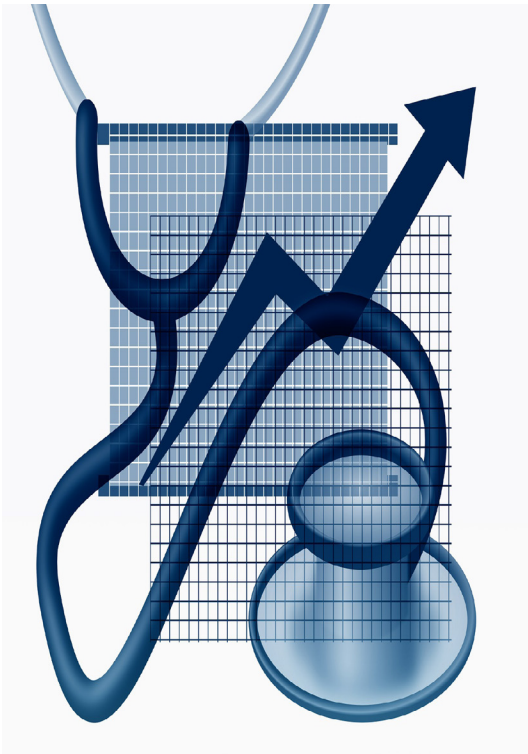




Improving Behavioral Health Access & Integration Using Telehealth & Teleconsultation: A Health Care System for the 21st Century

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This issue brief is intended to serve as a resource for state policymakers and other stakeholders as they build new or expand existing telehealth and teleconsultation programs. It offers strategies to address various regulatory and legal structures that present barriers to the diffusion of telehealth. It also offers strategies that may result in increased telehealth adoption and shares examples from five leading telehealth and teleconsultation programs in Alaska, Massachusetts, Mississippi, New Mexico, and Washington.

Introduction

Individuals with medical and behavioral health comorbidities often receive fragmented care, resulting in higher costs and poorer outcomes.¹ States, the federal government, and providers have all made significant investments to build and expand evidence-based integration models, such as the collaborative care model,² to reduce fragmentation and improve care. However, workforce shortages and limited resources may hinder the feasibility of these models, particularly in rural areas. Emerging evidence demonstrates that telehealth services and provider teleconsultation may be viable alternatives for individuals that are willing to participate and can deliver equal or better care when compared to traditional in-person care for individuals with behavioral health needs.^{3,4,5} While telehealth is often framed as a way to improve access in rural settings, patients in urban settings may also benefit.⁶

While some individuals may prefer to continue to receive traditional in-person care, telehealth and teleconsultation offer opportunities for states to increase patient choice and expand the scope of services individuals can receive at their usual care site—including primary care clinics, mental health centers, and correctional facilities. These programs may also build the primary care systems' capacity to treat mild-to-moderate behavioral health conditions. More research is necessary to understand the full effect on service utilization and healthcare costs, but early findings demonstrate that telehealth and teleconsultation programs for behavioral health services may reduce state spending or produce overall cost savings:

- Wyoming Medicaid found a 1.82:1 return-on-investment, and a 42 percent reduction in the number of children aged five or younger using psychotropic medications after implementing a psychiatric teleconsultation program to support primary care physicians serving children with behavioral health needs in the state.⁷

Using technology to connect patients and providers is often referred to by many names, including, but not limited to: telehealth, telemedicine, telebehavioral health, and telemental health. For the purposes of this issue brief, we use the following definitions:

- Telehealth or Telemedicine: A system in which patients receive services from providers in a different location.
- Telebehavioral health or Telepsychiatry: A subset of telemedicine that remotely connects patients with behavioral health providers.
- Teleconsultation: A system in which providers remotely consult with other providers in a different location.

Depending on the policies of individual states, these programs may or may not require a local provider's presence or referral for an individual to receive remote services. It is also important to note that there are various modes of telehealth, including real-time communication, asynchronous store-and-forward, remote patient monitoring, and mobile health.¹⁰ Unless otherwise noted, the scope of this paper is limited to real-time communication.

