Behavioral Health Telehealth

Commonwealth of Pennsylvania
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MERCER

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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1 Introduction

Background

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health.[1] For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes at a minimum, audio and video equipment.[2]

As a direct response to COVID-19, telehealth rules and practices have evolved at a rapid pace. Many states have expanded both the availability of telehealth geographically and the services that can be offered under this modality.

Telehealth has increasingly become an accepted method of delivering health services, including behavioral health (BH) services, improve access to providers and, due to COVID-19, to offer services in a safe, socially distanced manner.

Prior to the onset of COVID-19 in the US, the use of telehealth was inconsistent across states and there were few federal requirements for Medicaid's coverage of telehealth. Locally, states determined reimbursement rates as well as the types of services providers could deliver via telehealth. Practitioners often cited lower reimbursement rates as one of the reasons why they did not adopt telehealth modalities. Medicare regulations were also more restrictive, reimbursing only for telehealth provided in rural areas and requiring patients to travel to a local clinic or other facility to receive a telehealth service.[3]

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[1] *Medicare Telemedicine Health Care Provider Fact Sheet.* Centers for Medicare & Medicaid Services. (2020). Retrieved from https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet#:~:text=Telehealth%2C%20telemedicine%2C%20and%20related%20terms,to%20improve%20a%20patient's%20health.

[2] *Telemedicine.* Medicaid.gov. Retrieved from https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html.

[3] Butcher, L. (2020). *Is COVID-19 the Tipping Point for Telemedicine?.* Smithsonian Magazine. Retrieved from https://www.smithsonianmag.com/innovation/is-covid-19-tipping-point-for-telehealth-180975131/.

[4] For the purposes of this report, Mercer will be using the OMHSAS telehealth definition.

The Commonwealth of Pennsylvania (Commonwealth or Pennsylvania) Office of Mental Health and Substance Abuse Services (OMHSAS) has historically defined telehealth as the delivery of compensable BH services at a distance using real-time, two-way interactive audio-video transmission. Telehealth does not include telephone conversations (except where specified for emergencies), electronic mail messaging or facsimile (fax) transmissions. The Commonwealth currently allows telephonic BH services, but only as a temporary measure due to the COVID-19 Public Health Emergency (PHE).[4]

Objectives

OMHSAS in collaboration with Mercer Government Human Services Consulting (Mercer) solicited feedback on the future of telehealth, including the ongoing permissions OMHSAS should pursue once the Public Health Emergency (PHE) ends and other telehealth services OMHSAS should consider adopting. OMHSAS charged Mercer with researching emerging telehealth BH best practices and eliciting feedback from Primary Contractors (PCs), Behavioral Health Managed Care Organizations (BH-MCOs), individuals, providers and other stakeholders across the Commonwealth. The purpose of this report is to organize the gathered information and recommendations in an effort to inform OMHSAS' telehealth policy post pandemic. OMHSAS identified the following key focus areas:

- Service Delivery Considerations for BH telehealth:
  - Services provided via telehealth
  - Assessing when telehealth is a viable option
  - Addressing training needs for providers and members
- Telehealth Technology and Security:
  - Telehealth modalities
  - Platforms and Security
- Reimbursement:
  - Rate development considerations
- Quality Measures:
  - Early outcomes
  - Defining success
  - Fostering member engagement and satisfaction
- Creating a Culture of Inclusion in BH Telehealth:
  - Defining inequities
  - Addressing inequities

2 Methodology

Over the course of three months, Mercer set up a parallel process that included the completion of an environmental scan, implementation and facilitation of five virtual external stakeholder Focus Groups and implementation and facilitation of five meetings with a virtual steering committee comprised of leaders across key agencies and providers in the Commonwealth. In preparation, OMHSAS conducted outreach to stakeholders to solicit participation in Steering Committee and Focus Groups.

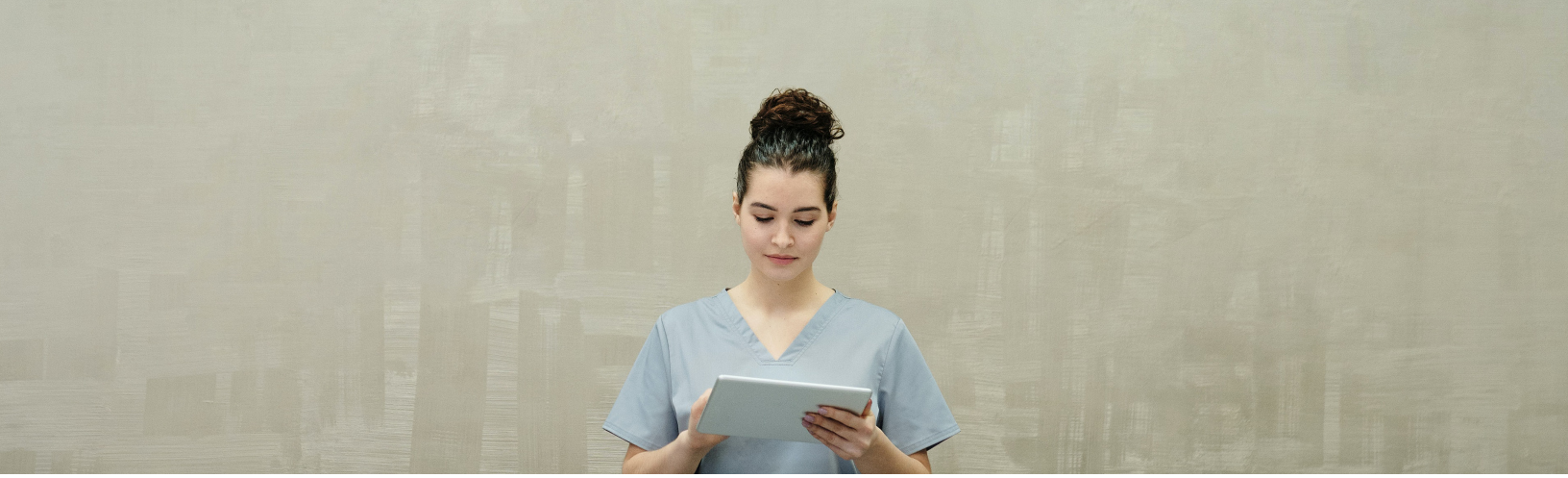
The environmental scan included a review of telehealth policy guidance and delivery modalities in the States of California and Minnesota (per OMHSAS request) as well as publicly available and issued guidance and training from the Centers for Medicare & Medicaid Services (CMS). Mercer also attended a training offered by the National Consortium of Telehealth Resource Centers through their Telehealth Hack series, which offered a virtual peer-to-peer webinar learning session to support the adoption of telemedicine across the nation.[5]

The environmental scan covered the previous three years. Search terms included a combination of telehealth, telehealth behavioral health, telemedicine, virtual services, rural barriers, cultural barriers, CMS, California, Minnesota, COVID-19 and telehealth innovation.

In partnership with OMHSAS, Mercer established a Steering Committee, which included representation from members, providers, advocacy groups, OMHSAS' Children's Bureau, OMHSAS' Bureau of Quality Management and Data Review, the Office of Medical Assistance Programs (OMAP), the Office of Developmental Programs (ODP), the Office of Long-Term Living (OLTL), the Department of Drug and Alcohol Programs (DDAP), the Pennsylvania Insurance Department (PID), the Mental Health Planning Council, PCs and BH-MCOs. Please refer to Appendix A for a list of invited Steering Committee attendees. There were five virtual meetings held between August and October 2020. The role of the Steering Committee was to review and discuss national telehealth definitions and guidance, and feedback from the Focus Groups, as well as provide additional insight and advice around recommendations.

In tandem with the Steering Committee meetings, Mercer facilitated five virtual Focus Groups between August and October 2020. Focus Group participants included but were not limited to members, PCs, BH-MCOs, providers, advocacy groups, OLTL, OMHSAS and ODP. Please refer to Appendix B for a list of Focus Group attendees. Each Focus Group addressed a targeted topic (e.g., BH Services to Continue via Telehealth; Technology and Security) and, following each Focus Group, Mercer summarized feedback and recommendations for the Steering Committee.

