair Health, *supra* note 211.

<sup>217</sup> *Id.*

<sup>218</sup> See Blue Cross Blue Shield, *Increasing Telehealth and Virtual Care in the COVID-19 Era*, (Oct. 2020) <https://www.bcbs.com/smarter-better-healthcare/article/increasing-telehealth-virtual-care-in-the-covid-19-era>.

<sup>219</sup> Blue Cross Blue Shield of Mass., *Blue Cross Blue Shield of Massachusetts Processes 1 Million Telehealth Claims in 9 Weeks: Health plan adds more than 400 mental health clinicians to network to help meet demand*, (May 21, 2020)

<http://newsroom.bluecrossma.com/2020-05-21-Blue-Cross-Blue-Shield-of-Massachusetts-Processes-1-Million-Telehealth-Claims-in-9-Weeks>.

daily by May 2020.<sup>220</sup> It further reported that nearly half the telehealth claims since the start of the pandemic were for behavioral health visits.<sup>221</sup>

Research is also beginning to emerge showing gaps in telehealth utilization during the pandemic as a function of patient characteristics. One study's results raise concerns about social inequities in telehealth, although the data analyzed were specific to primary care and medical specialties other than behavioral health care.<sup>222</sup> Based on medical record reviews, certain patient characteristics were found to be associated with lower rates of telehealth utilization.<sup>223</sup> Patients who were older, Black, Latinx, or had lower income were less likely to utilize teleconference-based telehealth.<sup>224</sup> When the data included telephone-based telehealth, patients who were older, Asian or had a preferred language other than English were less likely to use telehealth.<sup>225</sup> Older patients were less likely to use telehealth overall, whether using video technology or telephone.<sup>226</sup> A limitation of this study is that it did not collect data on the specific barriers limiting patients' telehealth use.<sup>227</sup>

Another study compared in-person medical visits to telehealth utilization during the pandemic at Mount Sinai Hospital in New York.<sup>228</sup> The study identified adults over the age of sixty-five as being the least likely to utilize telehealth.<sup>229</sup> Moreover, Black and Hispanic patients were more likely to pursue in-person than telehealth care, as compared to White and Asian

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<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> See Lauren A. Eberly et al., *Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic*, 3 J. of the Am. Med. Ass'n Network Open (Dec. 29 2020), <https://pubmed.ncbi.nlm.nih.gov/33372974/>.

<sup>223</sup> *Id.*

<sup>224</sup> *Id.*

<sup>225</sup> *Id.*

<sup>226</sup> *Id.*

<sup>227</sup> *Id.*

<sup>228</sup> Ellerie Weber et al., *Characteristics of telehealth users in NYC for COVID-related care during the corona virus pandemic*, 27 28 J. OF THE AM. MED. INFORMATICS ASS'N 1949, (Dec. 2020). <https://academic.oup.com/jamia/article/27/12/1949/5899728>

<sup>229</sup> *Id.*

patients.<sup>230</sup> In contrast, a study based on survey data collected by the Pew Research Center reported different results.<sup>231</sup> The survey was conducted in March 2020 and asked respondents if they used “internet or email” to communicate with a doctor during the COVID-19 pandemic.<sup>232</sup> The data indicated that Black individuals were more likely to use “telehealth” than White respondents and this difference was accentuated when the patients perceived COVID-19 as a “minor health threat.”<sup>233</sup> Notably, this study differs in design from the aforementioned studies given its broad definition of telehealth and self-report methodology.

