

Behavioral Health Provider Experiences with Telehealth in Michigan during COVID-19

January 2021

Project Team

Angela J. Beck, PhD, MPH

Cory Page, MPH, MPP

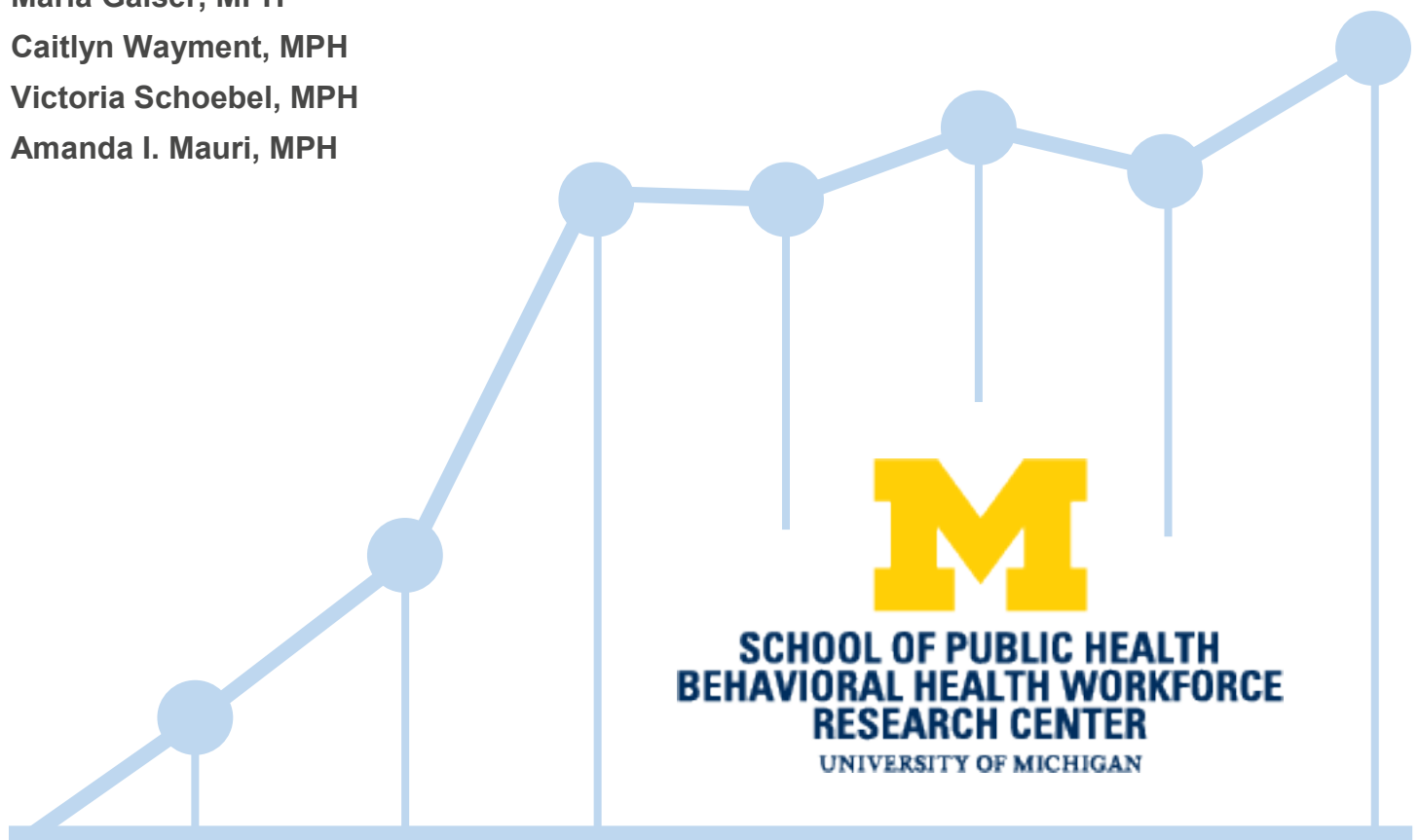
Jessica Buche, MPH, MA

Maria Gaiser, MPH

Caitlyn Wayment, MPH

Victoria Schoebel, MPH

Amanda I. Mauri, MPH



ACKNOWLEDGEMENTS

This project was funded by the University of Michigan Institute for Healthcare Policy and Innovation through the Policy Sprints program.



We appreciate the support from our partners at Southwest Michigan Behavioral Health and Community Mental Health Association of Michigan. Thank you for your guidance on study design, assistance in provider recruitment, and input on final reports.

