CBC COORDINATED BEHAVIORAL CARE

THE FUTURE OF TELEMENTAL HEALTH IS NOW: TELEMENTAL HEALTH POSITION PAPER

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COORDINATED BEHAVIORAL CARE | 55 Broadway, Suite 701, New York, NY 10006

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EXECUTIVE SUMMARY: A NEW OPPORTUNITY FOR TELEMENTAL HEALTH

The COVID-19 pandemic has substantially disrupted how healthcare is delivered and challenged *providers* to find new ways to engage with and treat their *clients* [1]. In response to enforced social distancing protocols and regulatory guidance requiring drastic reduction—if not outright elimination—of face-to-face visits, these unprecedented circumstances have mandated rapid changes to the delivery of care from in-person to telephonic/audio-visual means of connection and communication. In particular, the behavioral health (BH) sector has had to react quickly to the public health emergency. The rapid regulatory responses, through waivers at the federal and state level, resulted in realigned care practices and workflows at the clinical level. To ensure continuity of care for its most fragile and vulnerable populations, community-based health and human service agencies have had to make costly investments to properly equip staff and clients with mobile devices and other technology-assisted care solutions. Now, five months into the COVID-19 public health emergency, a new status quo has emerged, as providers and clients have adjusted to virtual service delivery in ways that were not imaginable before March 2020. Accordingly, Coordinated Behavioral Care's (CBC) network of over 50 community-based, not-for-profit, health and human service agencies, serving 100,000 Medicaid clients, is strongly advocating for the continuation of most current reforms and waivers that were temporarily enacted for telehealth services.

While New York State has made significant progress meeting the challenges of the pandemic, there remains mounting concern among community-based BH providers that these newly adopted virtual interventions and the telehealth regulations currently permitting them will be eliminated once the public health emergency subsides. The promising implementation of telemental health (a term used to encompass tele-psychiatry and tele-therapy) conducted by CBC Independent Practice Association (IPA) Network Agencies, CBC's Health Home Care Management Agencies (CMAs), NYS Office of Mental Health (OMH)/Office of Addiction Services and Supports (OASAS) programs and innovative CBC programs like Pathway Home™ and the positive experiences of both providers and clients—underscores the importance of and reliance on virtual care strategies to ensure and expand access during this pandemic. Now more than ever, it is vital to sustain virtual care growth, which will further increase timely access to needed services and provide client-driven choice bolstered by the strong support from providers and clients alike.

Beyond telehealth there are many use cases for technology-assisted care solutions in the mental health and substance use disorder treatment sector that can improve engagement, care delivery and health outcomes while reducing total cost of care value-based payment arrangements. Last summer, CBC published an "Emerging Technologies and Behavioral Health" whitepaper,

[1] In this Position Paper, we use the term "provider" to refer to any practitioner that practices and delivers healthcare services, and "client" refers to a recipient of these healthcare services.

which positioned CBC as a central resource to explore, vet, pilot, navigate and ultimately support and scale innovative solutions for providers and clients in the healthcare market. The whitepaper presented the unique needs and challenges of BH population and community providers with a special emphasis on client/family engagement, provider opinion and end-user feedback. CBC endorsed the use of technology-assisted care solutions and devices such as mobile platforms and telemental health to reduce barriers to care for vulnerable populations then, and this Telemental Health Position Paper expands upon that support by advocating for the flexible use of virtual care strategies as a standard practice of care and a complementary and adjunctive strategy in BH care delivery. Such virtual care strategies must be clinically driven, unencumbered by unnecessary administrative and regulatory burdens and responsive to client choice while preserving requisite privacy protections.

As CBC IPA continues on its path to a more clinically integrated delivery system, with an emphasis on continuous quality improvement and data analytics to support outcome measures that inform a transition to value-based care models, the role and impact of telemental health has emerged as a critical service delivery modality. If telehealth regulations roll back in a reversal to pre-pandemic policies, the BH sector's progress serving its most vulnerable populations will be stifled. In the past few months, telemental health has proven to be an effective and responsive engagement/communication strategy with individuals at varying levels of acuity and improved the client's healthcare experience. [1,2,3] We can increase access to care and advance the tenets of the Quadruple Aim by leveraging the technology tools that are available today. The right connection at the right time can save a life.

CBC ALIGNS TELEMENTAL HEALTH TO THE QUADRUPLE AIM [4]

Client Experience: Easy access, with fewer barriers to seek care

Population Health: Able to serve and treat more clients across regions with no barrier to transportation/travel

Reducing Cost: Reduced no-shows and lower administrative costs

Care Team Well-Being: Able to manage schedule and maintain meaningful connections throughout the transitions of care

Over time, more routine use of virtual care strategies will facilitate access to care, improve outcomes with timelier responses and proactively identify risks with potential cost containment through preventive care, as too many Americans are not currently seeking or receiving the BH services and treatments they need. By adding these critical and complementary tools to the provider's arsenal, he or she is empowered to deliver seamless, high-quality services and an improved client experience.

In this Position Paper, CBC recommends the following based on an analysis of its network—encompassing a significant portion of NYC's BH sector—and acknowledges the underlying need for social equity as the lens through which all relevant future policies are framed. Each of the following four categories will be described in more detail:

1. PERMANENT REGULATORY RELIEF FOR TELEMENTAL HEALTH

As a result of the COVID-19 pandemic, substantial regulatory relief was extended to providers by both local and national governing bodies. Providers and telehealth vendors have worked together to deliver safe and effective care, setting the stage for a new and more expansive service delivery methodology. CBC recommends the formal adoption of many of these regulatory waivers, such as expanded location of service, use of audio-only interactions and increased provider/client choice.

2. ADMINISTRATIVE FLEXIBILITIES FOR TELEMENTAL HEALTH

Administrative and workflow flexibility have, in the short-term, yielded promising results and warrant consideration for permanent adoption. Examples of promising temporary workflows include streamlining documentation requirements and reducing redundant or obstructive confidentiality requirements. These flexibilities have been especially essential for the population struggling with substance use disorder/opioid use disorder (SUD/OUD) during the pandemic.

3. ENHANCE WORKFORCE CAPACITY

As a result of relaxed workforce requirements, providers have been able to meet the needs of clients in a responsive manner during the pandemic. CBC recommends the relevant guidelines be made permanent, including those allowing providers licensed in New York but living out-of-state to offer telemental health services remotely. If a client is having difficulty with "technical literacy" that may prevent treatment engagement, BH providers should be able to support them and include this as billable time.