#### B. Federal Action Expanding Telehealth Access

The Social Security Act authorizes the Secretary of HHS to waive some of its requirements during national emergencies under § 1135 to ensure sufficient provision of health care to Medicare beneficiaries and reimbursement to Medicare providers, without penalization for noncompliance with exempted requirements.<sup>234</sup> Pursuant to this authority, the Secretary issued a waiver, effective March 2020, to permit providers to provide telehealth to Medicare beneficiaries nationwide during the COVID-19 pandemic.<sup>235</sup> This waiver exempted providers from the 42 CFR § 1834(m)(1) and §410.78(a)(3) requirement that “video technology” be used for telehealth, allowing use of telephones.<sup>236</sup> It also waived restrictions on the types of providers eligible to provide telehealth, making *all* providers eligible.<sup>237</sup> Furthermore, health care providers

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<sup>230</sup> *Id.*

<sup>231</sup> Celeste Campos-Castillo & Denise Anthony, *Racial and ethnic differences in self-reported telehealth use during the COVID-19 pandemic: a secondary analysis of a US survey of internet users from late March*, 28 J. OF THE AM. MED. INFORMATICS ASS'N 119, (Jan. 2021).

<sup>232</sup> *Id.*

<sup>233</sup> *Id.*

<sup>234</sup> See 42 U.S.C. § 1320b–5

<sup>235</sup> See Ctrs. for Medicare & Medicaid Servs., *Medicare Telehealth Care Provider Fact Sheet*, CMS.gov (Mar. 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>; Ctrs. for Medicare & Medicaid Servs., *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, CMS.GOV (Feb. 19, 2021), <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

<sup>236</sup> *Id.*

<sup>237</sup> *Id.*

were permitted, under the waiver, to use telehealth for both new and existing clients, eliminating the requirement of in-person assessments.<sup>238</sup> Congress’s intent as to the temporary nature of this exemption was clarified, however, when it enacted the Consolidation Appropriations Act of 2021 in December 2020, stipulating that providers treating mental health disorders must meet in person with patients within six months prior to providing telehealth.<sup>239</sup> The HHS waiver also permitted providers to deliver telehealth to beneficiaries in any location, including in their homes<sup>240</sup> and to waive beneficiaries’ cost-sharing.<sup>241</sup> CMS agreed to reimburse providers the same rate for telehealth services as for in-person services under the waiver.<sup>242</sup>

President Trump issued an executive order, *Improving Rural Health and Telehealth Access*, in August 2020, mandating the Secretary of HHS to “propose a regulation” for extension of the measures expanding telehealth services beyond the public health emergency.<sup>243</sup> The goal of this mandate was “to increase access to, improve the quality of, and improve the financial economics of rural healthcare, including by increasing access to high-quality care through telehealth.”<sup>244</sup> The Trump administration underscored challenges in rural communities preventing access to health care, such as transportation limitations and provider shortages.<sup>245</sup> Shortly thereafter, CMS issued the 2021 Physicians Fee Schedule Final Rule,<sup>246</sup> adding a variety of telehealth services, including psychotherapy, to the fee schedule to “allow beneficiaries in

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<sup>238</sup> *Id.*

<sup>239</sup> *See* Consolidation Appropriations Act of 2021, Pub. L. No. 116-260, § 123 (2020).

<sup>240</sup> *Id.*

<sup>241</sup> *Id.*

<sup>242</sup> Am. Med. Ass’n, CMS payment policies & regulatory flexibilities during COVID-19 emergency, <https://www.ama-assn.org/practice-management/medicare/cms-payment-policies-regulatory-flexibilities-during-covid-19> (last visited Mar. 21, 2021).

<sup>243</sup> *Executive Order 13941 of August 3, 2020: Improving Rural and Telehealth Access*, 85 Fed. Reg. 47,881 (Aug. 6, 2020).

<sup>244</sup> *Id.*

<sup>245</sup> *See Id.*

<sup>246</sup> *Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and other Changes to Part B Payment Policies*, 85 Fed. Reg. 84,472 (Dec. 28, 2020).

rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services.”<sup>247</sup> CMS cautioned, however, that “Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home.”<sup>248</sup>

The Coronavirus Aid, Relief, and Economic Security Act (CARES) appropriated \$200 million to assist providers in funding technology and equipment for telehealth services.<sup>249</sup> Furthermore, the HHS Office for Civil Rights (OCR) issued a statement on March 17, 2020 that it would exercise its enforcement discretion by “not enforce[ing] penalties...against covered health care providers for the lack of a BAA with video communication vendors or any other noncompliance with the HIPAA Rules that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency.”<sup>250</sup> Providers were permitted to use “popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth,” but not “Facebook Live, Twitch, TikTok, and similar video communication applications are public facing.”<sup>251</sup> Finally, the DEA applied the public health emergency exception, under 21 U.S.C. § 802(54)(D), to waive the Ryan Haight Act’s requirement of in-

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<sup>247</sup> <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment>

<sup>248</sup> Ctrs. for Medicare & Medicaid Servs., *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients*, CMS.gov (Dec. 1, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment>.