[5] *NCTRC Telehealth Hack Series.* National Consortium of Telehealth Research Centers. Retrieved from https://telehealthresourcecenter.org/resources/webinars/nctrc-telehealth-hack-behavioral-health-services-early-intervention/.



3 Summary of Findings

Mercer organized this section by focus area. Within each area, Mercer first summarizes findings from the environmental scan followed by input from the Focus Groups.

Service Delivery Considerations for Behavioral Health Telehealth

Services Provided via Telehealth

Environmental Scan

Federal

A 2017 Medicaid review of states found, in aggregate, 32 provider types were allowed to render services via telehealth, including physicians, nurses, BH providers (e.g., psychologists, social workers, behavioral analysts and substance use disorder [SUD] clinicians), and therapists such as physical and speech therapists. Most of these states required these providers be enrolled in the state Medicaid system, and did not permit services via telehealth from providers located in another state. Some states did allow an out-of-state provider to be either an originating- or distant-site and not have to enroll in payor state's Medicaid system.[6]

There are three primary areas of service delivery when discussing telehealth: telehealth visits, virtual check-ins and e-visits.[7] The most common uses of telehealth are for follow-up care, BH services and to mitigate barriers to transportation.

Since the outbreak of COVID-19 and the temporary relaxation of Federal rules around Medicaid, all but seven states have become more flexible in allowances for telehealth services, mostly via 1135 waivers approved by CMS for Medicaid changes during a time of emergency.

Unrelated to COVID-19, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been advocating for the use of telehealth as a means to increase access to mental health and SUD services, especially in underserved areas where the provider net-

[6] *March 2018 Report to Congress on Medicaid and CHIP.* MACPAC. (2018). Retrieved from https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/.

[7] *Medicaid COVID-19 Telehealth Regulations & Rules: An OPEN MINDS Market Intelligence Report.* OPEN MINDS. (2020). Retrieved from https://www.openminds.com/intelligence-report/medicaid-covid-19-telehealth-regulations-rules-an-open-minds-market-intelligence-report/.

work can be more fragmented. Services range from assessment, to treatment, to administration of medication for addiction treatment (Medication-Assisted Treatment [MAT]) for opioids. Most states have sought and obtained Federal authority allowing provider-to-provider e-consultations.[6]

Another notable regulatory relaxation implemented due to COVID-19 has been for Opioid Treatment Programs (OTPs). Guidance from SAMHSA allowed states to request blanket exceptions for all stable OTP patients to receive 28 days of take-home doses of medication. That OTP guidance also notes that states may request up to 14 days of take-home medication for those patients who are less stable but whom the OTP believes can safely handle this level of take-home medication. New patients admitted to an OTP for Opioid Use Disorder must receive a physical face-to-face evaluation if they are going to receive methadone.

Although individuals receiving methadone still must have an in-person evaluation prior to receiving medication, SAMHSA, has exempted OTPs from the requirement to perform a physical in-person evaluation for any new patient who will be treated with buprenorphine, allowing an evaluation by an attending physician or extender (including use of telephone-only, if needed). This exemption will last for the duration of the declared COVID-19 national emergency. The Drug Enforcement Administration has issued similar guidance for patients receiving buprenorphine under a DATA 2000 waiver.[8]

State Summaries

In 2011, the California legislature enacted the California Telehealth Advancement Act of 2011, which recognized telehealth as a legitimate way to deliver services in order to expand access to services in rural and underserved communities. The Act removed any requirement for an individual to have an in person meeting with a provider first before utilizing a virtual modality, and allowed for verbal consent for telehealth services from the individual.[9] During COVID-19, California further expanded the allowable provision of individual and group therapy via telephone, which was previously not an option. Other services during the pandemic cannot fully be delivered virtually, such as crisis stabilization, adult residential treatment and day rehabilitation, which require a clearly established site for services and some also include in-person contact with a member in order to be claimed. Where possible, California did try to make services more accessible and ease requirements around in-person requirements, such as allowing services to occur via telephone for a member quarantined in their room due to illness. After the PHE ends, the California Department of Health Care Services will continue to recommend that counties opt to reimburse services by telehealth, but telehealth is optional under the current 1115 waiver.[10]

Minnesota also expanded its telehealth permissions in 2015, well before COVID-19, in part requiring parity for services delivered via telehealth, and included coverage to store-

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[8] *Supporting Access to Telehealth for Addiction Services.* American Society of Addiction Medicine. (2020). Retrieved from https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth.

[9] *Assembly Bill 415.* Legislative Counsel - State of California. Retrieved from http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0401-0450/ab_415_bill_20111007_chaptered.html.

[10] *Behavioral Health Information Notice No: 20-009.* State of California Health and Human Services Agency, Department of Health Care Services. (2020). Retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/2020-BH-Information-Notices.aspx

and-forward functions, which involves the secure transmission of data, images, sound or video that are captured at the originating site and sent to specialists at a distant site for evaluation.[11] This change in policy covered SUD and BH services, as well as social workers and other providers beyond physicians and physician extenders. The state of Minnesota specifically excluded the following services from telehealth: children's day treatment, partial hospitalization, mental health residential treatment services and case management services delivered to children.[12] During COVID-19, Minnesota has temporarily expanded the providers who may provide treatment by telehealth to include but not be limited to licensed alcohol and drug counselors, alcohol and drug counselors, all mental health professionals, mental health certified peer specialists, and mental health family peer specialists.[13]

Focus Group Summary

Focus Group members noted that telehealth can allow for increased access to services, including access to specialists to address complex member situations. Local and in-network providers are preferred as the first line of service before referring an individual to a non-local and out-of-network (OON) provider. However, non-local and OON providers can supplement local access to services, especially for high needs practitioners such as child psychologists and psychiatrists. If the Commonwealth does decide to pursue allowance for OON providers, Focus Group members noted that these providers should seek enrollment as a Pennsylvania Medicaid provider and follow all of the same requirements. General BH services should remain with local network providers, and Focus Group members felt individuals should always have the option to access in-person services. Focus Group members did note that residential services should have an agreement with OON providers for ad hoc specialty services required by the child that are not available in the residential center to ensure they follow the same guidelines.

Assessing when Telehealth is a Viable Option

Environmental Scan

Federal

Based on a Focus Group recommendation, Mercer performed a research review to identify if assessments were available to determine if telehealth is appropriate for an individual and if so what type of telehealth delivery modality would be most appropriate for an individual as well as what needs the use of telehealth would address. Research at the Federal level and of other states did not yield significant information regarding assessments for the appropriateness of telehealth services. In part, this may be due to the expanded use of telehealth (due to COVID-19) being relatively recent, with less than a year of experience to

[11]Store-and-forward involves the secure transmission of data, images (e.g., x-rays, photos), sound, or video that are captured at the originating site and sent to specialists at a distant site for evaluation.

[12]*Telemedicine Delivery of Mental Health Services.* Minnesota Department of Human Services. (2018). Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_160257.

[13]*Temporary coverage of telemedicine visits for Substance Use Disorder and Mental Health providers.* Minnesota Department of Human Services. Retrieved from https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/types/sudmhcovidtele.jsp.

draw upon. However, a paper released by the National Committee for Quality Assurance (NCQA) in September of 2020 noted that individuals receiving telehealth should receive a choice in modality of service, whether it be in person or via telehealth, which could be part of an assessment process.[14]

State Summaries

Mercer did not identify state-specific information in research.

Focus Group Summary

Focus Group members recommended the use of an assessment for individuals to determine if telehealth services are appropriate, both clinically and operationally, as well as which modality is the best fit for the individual. Elements of the assessment may include the individual's preference and choice as well as if the individual has broadband internet, access to equipment (e.g., phone, computer), and a secure/private space. The assessment components may also identify and consider distractions such as children, siblings and shared living space. As treatment progresses, check-ins with the individual are an opportunity to ensure telehealth is still their preferred modality. The group strongly recommended that a hybrid model should always be an option to allow for a mix of in-person and virtual options.

In addition to assessments to determine whether telehealth use is appropriate or not, the group identified the treatment planning process as another opportunity for individual planning, in this case a review of whether clinical goals are achieved via telehealth. Focus Group members suggested that treatment plan reviews occur with individuals via screen sharing.