- Georgia is one of many states that have increased the use of telehealth to serve individuals in correctional facilities. The state reported savings of \$500 per telehealth encounter (\$9 million in fiscal year 2011), largely due to reduced transportation and staffing costs.⁸
- A study of 106 nursing homes residents in New York and Vermont found that a combined 278 telepsychiatry encounters resulted in estimated savings ranging from \$33,739-\$67,477 in reduced personnel costs and \$84,347-\$253,040 in avoided physician travel.⁹

Improving Patient Access Through Telehealth

When referrals to in-person services are not feasible, remotely connecting patients and providers through telehealth can be an effective way to increase the scope of services delivered at an individual's usual care site. Alaska and Mississippi are two leaders in this area, having built statewide telehealth programs that have expanded patient access to services and reduced costs (See Table 1).

Implementation

While many of the leading telehealth programs across the country are payer- or provider-driven initiatives, each state's unique policy environment has shaped how payers in the state treat telehealth services and provider adoption rates.¹¹ There are many important roles for states to play in supporting the development of new or enhancement of existing telehealth programs. As a purchaser, for example, the state can implement policies to provide reimbursement for telehealth services on behalf of the state employees or Medicaid and Children's Health Insurance Program (CHIP) enrollees. As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and telebehavioral health services.¹²

Beyond purchasing power, states can leverage their roles as lawmakers, regulators, and conveners to advance telehealth programs while also protecting consumers and payers. State officials may find the following strategies useful when determining how to leverage remote services to increase patient access to care:

1. Amend regulatory restrictions limiting reimbursement;
2. Foster or mandate multi-payer support;
3. Provide education and guidance on pertinent legal considerations; and
4. Leverage federal funds to develop broadband infrastructure in rural areas.

Table 1. Telebehavioral Health Services in Alaska and Mississippi

	Alaska Psychiatric Institute’s Telebehavioral Health Center	Center for Telehealth at the University of Mississippi Medical Center
Program Description	In 2003, Alaska began a telebehavioral health pilot. Today, the Frontline Remote Access Clinic, housed within the Alaska Psychiatric Institute (API), provides telebehavioral health services to individuals in approximately 26 towns and villages across the state—only four of which are connected to the state’s road system. ¹³	In 2003, the University of Mississippi Medical Center (UMMC) began their telehealth program for emergency medicine services in rural hospitals. ¹⁴ In 2008, telepsychiatry services were added to the program to serve mental health clinics and are available on an acute or scheduled basis. Today, UMMC’s Center for Telehealth includes more than 30 different specialties and serves patients at more than 194 locations across the state (including primary care clinics, mental health clinics, local health departments, schools, and prisons), and is expanding telepsychiatry services to nursing homes in 2015.
Funding	As the state’s psychiatric hospital, API is funded through legislative appropriations. The Frontline Remote Access Clinic within API bills remote sites at an hourly rate for their services. Grant funding also supports API’s telebehavioral health work.	The Center has developed a sustainable business model with revenue from contracts and insurance reimbursement for telemedicine services. Mississippi law requires private and public payers, including Medicaid, to reimburse for telehealth services. Approximately 100,000 telehealth visits occur annually.
Outcomes	API’s telebehavioral health services generated over \$1 million in avoided hospitalization costs in state fiscal year (SFY) 2015, building on the \$600,000 in avoided hospital costs in SFY2014. An additional \$70,000 in patient travel costs was avoided over those years. ¹⁵	Telepsychiatry is one of UMMC’s most demanded services and is being delivered to mental health clinics, group homes, emergency departments, primary care clinics and to students in schools and colleges. Although outcomes data specific to telepsychiatry are not available, the model has generated positive outcomes for other services. For example, the Center’s TelEmergency program reduced rural ED staffing costs by 25 percent and reduced unnecessary transfers to urban hospitals by 20 percent; patient outcomes in rural hospitals are equal to those at the academic medical center. ¹⁶

1. Amend Regulatory Restrictions Limiting Reimbursement

Nearly all Medicaid programs reimburse for telemedicine and telebehavioral health services. The federal Medicaid statute does not define telemedicine as a distinct service,¹⁷ and the Centers for Medicare & Medicaid Services (CMS) encourages states to “use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology.”¹⁸ As a result, states’ reimbursement policies vary widely as to which services are reimbursable, which providers can bill, and what types of technology can be used.¹⁹

Common state regulations and reimbursement policies include provider eligibility requirements, licensure requirements for providers across state lines, and in-person evaluation requirements for remote services. While these policies may limit the development of telehealth programs, they have often been put in place by states to address potential quality and patient safety concerns. If states choose to amend their policies to advance telehealth, it will be important to incorporate consumer protections into these policies.