4. EQUITABLE PAYMENT/RATES

Telehealth has been shown to increase access and adherence to care through a combination of reduced barriers (like travel) and practice management tools (like appointment reminders). CBC recommends leveraging technology to promote more reliable and effective engagement efforts, as the sector shifts from fee-for-service (FFS) payment models to ones that focus on outcomes. Until such models are determined, CBC recommends that parity in payment and rates for services remain and that telehealth is reimbursed at the same rate as in-person treatment.

INTRODUCTION

As COVID-19 continues to spread across the United States, healthcare providers have been required to incorporate new telehealth strategies to address their clients' physical, behavioral and social determinants of health concerns while reducing face-to-face contact between client and provider. These efforts have been supported by state and federal decisions to temporarily suspend or modify certain requirements related to telehealth during the public health emergency. For example, the federal government has loosened previously stringent telehealth regulations in Medicare that required, with few exceptions, that the client be located in a rural area to receive services via telehealth. For the duration of the emergency, Medicare is permitting services delivery to beneficiaries regardless of geographic restrictions, allowing clients to receive care via telehealth in non-rural areas and in the safety of their own place of residence.

The regulatory changes and waivers set forth during these unprecedented circumstances have encouraged the BH sector to quickly adopt this new technology as part of the continuum of care delivery. On the following page, CBC has documented pre-existing telehealth policies to contrast with changes enacted in the context of the public health emergency. See Table #1: Telehealth Changes During COVID-19 Emergency.

TELEHEALTH DEFINITION

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media and terrestrial and wireless communications.

The New York State Office of Mental Health (OMH) defines telemental health as the use of two-way real-time interactive audio and video equipment to provide and support mental health services at a distance. Such services do not include a telephone conversation, electronic mail message or facsimile transmission between a provider and recipient or a consultation between two professionals or clinical staff. [5,6]

Telehealth can be delivered via a range of technologies including telephone, internet and email, virtual reality simulators, and videoconferencing. Telehealth applications include:

- Live (synchronous) videoconferencing: a two-way audiovisual link between a patient and a care provider;
- Store-and-forward (asynchronous) videoconferencing: transmission of a recorded health history to a health practitioner, usually a specialist;
- Remote patient monitoring (RPM): the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time;
- Mobile health (mHealth): health care and public health information provided through mobile devices. The information may include general educational information, targeted texts and notifications about disease outbreaks.

TABLE #1: TELEHEALTH CHANGES DURING COVID-19 EMERGENCY [7]

Agency	Existing Policy	COVID-19 Emergency Changes
NYS Department of Health (DOH)	NYS Medicaid currently covers telemedicine, which consists of two-way audio-visual communications to deliver clinical healthcare services from a distant site, remote patient monitoring and store-and-forward technology.	NYS Medicaid will reimburse any covered service provided telephonically, as long as it is appropriate to be delivered by telephone. During the State of Emergency all sites are eligible to be distant sites for delivery and payment purposes. Services may be provided to new or established patients. Patient cost sharing is waived for all telehealth services.
NYS Office of Addiction Services and Supports (OASAS)	Telepractice is a means of delivering services provided by an OASAS certified program subject to any other regulations applicable to the program's certified modality regarding evaluations, admissions, treatment/recovery plan development and review, discharge, etc. The program must have received an operating certificate "designation" from the OASAS to utilize this means of service delivery.	OASAS issued a waiver to allow current providers to more rapidly deliver services via telepractice (including telephonic) and permits all providers to offer services via telepractice for the duration of the COVID-19 emergency. Providers who do not already have approval for telepractice must self-attest that they will meet qualification standards, use a secure and credible technology system, maintain confidentiality, and use appropriate telehealth modifiers in billing, among other requirements. Patient cost-sharing is waived for all telehealth services.
NYS Office of Mental Health (OMH)	OMH allows for services to be provided via telemental health, which is the use of two-way real-time interactive auadio and video equipment to provide and support mental health services at a distance.	All Article 31 licensed programs may offer services via telehealth (including telephonic) for the duration of the COVID-19 emergency. Providers, which may include paraprofessionals and unlicensed behavioral health staff, must self-attest that they will meet qualification standards, use a secure and credible technology system, maintain confidentiality and use appropriate telehealth modifiers in billing, among other requirements. Patient cost-sharing is waived for all telehealth services.telehealth services.
Medicare	Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. With a few exceptions, the beneficiary must generally be located in a rural area and in a medical facility. The beneficiary's home is generally not an eligible originating site.	Effective March 6th, services delivered by telemedicine to a Medicare beneficiary are reimbursable regardless of geographic restrictions or originating site limitations. This includes services delivered to beneficiaries in non-rural areas and/or located in their own homes. Providers may choose to reduce or waive patient cost-sharing for services delivered by telehealth. Patients no longer need to have a prior relationship with the telemedicine provider. CMS will now reimburse for many additional CPT codes by telehealth. Virtual check-ins and e-visits may be delivered to new patients. Virtual check-ins and remote patient monitoring may be offered by behavioral health and other therapists. Some services may be delivered by telephone (audio-only). CMS will allow anyone who is eligible to bill Medicare to bill by telehealth from a distant site, including physical therapists, occupational therapists and speech language pathologists.

The COVID-19 pandemic necessitated these temporary changes to telehealth regulations, resulting in a dramatic increase in the use of telehealth service interventions. Accordingly, the New York BH sector is tracking and documenting the impact of telemental health on quality and access to care and using this information to advocate for the permanent authorization of telehealth and complementary regulatory relief. The proposed changes outlined in this Position Paper will permit BH providers and clients to continue to use these technologies in a more streamlined and efficacious manner, while mitigating ongoing concerns of infection and other safety risks. In the future, telemental health will play a critical role in supporting the BH needs of a population that will likely grow more fragile; this is of particular concern as the pandemic extends to the fall and winter months—presenting fewer opportunities to interact outdoors, a new flu season and the potential for increased infection rates.

