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The Doctor is Online: How the COVID-19 Public Health Emergency Created a Pathway to Increased Access to Mental Healthcare Treatment

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INTRODUCTION

Reported diagnoses of mental and behavioral health disorders in the United States have steadily increased over time, with a marked increase following the onset of the COVID-19 pandemic. Patients report that obtaining medical care for these types of disorders is often difficult due to issues with provider and appointment availability, insurance coverage, and high out-of-pocket costs. During the COVID-19 pandemic, health care providers and patients were forced to utilize telemedicine broadly, and in doing so, created a new norm for healthcare delivery. These system-wide changes created an opportunity for the permanent expansion of the practice which could lead to an increase in access to care for patients.

This first section of this paper will discuss the development of the mental health crisis in the United States and the primary drivers for the insufficient treatment options available to patients. The second section will describe how the COVID-19 pandemic sparked a dramatic change in the use of telemedicine in medical treatment and highlight the changes made by the federal government which expanded access to virtual care. The third section will discuss the primary barriers and challenges that impede the expansion of telemedicine treatment broadly. Finally, the last section will present suggested solutions that could be implemented to permanently expand access to care for mental and behavioral health treatment.

BACKGROUND

Mental and behavioral health conditions are on the rise in the United States, and the number of medical professionals equipped to treat these conditions have not kept up with the needs of the patient population.[1] Half of adults in the U.S. report that a member of their family

[1] American Psychological Association. 2022 COVID-19 Practitioner Impact Survey.

has experienced a severe mental health crisis.[2] There are many barriers to receiving treatment for a mental health condition, and over a quarter of adults in the U.S. have had at least one experience in a12-month period where they thought they needed mental health services, but did not get them.[3] The primary barriers to receiving necessary mental health care cited by respondents include rising costs, insufficient insurance coverage, inadequate access to local providers, and fear of stigma.[4] To address this growing crisis and overcome some of the common barriers to receiving care, many patients have begun turning to telemedicine to obtain the mental and behavioral health care that they need.

The use of telehealth and telemedicine became ubiquitous in our medical culture seemingly overnight at the onset of the COVID-19 pandemic. Telehealth is defined as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related educations, health administration, and public health."[5] In this paper, I will be referring to telemedicine, which is "medical care provided remotely to a patient in a separate location using two-way voice and visual communication."[6]

A. The prevalence of mental and behavioral health disorders is increasing.

In 2019, 19.86% of American adults experienced a mental illness.[7] In 2023, that number had risen to over 30%.[8] The number of adults who reported feelings of anxiety and depression

[2] Lunna Lopes, et. al., *KFF/CNN Mental Health In America Survey* (Oct. 5, 2022) www.kff.org/report-section/kff-cnn-mental-health-in-america-survey-findings
[3] *Id.*
[4] *Id.*
[5] *What is Telehealth?*, Health Resources and Services Administration. (Last Reviewed Mar. 2022) www.hrsa.gov/telehealth/what-is-telehealth.
[6] *Telemedicine*, MERRIAM-WEBSTER DICTIONARY (New Edition 2022)
[7] Maddy Reinert, Theresa Nguyen, and Danielle Fritze. *The State of Mental Health in America 2022*, Mental Health America (Oct 2021)
[8] National Center for Health Statistics. U.S. Census Bureau, Household Pulse Survey, 2020–2023. Anxiety and Depression. Generated interactively: from https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm

increased during the height of the COVID-19 pandemic in 2020 and 2021, but those instances have not returned to pre-pandemic levels.[9] Additionally, half of American parents report that the COVID-19 pandemic had a negative effect on their children's mental health.[10]

B. There are insufficient providers to treat the patient population.

Shortages of healthcare providers in the United States have been increasing over time and have left millions of Americans without access to appropriate, local medical care.[11] This gap in professional services is particularly stark for medical providers who treat patients for mental and behavioral health disorders.[12] There are an estimated 167 million Americans who live in areas that are experiencing shortages of mental health providers.[13] Specialists in mental health care are not entering the marketplace at an adequate pace to meet the needs of the American population as it grows and as instances of mental illness increase.[14] By 2025, estimates show that there will be shortages in nearly all types of behavioral health practitioners, including psychiatrists, psychologists, and mental health and substance abuse social workers.[15]

In addition to the lack of mental and behavioral health specialists, many primary care providers feel that they are ill-equipped to diagnose or treat mental illnesses and are frequently unable to refer their patients to appropriate services.[16] However, despite this fact, primary care

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[9] *Id.*
[10] Lopes, et. al. *supra*
[11] Health Resources & Services Administration. Health Workforce Projections. (Last Reviewed Mar. 2024) https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand.
[12] *Id*.
[13] Health Resources and Services Administration (HRSA) Bureau of Health Workforce (June 2021)
[14] Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. 2015. National Projections of Supply and Demand for Behavioral Health Practitioners: 2013-2025. Rockville, Maryland.
[15] *Id.*
[16] Peter J. Cunningham, *Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care.* Health Affairs Vol. 28, Issue Supplement 1, w490-w500

providers are one of the main sources of mental health care treatment in the US.[17] In many communities who experience a shortage of specialists, patients who seek help for mental or behavioral health concerns must choose between relying on their primary care provider or foregoing treatment entirely.