<sup>249</sup> Fed. Comm’n Comm’n, *COVID-19 Telehealth Program*, FCC.gov, <https://www.fcc.gov/covid-19-telehealth-program> (last visited Mar. 21, 2021) (reporting appropriation of funding between 2021 and 2025 for grants developing “evidence-based telehealth technologies and telehealth networks”).

<sup>250</sup> U.S. Dept. of Health & Human Servs. *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, HHS.gov, <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html> (last visited on Mar. 20, 2021).

<sup>251</sup> *Id.*

person assessments prior to prescribing controlled substances via telehealth.<sup>252</sup> Under this exception, “DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation” provided certain conditions are met.<sup>253</sup>

### C. State Action Expanding Telehealth Access

#### 1. *Executive and Legislative Action Reducing Reimbursement Barriers*

To encourage and support states governments in expanding telehealth coverage under Medicaid, CMS released the State Medicaid & CHIP Telehealth Toolkit in March 2020.<sup>254</sup> In the toolkit, CMS encouraged states to permit their Medicaid programs to provide telehealth benefits during the pandemic.<sup>255</sup> CMS issued guidance on reimbursement policies, granting states “great flexibility with respect to covering Medicaid services provided via telehealth,” including the authorization to pay for telehealth services “in the same manner as when the service is furnished in a face-to-face setting.”<sup>256</sup> If a state chose to implement different reimbursement methodology or reimbursement rates, an approved state plan was required, including submission of a Statement Plan Amendment.<sup>257</sup> In response, thirty-nine states implemented payment parity, requiring at least some telehealth services be reimbursed at the same rates as in-person

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<sup>252</sup> See U.S. Dept. of Just. Drug Enforcement Admin. Diversion Control Div., *COVID-19 Information*, [https://www.deadiversion.usdoj.gov/faq/coronavirus\\_faq.htm](https://www.deadiversion.usdoj.gov/faq/coronavirus_faq.htm) (last visited Mar. 20, 2021).

<sup>253</sup> *Id.* (requiring that “[t]he prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and the practitioner is acting in accordance with applicable Federal and State laws.”)

<sup>254</sup> Ctrs. for Medicare & Medicaid Servs., *State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth: COVID-19 Version*, Medicaid.gov (2020), <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>.

<sup>255</sup> *Id.*

<sup>256</sup> *Id.*

<sup>257</sup> U.S. Dept. of Health & Human Servs., *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, HHS.gov, <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html> (last visited Mar. 21, 2021).

services.<sup>258</sup> States also took additional steps to expand telehealth coverage, per the toolkit's recommendations. Forty-one states permitted coverage for behavioral telehealth.<sup>259</sup> Twenty-six states permitted patients to participate in telehealth from their homes.<sup>260</sup> Thirty-eight states permitted audio-only (non-video) communication technologies for telehealth.<sup>261</sup> Eleven states waived in-person assessment requirements prior to the provision of telehealth.<sup>262</sup> Finally, twenty states waived or decreased beneficiary cost-sharing requirements for telehealth.<sup>263</sup>

Beyond Medicaid, numerous states took executive action to reduce reimbursement barriers to telehealth by private payers. Sixteen states took executive action mandating or expanding mandated coverage parity for telehealth services.<sup>264</sup> Four states mandated telehealth parity as to all in-person services,<sup>265</sup> while others mandated coverage for specific services.<sup>266</sup> New Jersey and New Mexico had pre-existing parity statutes, but took executive action to remind insurance companies of these mandates.<sup>267</sup> Seventeen states also took executive action mandating (or reminding payers of the statutory requirement of) payment parity for all services provided via telehealth.<sup>268</sup> Finally, eight states took executive action to waive or limit consumer cost-sharing for telehealth services.<sup>269</sup> Some states required cost-sharing be equal or less than