At the federal and state level, there is growing recognition of the importance of telehealth services. Modest efforts are underway to codify the temporary exceptions into permanent changes. In Washington, a bipartisan group of senators is advocating for the permanent continuation of many pandemic-related telehealth changes, ranging from greater flexibility in the physical location where a Medicare beneficiary is receiving services (related to the "hub and spoke" requirements) to ensuring additional types of services remain reimbursable by Medicare. Here in New York, Governor Cuomo recently signed Senate Bill S8416 (Assembly Bill A10404) into law, which made permanent the provision allowing audio-only services reimbursement under telehealth—previously only permitted as an emergency regulation during the pandemic. These are important first steps to ensure providers can continue to do the invaluable work of caring for some of our most exposed populations during this historically period.

BACKGROUND AND EVIDENCE

While it is widely known that BH disorders are common among adults, children and adolescents—one in five American adults has been diagnosed with a mental health disorder—in a given year, more than half (56%) of those who would benefit from care are not receiving care in the manner they require, if at all. [8,9] While this phenomenon is an incredibly complex and multicausal problem, the lack of access to quality care, high cost of care and inadequate or absent insurance coverage exacerbates the arising health disparities across the country, leaving over 100 million people without appropriate access to needed BH services. [10,11]

Telehealth is a promising conduit to improved outcomes across these metrics. There is a growing body of literature that supports technology adoption in BH—predominantly in mobile-based care and telemental health—with demonstrated client satisfaction, improved outcomes and cost effectiveness. [12] A review of survey data regarding telehealth adoption from June 2015 to August 2019 showed that interest in and adoption of telemedicine has been steadily increasing, but over 75% of practices surveyed did not offer telemedicine at the time of the survey. 64% planned on implementing telehealth within “one month” of the survey, and most notably, mental health professionals were by far the most interested in telehealth. [13]

Mental health services delivered via telehealth applications appear, in some studies, to be clinically superior to reduced or no mental health services at all. One review found that telemental health services are comparable to in-person care and are effective for diagnosis and assessment across many populations (adult, child, geriatric and ethnic) and disorders. [14] In addition to the positive clinical effects of virtual care, there are numerous other benefits for both providers and clients, as listed below. [10]

CONVENIENCE	Clients and providers simply need a computer, webcam and broadband internet access.
ACCESSIBILITY	Clients who live in remote areas, are housebound, have difficulty arranging child-care or can’t otherwise make time for regular therapy sessions, can now access their treatment provider remotely.
OUTREACH	Providers who offer services virtually can expand their reach to new clients with less stigma attached to accessing BH care virtually.
CUSTOMIZATION	Clients and providers can focus on how, when and where care is delivered through appropriate assessments and track trends and progress over time.
ADHERENCE	Clients face fewer barriers (and less stigma) to attending treatment when they can meet from wherever they are located, and accordingly are more likely to remain in treatment, as necessary.

However, while there is a clear use case for telemental health during this emergency, there are additional benefits of telemental health under standard circumstances that will become even more apparent during this increased uptake of virtual delivery services. Particularly for the mental health population, telehealth benefits include:

- More efficient provider consultation with specialists to ensure the best care decisions are made for patients—such as an eating disorder expert or a child/adolescent prescriber.
- Increased support to clients and providers in rural or isolated geographic areas and increased points of contact with clients that may be isolated and/or experiencing loneliness because of social distancing.
- Additional flexibility for clients who may be homebound or have difficulty traveling to receive care due to an underlying psychiatric condition.
- In urgent situations, immediate access to providers who can guide clients on appropriate next steps, potentially avoiding emergency department visits and inpatient hospitalization.

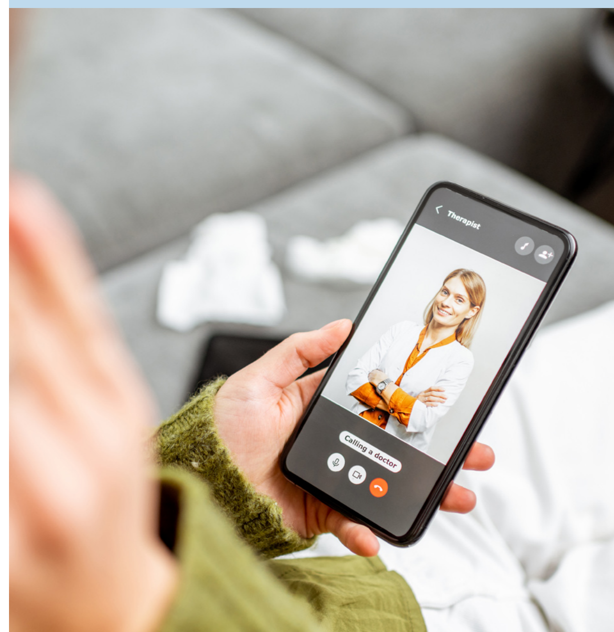
It is essential to implement a telemental health technology solution that is not only acceptable to providers but also caters to the unique needs of the individuals served. For example, offering an easy-to-use application with relevant features (such as appointment reminders) to the population that may have limited technology literacy or would benefit from additional supports can significantly improve virtual care delivery. While technology-driven care can transcend access barriers to quality BH care for clients and administrative burdens for providers, the fact that high-speed internet/broadband is not yet universally accessible presents an important caveat. Ensuring access to connected devices and adequate Wi-Fi among lower-income communities is essential. Earlier this year, EmblemHealth surveyed 1,000 NYC residents in collaboration with ANA Research and responses revealed that insufficient electronic device ownership and internet services can limit access to telehealth services. [15]

EMBLEMHEALTH SURVEY

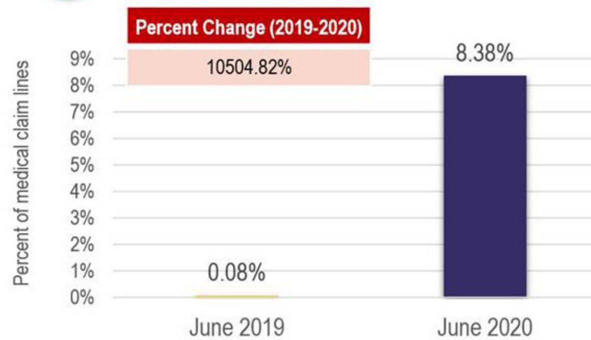
Low-income and Black New Yorkers are more likely than the general population to have access to only one electronic device at home, limiting their ability to access telehealth services when other household members are using the device.

Nearly 80% of the general population reported having access to two or more devices at home, compared to 69% and 67%, respectively, of low-income and Black households.

Additionally, while 82% of the general population reported having access to regular and adequate internet at home during the pandemic, about a quarter of low-income households and a third of Black households reported having inadequate internet access.