Eligible practice settings and technologies

Challenges: Many states place restrictions on where patients can be seen in order for providers to bill for remote services, such as limiting the types of providers who may provide remote services, limiting the setting in which remote services are billable, or establishing minimum mileage requirements between the patient and remote provider as a condition of payment.²⁰

Strategies: Many states have telehealth laws that allow reimbursement in non-traditional care settings; for example, 16 states allow for remote services at schools or school-based health centers, and 25 states allow patients to receive telehealth services at home.²¹ Furthermore, while most states have removed mileage requirements for reimbursement—Colorado expanded their law earlier this year²²—exceptions may still apply.²³ In 2014, Indiana promulgated a regulation removing a mileage requirement for federally qualified health

centers, rural health clinics, community mental health centers, and critical access hospitals, but maintained a minimum required distance of 20 miles when reimbursing other eligible providers.²⁴ Similarly some states place limitations on which technologies can be used for provider-to-patient communication (e.g., live communication, asynchronous communication); approximately half of states limit reimbursement to real-time communication.²⁵

As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and telebehavioral health services.

Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement (Washington, D.C.: American Telemedicine Association, May 2015). <http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf>.

Practicing telehealth across state lines

Challenges: When telehealth services are provided across state lines, cross-state licensure issues arise. The majority of state medical boards require physicians to hold active licenses in each state where patients receiving telehealth services legally reside,²⁶ although some states have exceptions to their licensure laws that allow physicians to provide infrequent services either directly to patients or in consultation with another physician without procuring a license from each state.²⁷

Strategies: In September 2014, the Federation of State Medical Boards introduced model legislation for states interested in adopting the Interstate Medical Licensure Compact to reduce administrative burden of physicians applying for licenses in additional states.²⁸ Under the Compact, each state retains its authority to regulate the practice of medicine, and out-of-state physicians are subject to the laws and rules set forth by the legislatures and medical boards in the state where the patient is located. Within a span of a year, 11 states have enacted the Compact through legislation;²⁹ although some state medical boards have expressed concerns.³⁰ The Consortium of Telehealth Resource Centers has suggested other potential models to mitigate licensure barriers, including endorsement, mutual recognition, reciprocity, and limited licenses.³¹



In-person requirements for remote services

Challenges: Some state laws and regulations require an in-person visit before an individual can receive services remotely. For example, the Arkansas Medical Board requires an in-person evaluation prior to most remote services,³² and the Texas Board of Medicine requires that patients receive an in-person evaluation annually after remote consultations.³³ These medical practice standards are particularly important for providers using telemedicine to remotely prescribe medication, as those are subject to various state and federal laws intended to ensure proper prescribing and use. This is an important consideration given the U.S. Government Accountability Office's findings that children in Medicaid are already prescribed psychotropic and antipsychotic medications at higher rates than privately insured children.³⁴ Although federal law provides some exemptions for prescribing controlled substances via telemedicine, the interpretation of these exemptions have been left to local Drug Enforcement Agency (DEA) branches, which has established procedures that require face-to-face office visits before providers can prescribe controlled substances in some telemedicine programs.³⁵

Strategies: Some state legislatures agencies have passed legislation or released administrative guidance clarifying what is and is not acceptable when providing remote services under state law. For example, Alaska recently passed legislation stipulating a physician can prescribe, dispense, or administer prescriptions for controlled substances without a physical examination as long as: 1) the physician is licensed and physically located in the state and 2) the patient has access to follow-up care and agrees to have all medical records from remote encounters sent to his or her primary care provider. In addition to these requirements, a physician must either have a previously established relationship with the patient or have another appropriate licensed provider physically present with the patient to aid the prescribing physician with an examination and diagnosis.³⁶ Alaska's policy serves as a reminder that state officials should carefully consider when it is appropriate to require that a local provider be involved in the provision of remote services.