Addressing Training Needs for Providers and Individuals

Environmental Scan

Federal

The number of physicians using telehealth has doubled since 2016 from 14% to 28% according to a recent American Medical Association (AMA) study, and although the numbers have increased, there is opportunity to further develop virtual options for treatment.[15] The AMA has noted the need for providers to become better educated in the delivery of telehealth services and developed a Telehealth Implementation Playbook15 to assist providers in increasing their competency and comfort in delivering telehealth services. The Playbook notes that telehealth is a key part of a social distancing strategy, preventing patients from endangering themselves and front line providers when it is not necessary.

> Ensuring individuals know what to expect and the potential benefits of telehealth, (e.g., reduced travel time, accessing services from home) can increase excitement and engagement.

[14] *Overarching Issues.* National Committee for Quality Assurance. Retrieved from https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-findings-and-recommendations-overarching-issues/.

[15] *Telehealth Implementation Playbook.* American Medical Association. (2020). Retrieved from https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf.

It is important to have buy-in from team members from the beginning when planning for and implementing telehealth; the adoption process can be lengthy and requires staff support throughout the process to be successful. Both practitioners and individuals are more likely to continue to use telehealth if the first encounter goes smoothly.

Providers utilizing telehealth will want to consider how to engage and collaborate with individuals in a virtual relationship. Many opportunities for education about telehealth options exist, such as during in-person sessions, when scheduling appointments and through other means (e.g., mailing information packets, television advertisements). The chosen telehealth vendor should be able to help develop these resources. Practitioners may want to practice with each other before seeing clients, as well as slowly phase-in the new modality in order to ensure a positive reaction from both staff and clients, working out any problems that may occur. This may mean beginning with routine medication monitoring appointments with individuals that have been presenting as stable before moving on to more complex individuals or assessments for new patients.[15]

State Summary

Mercer did not identify state-specific information in research.

Focus Group Summary

Focus Group members noted training is an important component for both providers and individuals on telehealth modalities. Testing of connections internally within the agency and with individuals is essential.

> Provider training on understanding visual cues via telehealth and how they may differ from in-person was also discussed as an important element of training.

Recipient education recommendations included training on the process, technology platform, and the options of different telehealth modalities as well as in-person and a combination of virtual and in-person options. Focus Group members also felt training for individuals should include security, use of virtual breakout and waiting rooms, and privacy and confidentiality components specific to telehealth, such as access to a private space for services.

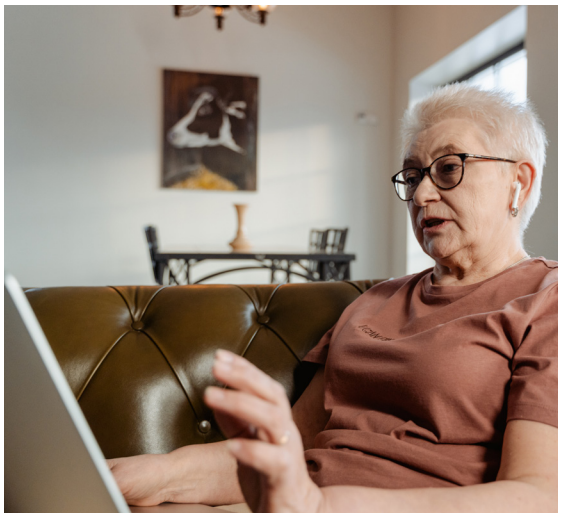
Telehealth Technology and Security

Telehealth Modalities

Environmental Scan

Federal

The most common type of telehealth delivery is a live audio-video modality, which mimics a traditional in-person visit except delivery is via live video instead of being in the same room. Additionally, virtual self-care applications such as myStrength and Calm are available to assist in treatment, although they may not be directly reimbursed by Medicaid. Telephone-only communications are newly allowed during the COVID-19 PHE, and although previously allowed, the use of remote patient monitoring, such as having a patient wear a sleep monitoring device or a blood pressure cuff, has expanded for BH conditions. There are no specific billing codes to support remote monitoring of BH conditions. However, integration of care across providers improves when remote monitoring results are stored in a shared Electronic Health Record (EHR). For example, this allows a BH professional to track remotely monitored blood pressure and other vital diagnostic signs and symptoms, which may be vital information when prescribing certain psychotropic medications. In order to ensure the individual's comfort with changes in how their services are accessed through telehealth, early research is demonstrating the efficacy of utilizing peer support specialists in a virtual environment, although it is too early to have fully studied outcomes in clinical trials.[16]



Due to COVID-19, CMS has allowed telephonic access to services through telehealth under Medicare to assist with ensuring patient safety. Medicare has also allowed reimbursement for virtual check-ins, which are short, patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for e-visits, which are non-in-person, patient-initiated communications through an online patient portal. Medicaid has also allowed for relaxation of many rules, including telehealth under 1135 waivers. These waivers allow for temporary easing of restrictions during disasters or public health emergencies. All 50 states and the District of Columbia have requested increased access to telehealth services due to COVID-19.[17] The Centers for

[16]Fortuna, K., Naslund, J., LaCroix, J., Bianco, C., Brooks, J., Zisman-Ilani, Y., Muralidharan, A., & Deegan, P. (2020). *Digital Peer Support Mental Health Interventions for People with a Lived Experience of a Serious Mental Illness: Systematic Review. National Center for Biotechnology Information.* Retrieved from https://pubmed.ncbi.nlm.nih.gov/32243256/.

[17]*Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19.* Kaiser Family Foundation. (2020). Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table1.

[18]*Telehealth and Telemedicine.* Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/phlp/publications/topic/telehealth.html.

Disease Control has also noted that telehealth has been a tool to increase access to health services for individuals in rural areas or without transportation prior to the current PHE.[18]

CMS is considering allowing many of the temporary expansions to telehealth services become permanent, including lifting limitations on the allowable number of visits. Although there is not a current plan to extend telephonic services (without video) post COVID-19, CMS is seeking feedback on proposed rule changes for 2021, including allowing telephonic services to continue for at least a year post pandemic.[19]

State Summaries

California Medicaid's (Medi-Cal) telehealth policy prior to COVID-19 gave providers flexibility to determine if a particular service or benefit was clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via live audio-visual, two-way, real-time communication or store-and-forward. Services must meet the procedural definitions and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

Medi-Cal pays providers an originating site fee for services provided either for store-and-forward, in which information is saved and forwarded to a consulting practitioner, or audio-visual, two-way communication in real time with an individual. Medi-Cal also pays transmission fees to providers at both the originating and distant site for services provided via audio-visual, two-way, real-time communication. Another service reimbursed by Medi-Cal is e-consults, in which the provider at the distant site may bill for services if engaging in more than five minutes of consultative time with an individual. The provider must also have not seen the individual in the last 14 days and the consult does not result in a follow-up appointment with the distant site provider.[20]

Minnesota also covered live video, store-and-forward, and remote patient monitoring prior to the COVID-19 pandemic. The state paid the same rate as in-person services, and the frequency of services was limited to three per week, although during COVID-19, the current limitation of three telehealth encounters per week has been waived.[21] Minnesota currently allows for delivery of services through the telephone, but providing telehealth via phone will be suspended when the COVID-19 emergency is over.[22]

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[19] *Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021.* Centers for Medicare and Medicaid Services. (2020). Retrieved from https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-4.

[20] *Medicine: Telehealth.* State of California Medi-Cal. (2020) Retrieved from https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf.

[21] *Coronavirus (COVID-19).* Minnesota Department of Human Services. (2020). Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-320036#CS_Telehealth.

[22] *Telephonic Telemedicine Provider Assurance Statement.* Minnesota Department of Human Services. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6806A-ENG.

Focus Group Summary

Participants in the Focus Group noted that live audio-visual is working well for both individual and group therapy. Individuals are open to new technologies and are willing to try them, with sufficient education on how to use the technology. The group identified some unique opportunities, including the possibility of eventually using avatar therapy, with the individual creating an avatar instead of live video, which has shown some early promise in the treatment of post-traumatic stress disorder. A few examples of technology platforms that have been working well include Zoom for Healthcare, Google Meet, Doxy.me and myStrength. Providers would like to continue to have the option to choose their platform.