This gap in coverage is felt most acutely in rural communities, where access to any type of medical care is more limited than in urban areas.[18] Mental and behavioral health care is even more difficult to obtain because 65% of rural counties in the U.S. report not having a psychiatrist and 81% report not having a psychiatric nurse practitioner.[19]

C. Common mental and behavioral health disorders can be effectively treated via telemedicine.

Many studies have compared the effectiveness of mental and behavioral health interventions when provided in-person vs. virtually and have shown that the treatments produced the same outcomes.[20] Telemedicine has been found to be just as effective as in-person care for treatment of a wide range of mental illnesses, including depression, anxiety, and PTSD.[21] Data has demonstrated that patients who receive psychiatric care virtually experience good outcomes including reduced symptoms of their disorders, strong adherence to prescribed medications, and high levels of patient satisfaction.[22]

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[17] *Id.*
[18] *Rural Mental Health Crisis*, Mental Health America. (Mar 13, 2024) https://mhanational.org/rural-mental-health-crisis.
[19] *Id.*
[20] Christina S. Palmer, et. al., *Virtual Care for Behavioral Health Conditions*. Prim. Care: Clinics in Office Practice Vol. 49, Issue 4, 641-657 (Dec 2022)
[21] *Id*.
[22] Donald M. Hilty, et. al., *The Effectiveness of Telemental Health: A 2013 Review*. Telemedicine and e-Health, 444-454 (Jun 2013)

The existence of virtual behavioral healthcare and its benefits have been known for many years, however, the adoption of the practice by medical providers was very limited prior to the COVID-19 pandemic.[23] Despite the fact that providing care virtually was shown to provide time savings, an increase in patient access, high user satisfaction, and the same level of effectiveness as in-person treatments, it was rarely used.[24] Before the onset of the COVID-19 pandemic, psychologists performed just 7% of their clinical work via telemedicine.[25] After the pandemic began, psychologists reported that they were performing over 85% of their clinical work virtually.[26]

Some providers have noted that a potential disadvantage of providing mental health treatment via telemedicine is that it can result in difficulty "detecting nonverbal cues such as fidgeting or crying, poor hygiene, or signs of intoxication" which can result in developing a less effective therapeutic alliance between patient and provider.[27] However, providers also expressed that treating their patients virtually gave them additional, valuable context about their patient's lives.[28] With many patients speaking with their providers via videoconference from their homes, providers are able to gather additional insights into the living conditions of their patients, which can provide useful insights into relevant conditions such as a person's sleeping environment or medication storage.[29] They are also given an opportunity in some instances to observe objects, pets, or other items in a person's home which allows them to better understand their patient and

[23] Palmer et. al., *supra.*
[24] *Id.*
[25] Bradford S. Pierce, et. al., *The COVID-19 Telepsychology Revolution: A National Study of Pandemic-Based Changes in U.S. Mental Health Care Delivery*, 76 Am. Psychol. 14 (Aug. 20, 2020)
[26] *Id.*
[27] Samantha L. Connolly, et. al., *A systematic review of providers' attitudes toward telemental health via videoconferencing.* Clin Psychol, Vol. 27(2), Article e12311 (Jan 2020)
[28] Hilty, et. al., *supra*.
[29] *Id.*

build rapport with them.[30] Overall, data suggests that the therapeutic alliances formed when treating patients via telemedicine are as strong as those formed during in-person care.[31]

Another commonly cited concern for providers was technological challenges that could arise out of offering virtual care, including concerns about malfunctions during treatment sessions and the need for technical support and training with telehealth systems.[32] However, these concerns have begun to be addressed in a few ways. Prior to the COVID-19 pandemic, some undergraduate and graduate schools were already beginning to build telemedicine curricula into their programs.[33] In 2020, the United States Medical Licensing Exam incorporated phone interactions with patients into a Clinical Skills exam.[34] As providers begin to receive training in telemedicine delivery during their schooling, and the familiarity with the practice of telemedicine expands in the general population, the comfort experienced by providers and patients in providing and receiving care virtually should increase in-step.

A NEW APPROACH

A. COVID-19 jumpstarted the mass adoption of telemedicine.

Prior to the peak of the COVID-19 pandemic, telemedicine made up less than 1% of all medical services provided in the United States.[35] In 2020, the number of health care visits conducted via telemedicine rose to 20% of all medical care visits.[36]

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[30] *Id.*
[31] Palmer, et. al., *supra*
[32] Connolly, et. al., *supra*
[33] Ariella Magen Iancu, et. al., *Unmuting Medical Students' Education: Utilizing Telemedicine During the COVID-19 Pandemic and Beyond.* J Med Internet Res., Vol. 22(7), Article e19667 (Jul 2020)
[34] *Id.*
[35] Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*. Primary Care: Clinics in Office Practice, Vol. 49, Issue 4, 517-530 (Dec 2022)
[36] *Id.*

In March 2020, the onset of quarantine mandates reduced the ability of patients to seek in-person health care, except in emergencies, which drove down the overall utilization of medical services dramatically.[37] Patients and providers were forced to adapt quickly to ensure that patients could still receive the treatment they needed and health plans and health systems were forced to expand the ability for providers to see their patients virtually.