Localities, states and the federal government must continue to increase access to broadband networks and ensure that socioeconomic barriers do not impede individuals from needed care. Recently, NYC Mayor DeBlasio announced a step to bridging the city's digital divide by promising to expand internet access to 600,000 underserved New Yorkers—1/3 of whom live in NYC public housing.



Physical inability to participate in therapy should never prevent an individual from receiving clinical support and care. Telehealth has filled this substantial gap in the short run. A study by the Commonwealth Fund found that as the number of in-person visits declined sharply at the start of the pandemic, the number of visits delivered via telehealth increased significantly. [16] Forrester Research predicts that virtual care visits in the U.S. will increase to more than 1 billion this year. [17]

FAIR Health Monthly Telehealth Regional Tracker data show an increase in volume of total (private insurance population, excluding Medicare and Medicaid) telehealth claims in the Northeastern U.S. (CT, ME, MA, NH, NJ, NY, PA, RI, VT) from 0.08% of medical claim lines in May 2019 to 12.49% in May 2020. [18] Many temporary prohibitions of elective procedures and non-emergency medical care expired in May, and the June data accordingly show a proportional drop in telehealth claims to 8.4% of all medical claims, a figure that's still exponentially higher than year-over-year rates. See Graph #1: Volume of Claim Lines, Northeast, 2019 vs. 2020. Furthermore, the proportion of telehealth claims that were for mental health services increased from 41% in May to 48% in June, suggesting that telehealth currently remains a preferred venue for these services, even though in-person modalities of care delivery are permissible.

In 2018, CBC conducted a survey consisting of 429 Medicaid clients across six different BH program sites in the Bronx. The purpose of the survey was to collect information about client technology use and determine how technology could improve engagement in BH treatment. The high number of "no-shows" across the BH sector remains a formidable barrier to care. In relation to no-shows, CBC surveyed clients on the most common barriers (e.g., insufficient transportation/ proximity and lack of scheduling flexibility) that prevented attendance at a scheduled appointment. See Table #2: CBC Participant Survey: Barrier to Routine BH Care. [19]

TABLE #2: CBC PARTICIPANT SURVEY: BARRIER TO ROUTINE BH CARE

- 46% Lack of transportation
- 31% Lack of motivation or readiness
- 27% Distance to service from home
- 18% Conflict with work or school

Telehealth mitigates three of the four most common barriers to routine BH care indicated in the survey—"lack of motivation or readiness" is the only barrier not directly impacted, and with additional interaction using virtual tools, a provider could help a client work though ambivalence, resistance and/or lack of motivation.

For clients served by CBC's network, the transition to telemental health has demonstrated improved access to care, greater convenience and reduced wait times. A recent sample of clients across BH populations within the CBC network reveals overall satisfaction with telemental health services:

“The Zoom meetings have helped me in many ways. First, they keep me connected to my program. Second, they have kept me occupied so my day goes faster. Thirdly, they are interesting and leave me with a positive feeling at the end of the day. Fourth, the meetings allow me to be productive and make me feel good about myself - I feel very productive and accomplished. Lastly, the positive energy which emanates from the case workers and members makes me feel more positive and productive about myself.”

- Michelle

“In many ways the virtual Venture House has been more vital to me than the brick and mortar version. During this COVID 19 shut down the need for contact and networking with our extended Venture House family has been indispensable for my mental health and wellbeing. Under normal circumstances I have many more social outlets available. It is for this reason our community plays an even more crucial role in my life virtually, than under normal circumstances’ gives me strength and solace knowing that Venture House is there continually as a resource daily, a forum that I can rely on, especially during these difficult times!”

- Avi

More broadly, there is mounting evidence that both clients and providers experience high satisfaction rates following a telehealth session, indicating a preference for telehealth over an in-person visit and confidence in the telehealth platform. [2] Individuals who accessed healthcare services virtually during the pandemic will likely expect these benefits to continue post-pandemic. Returning instead to the previous status quo could cause a greater disruption to the health system. Furthermore, telehealth has helped bolster the use of and need for virtual care to improve outcomes, address gaps in access, increase adherence and follow-up and manage workforce shortages. This is especially evident in remote and underserved areas with limited provider infrastructure and populations with specialized psychiatric needs, such as children/adolescents or forensics, where there is opportunity to introduce new models of care. [20]

CBC NETWORK PROGRAMS DATA ANALYSIS

Amid the pandemic, CBC analyzed program data related to telemental health utilization and found it consistent with broader trends suggesting the positive impact of higher-touch virtual care options. The analysis included appointment and billing information derived from CBC IPA network agencies, the CBC Medicaid Health Home and CBC's intensive care transition program, Pathway Home™. The study compared pre-pandemic service utilization activity to activity following the COVID-19 public health emergency declaration in March 2020, to better understand the effects of telemental health during the pandemic. CBC analyzed three program sectors:

- IPA Network Agencies: Collected data on encounters and utilization in ambulatory programs for several psychiatric/clinical billable services, as well as the number of appointments scheduled, while monitoring no-show trends.
- Health Home (HH): Reviewed billable encounter data and core service utilization, as well as newly enrolled members post-outbreak across CBC's Health Home Serving Adults (HHSA) and Health Home Serving Children (HHSC) programs.
- Pathway Home™ (PH): Collected data from several sources, including demographics and 2020 encounters across several of the existing PH teams working with members referred from the NYC Health + Hospitals (H+H) system.

The data demonstrated that total client encounters increased, while previously in-person services decreased following the COVID-19 outbreak.

IPA NETWORK AGENCIES

CBC IPA's network, comprised of over 50 community-based non-profit BH agencies serving over 100,000 Medicaid clients, contributed to a standard data collection process. Data findings showed:

- In a cross-section of outpatient clinic settings, the proportion of psychiatry sessions conducted via telehealth increased by almost 95 percentage points.
- The follow-up rate increased from 78% pre-pandemic (predominantly in-person) to 83% post-outbreak (predominantly telemental health).
- Among the clinics' mental health providers, the proportion of telehealth appointments scheduled increased by almost 92%, with a 77% follow-up rate compared to 59% pre-outbreak.