> The top three modalities recommended to preserve post COVID-19 include audio-only (telephonic), audio with video, and in-person with the opportunity for individuals to always be able to choose between the options.

Technology concerns focused on the preference of individuals wanting to use audio-only as well as whether virtual options were appropriate for individuals with certain conditions such as attention deficit disorder or paranoia. These concerns could be mitigated by determining the appropriateness of telehealth services during the assessment process, with continued regular check-ins, as well as ensuring flexibility for individuals to be able to use a combination of in-person and virtual modalities to access services.

Several benefits of telehealth services included decreased need for transportation as well as increased anonymity as individuals do not have to be seen going into a mental health or substance use facility or clinic. In addition, telehealth services can offer greater cultural and linguistic diversity, allowing individuals access to a provider who “looks like me” or who can deliver services in a different language without the need for an interpreter. There was universal feedback that flexibility in telehealth modalities was of paramount importance, allowing for a combination of virtual and in-person services to fully meet the needs of individuals.

> A common theme was the need for education for individuals and families about telehealth modalities and the use of the technology.

The most common concerns related to access to telehealth is equipment or limited equipment that family members must share, data plans with insufficient minutes, and poor audio and visual connections. An additional concern/question noted was copay and whether or not a copay would be required for telehealth services.

Focus Group members recommended several mitigation strategies. Providers noted that telehealth services do present an opportunity for families to be more engaged in services. Another common theme for increased engagement was the use of care managers, peer specialists, or other services such as psychosocial services to both educate the individual and family members on the use of technology and if needed, participate in initial sessions to help increase comfort with a new service delivery modality.

Platforms and Security

Environmental Scan

Federal

One of the notable changes to telehealth delivery during the COVID-19 pandemic was the relaxation of the enforcement of HIPAA. The Health and Human Services Office for Civil Rights (OCR) issued a "Notification of Enforcement Discretion for Telehealth" remote communications during COVID-19. If covered health providers provided services in good faith, OCR waived penalties for noncompliance with the regulatory requirements under the HIPAA rules. The relaxation of the HIPAA requirements will not continue post COVID-19, and current providers of telehealth using non-compliant platforms will need to work with their vendors to determine if the technology allows additional security for HIPAA compliance or if services will need another platform. At this time, penalties are relaxed on covered health care providers who have not entered into Business Associate Agreements with video communication vendors as part of the good faith provision of services, but this exception will not be prolonged after the pandemic.[23]

Another relaxation of telehealth rules at the Federal level has been the types of technology permitted for conducting telehealth services. In part, some of the previous restrictions have been in place because the technology is not HIPAA compliant and secure. Permitted methodologies include any non-public facing remote communication product that is available to communicate with patients including FaceTime, Facebook Messenger video chat, Google Hangouts video or Skype.

According to the AMA Telehealth Playbook, when choosing a telehealth vendor, providers will want to look for a product that has proven results and meets security and clinical validation requirements. One other important aspect of choosing a vendor will be customer service, and whether or not they offer ongoing support and training on the product to both practitioners and administrative staff, as well as individuals. Training on the technology and workflow should also include an orientation processes in all areas, from schedulers to medical billers.[15]

Findings from the AMA Telehealth Playbook reflect that workflows for making appointments, triage, documenting services, and billing change with telehealth implementation. The Playbook also notes the need to develop new policies and procedures and train staff on these new protocols to ensure transition is smooth and appears seamless to the individual.

[23] *FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency.* U.S. Department of Health and Human Services, Office of Civil Rights. Retrieved from https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf.

Training on the technology system, new CPT codes, and HIPAA requirements is necessary to ensure staff have the necessary information to perform their job on a new platform.[15]

State Summaries

States may have their own laws and regulations regarding protected health information and what is required to protect and secure it. Federal actions do not explicitly address state enforcement of those state laws and regulations, and the states have flexibility in deciding which rules to relax, if any.[24]

Focus Group Summary

The biggest concerns of Focus Group and Steering Committee members centered on security as well as limited access to broadband internet in more rural areas, preventing access to virtual applications. One major security concern expressed by the Focus Group members was the setting of the individual in the home during the telehealth appointment and the importance of privacy as well as limiting distractions, such as children and life partners. An additional source of privacy concern for live audio visual services is providers can see the individual's home, which may be a source of discomfort.

The Focus Group members noted that most providers already use secure platforms, but are seeking guidance from the Commonwealth on HIPAA compliant technology platforms that will be allowed post COVID-19. Consideration should take into account members having to download multiple applications for different providers. OMHSAS staff indicated that guidance on appropriate technology would be issued in broad guidelines to ensure standardization and compliance with HIPAA concerns while allowing providers to use a compliant platform with which they are most comfortable. In addition, the secure storage of data such as text messages and other potential forms of technological services was a source of concern, which may be addressed by further guidance around the parameters of the EHR.

[24] *General Provider Telehealth and Telemedicine Tool Kit.* CMS. Retrieved from https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf.

Reimbursement

Rate Development Considerations

Environmental Scan

Federal

The Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed March 27, 2020, has given a huge financial boost to telehealth, providing $200 million to telehealth activities. States and private health insurers have been investing in payment parity during the COVID-19 pandemic, and insurers are looking for ways to expand telehealth, such as eliminating cost-sharing requirements.[25] CMS is currently evaluating maintaining equitable rates for Medicare services post-pandemic for telehealth services. Factors influencing the continued payment of rates will include infrastructure costs such as disinfectant and other items included in in-person rates as well as concerns about program integrity such as providing shorter visits or more visits than are allowed in one day in order to increase revenue.[26] In August 2020, CMS issued proposed changes to Medicare telehealth policy for 2021. CMS has clarified that licensed clinical social workers and clinical psychologists can furnish brief online assessments and management services as well as virtual check-ins and remote evaluation services, utilizing new HCPCS G-codes, G2010 and G2012. CMS is also seeking public comment about retaining audio-only telehealth post pandemic. In addition, CMS is soliciting input on whether or not it should develop coding and payment for a service similar to the virtual check-in but for longer unit of time and higher reimbursement.[19]

State Summaries

Prior to the COVID-19, both California and Minnesota paid the same rates to providers utilizing telehealth as they did to providers utilizing in-person visits. As of July 1, 2019, Medi-Cal allowed providers to determine the methodology for services, such as audio-visual real-time communication or in-person. In addition, limitations were not placed on originating or distant site locations with all telehealth place of service codes being 02 for community place of service and a service modifier of 95 as an indicator of telehealth on all audio-visual communication. E consults were allowed under store-and-forward with a CPT code of 99451 and GQ modifier.[27]

An additional consideration for states is the increased focus on value in the marketplace, moving services from a fee-for-service reimbursement to an alternative payment methodology, or Alternative Payment Models (APMs), such as case rates and episodic payments. The focus on value began prior to the COVID-19 and has increased since then. APMs allow

[25]Knopf, A. (2020). *Telepsychiatry coming into its own with COVID-19*. Wiley Online Library. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1002/cpu.30487.

[26]LaPointe, J. (2020). *CMS to Assess Telehealth Reimbursement Rates Post-Pandemic.* RevCycle Intelligence. Retrieved from https://revcycleintelligence.com/news/cms-to-assess-telehealth-reimbursement-rates-post-pandemic.

[27]*Medi-Cal & Telehealth.* State of California Medi-Cal. Retrieved from https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.

[28]Oss, M. (2020). *From Fee-For-Service to Episode-Based Payments: The Shift Continues.* Open Minds. Retrieved from https://www.openminds.com/market-intelligence/executive-briefings/from-fee-for-service-to-episode-based-payments-the-shift-continues/.

for a focus on integrated care, increased BH needs, provide steady income for providers, and shift some administrative cost to providers.[28]

Focus Group Summary

Focus Group participants offered numerous additional considerations that can impact reimbursement (e.g., physical office space, staffing and infrastructure). A major theme raised was a need for in-person and virtual services to be paid the same rates. They also felt the presence of clinical staff at a physical location remains necessary for individuals that prefer to be seen in-person or due to conditions that telehealth cannot sufficiently address. Another aspect to consider is if the provider delivering services must be present at a business office site. If this is the case, providers may be faced with increased costs to maintain an office space in addition to or in lieu of a home space as well as any associated equipment and platform fees. One benefit of telehealth expansion has been access to more specialty BH providers, although the cost of the provider to the payer may have increased due to the specialization of services.