These needs were supported by the federal government in many ways. On March 6, 2020, President Trump signed the Coronavirus Preparedness and Response Supplemental Appropriation Act of 2020 into law.[38] The Act provided $8.3B in funding for federal agencies to respond to the COVID-19 pandemic.[39] The Act also contained a section called "Division B" that was specifically geared towards promoting the expansion of telehealth services.[40] Division B of the law authorized the Department of Health and Human Services (HHS) to waive requirements of Medicare relating to which providers could provide covered telehealth services and the geographic restrictions which only allowed some Medicare members to be eligible for covered virtual care.[41]

Acting under the authority of this law, the Centers for Medicare and Medicaid Services (CMS) put several blanket section 1135 waivers into effect to create flexibility for more providers and patients to utilize telemedicine.[42] These waivers are authorized under section 1135 of the Social Security Act and can be used by the Secretary of HHS to temporarily change or

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[37] *Id*.
[38] Coronavirus Preparedness and Response Supplemental Appropriation Act of 2020, HR 6074, 116th Cong, 2nd Sess (2020)
[39] *Id.*
[40] *Id. See* Division B.
[41] *Id.*
[42] Centers for Medicare and Medicaid Services, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers.* (Last Updated Oct 13, 2022)

waive certain requirements of federal insurance programs in the event of a national emergency.[43] "Blanket" Medicare waivers apply to all "similarly situated providers" in an area which has been found to be in a state of emergency.[44] The actions taken by the waivers included allowing more types of providers to bill Medicare for telehealth services and for patients to receive care via telemedicine from their homes.[45] The waivers also allowed any Medicare recipient to receive care via telemedicine regardless of where they live[46] and to allow for the use of audio-only communications via telephone to be eligible as a reimbursable service.[47]

Other notable changes implemented under the blanket waivers were that CMS relaxed their restrictions on state-specific licensure to allow providers to treat patients in states other than the state, or states, the provider was licensed to practice in[48] and altered reimbursement terms for some appointments provided virtually.[49] Under the waivers, Medicare payments for virtual

[43] Centers for Medicare and Medicaid Services, *1135 Waivers*, (Last modified Sept. 6, 2023) https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/1135-waivers

[44] *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, supra* at 44.

[45] *Id.* at 1. Announcing the waiver of 42 CFR § 410.78(b)(2) to allow any practitioner registered with CMS to provide telemedicine rather than only approved provider types and waiver of 42 CFR § 410.78(b)(3) to allow patients and providers to participate in telemedicine appointment from their homes without needing to fall under one of the exceptions included in the regulations. Prior to the waiver of this regulation Medicare beneficiaries had to participate in their telemedicine appointments at a Medicare Originating Site where they would use the facility's technology to speak with their provider in accordance with 42 CFR § 410.78(b)(4).

[46] *Id.* Prior to the implementation of the section 1135 waivers, Medicare beneficiaries could only access virtual care in their homes under very specific circumstances as outlined by 42 CFR § 410.78(b)(3) or at another "originating site" which were only set up in areas considered to be "health professional shortage areas" or other acceptable geographic regions as laid out in 42 CFR § 410.78(b)(4).

[47] *Id.* at 1. Announcing waiver of the requirement in 42 CFR § 410.78(a)(3) that all eligible appointments must be conducted via technology with two-way audio and video communication and allowed for some reimbursable services to be provided via telephone in an audio-only format.

[48] *Id* at 36. See "Practitioner Locations". Allowing for practitioners who are registered providers with CMS to provide virtual or in-person care to patients based in a state other than their state of licensure.

[49] Centers for Medicare and Medicaid Services, *Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19.* (Last Updated Nov. 6, 2023). *See* "Telephone Evaluation, Management/Assessment and Management Services, and Behavioral Health and Education Services".

appointments were equivalent to payments rendered for the same appointment type provided in-person.[50]

Private health insurance plans are not subject to section 1135 waivers and there are no federal requirements that private insurance plans offer telehealth coverage.[51] However, CMS and the Departments of Health and Human Services, Labor, and the Treasury also issued guidance for private insurance plans which included temporary flexibilities that would allow the insurance plans to adjust their plans to promote patient use of telemedicine services.[52] The guidance allowed for plans to make mid-year changes to their plan designs that would provide increased coverage for telemedicine care or reduce patient cost-sharing for telemedicine appointments.[53] Some plans were given temporary authority to grant telehealth-only coverage to employees who were not otherwise eligible to enroll in the other plans offered by the employer, and catastrophic and high deductible health plans were authorized to cover telemedicine services pre-deductible.[54]

The rapid and widespread adoption of telemedicine services which occurred following the changes discussed above created a sea-change in the industry for providers and patients, and in doing so, created a blueprint for how the healthcare delivery model could be altered to better serve communities and patients going forward.