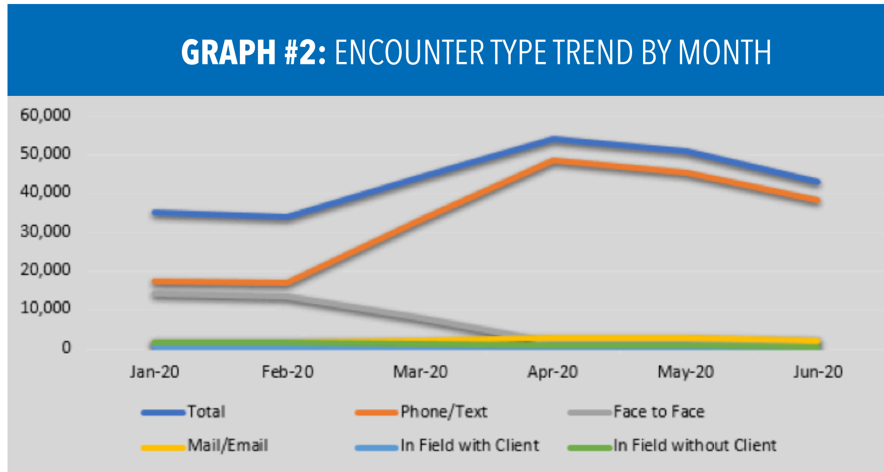
Initial feedback from CBC IPA network agencies indicates that the rate of appointments kept post-outbreak also increased when compared to pre-pandemic rates, and that no-shows have been reduced through the adoption of telehealth. Their experience aligns with a mid-May APA survey of over 500 psychiatrists, which found that the percentage of psychiatrists with 100% attendance rates increased from 9% to 32% following the COVID-19 state of emergency declaration. [21] These findings were consistent across all three program areas (IPA network agency clinics, HH and PH) and are likely due to the removal of barriers to care for CBC's client population courtesy of greater virtual options.

HEALTH HOME CARE MANAGEMENT AGENCIES

CBC's Health Home program, consisting of 47 care management agencies (CMAs) with approximately 17,600 members, collected data from CBC's centralized technology platform that yielded similar results. CBC's analysis of pre-pandemic and post-outbreak data from its HH programs revealed a number of trends consistent with the sector's broader shift toward telehealth:

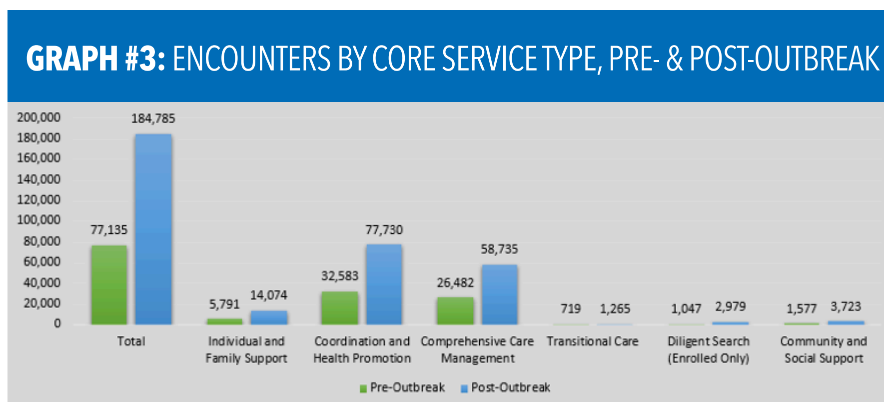
- The average monthly number of face-to-face encounters decreased by over 75%.
- The average number of remote encounters – Phone/Text – increased by approximately 139%.
- The average monthly number of all encounters increased by 35%.

These dramatic shifts in healthcare utilization are illustrated in Graph #2: Encounter Type Trend.



GRAPH #2: ENCOUNTER TYPE TREND BY MONTH

- The average number of encounters specific to HH core services increased across all types by up to 70% from their pre-outbreak averages. Core service encounters include Individual and Family Support, Coordination and Health Promotion, Comprehensive Care Management, Transitional Care, Diligent Search (Enrolled Only) and Community and Social Support.
- The data demonstrate that CMAs, while unable to conduct in-person visits, are still able to provide needed services to this vulnerable population, dealing with serious behavioral and substance-use disorders and multiple co-morbid chronic health conditions. See Graph #3: Encounters by Core Service Type, Pre- and Post-Outbreak.
- Moreover, following the outbreak, the Health Home program enrolled over 800 additional adult and children/adolescent members by verbal consent. Without the regulatory relief allowing for verbal consent in lieu of written consent authorization, these members would not have been afforded the care coordination services necessary to effectively manage physical and behavioral health needs during the pandemic.