Focus Group members suggested more staff might be necessary to ensure appropriate workflows and synchronization of technology. This will likely be important to ensure compliance oversight as well as ensuring compliance with regulatory requirements. Additionally, Focus Group members shared they anticipate increased administrative costs for staff conducting more follow-up via email and telephone for appointments and missing documentation from other providers or collateral sources for assessments and prior authorizations, leading to cost shifting rather than cost savings. Other workflow considerations include certain services such as mobile psychosocial rehabilitation and Transition to Independence Program, in which individuals are more successful with practicing skills one to two times per week in-person versus through a telehealth option, requiring staff to be available in-person as well as remotely.

Other considerations for provider capacity include whether audio-only services will continue to be reimbursed. In addition, discussion occurred around reimbursement for services not currently reimbursable through telehealth such as brief check-ins for MAT. Another capacity staffing consideration is for smaller providers who may not be able to provide the infrastructure or access to specialty providers available from larger provider groups. Some providers have the ability to perform tests such as blood draws in a safe and secure environment, while others may need to consider coordination with external lab providers. Focus Group members noted that some providers have not extended hours but have hired clinical staff to support increased demand for telehealth sessions, which has also had an impact on staffing costs. Members also noted that providers are seeing individuals in 30-minute appointments rather than hour-long appointments. Cost modeling of shorter sessions will assist in maximizing clinical staff time and productivity.

> Focus groups and steering committee members have repeatedly emphasized, there is a strong desire for in-person and hybrid model (virtual and in person) services to remain available. Providers need to estimate this balance in order to determine physical space needs, and with social distancing capabilities in mind.

In addition, providers expressed concern that prospective payment of services stemming from federal relief funds due to the PHE is currently assisting providers to remain solvent and loss of that resource will impact the ability to retain staff and services. The group also flagged concerns about passing on costs to individuals through copays, both for telehealth and for personal protective equipment for in person visits.

Physical space may be an area where providers can achieve economies of scale, but there are factors to consider. For example, many providers have long-term leases that inhibit their ability to downsize in the short term.

Focus Group members discussed what telehealth services may still be retained and what costs would be for equipment, technology platform and internet access, and other service unit costs. One of the technology costs noted for providers is moving individuals to a formal platform such as Doxy.me and Zoom for Healthcare, which can cost up to approximately $100,000 annually for larger provider organization, instead of a less secure platform such as FaceTime. Other costs noted were those associated with integrating telehealth records into an EHR and the need to upgrade both provider and individual equipment. Connecting to the Health Information Exchange will assist in consistent communication between providers on an individual's care, but there will be an increased cost, especially concerning for smaller providers.

There was discussion about unique ways of funding new or refurbished equipment. One of the counties, for example, looked for unique alternatives due to an influx in need yet had a lack of equipment and applied for foundation and federal grants to upgrade equipment, purchase platforms, obtain data cards, and address other technological needs.

Quality Measures

Early Outcomes Environmental Scan

Federal

The AMA recommends utilizing a survey to identify front line staff needs as part of an implementation plan for telehealth. Providers should convene an implementation team consisting of both leadership and front line workers to ensure planning continues to focus on the needs of the individual and provider staff. As part of the planning process, providers will need to define measures of success whether it be reduced hospitalizations, increased efficiency in client caseloads, or increased satisfaction scores from both staff and patients. At the time of this report, NCQA updated 40 measure sets to include telehealth as part of the denominator, including BH measures. In addition, NCQA is temporarily allowing virtual access to meet provider network requirements for accreditation.[14]

> Providing training and education to both providers and individuals on the flexibilities of telehealth and the perceived barriers to telehealth implementation and utilization can help overcome reluctance to implement new processes.[15]

State Summaries

Because NCQA measure sets were recently updated and not all-inclusive, specific state information on telehealth measures is sparse. However, NCQA's taskforce on telehealth policy does recommend that "measure stewards" such as states should review all measures

to determine if there is a need for telehealth adaptation. Reviews should consider quality, safety and cost as well as access and outcomes. The taskforce also noted early indicators of reduction in no show visits and the ability of telehealth to address issues such as transportation and difficulty in accessing live services due to limited mobility by the elderly. The taskforce recommended pilots to further determine impact and outcomes.[14]

Focus Group members encouraged shorter telehealth sessions, which can allow for more meaningful contact with less telehealth fatigue.

Focus Group Summary

Focus Group members noted several areas that are early indicators of demonstrated improvement in NCQA measures that include telehealth. Many of the areas for expanded capacity for telehealth have only been in place since March of 2020 and it is too early to determine long-term impacts on quality. Focus Group members indicated there are some early signs of improved outcomes that will need monitoring for long-term results. Providers are currently seeing a reduction in no show rates when using telehealth. In addition, telehealth allows greater flexibility in scheduling appointments and performing individual check-ins within the boundaries of the CPT code definitions. For example, the decrease in no shows may lead to a decrease in use of higher levels of care. Barriers such as transportation and access to child-care during appointments has decreased which could be attributing to initial reductions in no show and cancellation rates. One item to note was the need to manage care across the entire episode differently, such as increased innovation in outreach to individuals via text, telephone and other methods. This could potentially lead to increased engagement throughout the treatment cycle with better long-term results.

The new types of telehealth modalities were also an area that Focus Group members felt may show long-term improved outcomes. Discussion on telehealth modalities led to discussion on partial hospitalization, where a hybrid model has allowed for smaller in-person groups and more virtual sessions. In home services for children, including those with autism may not have as much success in a telehealth modality, although for some services, telehealth has led to an increase in family engagement. Overall, the recommendation is to allow flexibility and choice of a hybrid model to allow individuals to access services in a modality that best fits their needs. Telehealth has been helpful for psychiatrists and other practitioners concerned with COVID-19 infection risks when seeing large caseloads of individuals in person.

Many Focus Group members did flag “telehealth fatigue” as a potential area of concern, as individuals are feeling the need for in-person interaction as isolation during the PHE continues to have a negative impact.

Some individuals are seen more regularly in a telehealth modality, while feedback from the focus groups suggested that the biggest improvement has been in mobile crisis capacity, allowing more individuals in crisis to be seen by a provider via telehealth. In addition, there has been improvement in no show rates in group therapy as members no longer have the obstacle of finding a location close enough to participate in a group therapy session. Long-

term efficiencies are not yet known, as the impact of the hybrid model of in-person and telehealth services has not been measured.

One area where Focus Group members did not have wide experience in telehealth was in the use of applications to help members to record vital statistics, reminders to take medications or other self-help resources. A Focus Group member reported that myStrength was one application successfully used and made available to all provider staff, recipients and family members. The application was reported as an effective extender to telehealth or in-person treatment. A provider may pay for an enterprise access annually and application is available to employees as well with an option to extend the resource to community partners. Although lacking in outcome measures, the tool has anecdotally assisted individuals in addressing mood instabilities such as depression, anxiety and borderline personality disorders.

Defining Success

Environmental Scan

Federal

One of the first steps to defining telehealth success is to gather baseline information from all states on standardized and validated quality measures. The following NCQA measure sets updated for BH telehealth[14] include:

- Antidepressant Medication Management
- Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication
- Follow-up After Hospitalization for Mental Illness
- Follow-up After Emergency Department Visit for Mental Illness
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

State Summaries

The NCQA changes to include telehealth went into effect July 1, 2020 and state information is not yet available.