SUGGESTED CITATION

University of Michigan Behavioral Health Workforce Research Center. Behavioral Health Provider Experiences with Telehealth in Michigan during COVID-19. Ann Arbor, MI: UMSPH; 2021.

Background

Telehealth is “the use of electronic information and telecommunication technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration.”¹ A variety of services can be provided via telehealth, such as general wellness visits, nutrition counseling, and behavioral health services.² Before the coronavirus 2019 (COVID-19) pandemic, telehealth services were widely underutilized despite the proliferation of Internet-enabled telecommunications technology.³⁻⁵ However, in March 2020, the federal government^{2,6} recommended the use of telehealth services to mitigate public health risks associated with COVID-19. Additionally, the Centers for Medicare and Medicaid Services adjusted regulations and reimbursement requirements for telehealth.⁷

In addition to federal efforts to support telehealth utilization, 30 states passed emergency orders to permit expansion of telehealth services. In Michigan, two executive orders issued after a March 2020 declaration of a COVID-19 State of Emergency supported telehealth expansion in the state by providing “temporary relief from certain restrictions and requirements governing the provision of medical services” and “encouraging the use of telehealth services during the COVID-19 emergency”. The orders also permitted defined expansions of some providers’ statutory scope of practice.^{8,9} In addition, the Medical Services Administration, Michigan’s Medicaid authority, released new Medicaid guidance in March 2020 in line with federal changes^{10,11} and several bills that were passed¹²⁻¹⁵ by the Michigan legislature to broaden how telehealth is defined and regulated.

These policies facilitated changes in behavioral health service delivery to improve access to care for those seeking treatment for mental health and substance use disorders.

Methods

This study aimed to assess impact of telehealth policy changes on provision of behavioral health services based on the experiences of psychologists, nurses, clinical social workers, professional counselors, substance use disorder counselors, and peer support providers throughout Michigan who are providing telebehavioral health services during the pandemic. Thirty-one providers participated in semi-structured interviews from July 29 to August 21, 2020 to report past and current use of telebehavioral health, provide insight on how policies impacted their use of telebehavioral health, and discuss methods to sustain telebehavioral health moving forward.

Key Findings

Analysis of key informant interviews produced the following primary themes:

Use of telebehavioral health has increased since March 2020.

Only 12 providers reported that their practice site used telebehavioral health prior to the pandemic. The most common barrier noted was an inability to get reimbursed for services provided. All interviewed providers reported using telebehavioral health during the pandemic and would like to see telehealth continue after the pandemic, especially in a hybridized model with in-person services.

State policies to expand telehealth services positively impacted continuation of behavioral health service delivery.

Individual providers and care organizations as a whole benefitted from policy changes. As stated by a provider, “I mean we would have been absolutely crippled, crippled if we had not had that ability to have our social workers [providing behavioral health services]; they’re our anchor.” However, some providers noted difficulties with using telebehavioral health for applied behavioral analysis testing services, group services, and physical health services that could not be done remotely (i.e., injections and drug testing).

Telebehavioral health expansion improved access to mental health care.

Twenty-eight providers reflected on telebehavioral health reducing some access to care barriers including transportation, which previously inhibited consumers from accessing or seeking care. One provider noted,

“Our public transit is very limited, and some people, they don't have a vehicle, or their vehicle is in bad shape, or they don't have money to get the gasoline, or somebody else is using the car. And it's just transportation's always been terrible for us, so this is really kind of exciting, and we're hoping that it can go past the pandemic because it really helps a lot of people.”

Some providers also noted a decrease in no-show rates and an increase in consumers from new geographic locations. Four metropolitan-based providers noted that they were capable of providing remote services to consumers who were located in more distant, or rural, areas. Additionally, 15 providers reported an increase in their caseload or more frequent contact with their current clients. Contributing to these changes were a reduction in travel time between appointments, an ability to immediately schedule a new appointment with a different client when a client canceled or did not show for an appointment, and providers calling clients between appointments. All of these services were linked to providers' newfound reimbursement authorizations.

Quality of care and patient satisfaction with telebehavioral health services may vary depending on service type.

Eighteen providers felt telebehavioral health quality of care is equivalent or better than quality of care for in-person services, and 30 providers reported patients being satisfied with their telebehavioral health sessions. For some providers, telebehavioral health fostered a sense of security, allowing for improved rapport and care quality. One provider said,

“I've had a couple of people say they really prefer doing it over video, because it feels less intense to them. And so they actually say they're able to talk more deeply about things than they can when they're in a room with somebody. So, for some clientele anyway, that little bit of distance feels more protective.”