2. Foster or Mandate Multi-Payer Support

In addition to deciding which telehealth services are reimbursable, payers also need to decide how much to pay for those services. When determining sustainable payment rates, state policymakers may also find that multi-payer participation is an important component of long-term support and sustainability for telehealth programs.

Challenges: Limited access to behavioral health services and workforce shortages affect the entire health care system, not just Medicaid. Some commercial health plans may set restrictive telehealth policies, limiting providers' ability to meet the needs of commercial populations.

Strategies: As more payers reimburse for telehealth services, the proportion of a practice's panel eligible to receive telehealth services increases. This not only increases patients' access to remote services, but it also may reduce the administrative burden on providers. This may also help promote sustainability if payers are supporting the infrastructural and operational costs of the same program.

For example, in 2013, Mississippi enacted a telehealth parity law that required Medicaid, state employee health plans, and private insurers to provide coverage for telehealth services to the same extent that the services would be covered if they were provided in-person.³⁷ The legislation received broad support, including, most notably, support from Governor Phil Bryant.

The University of Mississippi Medical Center's Center for Telehealth cites multi-payer telehealth payments as a critical aspect of the enduring success of its program; furthermore, payment parity has allowed the telehealth program to be sustainable outside of grant funding.³⁸ Mississippi Medicaid has also worked to ensure that its payment policies encourage the use of telehealth, including new originating site facility fees effective July 1, 2015.³⁹ As of July 2015, 28 other states and the District of Columbia have passed parity laws for private insurers.⁴⁰ Medicare has also covered telehealth services since the Balanced Budget Act of 1997, although federal law limits reimbursement to individuals seen in specific rural care settings.⁴¹

3. Provide Education and Guidance on Pertinent Legal Considerations

When providers practice medicine remotely, they must meet the same legal standards that apply when serving patients in their offices. State agencies have an important role in helping providers understand how to meet these legal obligations by providing education and policy guidance as necessary and appropriate. One important area in which states can provide guidance is on privacy laws and data sharing.

Challenges: Federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), set national privacy and security standards for holding and sharing protected health information. 42 CFR Part 2 extends further privacy and security standards to patients' behavioral health data for most drug and alcohol treatment providers.⁴² Some states have passed more stringent laws regulating protected health information.

Strategies: While privacy laws do not uniquely affect telehealth programs, they underscore the importance of secure data exchange to providing comprehensive care through telehealth. Telehealth services can be more effective when the remote provider can access and review patients' medical records. Regional and state health information exchanges can be an important tool to facilitate behavioral health information exchange across treating providers.⁴³ In the absence of a robust health information exchange, providers have entered into contractual arrangements to facilitate data exchange. For example, when providers in Alaska contract with the Frontline Remote Access Clinic housed within the Alaska Psychiatric Institute (API) for telebehavioral health services, API enters into a business associate agreement and memorandum of understanding that allows API's psychiatrists to access the other systems' electronic health records.^{44,45}



4. Leverage Federal Funds to Develop Broadband Infrastructure in Rural Areas

Access to secure, high-speed Internet service is critical to implementing telehealth programs. Providers in communities without access to affordable broadband service or computer equipment can leverage federal programs designed to promote the use of telemedicine.

Challenges: Despite significant investment over the past five years,⁴⁶ some rural and frontier providers still lack adequate access to high-speed Internet—and those that have access may find it prohibitively expensive.⁴⁷

Strategies: A range of federal grant and loan guarantee programs are available to help rural providers, practices, or communities-at-large maximize their financial investments by defraying some infrastructure costs:

- The Federal Communication Commission’s (FCC’s) Rural Health Care Program (RHC Program) includes two programs that provide up to \$400 million in funding annually:
 - Eligible providers participating in the [Healthcare Connect Fund](#) receive a 65 percent discount on all eligible expenses, including broadband service and equipment.
 - The [Telecommunications Program](#) subsidizes rural providers service costs, allowing rural providers to pay the same rates as urban providers.⁴⁸
- The United States Department of Agriculture and Rural Development (USDA) administers various pertinent grant and loan guarantee programs:
 - The [Distance Learning and Telemedicine Grant Program](#) provides competitive grants between \$50,000 and \$500,000 with a 15 percent match. The funds can be used to acquire necessary equipment and infrastructure as well as technical assistance to train staff in using the equipment.⁴⁹
 - The [Community Connect Grant Program](#) provides competitive grants between \$100,000 and \$3,000,000 with a 15 percent match. The funds can be used to build infrastructure in areas where broadband service is not available, as well as provide broadband service free-of-cost to critical community facilities (including hospitals and health care providers) for two years.⁵⁰
 - The [Telecommunications Infrastructure](#) and [Farm Bill Broadband Loans & Loan Guarantee Program](#) provide funding to construct, improve, or acquire facilities and equipment required to bring broadband service to eligible rural areas.^{51,52}

Due in part to implementation delays, the FCC only disbursed a total of \$327 million in the RCH Program’s first 12 years, a combined total less than the program’s \$400 million annual cap.⁵³ Funding requests have risen sharply in recent years (an average of nearly \$235 million annually across fiscal years 2013 and 2014), but as of September 30, 2015, less than \$100 million has been requested for fiscal year 2015.⁵⁴ States and local government agencies are eligible applicants for all of the USDA grant and loan programs identified above; states may also be in a position to assist providers in participating in these programs if they can cover a portion of the required matching funds or help secure foundation or private payer support.

Increasing Provider Capacity Through Teleconsultation

Remotely connecting patients to specialty providers can alleviate access issues, but access to specialty providers is only half of the equation. By providing distance learning opportunities and supports, the primary care system becomes better equipped at managing individuals’ behavioral health needs and referring out to specialty services as necessary. Two models in particular, the Massachusetts Child Psychiatry Access Project (MCPAP) and the University of New Mexico’s Project ECHO, have gained national momentum over the past few years (See Table 2).⁵⁵

Implementation

Comparatively, teleconsultation programs can be much easier to implement than telehealth programs. Many of the legal and regulatory issues discussed in the previous section are not applicable provided that the program does not create a new physician-patient relationship under state law (a legal standard that varies by state). Furthermore, only four states (Michigan, North Dakota, Pennsylvania, and South Dakota) do not have a law providing some exclusions to state licensure requirements for out-of-state providers when conducting physician-to-physician consultations.⁵⁶ Two key issues remain: provider buy-in and sustainability.

Table 2. Teleconsultation Services in Massachusetts and New Mexico

	The Massachusetts Child Psychiatry Access Project	University of New Mexico’s Project ECHO
Program Description	First piloted in 2003, the Massachusetts Child Psychiatry Access Project (MCPAP) telephonically connects pediatricians across the state with one of six regional behavioral health teams. The teams consist of a child psychiatrist, a social worker, and a care coordinator; all of whom assist pediatricians to diagnose, treat, and manage children with behavioral health needs. The program can provide one-time face-to-face consultations with patients and facilitates referrals to in-person services as necessary and appropriate.	Launched in 2003, Project ECHO is a hub-and-spoke model that uses web-based video to connect primary care providers with specialist mentors. Providers have applied the model to nearly 40 health conditions, including an Integrated Addiction and Psychiatry (IAP) TeleECHO Clinic . Participating primary care teams take part in case-based learning that includes a mix of didactic presentations and reviewing actual cases using de-identified information.
Funding	MCPAP is funded through a Massachusetts Department of Mental Health line item (\$3.1 million in FY2015) and, beginning in FY2015, commercial health plans pay a surcharge for their share of program costs. Budget shortfalls required the program to scale back in recent years, but it is currently being expanded through the state’s State Innovation Model Test Award.	Funded through a mix of federal, state, and philanthropic dollars, including consultative service payments to providers by New Mexico’s Medicaid managed care plans. In July 2015, the GE Foundation awarded a \$14 million grant to Project ECHO and the Institute for Healthcare Improvement to extend the model to additional community health centers across the country. ⁵⁷
Outcomes	In 2012, 92 percent of practices in the state with more than 2,000 children used the service. After using the service, prescriber-level psychiatric care remained with the primary care provider 67 percent of the time. A survey of participating providers found that 64 percent either agreed or strongly agreed that they could “meet the needs of children with behavioral health problems,” compared to 8 percent before enrollment. ⁵⁸	Although outcomes data specific to the IAP TeleECHO Clinic are not available, the model has generated positive outcomes for other conditions. Participating primary care providers were able to manage Hepatitis C treatment as effectively as an academic medical center with fewer reported serious adverse events. ⁵⁹ When the IAP network was used to recruit participants for buprenorphine training, more New Mexico physicians from traditionally underserved areas chose to be trained, compared with physicians nationwide. ⁶⁰
Spread	Similar programs are underway in various stages of implementation in 30 states and the District of Columbia. ⁶¹	Hubs currently operate in 22 states; some serve multiple states.