Focus Group Summary

Focus Group members noted a need for standardization among quality measures, rates for quality measures for value-based payment, and outcome measures. Increased Commonwealth-wide data sharing would allow for enhanced measuring of improvement in telehealth outcomes across the Commonwealth. A specific measure requested by Focus Group members was follow-up after crisis interventions. The Focus Group noted that direction on billing codes and modifiers would be useful to track what type of technology is most effective to fully measure outcomes and validate data. Some of the quality measures

suggested were appointment retention and ambulatory follow-up appointments after an individual receives higher levels of care. Currently, there is not enough information to determine performance goals for providers because there has not been enough time since the movement towards telehealth with only six months of data and many providers are not consistently sending in claims with COVID-19 place of service and modality indicators.

There may need to be a shift in value-based outcomes as there will need to be changes in how measures are captured, such as the changes to some of the BH measures in the NCQA data set. It would be especially valuable to determine if telehealth has an impact on readmission rates such as reduced readmission on both the physical health and BH inpatient stays. Providers have seen an increased utilization of telehealth services, and noted it would be helpful to have guidance on standardized outcomes to help ensure high quality, standardized service delivery. Although many individuals are now receiving telehealth services, there will be additional new individuals that will need assessment and telehealth education, and there has not been enough time to fully evaluate long-term outcomes, such as readmission rates and length of stay.

Fostering Member Engagement and Satisfaction

Environmental Scan

Federal

At the time of this report, Federal guidance has not been issued to capture member satisfaction with telehealth. A recent study of 4,000 Americans by Forbes indicated patient satisfaction with telehealth as a service modality and noted an increase in patient satisfaction and loyalty with healthcare services.[29] Long-term satisfaction may be measured as part of the Consumer Assessment of Healthcare Providers and Systems Survey or reviews of grievances and appeals, as noted in the California summary below.

States Summaries

In Medi-Cal, some of the metrics utilized to measure the efficacy of telehealth are access to specialty and primary care, type and location of providers, and utilization rates. In addition, patient and family satisfaction, appeals and grievances are also used. Prevention and recovery measures are also part of the California data set.[30] One study by the Kaiser Foundation conducted in 2015 noted that 93% of the Kaiser Northern California patients said video check-ups had met their needs; 92% felt their provider was familiar with their medical history;

[29]Prasad, A. (2020). *Telehealth Services as a Patient Satisfaction Tool.* Forbes. Retrieved from https://www.forbes.com/sites/forbesagencycouncil/2020/06/05/telehealth-services-as-a-patient-satisfaction-tool/#3eec447e262f.

[30]*Data & Statistics.* State of California. Retrieved from https://www.dhcs.ca.gov/dataandstats.

and 90% were confident in the quality of their care delivered through telehealth. Some of the positive telehealth outcomes noted were convenience, being able to see their regular primary care providers, and the perception that a video visit adequately addressed their needs.[31]

Focus Group Summary

All five Focus Groups emphasized the importance of flexibility for individuals to meet their needs, as well as the need for increased access to equipment and internet service to truly allow for better member engagement. Audio-only telehealth services was recommended as a modality to address some limitations in access to services as well as a personal preference to access treatment. Concerns with privacy in group living settings was again emphasized due to a lack of security around who may be present in a group member's home and listening to a session.

Focus Group members discussed satisfaction surveys as one method of measuring access to telehealth services. Some providers had instituted a quality callback system prior to COVID-19, and have added telehealth questions to the satisfaction survey. Individuals have reported they are satisfied with telehealth services, although many wish to return to in-person services, in part due to lengthy social isolation.

Other suggested questions to add to either a provider survey or a Commonwealth telehealth survey included questions about (a) the ease of scheduling a telehealth visit compared to an in-person visit, (b) reduction in the time to the first session and (c) increased access to providers with similar cultural and linguistic backgrounds through telehealth. OMHSAS issued three surveys in spring 2020 to recipients/family members, clinical practitioners, and non-clinical practitioners related to their experience of telehealth. OMHSAS intends to conduct this survey on an annual basis.

Creating a Culture of Inclusion

Defining Inequities

Environmental Scan

Federal

There are several racial inequity concerns in the burgeoning use of telehealth. One is access, as minority populations are more likely to have lower socioeconomic status, leading to a lack of access to technical resources. Another is an increase in distrust of the healthcare system from individuals who already note a bias against people of color. Telehealth algorithms may also be skewed when determining areas of need for equipment assistance and in measuring outcomes, failing to account for differences in diagnosis and treatment of disease for individuals of color and from lower socioeconomic backgrounds or with lower levels of education.[32]

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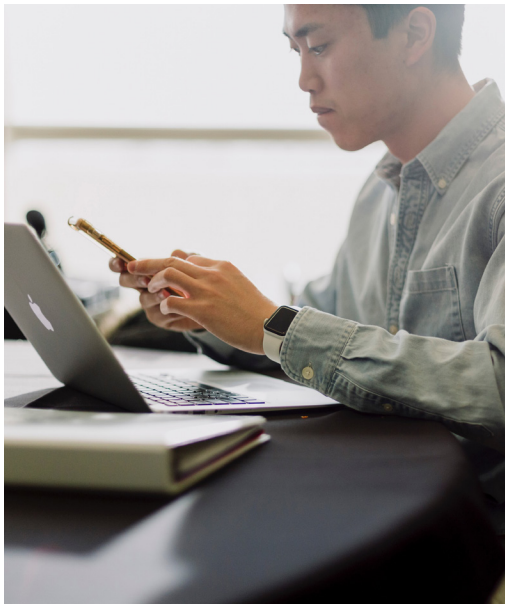
[31]Hagland, M. (2019). *Kaiser Northern California Study Finds High Levels of Patient Satisfaction with Video Visits.* Healthcare Innovation. Retrieved from https://www.hcinnovationgroup.com/population-health-management/telehealth/news/21079022/kaiser-northern-california-study-finds-high-levels-of-patient-satisfaction-with-video-visits.

[32]Clair, M., Clair, B., & Clair, W. (2020). *Unless it's done carefully, the rise of telehealth could widen health disparities.* STAT. Retrieved from https://www.statnews.com/2020/06/26/unless-its-done-carefully-the-rise-of-telehealth-could-widen-health-disparities/.

State Summaries

Although not a part of the two states of focus, Washington, Oregon, Nevada and Colorado have formed a partnership for sharing best practices for telehealth. The partnership is founded on seven key principles, one of which is "...focus on improving equitable access to providers and addressing inequities and disparities in care. Telehealth should be available to every member, regardless of race, ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location." The focus on equity in this partnership will be an opportunity for learning for other states.[33]



Focus Group Summary

The Focus Group identified numerous groups experiencing inequities based on race, language spoken, communication method, disabilities (physical, behavioral, developmental/intellectual), gender identity and expression, age, sexual orientation, literacy level, education, socioeconomic status and criminal background. One member pointed out that BH members are already at a great disadvantage due to the stigma of having a BH diagnosis. The social determinants of health are paramount for this population, particularly as it relates to having stable housing and economic security. Some groups are fearful to access the system, as they do not feel safe sharing personal information such as criminal history or gender identity.

Accurately identifying the makeup of the populations served by provider groups, PCs, BH-MCOs and other agencies is challenging. Current data collection tools may be limited in the data characteristics captured. For instance, "Black" can represent a very broad array of individuals such as Africans, African Americans and African Caribbean. Gender identity and expression is another example where it can be difficult to easily capture how a person identifies and the manner in which they would prefer their care.

Access to technology remains a barrier to fully utilizing telehealth for those with inequities. Individuals may not have adequate equipment or lack high-speed reliable internet connectivity. Some might be reluctant to use data allowances on telehealth visits.[34]

Those with visual challenges may struggle with font, colors, and contrast and people that have greater difficulties with literacy may have difficulty with check-in or other instructions to access telehealth. Individuals that are deaf or hard of hearing also have unique needs in a telehealth environment. Others may lack access to confidential space in order to have a private session. Still, many positives exist, such as removing barriers to transportation for appointments and practitioners have been developing creative ways to engage individuals remotely.

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[33]Miliard, M. (2020). *Western states embark on new telehealth partnership.* Healthcare IT News. Retrieved from https://www.healthcareitnews.com/news/western-states-embark-new-telehealth-partnership.

[34]Lewis, N. (2016). *Telehealth Helps Close Health Care Disparity Gap in Rural Areas.* Association of American Medical Colleges. Retrieved from https://www.aamc.org/news-insights/telehealth-helps-close-health-care-disparity-gap-rural-areas.