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<sup>258</sup> Madeline Guth & Elizabeth Hinton, *State Efforts to Expand Medicaid Coverage & Access to Telehealth in Response to COVID-19*, KASIER FAM. FOUND. (June 20, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicaid-coverage-access-to-telehealth-in-response-to-covid-19/>.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> *Id.*

<sup>263</sup> *Id.*

<sup>264</sup> Kaiser Fam. Found. *State COVID-19 Data and Policy Actions*, (Jan. 22, 2021), <https://www.kff.org/report-section/state-covid-19-data-and-policy-actions-policy-actions/#note-4-3>.

<sup>265</sup> *Id.* (Arizona, California, Montana, Vermont)

<sup>266</sup> *Id.*

<sup>267</sup> *Id.*

<sup>268</sup> *Id.* (Arkansas, California, Delaware, Illinois, New York had pre-existing payment parity statutes, but took the executive action for the purpose of reminding insurance companies about the payment parity requirement)

<sup>269</sup> *Id.*

that of in-person services,<sup>270</sup> while Arizona mandated that cost-sharing be *less* than that of in-person services.<sup>271</sup> Illinois, New Jersey, New York, and North Dakota waived cost-sharing for *all* telehealth services, although Illinois and New York limited these waivers to services provided by in-network providers.<sup>272</sup>

While many states took executive action to temporarily expand telehealth during the pandemic, some states took legislative action to make expansion efforts permanent. California<sup>273</sup> and Washington<sup>274</sup> passed telehealth parity bills that became effective in 2021. Massachusetts enacted legislation mandating both coverage and payment parity in 2021,<sup>275</sup> after the Governor issued an executive order on March 15, 2020 mandating coverage and payment parity.<sup>276</sup> New Hampshire passed a statute in July 2020 mandating payment parity for Medicaid and commercial payers.<sup>277</sup> This law eliminated patient site location restrictions and expanded the list of providers permitted to deliver telehealth to include psychologists, mental health practitioners, community mental health providers, and drug counselors.<sup>278</sup> The law further expanded telehealth for substance use treatment, including relaxing telehealth prescription restrictions.<sup>279</sup> Colorado passed legislation in July 2020 making it easier for providers to receive reimbursement for

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<sup>270</sup> *Id.* (California, District of Columbia, Oregon)

<sup>271</sup> *Id.*

<sup>272</sup> *Id.*

<sup>273</sup> Eric Wicklund, *California Enacts Telehealth Payment Parity, Boosts Asynchronous Care*, mHealthIntelligence.com (Oct. 21, 2019), <https://mhealthintelligence.com/news/california-enacts-telehealth-payment-parity-boosts-asynchronous-care>.

<sup>274</sup> *See* WASH. REV. CODE § 41.05.700 (2020); WASH. REV. CODE § 48.43.735 (2020).

<sup>275</sup> Commonwealth of Mass. Dept. of Pub. Health, *Governor Baker Signs Health Care Legislation Increasing Access to Quality, Affordable Care, Promoting Telehealth and Protecting Access to COVID-19 Testing, Treatment*, Mass.gov (January 1, 2021), <https://www.mass.gov/news/governor-baker-signs-health-care-legislation>.

<sup>276</sup> Commonwealth of Mass. Off. of Governor, *Order Expanding Access To Telehealth Services and To Protect Health Care Providers*, Mass.gov, (Mar. 15, 2020), <https://www.mass.gov/doc/march-15-2020-telehealth-order/download>.

<sup>277</sup> N.H. REV. STAT. ANN. § 415-J:3 (2020).