However, providers identified some patient subgroups whose quality of care seemed to worsen, including: younger children, older adults, individuals with a serious mental illness, individuals with language or speech barriers, individuals with a substance use disorder, and children with an autism spectrum disorder. These subgroups were reported as having more difficulty focusing on or understanding the content of telebehavioral health sessions, aggravated symptoms of paranoia when communicating digitally, and less trust with treatment when performed remotely. Some providers reported improvements among these subgroups, as long as the providers were willing to adjust their service delivery and techniques when care quality was reduced. For example, clients with an autism spectrum disorder who were particularly averse to direct eye contact or physical proximity had these barriers removed through telehealth. Parents of some patients engaged in the treatment of their children, leading to breakthroughs not only in the patients' treatment but also in relationships between parents and their children. Said a behavior analyst,

“And [it was] way easier to teach [the parents] something in the moment [because] their child [was] screaming in the background, and we could coach them through what to do right then and there. It was where the things actually take place. So I think for the parents it was great.”

Barriers to effective telebehavioral health provision still exist.

Despite the overall increase in care access, 15 interviewed providers cited clients' inadequate access to technology or Internet as the most significant barrier to providing telebehavioral health care. Telephonic or audio-only services were indispensable for these clients, and their providers advocated for continuing reimbursement for these modalities. As stated by a provider, "It's imperative that we can still bill for those phone conversations." Audio-only telebehavioral health services were viewed as equivalently effective as audio-visual services and could potentially be more effective for clients with anxiety or trauma who are uncomfortable with sharing space during in-person care. In reference to audio-only therapy sessions, a provider said,

"... on the phone and through the ear, you're just less vulnerable. And I think a lot of my clients are willing to go there more because it's like I'm not staring at them...it just is a less threatening thing."

Providers were supportive of continued telebehavioral expansion.

All 31 providers would like to see telehealth continue moving forward, typically as a hybridized model with providers resuming in-person services post-COVID-19 and simultaneously offering telebehavioral health services. Although telehealth may not work for all patients, it increases access to care, reduces clients' cost of seeking care (e.g., reduced travel time, fewer missed days of work, less need for child care), and improves the quality of care for some patients. As a provider explained, advocating for patient-centered care: "People need to have choice, they need to be able to have choice on what is effective for them." Similarly, another provider stated,

"If we want to provide ongoing and sustainable treatment... We have to meet those clients where they're at. And one of the places that they're at is in their home, and many don't have other options."

Some providers discussed how restricting telehealth now would be harmful to providers and clients alike, with one provider saying,

"We are humans; we are not robots. So you can't just snatch us from one thing, throw us in this situation and then snatch us from another thing, throw us in that situation and not expect productivity to maybe fall or people to be disgruntled in some kind of way."

Additional support for telebehavioral health providers may be beneficial; when asked about provider satisfaction, only 14 providers linked their use of telebehavioral health to increased job satisfaction and decreased feelings of burnout due to improved work–life balance and self-care practices.

Policy Considerations

Overall, providers felt that they should be allowed the flexibility to identify the most effective treatment for their patients' specific needs. Appendix A and B contain tables that highlight Michigan and federal telebehavioral health policies for private insurers and Medicaid before and during the COVID-19 emergency and proposed changes for both.

Providers' feedback could inform a range of policy implications to sustain and further improve access to care, including:

Authorizing payment for audio-only telehealth when other forms of care are not feasible.

Although some behavioral health treatments cannot be provided remotely and/or may be less effective, telephonic/audio-only telebehavioral health is the only feasible modality for some consumers,

especially those who are geographically isolated. Interviewees expressed concern that if telephonic services revert back to not being reimbursable some patients may no longer have access to care (e.g., due to travel distance, outdated digital communication technology, lack of adequate Internet access). Current state law allows private insurers to voluntarily cover audio-only services if they deem it can be provided appropriately.¹⁶ Legislators could amend the Insurance Code to mandate such coverage, allowing providers to use their professional judgment to determine which services are appropriate for audio-only provision. As for Medicaid, though the program historically did not cover audio-only services, it received time-limited authorization from the Centers for Medicare and Medicaid Services to provide audio-only telebehavioral health during the public health emergency.¹¹ To keep these services available for Michigan's most isolated citizens, Michigan Medicaid could request to continue authorizing these services after the pandemic through a plan and/or waiver amendment.

Improving telebehavioral health coverage for all Michiganders.