Addressing Inequities

Environmental Scan

Federal

> Telehealth can assist in maximizing provider networks, addressing some of the inequities in healthcare provision in more rural areas where transportation can present a major obstacle to healthcare services, especially if an individual needs to see a specialist, or if they cannot find a provider of cultural choice.[35]

Steps providers can take to mitigate racial disparities in telehealth include screening for access to equipment and internet as part of the health screening assessment, and offering education on how to utilize telehealth options. Care coordinators and care managers can be a good educational resource. In addition, although in-person options may be ideal, payers can ensure those without access to in-person delivery options for reasons such as transportation or lack of child-care can receive services via telehealth. Payors may want to consider providing inexpensive, refurbished equipment to individuals who do not otherwise have access to telecommunication devices.[35] Community resources such as the National Digital Inclusion Alliance are working to promote digital equity and are a good resource for low cost resources such as broadband plans available for less than $20 a month. Digital inequity is receiving national attention, as evidenced by a Congressional hearing on the topic in January of 2020, and continued focus from policy makers will be necessary to assist in ensuring equity going forward.[36]

State Summaries

States can also play a key role in addressing inequities in telehealth access and literacy. The Greenlining Institute in California recently created a digital health equity team of policy makers, community leaders and public health experts.[37] Recently introduced legislation in Utah could create an office for strategy and public-private partnerships to improve telehealth participation.[38] Development of policies to address inequities identified in local scans can help improve the access to and return on investment of BH telehealth services.[39]

Focus Group Summary

The Focus Group believes that addressing racial and demographic inequities is the right thing to do and that all individuals have equal rights to quality healthcare. Addressing inequities in diverse populations is a major component of the overall population health focus and affords the opportunity to improve quality of care and service delivery.

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[35]Nouri, S., Khoong, E., Lyles, C., Karliner, L. (2020). *Addressing Equity in Telemedicine for Chronic Disease Management during the Covid-19 Pandemic*. NEJM Catalyst. Retrieved from https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123.

[36]*COVID-19*. National Digital Inclusion Alliance. Retrieved from https://www.digitalinclusion.org/.

[37]*Office of Health Equity.* California Department of Public Health. Retrieved from https://www.cdph.ca.gov/programs/ohe/Pages/OfficeHealthEquity.aspx.

[38]Velasquez, D., & Mehrotra, A. (2020). *Ensuring The Growth Of Telehealth During COVID-19 Does Not Exacerbate Disparities In Care*. HealthAffairs. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/abs/.

[39]Velasquez, D., Mehrotra, A. (2020). *Ensuring The Growth Of Telehealth During COVID-19 Does Not Exacerbate Disparities In Care.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/full/.

Current considerations are focused on trying to develop a meaningful data structure, which involves education to the individuals seeking services about why questions are being asked as well as collaboration with data analysts to ensure quality metrics are captured. This has proven to be a difficult exercise in balancing being inclusive and obtaining minimal data. Another confounding factor is that disparities are most often “multi-layer”; for example, a person could be elderly, black, and poor with developmental disabilities.

In addition to evaluating the data collection related to the makeup of the individuals, Focus Group members described other efforts to promote inclusion and equality. Many have formed dedicated teams to develop strategic plans designed to evaluate opportunities. Efforts are made to survey employees in a confidential way about their opinions and experiences related to things like salary equity, hiring practices, diversity make-up and if people felt a sense of belonging.

Focus Group members shared examples of ongoing diversity and inclusion trainings and the evolution of those over time. Some have hired outside agencies or vendors to supply the program and encourage participation from all levels of the organization. As the data collection helps to identify the makeup of the population served, the information can ensure a review the staffing makeup and identify opportunities to better align staff diversity and practitioner representation with individuals seeking care.

One Focus Group member shared that her agency is reviewing and revising all policies and procedures to ensure they are reflective of the culture they are trying to promote. Another Focus Group member offered an example of a study that evaluated persons who were homeless and utilizing shelters that found micro aggressions and implicit bias by shelter staff related to non-white individuals receiving services. This population was not offered more independent housing as readily as others, with the frequent explanation being they were not stable enough or not quite ready.

4 Summary of Recommendations

The recommendations below from the Focus Groups and Steering Committee are for OMHSAS' consideration in development of future OMHSAS Behavioral Health Telehealth Policy. As the following recommendations are reviewed, consider the principal of telehealth as a tool to facilitate expedited communication and increase access and capacity of clinical services across system. Additionally, determining the use and applicability of telehealth during and post pandemic is recommended. Mercer recommends OMHSAS ensure there are not any mental health parity implications as policy decisions are made and implemented.

Service Delivery Considerations for Behavioral Health Telehealth

- Services Provided via telehealth:
  - Prioritize BH services with local providers, while also maintaining access to specialists, both in and OON, for individuals with complex situations.
  - Supplement local services through OON providers (e.g., child psychologists and psychiatrists).
  - Encourage implementation of SAMHSA guidance around permanently allowing for a virtual policy on take home MAT.
- Assessing when telehealth is a viable option:
  - Develop a provider-led assessment tool for individuals as part of the intake process to determine if telehealth services are appropriate, both clinically and operationally, as well as which modality is the best fit for the individual.
  - Ensure individual choice/preference is a key component of the assessment
  - Prior to each telehealth session, continue to check-in on the appropriate modality for the service.
  - Ensure the individual is educated on the security of the telehealth platform and the environment, including discussion of privacy in the setting of where the individual is receiving telehealth services.

  - Ensure the individual has access to necessary technology and equipment (e.g., internet, phone and computer) and ensure provision of education on telehealth delivery. Discuss their telehealth surroundings/environment to assess for appropriate level of privacy and potential distractions, such as children, siblings or neighbors.
  - Ensure telehealth is meeting treatment goals throughout the treatment episode. Consider sharing treatment plans via screen sharing or mailing a hard copy.
  - Encourage implementation of SAMHSA guidance around permanently allowing for a virtual assessment for OTPs for prescribing buprenorphine for the first time.
- Addressing training needs for providers and individuals:
  - Provide training on telehealth modality options (e.g., audio-only, audio-visual) and use of technology, as is recommended in the AMA Playbook.
  - Training providers and members to test connections (e.g., internally with providers and with individuals) prior to telehealth sessions to ensure clear audio and video.
  - Ensure provider training includes understanding of visual cues over video and how they may differ from in-person.
  - Train providers and individuals on the telehealth process, platform, and differences between telehealth and in-person visits.

Telehealth Technology and Security

- Telehealth modalities:
  - Retain flexibility of telehealth modalities and allow for hybrid models, such as a mix of audio visual and in-person sessions.
  - Retain audio-only as a telehealth modality option for individual and group services as allowed by Federal authority.
  - Identify and pursue options for increasing broadband internet to more rural areas, such as grants available through US Department of Agriculture or Housing and Urban Development.
  - Allow peer specialists, care managers, or other team members to provide education to the individual and family members on the use of technology and, if requested, to participate in initial and ongoing sessions as a way to increase the individual's comfort with this delivery modality.
- Platforms and security:
  - Develop electronic and verbal permissions to replace the need for written signatures for individuals who do not want to be seen in-person.
  - Allow for flexibility with place of service, such as allowing individuals to have sessions at a remote office using the technology of the remote provider if a private setting is unavailable in the home.
  - Ensure security, privacy and confidentiality when using telehealth (e.g., breakout rooms, waiting rooms).

- Review Federal guidance from CMS and the Office of Civil Rights to ensure appropriate technology platforms, standardization and compliance with HIPAA, the Office of Civil Rights and other state regulation/laws.

Reimbursement

- Rate setting considerations:
  - Provide the same rates for telehealth and in-person services.
  - Fully utilize all CPT, HCPCS, and modifier codes allowed under CMS authority to fully access and track all services/levels of care, such as brief check-ins and e-visits.
  - Evaluate increased costs for administrative staff and for maintaining additional clinicians for both in-person and virtual telehealth services.
  - Assess if increased access to specialty BH providers through telehealth may require a higher rate for specialist services such as child psychiatry.
  - Assess need and demand for in-person services post-pandemic; anticipate costs associated with office space that allows for social distancing, personal protective equipment and cleaning.
  - Assess additional cost considerations such as purchase of a formal technology platform, integrating telehealth records into the EHR, and upgrading both individual and provider technology equipment.