B. Federal investment in mental and behavioral health treatment services.

Long before the COVID-19 pandemic, the Federal government demonstrated the importance of expanding access to mental and behavioral health care by enacting parity laws, which are

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[50] *Id.*
[51] Katherine M. Kehres, *Federal Telehealth Flexibilities in Private Health Insurance During the COVID-19 Public Health Emergency: In Brief*, Congressional Research Service Report R47424 (Feb. 14, 2023)
[52] *Id.* at 2
[53] *Id.* at 3
[54] *Id.* at 4

intended to increase access to mental health treatment.[55] In recent years, the federal government has also dedicated meaningful funding to support the development of behavioral health infrastructure in communities through the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS).[56]

1. Evolution of Parity Laws.

Mental health parity laws are intended to ensure that insurers and employers cover mental health and substance use disorder treatments in the same way as they do medical or surgical treatments. While a version of these laws has been on the books for decades, there are many factors that make enforcing them effectively challenging.

Modern parity laws require, that patient cost-sharing (known as "financial requirements") for mental health and SUD treatments are "no more restrictive" than the requirements applied to "substantially all" medical or surgical benefits covered by a plan.[57] For example, the copay a member pays to see a doctor for ongoing, routine treatment of their diabetes should not be different than the copay that member pays to receive ongoing, routine therapy to treat an anxiety disorder. Other issues the law seeks to address are network restrictions, which place limits on which providers a member may see, and uneven requirements of step therapy, which require patients to try less expensive treatments than the one prescribed by their provider before the plan agrees to cover the recommended treatment.[58]

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[55] Colleen L Barry, Haiden A Huskamp, Howard H Goldman, *A Political History of Federal Mental Health and Addiction Insurance Parity*, Milbank Quarterly, Vol. 88, Issue 3, 404-433 (Sep 2010)
[56] Press Announcement, Biden-Harris Administration, *Biden-Harris Administration Announces $36.9 Million in Behavioral Health Funding Opportunities* (Feb 26, 2024)
[57] Center for Medicare and Medicaid Services, *Fact Sheet: The Mental Health Parity and Addiction Equity Act of 2008 (Jan. 29, 2010)* https://www.cms.gov/newsroom/fact-sheets/mental-health-parity-and-addiction-equity-act-2008-mhpaea
[58] *Id.*

Mental health parity laws are far from a new concept in the United States. Efforts to encourage health plans to cover psychiatric care date back to the early 1960s.[59] President Kennedy successfully pushed the Federal Employees Health Benefits Program (FEHBP), which provided health insurance to federal employees, to provide coverage for mental health care at the same level as was covered for general medical care.[60] However, the plans were permitted to scale back their mental health coverage over time and psychiatric care was no longer covered by FEHBP plans by 1975.[61] No meaningful changes to mandated mental health coverage by insurance plans were made again until the 1990's when the first federal mental health parity bills were introduced in Congress.[62]

The first federal law to provide standards for mental health parity by health plans was The Mental Health Parity Act of 1996 (MHPA).[63] However, the final version of the law that was enacted contained so many exemptions and limitations that its overall impact on health plans was minimal and it was ultimately viewed as little more than a symbolic victory for parity advocates.[64]

In 2008, an expanded version of the law passed both houses of Congress and was signed into law in conjunction with the passing of the bank bailout package following the housing market collapse.[65] The new version of the law is called the Mental Health Parity and Addiction Equity Act (MHPAEA).[66] The new law extended parity requirements for mental health care to

[59] Barry, et. al., *supra* See "The Early Years"
[60] Barry, et. al., *supra*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*

include to the treatment of substance use disorders (SUD).[67] This requirement states that if a plan covers mental health or SUD treatments, those treatments may not be subject to any greater patient cost-sharing or treatment limitations than other types of medical care covered by the plan.[68]

Unfortunately, some of the major exemptions that were available to health plans under the MHPA remained in place under MHPAEA, including that plans are not mandated to offer mental health or substance use disorder benefits to their members.[69] Thus, plans can avoid the parity requirements by never offering mental health and SUD benefits to begin with. Additionally, MHPAEA requirements only apply to plans which are "sponsored by private and public sector employers with more than 50 employees."[70] Meaning that the law does not apply to health plans sponsored by employers with 50 or fewer employees, to Medicare, or to other government-managed health plans. Finally, there is also an exemption that allows for plans who are subject to the law to avoid adherence if they demonstrate a threshold level of increased cost due to implementing the requirements of the law.[71]

Even for health plans that are subject to parity requirements, the enforcement of the laws is challenging and the experience for patients often falls far short of MHPAEA's goals. In evaluating whether health plans are adhering to the requirements of MHPAEA, two types of metrics are weighed.[72] The first are quantitative treatment limitations (QTLs), which include

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[67] *Id.*
[68] Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Act (MHPAEA)* (Last Updated Sep. 2023) https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] Substance Abuse and Mental Health Services Administration, *The Essential Aspects of Parity: A Training Tool for Policymakers,* Publication No. PEP21-05-00-001 (Apr. 2022)

quantifiable features such as the amount of a copay that a member pays for the services they receive, or the number of visits to a provider that the plan will cover.[73] The second are non-quantitative treatment limitations (NQTLs), which include standards to determine medical necessity of a treatment, standards for a provider to be admitted to a network and step therapy protocols.[74]

