National Association for Behavioral Healthcare

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NABH Analysis: Tele-Behavioral Healthcare in Medicare

On April 5, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized regulations changing how Medicare Advantage (MA) plans, which cover approximately one-third of all Medicare beneficiaries, can provide telehealth services.[i]

The new regulations permit MA plans to provide "additional telehealth benefits" as part of their "basic benefit packages." The regulations will effective for the annual Medicare Open Enrollment period beginning on October 15, 2019 and ending on December 7, 2019.

Before the rule, MA plans that wanted to offer telehealth services could do so in one of two ways: they could offer the same telehealth services covered in original, fee-for-service (FFS) Medicare, or they could offer other added telehealth services as a "supplemental benefit." Offering the services as a supplemental benefit meant that enrollees had to pay additional premiums or copayments to access such services. Because the rule permits inclusion of the additional telehealth benefits in the basic benefit packages, the costs associated with these services can now be included in the capitated payment to the MA plans. Therefore, beneficiaries will no longer need to pay the additional premiums, copayments, or rebates for the services.

The rule also permits MA plans that offer services under Part B as part of the new additional telehealth benefits to do so without having to meet restrictive requirements regarding the geographic location of the "originating site" and "distant site." This requirement has been widely recognized as one of the largest barriers to expanding telehealth services in the Medicare program.

CMS intends to release more detailed sub-regulatory guidance relating to telehealth for both FFS Medicare and MA plans in the near future.

This NABH Analysis discusses telehealth as it relates to behavioral healthcare (tele-behavioral healthcare) treatment in the Medicare program and the new final rule.

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Telehealth in Medicare

Quick Facts

- In 2016 nearly 90,000 Medicare FFS beneficiaries used more than 275,000 telehealth services, an increase of 48 percent since 2014.[ii]
- While the growth is rapid, only one-quarter of one percent (0.25 percent) of the more than 35 million FFS Medicare beneficiaries use telehealth services.[iii]
- Beneficiaries below age 65 use a disproportionately high amount of telehealth services (61.0 percent).[iv]
- The growth rate of telehealth use was highest among beneficiaries ages 85 and older.[v]
- 81 percent of MA plans in 2018 offered supplemental telehealth benefits in the form of remote access technologies, an increase from 77 percent in 2017.[vi]
- The 10 states with the highest FFS Medicare utilization of telehealth services are California, Georgia, Iowa, Kentucky, Missouri, Michigan, Minnesota, Texas, Virginia, and Wisconsin.

Background on FFS

Currently, payment for telehealth services in FFS Medicare is limited to specific services provided in real time via audio and video telecommunications between a Medicare beneficiary who is present in a certain originating site and provided by a physician or other specified practitioner at distant sites.

An originating site is the location of a Medicare beneficiary at the time a telehealth service is furnished. These sites are paid an originating site facility fee established by the statute for hosting the telehealth service. Originating sites are geographically limited to locations in:

- rural health professional shortage areas (HPSA),
- counties outside of a Metropolitan Statistical Area (MSA); or
- sites that are participating in a federal telemedicine demonstration project approved by the U.S. Health and Human Services department (HHS).

Additionally, current law only allows certain healthcare settings to serve as originating sites. Permitted origination sites include the following healthcare setting:

- offices of physicians or practitioners,
- hospitals,
- critical access hospitals,
- rural health clinics,
- federally qualified health centers,
- hospital-based critical access hospital-based renal dialysis centers (including satellites),

- skilled nursing facilities, and
- community mental health centers.

The practitioner furnishing the telehealth service is located at a separate site from the beneficiary, known as the distant site. The distant site practitioner receives payment for furnishing the telehealth service and that payment must be an amount equal to what the practitioner would have been paid for the same in-person service. Current law only allows certain types of practitioners to furnish and receive Medicare payment for telehealth services. These practitioners include:

- physicians,
- nurse practitioners,
- physician assistants,
- nurse-midwives,
- clinical nurse specialists,
- certified registered nurse anesthetists,
- clinical psychologists,
- clinical social workers, and
- registered dieticians or nutrition professionals.