Quality Measures

- Following-up on early outcomes:
  - Continue to monitor and compare no-show rates for in-person vs. telehealth services.
  - Monitor individuals utilizing telehealth for a decrease in higher-cost levels of care due to increased access to and/or utilization of lower levels of care via telehealth.
  - Determine if performance measures related to follow-up after a crisis intervention or hospitalization improves with telehealth availability.
- Defining success:
  - Incorporate NCQA updates to the BH Healthcare Effectiveness Data and Information Set (HEDIS) measures as reflected in HEDIS Volume 2 Technical Specifications published on July 1, 2020. This guidance specifies how telehealth visits can be used (i.e., denominator, numerator, exclusion) and what type of telehealth is permitted. Continue to monitor Core Measures, HEDIS and External Quality Review guidance for changes in protocol/methodology.
  - Review provider performance targets to determine if changes need to be made due to change in telehealth service delivery.
  - Include input from clinicians, members and families in the development of quality measures.
- Fostering member engagement and satisfaction:

- Update patient and family satisfaction surveys to incorporate questions about telehealth experiences, such as satisfaction with using telehealth, ease of scheduling telehealth sessions, and ability to access providers with similar cultural and linguistic backgrounds.
- Monitor complaints and grievances information as another source of telehealth satisfaction and quality.

Creating a Culture of Inclusion in Behavioral Health Telehealth

- Defining inequities:
  - Determine make-up of catchment areas at a more granular level, such as race, ethnicity gender identity, and sexual orientation.
    - Evaluate the community landscape to identify areas needing increased education and outreach to address distrust of individuals of government healthcare and access to telehealth services.
- Addressing inequities:
  - Ensure the telehealth assessment process considers the needs of those who may be visually or hearing impaired to determine if additional accommodations are needed in order to effectively access telehealth services.
  - Evaluate effectiveness of any diversity and inclusion trainings/committees/work groups on telehealth.
  - Review content of telehealth company materials such as the website and educational resources for cultural competency.
  - Review telehealth policies and procedures to ensure they are reflective of the culture the organization is trying to emulate.
  - Compare the telehealth staffing and provider network characteristics against the community and populations served.
  - Continue attempts to capture relevant data on the characteristics of the individuals and communities served via telehealth.
  - Develop suggestions for standardized monitoring that allows for cultural competency in comparisons.

Appendix A Steering Committee Members

Steering Committee members were allowed to send a representative to the Steering Committee meeting(s) if they were unable to attend.

Member/Organization Name	Member Type/Organization
Amanda Roth	OMHSAS Quality Management
Ana Arcs	Pennsylvania Department of Human Services (DHS)
Brandon Fisher	Provider/Merakey
Dale Adair	OMHSAS
David Buono	Pennsylvania Insurance Department
Dawn Williams	Individual/Family Members
Denise Macerelli	MCO/HealthChoices
Elise Gregory	OMAP
Ellen DiDomenico	DDAP
Farida Boyer	Mental Health Planning Council (MHPC) Children
Greg Cherpes	Office of Development Programs representative to the MHPC
Jim Sharp	Provider Organization- RCPA
Josh Nirella	Provider Organization — PA TOD
Kathy Quick	Advocacy Group- PMHCA
Katie Dzurec	Pennsylvania Insurance Department
Ken Thompson	Practitioner FQHC
LeeAnn Moyer	MCO/HealthChoices
Lloyd Wertz	C4CH
Marjorie Faisch	OLTL
Megan Barbour	Pennsylvania Insurance Department
Mike Quinn	Provider/Chestnut Ridge
Mitzi Motley	Individual/Family Members
Raven Ebeling	Individual/Family Members
Sandra Ykema	Pennsylvania Insurance Department
Scott Talley	OMHSAS Children's Bureau
Tracey Carney	MHPC Adult

Appendix B Focus Group Attendees by Session

Focus Group members were allowed to send a representative to the Focus Group meeting(s) if they were unable to attend.

Focus Group #1 — Behavioral Health Services to Continue via Telehealth

August 19, 2020

Behavioral Health Services to Continue via Telehealth Attendee List

Amy Williams	Kayla Sheffer
Angela Douglas	Kim Rog
Brandon Fisher	Marjorie Faish
Brian (Last name not available)	Mike Quinn
Dave McAdoo	Nancy DiNatale
Diane Conway	Samantha Harkins
Eric Kiehl	Scott Suhring
Jamey Welty	Shannon Shylkofski
Jennifer Smith	Sheila Theodorou
Jill Stemple	Tracey Carney
Jim Sharp	Victoria (Last name not available)
Kathy Quick	

Focus Group #2 — Technology, Security and Access

September 14, 2020

Technology, Security and Access Attendee List

Angela Douglas	Marjorie Faish
Courtney Malecki	Mark Wendel
David Gabello	Mary Doyle
Dianne Schrode	Marybeth Greenalgh
Gregory Cherpes, MD	Odysseus Marcopolus
Irakli Mania	Phil Rohrbach
Jill Stemple	Sharon Hicks
Katie-Marie Wilson	Sheila Theodorou
Kayla Sheffer	Stacy Nonnemacher
Kim Rog	Tracy Carney
Larry Trenga	Zachary Karenchek

Focus Group #3 — Billing and Reimbursement

September 21, 2020

Billing and Reimbursement Attendee List

Amanda Roth	Jim Sharp
Brandon Fisher	Kayla Sheffer
Chad Varney	Kenneth Inness
Courtney Malecki	Kim Rog
Anthony Curtis	Marjorie Faish
David Gabello	Mark Wendel
Dawn Hamme	Mary Copeland
Donald Jacobs	Michele Kicior
Emily Loscalzo	Mike Quinn
Eric K Jones	Scott Donald
Heidi Thomas	Steve Ross
Irakli Mania	Susan Teconchuk
Jamey Welty	Tina Hannahs
Jessica Fenchel	Zachary Karenchek
Jill Stemple	

Focus Group #4 — Quality Outcome Measures and Monitoring

September 25, 2020

Quality Outcome Measures and Monitoring Attendee List

Adam Sechrist	Kenneth Inness
Aelesia Pisciella	Kim Butsch
Amanda Roth	Kim Rog
Ann Ligi	Lloyd Wertz
Brandon Fisher	Karen Mallah
Carl Kelley	Marjorie Faish
Courtney Malecki	Mike Quinn
Drew Carter	Nancy Dinatale
Emily Loscalzo	Nancy Stadler
Jamey Welty	Pam Gehlmann
Jason Snyder	Pamela Sigman
Jeffrey Sensenig	Shannon Shylkofski
Jennifer Gesing	Stacy Nonnemacher
Jill Stemple	Stephanie Ford
Jim Martin	Steven Ross
Jim Sharp	Susanna Kramer
Jocelyn Maddox	Tara Giberga
Kayla Sheffer	TaWanda Jackson
Kelly Primus	Val Carpenter

Focus Group #5 — Racial, Ethnic and Social Disparities

September 30, 2020

Racial, Ethnic and Social Disparities Attendee List

Adrienne Dixon Sarah Reed	Ken Thompson
Amy Nemirow	Kim Rog
Angela Douglas	Mandy Fauble
Brandon Fisher	Marjorie Faish
Cameron Lamberson	Marybeth Greenalgh
Chakaris Henderson	Nancy Murray
Courtney Malecki	Orfelina Payne
Dave Fetterman	Pamela McClenton
Gina Smaller	Samantha Harkins
Gregory Cherpes, MD	Samer Abdelhadi
Irlene Sweets	Sarah Westerfield
Jill Stemple	Shannon Shylkofski
Joanne Wolf	Tammy Relken
Jocelyn Maddox	Tara Gaudin
Julie Dees	Vanessa L. White Fernandes
Jamey Welty	Zachary Karenchek
Kayla Sheffer	

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