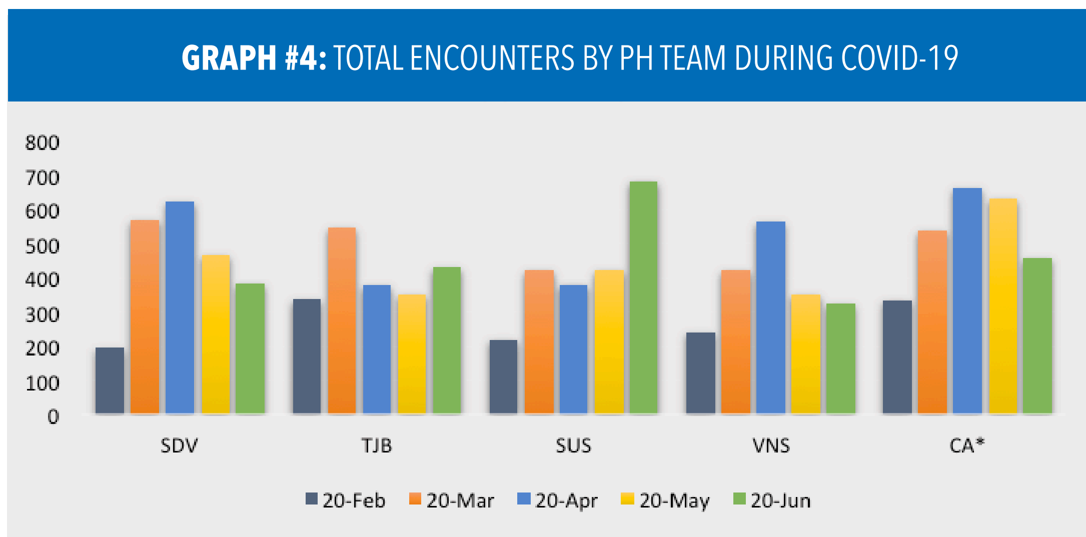


GRAPH #3: ENCOUNTERS BY CORE SERVICE TYPE, PRE- & POST-OUTBREAK

PATHWAY HOME™

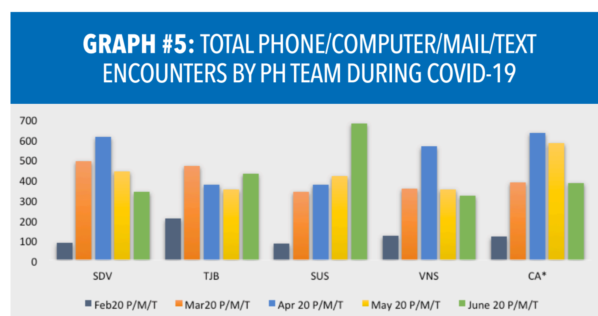
Similarly, CBC conducted an encounter analysis of its innovative programs, examining a cohort of Pathway Home™ (PH) teams (Samaritan Daytop Village (SDV), The Jewish Board (TJB), Services for the UnderServed (S:US) and Visiting Nurses Services of New York (VNSNY)) working with members referred from the NYC Health + Hospitals (H+H) system. Additional site-specific encounter data from Community Access' (CA) PH team was included in the analysis, which featured encounter data from CBC's health information technology platform between February and June 2020. The data revealed:

- A dramatic across-the-board increase in overall engagement and encounter efforts between February and March, ranging from 60% to 192%.
- A slight dip in encounters in subsequent months–though overall encounters remained well above their pre-pandemic totals–as team members continued to leverage technology as a means to maintain connection with clients. See Graph #4: Total Encounters by PH Team During COVID-19.

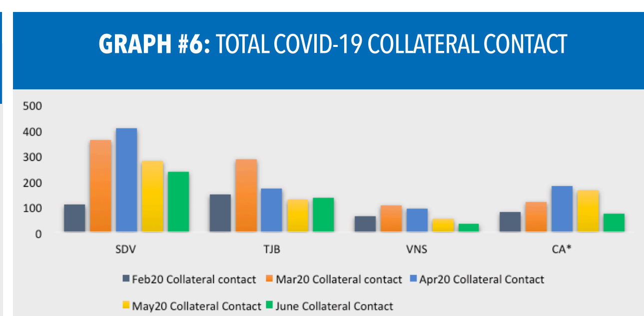


GRAPH #4: TOTAL ENCOUNTERS BY PH TEAM DURING COVID-19

As expected, in-person encounters declined due to social distancing requirements, while encounters conducted by phone, computer, text or mail increased significantly across the cohort. Since PH teams transitioned to remote work from mid-March to June, each team's total phone, computer, text or mail encounters ranged from 1588 to 1981, while serving approximately 300 members. These encounter totals represent a remarkable increase from pre-pandemic totals, ranging from 129% to 487% across teams. See Graph #5: Total COVID-19 Phone/Computer/Mail/Text Encounters. These encounters included communication not exclusively with members, but also their collaterals such as community providers and family to ensure continuity of care was being met during the pandemic. See Graph #6: Total COVID-19 Collateral Contact.



GRAPH #5: TOTAL PHONE/COMPUTER/MAIL/TEXT ENCOUNTERS BY PH TEAM DURING COVID-19

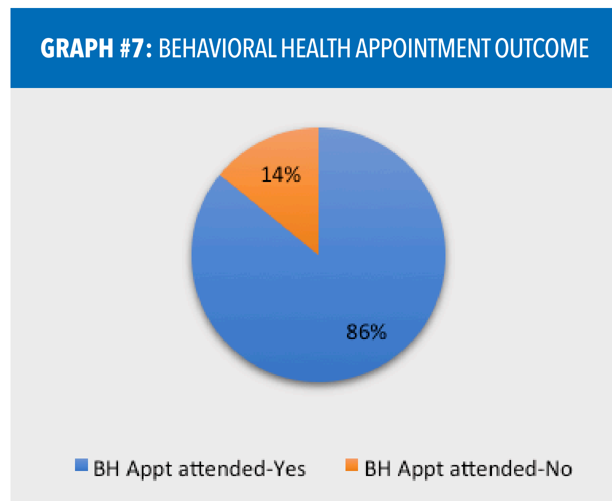


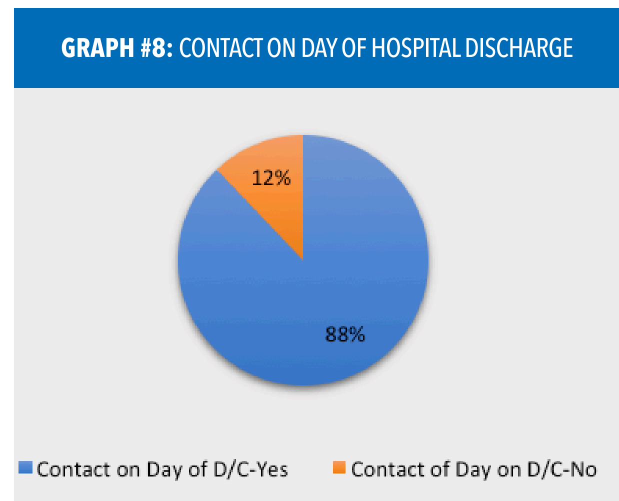
GRAPH #6: TOTAL COVID-19 COLLATERAL CONTACT

Over the February to June period, PH teams effectively enrolled 99 new members. Despite most of the work occurring remotely through telemental health, an analysis of outcome data indicated that 86% of enrollees during this period were successfully connected to BH services post-hospital discharge. See Graph #7: Behavioral Health Appointment Outcome.

A common practice of PH is accompaniment home on day of hospital discharge, which became impossible at the height of the public health crisis. Through telehealth, PH staff was still able to connect with members to ensure they returned home safely from the hospital and that immediate needs were met at community re-entry. Of the members enrolled between February and June, 88% were successfully contacted on day of discharge. See Graph #8: Contact on Day of Hospital Discharge.

This analysis demonstrated that when in-person visits weren't viable, some of New York's most vulnerable population living with serious mental illness and complex medical needs were still able to access essential services and connect to providers.