Numerical standards such as QTLs are easier to monitor and enforce than NQTLs.[75] Without set numbers to rely on for comparison, the law requires that NQTLs for behavioral health benefits be "comparable to and applied no more stringently" than they are to other covered medical benefits.[76] However, the term "comparable" and the phrase "no more stringently" do not have bright line definitions, making adherence to, and detection of violations of, the rule challenging.[77]

The federal government's intention to create parity in coverage between mental health care and other types of medical care is well-intentioned, but in practice, there is much to be done to modify and enforce the laws to create actual parity for patients. Parity laws must be enhanced to ensure that they are supporting a complete system which treats mental health care equally to all other types of medical care.

2. Substance Abuse and Mental Health Services Administration (SAMHSA) investments.

The federal government has recently made large investments in community resources geared towards mental and behavioral healthcare.[78] In February 2024, the Biden-Harris

[73] *Id.* at 8
[74] *Id.* at 11
[75] *Id.* at 1
[76] 45 CFR § 146.136(c)(4)(i)
[77] SAMHSA, *supra* p. 14
[78] Substance Abuse and Mental Health Services Administration, *Biden-Harris Administration Announces $36.9 Million in Behavioral Health Funding Opportunities* (Feb 26, 2024)

administration announced a $36M grant program administered by HHS to provide communities with funding for the development of local resources to address mental health crises and substance abuse issues.[79] The grants will be administered through SAMHSA and funneled towards community outreach programs, universities, consumer-run organizations, and others, to promote and expand access to mental health and substance use services.[80]

This investment by the government is meaningful because it acknowledges the gravity of the consequences that untreated mental and behavioral health conditions can have on a community. However, even with generous financial commitments, the number of communities who can utilize such funds remain limited by the finite nature of money. Thus, the immediate impact of the programs using these funds are limited to the geographic area of the communities who receive the grants. Localized solutions are great for the members of those lucky communities who receive them, but they do little to address the more rampant lack of access to care that people in many other areas of the country experience.

BARRIERS AND CHALLENGES

A. There are an insufficient number of mental health care providers practicing and entering the workforce.

Regardless of whether providers see their patients in-person or virtually, the number of mental and behavioral health specialists in the U.S. falls below what the current population demands.[81] The shortage of health care providers is felt across all areas of medicine but is

[79] *Id.*
[80] *Id.*
[81] National Supply of Supply and Demand for Behavioral Health Practitioners, *supra*

particularly acute in mental and behavioral health.[82] These shortages are driven by macro trends including the exorbitant cost of receiving a higher education and the high level of burn out experienced by providers.[83] The shortage of physicians is most stark in rural areas where 20% of the population has access to just 11% of the practicing physicians in the country.[84]

B. State-specific licensure requirements.

Health professional licenses are issued by the individual states where providers practice, and providers must be licensed in any state where they see patients.[8586] The process of obtaining a license to practice medicine is very time-consuming and costly.[87] Professional licensure requirements for medical providers don't vary for providers who provide care to their patients in-person, virtually, or both.[88] However, the limitations of individual state licensure are felt much more acutely by providers who see patients virtually yet are still limited to caring for patients who are based in the same state.

The COVID-19 pandemic was not the first time that the federal government changed rules regarding state licensure to allow providers to treat patients across state lines via telemedicine. In 2018, the Department of Veterans Affairs (VA) implemented a regulation allowing for VA medical providers to treat veterans virtually regardless of where the provider or veteran was

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[82] Reinert, et. al., *supra* at 39.
[83] Kristy Wang, *The Hidden Health Crisis: America's Physician Shortage is Slowly Worsening*, Columbia Political Review (Feb 12, 2024) www.cpreview.org/articles/2024/2/the-hidden-health-crisis-americas-physician-shortage-is-slowly-worsening
[84] *Id.*
[85] Licensure requirements vary by provider type. Mental and behavioral healthcare professionals who can provide care to patients may be physicians, nurse practitioners, nurses, counselors, social workers, and others, and all have different licensure requirements associated with their professions. The remainder of this section of the paper will be referring to physician licensure only for illustrative purposes.
[86] Federation of State Medical Boards, *About Physician Licensure* (last visited Mar 15, 2024) www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure
[87] *Id*.
[88] American Medical Association, *Licensure & Telehealth*, Issue Brief (2022)

located.[89] The regulation includes a provision preempting state laws which may restrict a VA provider from treating a veteran across state lines.[90] In conjunction with the new rule, the VA also launched a video conferencing system that could be used for veterans to receive virtual care from their homes, or anywhere else.[91]

For providers who practice entirely in-person, there is little need for multi-state licensure because it is not logistically practical for most providers to relocate frequently and provide care in multiple states. With the uneven distribution of medical providers in our country, it is illogical that a provider who sees patients via telemedicine not be able to care for patients who need medical services simply because they live in another state. Rural communities especially continue to suffer due to a lack of qualified providers in their immediate areas. The law as it stands prevents that problem from being solved. If providers have capacity in their workdays to see additional patients, where that person lives should not be a barrier to them receiving treatment.