<sup>278</sup> *Id.*

<sup>279</sup> *Id.*



telehealth.<sup>280</sup> The statute prohibits private payers from limiting telehealth coverage to the use of specific technologies or to providers with specific telehealth training or certification.<sup>281</sup>

Additionally, the statute prohibits private payers from restricting reimbursement to patients with whom providers have pre-existing treatment relationships.<sup>282</sup> Prior to the pandemic, Washington passed payment parity legislation scheduled to take effect in January 2021, but the Governor ordered that it take effect in March of 2020 via executive action.<sup>283</sup>

## 2. *Executive and Legislative Action Expanding Interjurisdictional Practice*

During the COVID-19 pandemic, the APA issued the following statement:

We are asking state policymakers to temporarily suspend state licensing requirements for telepsychological services, which would allow patients greater access to their providers and ensure continuity of care during this crisis[.] Essential psychological services can, and in many cases, should be delivered through telehealth. It is critically important that psychologists are able to meet the needs of their patients and communities during this difficult time, without further increasing the risk of contagion.<sup>284</sup>

In March 2020, the Secretary of HHS invoked the § 1135 waiver to grant health care professionals exemption from the 42 CFR §485.608(d) requirement<sup>285</sup> that they hold a license in the state where they provide health care services.<sup>286</sup> Specifically, CMS stated that it was “temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state.”<sup>287</sup> Two days later, CMS

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<sup>280</sup> Colo. Rev. Stat. § 10-16-123 (2020).

<sup>281</sup> *Id.*

<sup>282</sup> *Id.*

<sup>283</sup> See State of Washington Off. of the Governor, *Proclamation by the Governor: Amending Proclamation 20-05*, governor.wa.gov (March 25, 2020), [https://www.governor.wa.gov/sites/default/files/proclamations/20-29%20Coronavirus%20OIC%20%28tmp%29.pdf?utm\\_medium=email&utm\\_source=govdelivery](https://www.governor.wa.gov/sites/default/files/proclamations/20-29%20Coronavirus%20OIC%20%28tmp%29.pdf?utm_medium=email&utm_source=govdelivery).

<sup>284</sup> Am. Psychol. Ass’n., *APA To States, Insurers: Provide Access to Mental Health Care During COVID-19 Public Health Crisis*, APA.org (Mar. 24, 2020), <https://www.apa.org/news/press/releases/2020/03/mental-health-care-covid-19>.

<sup>285</sup> 42 CFR §485.608(d)(requiring licensure, certification or registration “in accordance with applicable Federal, State, and local laws and regulations”).

<sup>286</sup> Ctrs. for Medicare & Medicaid Servs., *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, CMS.gov (Dec. 1, 2020), <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

<sup>287</sup> *Id.*

clarified that states would also need to waive licensure requirements for “physician or non-physician practitioner to avail him- or herself of the 1135 waiver [because the waiver] does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements.” On March 24, 2020, the Secretary of HHS submitted a letter to state governors requesting they take action to facilitate telehealth access in their states.<sup>288</sup> The Secretary encouraged governors to permit health professionals licensed in other states to provide both telehealth and in-person health care in the governors’ states.<sup>289</sup> He additionally requested that states waive statutory restrictions on “establish[ing] a patient-provider relationship, diagnos[ing] and deliver[ing] treatment recommendations utilizing telehealth technologies.”<sup>290</sup>

By June 2020, all states utilized § 1135 waivers to permit out of state providers to provide interjurisdictional health care to their Medicaid beneficiaries.<sup>291</sup> State governors in most states issued emergency declarations amending professional licensure requirements and approving temporary provisions for health care providers licensed across state lines to provide interjurisdictional services.<sup>292</sup> Behavioral health providers across different disciplines struggled to understand the patchwork of temporary licensure waiver statutes across various states, in

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<sup>288</sup> Alex M. Azar II, *Letter to Governors from the Secretary of Health and Human Services*, NCSBN.com (Mar. 24, 2020), [https://ncsbn.org/HHS\\_Secretary\\_Letter\\_to\\_States\\_Licensing\\_Waivers.pdf](https://ncsbn.org/HHS_Secretary_Letter_to_States_Licensing_Waivers.pdf).