1. Provider Buy-in

A teleconsultation program's success depends on providers' willingness to participate. Provider outreach and engagement activities that make the case for participation to both specialty and primary care providers may have the greatest impact.

Challenges: Specialists may be resistant to sharing their expertise, particularly if it means fewer referrals. Primary care providers may also be hesitant to work with behavioral health providers with whom they do not have an established working relationship.

Strategies: Teleconsultation programs have benefitted from identifying and engaging specialty physicians who will champion the model.⁶² Messaging can be critical, and it is important to remind stakeholders that the purpose of these types of programs is not to supplant specialty care, but rather ensure that patients receive appropriate care in the appropriate setting. Facilitating face-to-face introductions between the primary care providers and consulting physicians may increase the comfort levels of both participating providers and risk managers, even if it's a one-time meeting.⁶³

2. Sustainability

The physical infrastructure required for teleconsultation programs can cost significantly less compared to telehealth programs. For example, MCPAP requires nothing more than a telephone line and telephone. Sustaining teleconsultation programs may require significant funding commitments depending on the staffing model and whether participating providers are compensated for their time, but larger providers hosting or administering teleconsultation programs may be in a financial position to bear some of the associated costs.

Challenges: Grant funding and/or annual legislative appropriations is sometimes used to provide seed funding to launch or maintain teleconsul-

tation programs; however, given the scarcity of state financial resources, relying on grants and appropriations creates uncertainty as to whether the program will be sustainable. Traditional fee-for-service billing may not be appropriate for programs that do not provide direct medical services to patients. Even if a direct billing mechanism is created, it does not necessarily mean the program will be sustainable. In other child psychiatry access programs, fee-for-service was not a sustainable payment methodology due to variable billing volume and cumbersome billing processes, as well as increased legal risk due to the fact that the payment created new physician-patient relationships.⁶⁴

Strategies: Teleconsultation programs may be more sustainable when paid for using alternative, value-based payment models that promote team-based care and allow flexibility to cover services that may be non-billable, including physician consultation and care coordination. Furthermore, like other payment and delivery system reforms, sustainability may rest in multi-payer participation. This was a particularly important issue in Massachusetts, where more than half of the MCPAP encounters in FY2014 (58 percent) were for children covered by commercial insurance.⁶⁵ With legislative authority granted in the state's FY2015 budget, the Massachusetts Department of Public Health promulgated new regulations ensuring commercial plans would proportionally share in their cost to the program.⁶⁶

Blending Telehealth and Teleconsultation

In addition to the telehealth and telepsychiatry services described earlier, the programs in Mississippi and Alaska also offer educational services that build provider capacity similar to Project ECHO. For example, the University of Mississippi Medical Center's Distance Learning Educational Series for Behavioral Health is available to all of the sites for which it provides telemedicine and telepsychiatry services.⁶⁷

Simultaneously expanding direct access through telehealth and improving provider capacity through teleconsulting may have an additive effect. Representatives from both the University of Mississippi Medical Center's Center for Telehealth and Project ECHO discussed potential benefits of blending their programs.^{68,69}

One Medicaid managed care plan in Washington found that telepsychiatry was most effective in a stepped-care model where primary care providers worked with a behavioral health coordinator and consulting psychiatrist before connecting patients with the psychiatrist through telepsychiatry (see Table 3); practices using telepsychiatry alone have had a harder time integrating remote services into their workflows.⁷⁰ As new initiatives are launched, program leaders may wish to explore how telehealth and teleconsultation services can be combined to achieve program goals.