Background on MA

While FFS Medicare covers the majority of Medicare beneficiaries, nearly one third of beneficiaries are now enrolled in Medicare Advantage (MA) plans. MA plans must cover all telehealth benefits covered under Medicare FFS and MA plans may offer benefits in addition to the covered FFS benefits as a supplemental benefit. However, these supplemental benefits are not covered by the capitation rate to the MA plan and are funded via rebate dollars or supplemental premiums from enrollees.

MA plans must also comply with the originating and distant site requirements when providing telehealth services.

Barriers to Use

According to a recent report[vii] from CMS, the most significant barriers preventing the expansion of telehealth services in Medicare are:

- requiring the originating site to be located in certain types of rural areas, and
- not allowing the beneficiary's home to be an eligible originating site.

Background on Tele-Behavioral Healthcare in Medicare

Quick Facts

- In 2016 85 percent of all telehealth users (74,547 beneficiaries) had a mental health diagnosis.[viii]
- 37 percent of Medicare beneficiaries who received telehealth services in 2016 had diagnoses of a recurring major depressive disorder, bipolar disorder, and schizoaffective disorders.[ix]
- 7.9 percent of Medicare beneficiaries who received telehealth services in 2016 were treated for schizophrenia and 5.1 percent (4,554 beneficiaries) for an episode of depression.[x]
- In 2016, there were 33,892 beneficiaries diagnosed with depression and hypertension who accounted for 38 percent of the telehealth beneficiaries, but they received 46 percent of all telehealth services.[xi]
- While substance use diagnoses show high prevalence in Medicare, telehealth usage is low, in part due to low rates of telehealth visits for substance use disorder in general, representing just 1.4 percent of telehealth visits for any health condition.[xii]
- However, rates of telehealth visits for substance use disorder increased quickly between 2010 and 2017, from 0.62 visits per 1,000 diagnosed in 2010 to 3.05 visits per 1,000 diagnosed in 2017,[xiii] suggesting future rapid increases in Medicare.

Mental Health

- In 2008, 41 percent of beneficiaries dually eligible for both Medicare and Medicaid had at least one mental health condition.[xiv]
- And among all Medicare beneficiaries in 2015:[xv]
    - 17 percent had depressive disorders,
    - 15 percent had anxiety disorders,
    - 4 percent had schizophrenia and other psychotic disorders,
    - 3.6 percent had bipolar disorder,
    - 1 percent had post-traumatic stress disorder (PTSD), and
    - 0.8 percent had personality disorders.

Substance Use

- The prevalence of substance use disorders and substance use-related conditions account for three out of the top seven (42%) other chronic or disabling condition for Medicare beneficiaries for 2007-2016.
- The Medicare population has among the highest and fastest-growing rates of opioid use disorders, currently more than 6 of every 1,000 beneficiaries.
- Eight out of 10 of the states with the highest opioid *rates* are composed of 20 percent to 25 percent Medicare beneficiaries.[xvi]

- Eight out of the 10 states with the greatest *number* of opioid deaths are composed of 18 percent to 25 percent Medicare beneficiaries.[xvii]

Background

75 percent of U.S. counties are designated as mental health shortage areas, and more than half have no mental health professionals.[xviii] In addition, 82 percent of rural residents live in a county without a detox provider for substance use,[xix] and more than half of all rural counties (56.3 percent) still lack a buprenorphine provider. [xx]

"Structural barriers is the leading reason adults with unmet mental health needs cite as why they do not receive treatment. These barriers include transportation issues, inconvenience, and time constraints.[xxi] Early studies show that telepsychiatry may reduce disparities in access to psychiatric care. One such study demonstrated that remotely provided psychiatric care improved the chances that individuals in rural settings could access culturally and linguistically competent care.[xxii] Separate research shows that telepsychiatry can obtain results similar to face-to-face therapy for certain mental health diagnoses[xxiii] and may be a viable alternative when face-to-face therapy is not accessible.[xxiv] Research indicates efficacy for substance use treatment as well.[xxv'xxvi'xxvii]

Currently in the Medicare program telehealth services are primarily used to provide treatment for beneficiaries with mental health diagnoses.[xxviii] And, psychotherapy is among the services most commonly furnished through telehealth.[xxix] The overwhelming majority of Medicare telehealth users between 2014-2016 were diagnosed with one of eight common mental health and substance use conditions.[xxx]

Top Ten Principal Diagnoses for Medicare Telehealth Users (2016)[xxxi]