<sup>289</sup> *Id.*

<sup>290</sup> *Id.*

<sup>291</sup> See Kaiser Fam. Found., *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19*, KFF.org (March 29, 2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19>.

<sup>292</sup> See, e.g., Fed’n of State Med. Bds., *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, fsmb.org, <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf> (last updated Mar. 16, 2021); Ass’n. of State & Provincial Psychol. Bds., *Temporary/Telepsychological Practice and COVID-19*, aspbb.net (Sept. 8, 2020), [https://cdn.ymaws.com/www.aspbb.net/resource/resmgr/covid19/9.8.2020\\_temporary\\_&\\_telepsy.pdf](https://cdn.ymaws.com/www.aspbb.net/resource/resmgr/covid19/9.8.2020_temporary_&_telepsy.pdf).

response to which professional organizations published summaries of state-specific interjurisdictional practice waivers across the nation.<sup>293</sup>

In May 2020, CMS issued a statement that “the interstate license compacts, for [certain] provider types, will be treated as valid, full licenses for the purposes of meeting our . . . license requirements.”<sup>294</sup> Psychologists and physicians were identified as disciplines for which CMS would recognize such licenses.<sup>295</sup> Additionally, some states took legislative action to join interjurisdictional licensing compacts. Virginia enacted PSYPACT legislation in April 2020, becoming the thirteenth state to do so, followed by Pennsylvania in May 2020, North Carolina in July 2020, and the District of Columbia in December 2020.<sup>296</sup> Eight additional states introduced pending PSYPACT legislation since the start of the COVID-19 pandemic.<sup>297</sup> Moreover, Pennsylvania, Delaware, and Washington D.C. passed statutes to join the Interstate Medical Licensure Compact.<sup>298</sup> New Jersey and Missouri introduced bills to join the Compact in 2020, while Oregon, Texas, Ohio, and New York introduced bills in 2021.<sup>299</sup>

## **V. ROADMAP FOR THE FUTURE OF BEHAVIORAL TELEHEALTH**

### **A. Overview**

Telehealth can improve behavioral health care access by decreasing barriers related to general provider shortages, shortages of providers who accept health insurance, and narrow

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<sup>293</sup> See, e.g., Fed’n of State Med. Bds., *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, fsmb.org, <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf> (last updated Mar. 16, 2021); Ass’n. of State & Provincial Psychol. Bds., *Temporary/Telepsychological Practice and COVID-19*, aspnb.net (Sept. 8, 2020), [https://cdn.ymaws.com/www.aspnb.net/resource/resmgr/covid19/9.8.2020\\_temporary\\_&\\_telepsy.pdf](https://cdn.ymaws.com/www.aspnb.net/resource/resmgr/covid19/9.8.2020_temporary_&_telepsy.pdf).

<sup>294</sup> Ctrs. for Medicare & Medicaid Servs., *Medicare Clarifies Recognition of Interstate License Compacts*, CMS.gov, (May 5, 2020), <https://www.cms.gov/files/document/SE20008.pdf>.

<sup>295</sup> *Id.*

<sup>296</sup> See PSYPACT, *supra* note 188.

<sup>297</sup> See *Id.*

<sup>298</sup> See Interstate Med. Licensure Compact, *supra* note 175.

<sup>299</sup> *Id.*

insurance networks. It may offer patients more access to specialty providers, including those offering specialized treatments and services in different languages. Burdens related to social resources deficits disproportionately impacting poor and rural communities, such as lack of reliable transportation, inadequate childcare, and the inability to take paid time off work, may be alleviated by telehealth. Additionally, telehealth may save patients costs by decreasing burdens on these valuable resources.