C. Limitations on providers' prescriptive authority via telemedicine.

State laws dictate how providers may prescribe drugs to their patients via telemedicine and which types of providers have which levels of prescriptive authority.[92] Most states require that before a provider can write a script for a patient, they must establish a patient-provider relationship by conducting an in-person examination.[93]

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[89] 38 CFR § 17.417
[90] 38 CFR § 17.417(c)
[91] Department of Veteran Affairs, *VA Expands Telehealth by Allowing Health Care Providers to Treat Patients Across State Lines*, Press Release (May 11, 2018) https://news.va.gov/press-room/va-expands-telehealth-by-allowing-health-care-providers-to-treat-patients-across-state-lines/
[92] Phillip Zhang and Preeti Patel, *Practitioners and Prescriptive Authority*, StatPearls Publishing (Last updated Nov 13, 2023) www.ncbi.nlm.nih.gov/books/NBK574557
[93] Center for Connective Health Policy, *Professional Requirements: Online Prescribing* (Last viewed May 7, 2024) www.cchpca.org/topic/online-prescribing

When treating a patient who requires the use of a controlled substance, the rules become even stricter. The act of prescribing scheduled drugs without an in-person appointment is a challenge for many providers who treat patients with SUD, particularly those who treat patients with an Opioid Use Disorder (OUD).[94] An example is the heavy regulations placed on the drug buprenorphine, which is an opiate commonly prescribed to treat OUD.[95] Prior to the onset of the COVID-19 pandemic, in most states, patients with OUD were required to undergo an in-person evaluation with a provider before being prescribed buprenorphine, attend in-person follow-up visits, and could only receive a 30-day supply of the drug at a time.[96]

However, during the COVID-19 public health emergency, the Drug Enforcement Agency (DEA) and HHS allowed for the temporary authorization of providers to write scripts for controlled substances for patients seen only via telemedicine.[97] The DEA has since proposed rules that would make many of the changes to telemedicine prescriptions of controlled substances permanent.[98]

Ultimately, state laws govern the prescriptive authority of providers. Thus, any limiting requirements associated with prescribing medication via telemedicine will need to be addressed by state legislatures to effectuate changes. However, shifts in federal policy regarding controlled

[94] SAMHSA, *Medications for Substance Use Disorders*, (Last updated Feb 2, 2024) www.samhsa.gov/medications-substance-use-disorders
[95] Matisyahu Shulman, MD, et. al., *Buprenorphine Treatment for Opioid Use Disorder*, 33(6) CNS Drugs, 567-580 (2019)
[96] Kathleen M. Ward, et. al., *Impact of reduced restrictions on buprenorphine prescribing during COVID-19 among patients in a community-based treatment program*, Drug Alcohol Depend Rep. (June 2022)
[97] Health and Human Services, *Prescribing controlled substances via telehealth* (Last updated Oct 16, 2023) https://telehealth.hhs.gov/providers/telehealth-policy/prescribing-controlled-substances-via-telehealth
[98] See Drug Enforcement Administration. "*DEA Announces Proposed Rules for Permanent Telemedicine Flexibilities"* (Washington D.C., 2023) https://www.dea.gov/press-releases/2023/02/24/dea-announces-proposed-rules-permanent-telemedicine-flexibilities

substances creates the opportunity for state governments to make corresponding changes to their laws and increase patient access to treatments like buprenorphine.

D. Increased potential for telemedicine fraud.

With the expansion of any new practice comes opportunists who will seek to illegally benefit from exploiting a new or growing system. During the height of the COVID-19 pandemic, some bad actors seized on the opportunity to defraud the government through telemedicine scams.[99] Prior to the blanket section 1135 waivers implemented in 2020, Medicare provided very limited coverage for telemedicine treatment which was limited to providers and patients in specifically defined rural areas.[100] However, when the waivers went into effect and the use of telemedicine appointments surged, fraudsters were able to identify a large new source of Medicare beneficiaries to target.[101] A common type of fraudulent scheme during the peak of the COVID-19 pandemic involved marketing companies who would partner with telemedicine companies, DME providers, or laboratories.[102] The fraudsters would target Medicare beneficiaries through calls, mail, and online ads.[103] They would then collect their Medicare information and the DME provider or laboratory they partnered with would write prescriptions for tests or DME that the beneficiary did not need and submit the claims to Medicare.[104] These schemes are known as "telefraud" and have become so prevalent that the Office of the Inspector General (OIG) issued a Special Fraud Alert to practitioners warning them to closely evaluate any telemedicine companies who sought to enter into arrangements with them.[105]

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[99] Katrice Bridges Copeland, 108 Iowa L. Rev. 69, 98 (2022)
[100] *Id.* at 83-84
[101] *Id.*
[102] *Id.* at 98-99
[103] *Id.*
[104] *Id.*
[105] *Id.*

While the expansion of the practice of telemedicine has created another way for fraudsters to attempt to defraud the government, seeing an uptick in fraud in a rapidly growing segment of the health care industry is not a new phenomenon.[106] An increase in fraud is a disadvantage of the expanded practice of telemedicine and should be weighed against the benefits of increased access to care as the laws and their enforcement mechanisms evolve.