1. Major depression, recurrent
2. Bipolar disorder
3. Schizoaffective disorders
4. Schizophrenia
5. Major depression, episode
6. Other anxiety disorders
7. Reaction to severe stress
8. Sleep disorders
9. Cerebral infarction
10. Alzheimer's disease

Charts on Medicare Tele-Mental Health Usage

Telehealth Service Type	2014	2015	2016	Percent Increase
Individual psychotherapy	19,859	32,122	53,663	170.2
Psychiatric diagnostic interview examination	12,644	14,008	14,190	12.2
Neurobehavioral status examination	33	136	267	709.1

Delivery of Common Telehealth Services by Type	Telehealth Delivery	In-person
Individual psychotherapy	53,663	13,724,561
Psychiatric diagnostic interview examination	14,190	1,328,021
Neurobehavioral status examination	267	112,930

Background on the Medicare's Telehealth Rule for MA Plans

Using new authority provided to them under the *Bipartisan Budget Act of 2018* (BBA), CMS has issued a final rule allowing MA plans to provide ''additional telehealth benefits'' to enrollees starting in plan year 2020. Under this proposal, as [art pf the basic benefit package, MA plans would be permitted, but not required, to offer additional telehealth benefits beyond what is currently allowable under the original Medicare telehealth benefit. In the final rule CMS states the agency believes that allowing MA plans to provide "additional telehealth benefits would increase access to patient-centered care by giving enrollees more control to determine when, where, and how they access benefits."[xxxii]

This change means that an MA plan may build the cost of "additional telehealth services" into its bid as a Part B benefit even though the service is not permitted to be provided as a telehealth benefit in FFS Medicare. Therefore, costs associated with these additional services may be included in the capitated payment and plans are not restricted to using only rebate dollars or premiums for funding as they had been prior to the rule.

Additional Telehealth Benefits

In the rule CMS limits "additional telehealth benefits" to:

- Services available to beneficiaries under Medicare Part B, but are currently prohibited based on:
    - the geographic requirements related to "originating sites," or
    - the patient being in their home when receiving such telehealth benefits.
- Services that have been identified for the applicable year as clinically appropriate by the MA plan to furnish through electronic information and telecommunications technology.

Therefore, under the rule a MA plan may offer a Part B service via telehealth even if the originating site is not in a:

- rural HPSA,
- counties outside of an MSA, or
- site that is participating in a federal telemedicine demonstration project approved by HHS.

As it relates to the "services that have been identified for the applicable year as clinically appropriate by the MA plan to furnish through electronic information and telecommunications technology," the rule does not provide specific text defining "electronic information and telecommunications technology." CMS stated it "believes this broad and encompassing approach will allow for technological advances that may develop in the future and avoid tying the authority in the regulation to specific information formats or technologies that permit non-face-to-face interactions for furnishing clinically appropriate services."

CMS also chose not to define ''clinically appropriate.'' The rule allows MA plans to independently determine which services each year are clinically appropriate to furnish in this manner. Since existing regulations require each MA plans to agree to provide all benefits covered by Medicare ''in a manner consistent with professionally recognized standards of healthcare'' CMS decide to only require MA plans meet this requirement when providing additional telehealth benefits. Therefore, if MA plans meet that requirement they will be considered to be in compliance with the ''clinically appropriate'' requirement in this rule. CMS

stated in the rule that it believes “MA plans are in the best position to identify each year whether additional telehealth benefits are clinically appropriate to furnish through electronic exchange.”

Additionally, existing regulations require MA plans to disclose the benefits they offer, including “limitations, premiums and cost sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits.” MA plans satisfy this requirement through the Evidence of Coverage (EOC) document provided to all enrollees, which now would have to include the “additional telehealth benefit” limitations. CMS believes that it is through the EOC that MA plans will identify each year which services are clinically appropriate to furnish through electronic exchange as additional telehealth benefits.

Beneficiaries

Existing federal law mandates that enrollee choice be a priority and therefore a MA plan covering Part B service as an “additional telehealth benefit” must also provide access to such service through an in-person visit. The plans cannot only provide access through electronic exchange; the enrollee must be provided the option to receive the service through an in-person visit. The rule also requires that at a minimum the MA plans to use their EOC to advise enrollees that they may receive the specified Part B services either through an in-person visit or through electronic exchange.