Behavioral telehealth utilization increased substantially during the COVID-19 pandemic, as illustrated by significant increases in medical claims for these services. Behavioral health providers and patients quickly transitioned to using telehealth out of necessity, in response to safety restrictions against the provision of in-person behavioral health services. This transition has the potential to permanently impact behavioral health care, as it is particularly amenable to delivery via telehealth. To date, research on telehealth during the COVID-19 pandemic has primarily focused on service utilization. The HHS Assistant Secretary for Planning and Evaluation has called for outcome research evaluating the impact of COVID-19 telehealth expansion on access to care and health outcomes, especially for underserved populations.<sup>300</sup> Prior to the pandemic, however, a large body of research demonstrated behavioral telehealth to be as effective as in-person treatment across a variety of clinical populations.

Prior to the COVID-19 pandemic, government and private payers either refused to cover telehealth services or set up significant reimbursement barriers to coverage, including limitations on how, when, and to whom providers could provide telehealth. When telehealth was reimbursed by payers, providers were paid lower reimbursement rates relative to rates for the same in-person

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<sup>300</sup> U.S. Dept. of Health & Human Servs., *Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the COVID-19 Pandemic*, ASPE.HHS.gov, (July 28, 2020), <https://aspe.hhs.gov/system/files/pdf/263866/hp-issue-brief-medicare-telehealth.pdf>.

services, disincentivizing them from providing telehealth. Some insurance plans imposed higher cost-sharing requirements for patients, making it more costly for them to receive telehealth. During the pandemic, the federal government took executive action to expand telehealth coverage by Medicare. Similarly, governors across the nation issued executive orders mandating telehealth coverage and payment parity, although the reach of these orders was limited to Medicaid and fully-funded insurance plans. Federal and state governments took additional actions to expand telehealth, with some legislatures making these actions permanent. Additional legislative action should be taken to permanently expand behavioral telehealth post-COVID-19.

A. Recommendations for Continuation of COVID-19 Actions

It is recommended that the following telehealth expansion actions taken during the COVID-19 pandemic be made permanent via legislative action:

1. Telehealth coverage parity should be mandated for behavioral health care, at least as to psychotherapy services, requiring all payers to cover telehealth without restrictions beyond those required for in-person services.
2. Restrictions limiting provider disciplines eligible to deliver behavioral telehealth should be eliminated to the extent that providers eligible to deliver specifically services in person be permitted to deliver those services via telehealth.
3. Requirements that treatment relationships be established in person prior to initiating telehealth, including in-person assessment requirements, should be eliminated as to behavioral health assessments. Unlike traditional medical services requiring physical examinations, behavioral health care assessments are conducted via verbal or similar communicative means and do not necessitate in-person physical examinations. Moreover,

research has demonstrated that behavioral health assessments conducted via telehealth are as effective as when conducted in person, often yielding identical results.<sup>301</sup>

4. Geographic site restrictions (e.g., to rural areas with provider shortages) as to patient eligibility for telehealth should be eliminated.
5. Restrictions on the location of the patients' originating site should be eliminated, permitting patients to receive behavioral telehealth in their homes.
6. Federal and state governments should help fund and provide infrastructural support to behavioral health providers to improve their ability to deliver telehealth to the public.
7. Given the dearth of evidence that behavioral health care providers save costs by providing telehealth, payment parity for behavioral telehealth should be mandated. Providers should be reimbursed for telehealth services at the same rates as for in-person services. Payment parity mandates will incentivize providers to provide telehealth.
8. While the continuation of cost-share waivers may be financially impractical post-COVID-19, payers should be prohibited from implementing telehealth cost-sharing requirements on consumers exceeding those for in-person services.
9. The Social Security Act, ERISA, state Medicaid, and private payer statutes should be amended to make the afore-mentioned recommended actions applicable to *all* federal and private payers in the United States. Alternatively, the ACA should be amended to require the actions apply to all payers.
10. Physician and psychologist licensing boards should join existing interstate licensing compacts to permit providers to offer telehealth across state lines. Licensing boards for other behavioral health provider disciplines (e.g., social work, counseling, marriage and

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<sup>301</sup> Ruskin *supra* note 80.

family therapists) should develop interstate licensing compacts, utilizing the PSYPACT or IMCL act as a model. These compacts offer states the option of two different approaches, giving legislatures the flexibility to adopt or adapt the approach that best suits their public policy goals. One approach centralizes and facilitates licensure amongst member states simultaneously, while the other directly licenses providers to provide interjurisdictional telehealth.