E. Need for telehealth parity laws.

When the use of telemedicine surged in 2020 and 2021, private insurers paid providers similar amounts for appointments regardless of whether they were in-person or virtual.[107] This was also true for mental health therapy claims regardless of the severity of the condition being treated.[108] While these outcomes are ideal for proponents of telemedicine expansion, there is not current law on the books mandating pay parity between in-person and virtual appointments.

There are several bills currently being considered by Congress that aim to extend pay parity and ensure that providers are reimbursed at comparable levels for the care they provide regardless of whether they see their patients in-person or virtually.[109] It is important that the medical community ensures that pay parity laws for telemedicine are protected by being enshrined in law at the federal level.

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[106] *Id.* at 126
[107] Shameek Rakshit, et. al., *Private insurer payments for telehealth and in-person claims during the pandemic* (Sep 26, 2023) healthsystemtracker.org/brief/telehealth-payments-similar-early-in-the-pandemic
[108] *Id.*
[109] *Id.*

SUGGESTED SOLUTIONS

While there are many compounding variables that have led to the current mental health crisis in the United States, there are legal mechanisms which could be leveraged to increase the supply of care for patients.

A. A national licensure system.

Medical providers have long adhered to the patchwork of state-by-state regulations that oversee the practice of medicine.[110] However, there is little rationale to explain why different standards should be applied to providers in different states. While providers in each state are governed by the local medical board, states are generally trending towards having uniform requirements for licensure.[111] Overall, there is no clinical reason to believe that a doctor in New Jersey should be evaluated under a different set of standards that a doctor in Arizona, nor that that a doctor in New Jersey would treat a patient differently in their own state than they would in any other.

Our current system only allows for doctors to practice in a state where they are licensed and makes the process of getting licensed in multiple state cumbersome and expensive.[112] Some states offer reciprocity to providers in neighboring states; however, these practices have been largely discontinued, requiring providers to go through the full process of applying for a license in every state where they seek to treat patients.[113] However, when providing care via telemedicine services, providers have no reason to be limited to only treating the patients who

[110] AMA, *Licensure & Telehealth, supra*
[111] AMA, *Navigating state medical licensure* (Last updated Feb. 2, 2023) www.ama-assn.org/medical-residents/transition-resident-attending/navigating-state-medical-licensure
[112] FSMB, *supra.*
[113] AMA, *Navigating state medical licensure, supra*

live in or near the state where they are based when each state's requirements to practice so closely resemble one another.

A potential solution to the challenge of state-specific licensure is to implement a national system of licensure for medical professionals. However, such a change to the existing system would require a tremendous undertaking for federal and state governments. A national licensure system would require the creation of a federal agency tasked with issuing and overseeing licenses and would usurp power from state medical boards. Obtaining legislative support for system-wide change such as this is unlikely. It would require a sizeable financial investment to establish and run and would likely face meaningful pushback from states who wish to retain control of the licensing process and oversight of providers in their states.

The Interstate Medical Licensure Compact has gained significant traction since it became operational in 2017 and could provide a ready alternative to our current system.[114] The Compact is an agreement among 40 States, the District of Columbia, and the territory of Guam.[115] It allows physicians who hold unrestricted licenses in a member state to apply for a license to practice in any, or all of the other, member states through a single application.

Participation by states in the Compact has increased rapidly in the years since it was created. Of the remaining 10 states that are not currently members of the Compact, 3 have legislation pending related to joining, which would leave just 7 U.S. states as non-members.[116]

[114] Interstate Medical Licensure Compact. *About the Compact* (Last visited May 7, 2024) www.imlcc.org/a-faster-pathway-to-physician-licensure
[115] *Id. See* About the Compact
[116] *Id.*

There is also a multi-state Compact for Nurses called the Nurse Licensure Compact which has a similar level of membership in U.S. states and territories as the IMLC.[117]

Multi-state licensure allows for providers in more populous states to operate in states that are suffering from a shortage of medical providers, assists locum tenens providers who travel between states providing care, and would allow for providers to move quickly into a neighboring state to provide care in the event of a large-scale emergency. In rural areas of the country, this type of resource sharing could make a tremendous impact and bring very necessary care to a population that has long struggled to find consistent, accessible care in their communities.

B. Enforcement of parity laws.

As previously discussed, MHPAEA laws are not currently enforced with sufficient rigor to ensure that mental and behavioral health disorders are treated equitably with other medical treatments. As the use of telemedicine to provide mental and behavioral health services expands, so too does the importance of effectively enforced parity laws. These laws must be used in tandem with one another to make an optimal impact on the health system overall and its ability to serve the American patient population.