CBC POSITION STATEMENT AND RECOMMENDATIONS

The temporary changes to telehealth regulations have been essential to protect the safety of providers and clients while ensuring continuity of care during the public health emergency. The continued access to services is particularly essential for the population which CBC's network serves—a group largely made up of individuals with moderate to severe mental illness, substance use disorders, minors with serious emotional disturbances, individuals with multiple comorbidities and those negatively impacted by the social determinants of health. These individuals generally benefit from a high-touch approach, requiring frequent communication and contact with care managers, therapists and psychiatrists. Furthermore, telemental health can quickly connect individuals with providers and deliver timely services, thereby limiting emergency room visits. This is especially vital when inpatient units must primarily focus on responding to the COVID-19 pandemic.

CBC's unique perspective is informed by its close partnership with over 50 small, medium and large community-based BH organizations in NYC serving more than 100,000 Medicaid clients. Through surveys, collectively implemented direct programs, community events and targeted information gathering, CBC is intimately aware of the needs of both providers and clients in NYC. One of the most critical aspects of the transition to a more permanent approach to telemental health is a greater emphasis on provider and client choice. It will be essential to promote clinically-driven decision-making, including on the type of intervention—in-person vs telemental health—that's best for the client, and on the timing, frequency and duration of service delivery. These decisions should be left to the client and his or her provider.

Equipped with this knowledge and access to industry leaders, CBC makes the following four recommendations to support the use of telehealth beyond the COVID-19 public health emergency:

1. PERMANENT REGULATORY RELIEF FOR TELEMENTAL HEALTH

The public health emergency provided immediate authority for providers to offer critical BH services via telemental health. In the months since regulatory relief was granted, numerous benefits have demonstrated the need to make the relief permanent. Therefore, CBC recommends that federal and state agencies:

- Continue to allow telemental health services delivery regardless of where the client and provider are located by removing relevant geographic requirements. This will require that the provider community be effectively trained in ensuring privacy and confidentiality when working from a "home office." The provider and client should have decision-making agency regarding when and how to utilize telemental health services.
- Remove the requirement for an in-person service prior to being eligible for telemental health services. This would allow new clients a more seamless entry to treatment without unnecessary barriers and delays.
- Continue to authorize greater flexibility prescribing and dispensing buprenorphine and methadone for Opioid Use Disorder (OUD), including:
  - Allow treatment, monitoring and prescribing for people receiving OUD medications to be delivered via telehealth/telephone.
  - Permanently remove the initial in-person medical evaluation as a prerequisite for prescription of buprenorphine via telehealth/telephone and permit the ongoing use of telehealth/telephone for prescribing OUD medications.
  - Maintain the Medicaid managed care plan requirement to reimburse Opioid Treatment Programs (OTPs) for methadone dispensing using a newly created weekly bundled rate, based on Medicare's weekly bundled rates
  - for OTPs.
  - Continue Medicare's reimbursement of OTPs for audio-only therapy and counseling services as part of its weekly bundled rate.

2. ADMINISTRATIVE FLEXIBILITIES FOR TELEMENTAL HEALTH

In addition to regulatory relief, additional administrative and workflow flexibilities that have shown promise should remain permanent. To that end, CBC acknowledges and endorses NYS Office of Mental Health's (OMH) recent amendment to Part 599.10 of New York Codes, Rules and Regulations' (NYCRR) Title 14,which regulates Article 31 clinics' development and execution of patient treatment plans. The terms of this amendment extend timeframes for treatment plan reviews and remove both provider signature requirements at periodic reviews when treatment plans haven't changed and previously imposed criteria for determining when client discharge should occur. CBC recommends further but comparable reforms that account for the value of telemental health as a viable service delivery modality, including:

- Streamline clinical documentation practices to reduce onerous processes that create barriers to care by increasing paperwork without adding value to the provider/client.
  - When a provider and client agree to additional services, they can be provided and reimbursed without a mandated update to the treatment plan; the following treatment plan review should include discussion of telemental health service delivery as an agreed-upon modality.
  - Eliminate the requirement of annual Home and Community-Based Service (HCBS) eligibility determination reassessment for children obtaining HCBS, as it functions as a barrier to care that prevents otherwise eligible children from receiving services.
  - Permit assessments—even for new clients—to be delivered via telemental health, where/whenever clinically appropriate and at the client's discretion.
  - Authorize the admitting provider (i.e., intake worker, clinician)—with the client's input and consent—to decide the course of treatment and to commence treatment without requiring an internal written utilization review.
  - Grant providers the authority to decide—with the client's input and consent—the appropriateness of service delivery modality (i.e. telemental health) without requiring substantial documentation or attestation.
- Reduce the need for duplicative and unproductive confidentiality restraints that prevent timely interaction with clients and/or providers, including:
  - Authorize use of non-HIPAA compliant communication platforms if deemed by the provider to be the only method to ensure care continuity.
  - Permanently codify the CFR 4 Part 2 modifications, allowing providers to disclose information without consent in medical emergencies.
  - Allow verbal consent to be equivalent to written consent when the latter cannot be obtained for logistical reasons. Verbal consent must be documented in the client record, and written consent is to be obtained wherever possible. Allow for use of electronic signatures.
  - Permit the disclosure of protected information for treatment and payment purposes without additional authorizations.
- Leverage alternate sites of care for BH providers to allow greater flexibility for providers and increased capacity to recruit high-quality clinical staff members. When HIPAA considerations are effectively managed, remote work capability grants community-based providers with a critical tool to compete for high-quality clinicians.

3. ENHANCE WORKFORCE CAPACITY

Telehealth has the potential to empower a more dynamic workforce by supporting clinicians' ability to practice at the top of their license while removing restrictions that prevent portions of the workforce from engaging in the New York BH community, including:

- Permit any clinician who was approved to bill for in-person services be similarly approved to bill for telehealth services.
- Enable all clinicians with valid NYS licensure who live out of state (e.g., New Jersey) to provide telehealth services to New York clients from their homes.
- Allow providers to bill for provision of technical literacy training that enables clients to participate in telehealth services if the training occurs as a precursor treatment and is part of a therapy session, and not a stand-alone technical support appointment.
- Similarly, establish means for payers to reimburse for expenses related to the purchase of devices, phones and/or internet service for clients to participate in telehealth services. CBC and its network would like to work with payers to eliminate barriers to service through creative partnerships that ensure all clients have the technology required to participate in telehealth.