Table 3. Washington State's Mental Health Integration Program

Washington State Mental Health Integration Program (MHIP)	
Program Description	Launched in 2008, Community Health Plan of Washington (CHPW), one of the state's Medicaid managed care plans, administers the Washington State Mental Health Integration Program (MHIP). Building on the Collaborative Care Model, ⁷¹ behavioral health coordinators embedded in over 100 community health centers across the state work closely with primary care teams and meet weekly with a remote consulting psychiatrist at the University of Washington Medical Center. ⁷² Primary care physicians can also consult directly with the psychiatrist as needed. Since launch, CHPW has introduced telepsychiatry services into MHIP, allowing patients to remotely meet with the consulting physician.
Funding	<p>First supported through legislative appropriations, CHPW provides two payments: one to community health centers to hire the behavioral health coordinator; and a second to University of Washington Medical Center to pay for a portion the consulting psychiatrists' time. A unit-based caseload rate provides the necessary flexibility to cover the coordinators' time spent consulting with the primary care providers and psychiatrist, as well as entering data into a registry. It also provides flexibility for the psychiatrists, who allocate their time between working in the registry and consulting with the coordinator, primary care team, and patients.</p> <p>A 2015 law requires Washington's Medicaid managed care, state employee, and commercial health plans to begin reimbursing for telemedicine services no later than January 1, 2017.⁷³ CHPW is actively exploring how the new law impacts their payment model for direct telepsychiatry services, but the law does not provide reimbursement for remote consultation.</p>
Outcomes	MHIP has decreased specialty referrals and increased primary care providers' ability to meet the behavioral health needs of their patients. ⁷⁴ In the first 14 months, the program reports that it saved more than \$11 million in avoided hospital costs; the program also created positive social outcomes, including fewer arrests and smaller increases in homelessness. ⁷⁵

Preparing for Future Innovations

Technology continues to change the way in which patients receive services. Mobile and home-based technologies that remotely connect patients with providers and their peers are shaping the future of the health care system. For example:

- Payers and providers across the country are beginning to partner with Big White Wall, an “anonymous clinically facilitated peer community” that connects individuals with credentialed therapists and peer supports online.⁷⁶
- In June 2015, former executives from Facebook, Google, and other leading technology companies launched Lyra Health, a startup that plans to use web-based screening tools and data analytics to identify individuals with unmet behavioral health needs and connect them with providers that match their preferences.⁷⁷

It remains to be seen how or if states will adopt these or similar initiatives in their public insurance programs. When deciding which new technologies to implement, states will need to weigh the costs of implementation with their fiscal climate and the potential for the technology to create a return on investment. Once a technology is selected for implementation, states will need to examine whether any state-level legal or regulatory barriers will make implementation challenging or restrict its effectiveness. Flexibility can be important when designing new state laws and regulations affecting telehealth policy because it is likely that technological innovations will outpace the laws and regulations.

Ultimately, it is in states’ best interest to have a process in place to ensure that new technologies are cost-effective and safe. States’ Medicaid advisory committees and similar oversight and evaluation committees are important partners for policymakers when determining which technologies to adopt and how to implement and pay for these technologies to ensure appropriate consumer protections, limit inappropriate utilization, and manage costs.

Conclusion

As the programs discussed in this issue brief show, telehealth and teleconsultation programs have the potential to improve access, increase provider and system capacity, and promote a health care system in which appropriate services are provided in the appropriate setting. Mild-to-moderate behavioral health conditions are prevalent in primary care, and primary care providers play an important role in addressing these conditions while simultaneously managing physical health comorbidities.⁷⁸ As primary care providers’ capacity to treat mild-to-moderate conditions increases, specialty providers have more time to spend with complex, high-need individuals.

Additional Resources

State officials and other stakeholders interested in learning more are encouraged to visit the following organizations’ websites:

- [American Telemedicine Association: State Policy Resource Center](#)
- [Center for Connected Health Policy: Telehealth Medicaid & State Policy](#)
- [National Conference of State Legislatures: State Coverage for Telehealth Services](#)
- [Health Resources and Services Administration: Telehealth](#)
- [SAMSHA-HRSA Center for Integrated Health Solutions: Telebehavioral Health](#)
- [Consortium of Telehealth Resource Centers](#)
- [Center for Technology and Behavioral Health](#)

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