#### B. Considerations for Other COVID-19 Actions

Other measures taken during the COVID-19 pandemic, while conducive to behavioral telehealth expansion, may face significant regulatory and practical obstacles if implemented permanently. The waiver of certain HIPAA requirements, for example, may expose patients to risks of confidentiality and PHI breaches. While the incorporation of mainstream technology applications in telehealth should continue, the waiver implemented during the COVID-19 pandemic as to HIPAA is overbroad, exposing patients to unnecessary risks. Instead, efforts should be made to integrate mainstream technological applications in telehealth delivery, given their accessibility to the public and potential to decrease technological barriers. Making widely used technology applications HIPAA-compliant, for example, addresses the dual goals of protecting patient confidentiality and PHI, while increasing telehealth access. Finally, as to limits on telehealth prescribing, additional research on the clinical effectiveness of psychopharmacological telehealth services is needed. Moreover, careful consideration of risks associated with online prescribing is warranted prior to taking permanent legislative action, but beyond the scope of this paper.

#### C. Recommendations Beyond COVID-19 Actions

These recommended legislative actions should not occur in a vacuum. Federal and state efforts to minimize other telehealth barriers, beyond those addressed during the COVID-19 pandemic, are also warranted. Technological barriers, in particular, risk exacerbating social inequities in health care, giving rise to that recommendation that telehealth should be offered alongside traditional in-person services, rather than *in lieu* of such services, whenever possible. This recommendation is also relevant as to patients for whom telehealth may be contraindicated (e.g., domestic violence victims residing with perpetrators).

Continued efforts to improve technology access, literacy, and accessibility in the United States should be an integral aspect of telehealth expansion. Additional funding and support is needed to improve access to stable high-speed internet and technology with video conferencing capabilities. Training on the use of telehealth applications should be provided to patients prior to initiating telehealth. Telehealth software should be available in different languages, enabling patients to access the software in their first language. Moreover, development efforts should focus on making telehealth technology more accessible to elderly and disabled populations.

Finally, HHS's efforts to identify telehealth fraud and abuse should continue, with the goal of preventing such fraud before it becomes widespread, unwieldy, and costly. The American Telemedicine Association (ATA) issued a press release addressing this issue, in which it noted that the defendants indicted by the DOJ to date for telehealth fraud were "call centers and international marketing centers" that "do not represent the legitimate practice of telemedicine or the well-established operations of health systems and telehealth companies."<sup>302</sup> The ATA called for use of technology to develop "fraud detection models, systems, and audit mechanisms to

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<sup>302</sup> American Telehealth Association, *ATA Comments on National Health Care Fraud and Opioid Takedown and International Telemarketing Scammers*, AMERICANTELEMED.ORG, <https://www.americantelemed.org/press-releases/ata-comments-on-national-health-care-fraud-and-opioid-takedown-and-international-telemarketing-scammers/> (last visited Apr. 14, 2021).



catch illegal prescribing and billing.’<sup>303</sup> HHS’s efforts should focus on the development of technology that can identify fraudulent billing practices particularly likely to arise in the context telehealth. Fraud and abuse risk exists in the context of any health care delivery modality, however, and should not otherwise impede telehealth expansion.

### **CONCLUSION**

Federal and state governments should continue efforts to expand behavioral telehealth post-COVID-19. Telehealth has long been considered a solution to significant health care barriers and research demonstrates that behavioral health care, particularly psychotherapy, is well suited for delivery via telehealth. The COVID-19 pandemic forced federal and state governments to quickly expand telehealth access to address unique health care access barriers arising during the pandemic. These expansion efforts provide a roadmap for the effective expansion of behavioral telehealth after the pandemic recedes. Some state legislatures have already utilized this roadmap to enact permanent legislation. Federal and state legislatures should continue these efforts, in addition to turning its attention to additional behavioral telehealth barriers that were not addressed during the pandemic.

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<sup>303</sup> *Id.*