4. EQUITABLE PAYMENT/RATES

CBC supports expanded use of technology, both audio-visual and audio-only, with equitable payment rates that are sufficient to pay for both service delivery and investment in the expansion of innovative technology. Critical to this change in service delivery is a comprehensive method for capturing and analyzing data in a manner that forwards best practice and allows for pivots from less promising service delivery modalities. Technologies can improve communication, lead to more timely intervention and create critical touch points that otherwise are not available. Each advancement requires measurement and analysis, with focus on continuous quality and program improvement. Additional considerations related to equitable reimbursement include:

- Maintain reimbursement rates for telemental health equal to rates for in-person services. Reduction in rate could lead to an inability for community-based organizations to invest in the technology and innovation required to participate in activities that improve outcomes.
- Continue to cover telephonic service at the same rate as offered in-person for clients who otherwise would not have the ability to participate in virtual care services. This ensures continuity of care for people with limited technology, people who are more comfortable interacting telephonically and people who reside in residences where telephonic interaction allows for better privacy.
- Partner with managed care organizations (MCOs) to explore alternate payment models, including bundled rates that reflect value-based payments and outcomes-focused dynamics. As a therapeutic tool and when coupled with data analytics)– telehealth has the potential to improve outcomes by stratifying risk and enabling interventions to prevent downstream utilization and unnecessary costs.
- Ensure that MCOs reimburse providers at equitable rates. MCOs are aware of shifts to the manner in which services are being delivered during the pandemic and should not contemplate reduction in reimbursement rates without provider input and consideration of unintended consequences, including impact on workforce and inability for agencies to invest in innovative solutions.

IMPORTANT FUTURE CONSIDERATIONS

While CBC is advocating for greater telehealth opportunities, providers should still partake in the necessary diligence to select a telemental health tool that meets privacy, security, quality and cost standards for its users.

Innovative Management Solutions New York (IMSNY) supported over 500 BH agency staff in selecting high-quality technology solutions for delivering services via telehealth. IMSNY vetted telehealth vendors, led pricing negotiations with Doxy.me and Zoom on behalf of interested agencies and negotiated group discount rates, where applicable. IMSNY secured licenses during the height of the pandemic with a 25-60% discount for participating agencies. As explored by IMSNY, vendors offering telehealth and other virtual communication tools use encryption, passwords and other security measures to ensure that platform users are protected from those seeking to exploit private information. Despite the occasional headline regarding privacy-related challenges, solutions generally build sufficient protection into their software. Where privacy is more vulnerable is at the client's home and/or the provider's home office. If providers and/or clients are not versed in how to protect their home environment, there is little software vendors can do to protect them. For example, privacy cannot be assured if a person uses an open Wi-Fi network. Significant training is required in this area, which ultimately is the responsibility of the service provider. This includes clear disclosure to clients regarding risks associated with use of virtual care delivery and clear explanation of steps required to mitigate risk.

CBC and IMSNY are committed to supporting providers during this difficult time for the healthcare industry and helping them maintain high-quality care for New York's most vulnerable communities. Our efforts to make telehealth more accessible for BH agencies aligns with the Quadruple Aim by delivering care in an efficient and cost-effective manner that engages clients and providers. Once the public health emergency wanes and the BH sector adjusts to a new normal in how, when and where services are delivered, the adoption of telemental health and other technology-assisted care solutions will become part of the standard of care. We cannot lose sight of the need for a comprehensive and ongoing evaluation of the impact of these service delivery changes on outcomes and treatment benefits.

Accordingly, it will be necessary to have more methodologically sound studies of telemental health to continue to ensure that virtual assessments are as reliable as in-person evaluations, services lead to improved clinical status and increased client/provider satisfaction and telemental health service delivery is cost-effective. The transition to more innovative service models will also require further research into emergent legal and ethical issues as the BH delivery system evolves. [22]

CBC strongly encourages the field to continue further research in order to assess the types of clients and services that telemental health is most appropriate for. Providers will need guidance on how to optimally implement and sustain telemental health services. Establishing a telemental health program requires a comprehensive approach with up-to-date legal and technological considerations. Relatedly, providers will need to determine the type of telemental health services to offer, to which population and at what frequency the intervention(s) should be delivered. The BH sector will need to invest heavily in developing and delivering competence-based trainings for providers to ensure they are adhering to the same standards and competencies required for in-person treatment services.

In addition to the continued need to study and develop tech-enabled care models, there remains much to learn about the optimal cost structure of a predominantly virtual care delivery environment. There are obvious increases in technology costs, cyber insurance and related practice management tools, with potential consequent decreases in office and staffing costs. Substantial financial modeling—in partnership with federal/state governments and payers—is required as the virtual care delivery environment continues to evolve. It will be necessary to establish the most equitable reimbursement rates to cover service costs and create a dynamic where agencies are encouraged to continue investing in technology and evolving client-centered enhancements. CBC and its network would like to work with payers to eliminate barriers to service through creative partnerships that ensure all clients have the technology required to participate in telehealth.

Finally, while this Position Paper focuses on COVID-19's role shifting the paradigm for how providers can leverage technology to deliver services, it's essential to be mindful of preexisting disparities around access and use of these technologies. Not all communities have the high-speed internet and other fundamental resources necessary to fully realize telehealth's potential. For the system to effectively and equitably deliver care across all populations, there needs to be recognition of baseline community needs and corresponding action to ensure an individual's demography is not a barrier to care.

ABOUT CBC AND IMSNY

Coordinated Behavioral Care (CBC) is a member-led, not-for-profit organization dedicated to improving the quality of care for New Yorkers with serious mental illness, chronic health conditions and/or substance use disorders. These populations are served by CBC's community-based health and human services organizations through a Medicaid Health Home and an Independent Practice Association (IPA), as well as a continuum of innovative care management programs. CBC seeks to create a healthcare environment where New Yorkers negatively impacted by social determinants of health and those with BH problems receive coordinated, individualized and culturally competent community-based care that is effective in preventing and managing chronic physical and BH conditions.

Innovative Management Solutions New York (IMSNY) is a joint venture between CBC and Coordinated Behavioral Health Services IPA (CBHS). IMSNY's core mission is to improve BH delivery systems, representing large networks of social service organizations offering a continuum of community-based services including mental health, substance use treatment services, supportive housing, primary medical, recovery, support services, food, employment and housing. IMSNY is leading the sector in the development of robust data collection and analysis via a central cloud-based data warehouse, powered through Arcadia, that allows for more real-time and actionable data in order to improve outcomes and meaningfully engage in value-based contracting with payers.

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Thank you!

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