In 2019, a report prepared by the Government Accountability Office (GAO) found that most states reported reviewing group and individual insurance plans for compliance with parity requirements before they were sold to customers, but few conducted reviews after beneficiaries enrolled in the plans.[118] Additionally, the Departments of Labor and Health and Human Services

[117] Nurse Licensure Compact, *About the NLC* (Last visited May 7, 2024) www.nursecompact.com/about.page
[118] U.S. Government Accountability Office, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies* (Dec. 13, 2019) https://www.gao.gov/products/gao-20-150

only conduct targeted reviews of plans if they receive a consumer complaint, or other information indicating that the plan may be noncompliant with parity requirements.[119]

It is not unreasonable for consumers to be expected to lodge complaints regarding quantitative treatment limitations (QTLs), such as having a higher copay to see their psychologist than their cardiologist. However, it is not tenable to place the same responsibility on consumers to identify and flag non-quantitative treatment limitations (NQTLs), because NQTLs are difficult to define and identify. Enforcement efforts must be reimagined to create effective mechanisms to identify and rectify plans which are providing coverage inequitably via NQTLs.

Additionally, while it would face tremendous opposition, an addition should be made to MHPAEA that requires all health plans to offer mental health and SUD benefits instead of just enforcing parity requirements for the plans who choose to include them. Ideally, capitalist forces would push insurers to include such benefits or run the risk of them not being purchased by employers, thus expanding mental health and SUD benefits to all insurance beneficiaries. Unfortunately, that has not played out in the real world and may require a regulatory push to increase adoption.

C. Increased reimbursement rates for mental and behavioral health care services.

Reimbursement rates paid to mental and behavioral health providers are lower than rates paid to other types of medical providers.[120] This must be rectified to make the practice of mental and behavioral health attractive to current and future medical providers, and to increase in-network participation by providers. The average in-network reimbursement rate for a primary care visit

[119] *Id.*
[120] Steve Melek, et. al., *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*, Millliman Research Report (Nov. 19, 2019)

was over 23% higher than the reimbursement rate for a behavioral health visit in 2017.[121] However, in 11 states during the same period, the reimbursement rate for primary care visits was over 50% higher than for behavioral health visits.[122]

Low in-network reimbursement rates lead to fewer mental and behavioral health specialists participating in insurance networks which requires patients to seek care from out-of-network providers for mental health and SUD services.[123] In-patient behavioral health facilities are over 5 times more likely than medical or surgical in-patient facilities to be utilized out-of-network.[124]

Mental and behavioral health providers are underpaid by insurance plans, and as a result they are less likely to participate in-network with plans.[125] As a result, the cost of care for patients increases because they pay more out of pocket for out-of-network care compared to in-network, and fewer providers are incentivized to enter the field or continue practicing in these specialties.

D. Telemedicine parity.

A federal parity requirement for telemedicine services should also be added to existing mental health parity laws. By not requiring health plans to equitably compensate providers for the care they are providing regardless of the format, they disincentivize providers from expanding their telemedicine practices, despite the many positive effects having a virtual option offers patients.

At the onset of the COVID-19 pandemic, many payors increased their reimbursement rates for telemedicine care to encourage use by providers.[126] Throughout 2020 and 2021, plans

[121] *Id.* at 6-7
[122] *Id.*
[123] *Id.* at 6
[124] *Id.*
[125] *Id.*
[126] *Id.*

continued to reimburse providers similarly for in-person and telemedicine visits.[127] While this had the desired effect of encouraging more providers to offer care virtually, there is not a pay parity requirement for telemedicine under current federal law.

Some states have begun to pass parity laws specifically for telemedicine care. For example, in New Jersey, the state passed a law in 2021 that requires payors pay the same reimbursement rate to a provider offering care via telemedicine as they would to a provider offering the same care in-person.[128] However, while the law has been extended, it will only remain in effect through the end of 2024 and it is limited to providers who also provide in-person care to patients in the state.[129]

The actions of states to put such laws on the books is promising but is yet another example of the ways in which our healthcare system is guided by a disjointed set of laws that vary from state to state. This makes providing care across multiple states by individual providers extremely complicated, or altogether impossible.

CONCLUSION

Telemedicine is a powerful tool that should be wielded more broadly to address the growing mental health crisis in the United States. Evidence shows that telemedicine treatment is clinically effective and is more accessible to a large percentage of the population than receiving in-person treatment.[130]

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[127] Shameek Rakshit, et. al., *Private insurer payments for telehealth and in-person claims during the pandemic*, Peterson-KFF Health System Tracker (Sept. 26, 2023)
[128] State of New Jersey, *Governor Murphy Signs Important Telehealth Legislation* (Dec 22, 2021) www.nj.gov/governor/news/news/562021/20211222c.shtml
[129] *Id.*
[130] Hilty, et. al., *supra*.

The U.S. could make access to care for more people possible by looking to the system that came into existence during the COVID-19 pandemic for inspiration. By implementing new rules governing licensing providers, new laws requiring health plans to treat telemedicine providers equitably, and by more effectively enforcing existing mental health parity laws, the U.S. has an opportunity to remedy the dearth of mental and behavioral health services available to many Americans and increase the overall health of the population.