Providers

A MA plan must have written policies and procedures for the selection and evaluation of providers and must follow a documented process with respect to providers and suppliers. Further, the rule requires that MA plans, when providing additional telehealth benefits, ensure through its contract with the provider that the provider meets and complies with applicable state licensing requirements and other applicable laws for the state in which the enrollee is located and receiving the service.

The rule also requires MA plans furnishing additional telehealth benefits to only do so using contracted providers. In the rule CMS says it believes “limiting service delivery of additional telehealth benefits to contracted providers offers MA enrollees access to these covered services in a manner more consistent with the statute because plans would have more control over how and when they are furnished.”

Finally, MA plans have to use their provider directory to identify any providers offering services for additional telehealth benefits and in person visits or offering services exclusively for additional telehealth benefits.

Capital and Infrastructure Costs

The final rule excludes the “additional telehealth benefits” from being used for any capital and infrastructure costs and investments. However, again the rule does not provide a specific definition. The rule states “the costs and investments needed and used to provide additional telehealth benefits will vary based on the individual MA plan’s approach to furnishing the benefits and the MA plan’s contracts with providers.” However, CMS provides the following non-comprehensive examples of capital and infrastructure costs:

- high-speed internet installation and service,
- communication platforms and software, and
- video conferencing equipment.

Additional Information

The rule requires MA plans to make information about coverage of additional telehealth benefits available to CMS upon request. The rule states that the information may include:

- statistics on use or cost of additional telehealth benefits,
- manner(s) or method(s) of electronic exchange,
- evaluations of effectiveness, and
- demonstration of compliance with the requirements in proposed regulation.

In a separate action by CMS, the agency revised the Medicare telehealth regulations to reflect the amendments made by section the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act*. Those amendments permitted CMS to remove the originating site geographic requirements and to add the home of an individual as a permissible originating site with respect to telehealth for services the treatment of an individual with a substance use disorder or co-occurring mental health disorder effective July 1, 2019 (83 FR 59494 through 59496).

This provision of the *SUPPORT Act* is different from the rule discussed at length in this analysis because the *SUPPORT Act* provision applies to both FFS Medicare and MA plan, whereas the new CMS rule applies only to MA plans and does not extend to FFS Medicare.

Concerns with the Final Rule

NABH is concerned the rule is primarily focused on Medicare Part B benefits. As mentioned previously, the rule allows two categories of services to be provided under the new definition of Additional Telehealth Benefits: services available to beneficiaries under Medicare Part B, and services identified as clinically appropriate by the MA plan.

When considering the services that will be available under the Part B provision, it is important to note that the behavioral healthcare benefit under Part B is very limited. Some examples of this include:

- Mental health and substance use disorder parity does not apply to Medicare and therefore does not apply to Part B;
- Reimbursement rates for services provided by psychiatrists are among the lowest in the Medicare program;
- Part B does not cover evidence-based recovery services such as peer support, assertive community treatment, or other support services.
    - Medication Assisted Treatment (MAT) is not yet covered under Part B. The *SUPPORT Act* (mentioned above) does allow CMS to start reimbursing for MAT under Part B but those rules have not been issued yet.

CMS tries to account for this by focusing on the second part of the provision, which allows services identified as clinically appropriate by the MA plan to be covered under the rule. However, this process and the definitions associated with it are not made fully clear in the rule. As noted earlier, CMS did not define ‘‘clinically appropriate’’ and instead has allowed MA plans to determine which services are clinically appropriate. Without clear guidance on how this process will play out, it is unclear if this provision will be sufficient to overcome the shortcomings of the behavioral healthcare benefit under Part B.

Pending Telehealth Legislation

Reps. Suzan DelBene (D-Wash.) and Tom Reed (R-N.Y.) introduced the *Mental Health Telemedicine Expansion Act* (H.R. 1301) on February 15, 2019. The legislation exempts from the current originating site requirements mental health providers delivering psychotherapy under CPT 90834 and 90837 through real-time, interactive audio and video telecommunications. Under the legislation, an initial assessment of the patient's needs must still occur in person prior to the use of telehealth services.

NABH has endorsed H.R. 1301 and is working with a coalition of mental health advocates to push for a Senate version of the legislation. Sen. Kamala Harris (D-Calif.) led that effort in the last Congress.

Endnotes

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