Policy discussions of expanding telehealth coverage often revolve around two concepts: reimbursement parity, the practice of paying for telebehavioral health services at the same rate as equivalent in-person services, and service parity, the practice of allowing covered in-person services to be covered via telehealth so long as they can be provided appropriately. Both forms of parity allow providers to offer beneficial health services to clients through the best available modality. Private payer service parity existed in Michigan prior to the pandemic,¹⁶ however, private insurers may interpret the word "cover" in the Insurance Code as requiring service parity but not reimbursement parity. State legislators could consider amending the Insurance Code to mandate equivalent reimbursement. Conversely, Michigan Medicaid historically had reimbursement parity in place prior to the pandemic, with providers billing the same procedural codes for in-person or telehealth provision.¹⁷ The Medicaid program restricts which codes it allows for telehealth provision to a specified list of services, however.¹⁸ Michigan Medicaid could eliminate this list, allowing providers to bill all services via telehealth, provided the service is of equivalent quality as in-person care (disqualifying some services, such as injections) and in-person care is infeasible for the client.

Removing certain procedural barriers for providers offering telehealth services.

Obtaining written consent for telehealth treatment could be difficult, as clients often lacked the technology required to e-mail/fax physically signed forms. This problem existed prior to the pandemic but was exacerbated when patients were not allowed to access care sites in-person. Verbal consent is more easily obtained, as most clients had access to a telephonic device. Michigan's Public Health Code does not specifically require written consent for treatment¹⁹ nor does its associated regulations,²⁰ though policymakers and regulators could amend the statute and rule to clarify this leniency. Private insurers and Michigan Medicaid could voluntarily continue allowing for written consent and announce this action through policy bulletins to enrolled providers.

References

1. Telehealth programs. Health Resources and Services Administration website. <https://www.hrsa.gov/rural-health/telehealth>. Updated September 2020. Accessed September 2, 2020.
2. Telehealth: Delivering care safely during COVID-19. U.S. Department of Health and Human Services website. <https://www.hhs.gov/coronavirus/telehealth/index.html>. Updated July 15, 2020. Accessed September 2, 2020.
3. Harvey JB, Valenta S, Simpson K, Lyles M, McElligott J. Utilization of outpatient telehealth services in parity and nonparity states 2010-2015. *Telemed J E Health*. 2019;25(2):132-136. doi:10.1089.tmj.2017.0265.
4. Tuckson RV, Edmunds M, Hodgkins ML. Telehealth. *N Engl J Med*. 2017;377:1585-1592, doi:10.1056/NEJMSr1503323.
5. Weil AR. Telehealth. *Health Aff*. 2018;37(12):1915. doi:10.1377/hlthaff.2018.05262.
6. Using telehealth to expand access to essential health services during the COVID-19 pandemic. Centers for Disease Control and Prevention website. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html>. Updated June 10, 2020. Accessed September 2, 2020.
7. Centers for Medicare and Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. CMS.gov. <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>. Revised September 29, 2020. Accessed August 8, 2020.
8. State of Michigan Office of the Governor. EXECUTIVE ORDER No. 2020-30 Temporary relief from certain restrictions and requirements governing the provision of medical services. Legislature.MI.gov. <http://www.legislature.mi.gov/documents/2019-2020/executiveorder/pdf/2020-EO-30.pdf>. Published March 30, 2020. Accessed September 4, 2020.
9. State of Michigan Office of the Governor. EXECUTIVE ORDER No. 2020-86 Encouraging the use of telehealth services during the COVID-19 emergency. Legislature.MI.gov. <http://www.legislature.mi.gov/documents/2019-2020/executiveorder/pdf/2020-EO-86.pdf>. Published May 15, 2020. Accessed September 4, 2020.
10. Michigan Department of Health and Human Services, Medical Services Administration. MSA Bulletin 20-09. Michigan.gov. https://www.michigan.gov/documents/mdhhs/MSA_20-09_683712_7.pdf. Published March 12, 2020. Accessed September 4, 2020.
11. Michigan Department of Health and Human Services, Medical Services Administration. MSA Bulletin 20-13. Michigan.gov. https://www.michigan.gov/documents/mdhhs/MSA_20-13_684352_7.pdf. Published March 20, 2020. Accessed September 4, 2020.
12. State of Michigan 100th Legislature. Act No. 97, ENROLLED HOUSE BILL No. 5412. Legislature.MI.gov. <http://www.legislature.mi.gov/documents/2019-2020/publicact/htm/2020-PA-0097.htm>. Published June 24, 2020. Accessed September 4, 2020.
13. State of Michigan 100th Legislature. Act No. 98, ENROLLED HOUSE BILL No. 5413. Legislature.MI.gov. <http://www.legislature.mi.gov/documents/2019-2020/publicact/htm/2020-PA-0098.htm>. Published June 24, 2020. Accessed September 4, 2020.
14. State of Michigan 100 Legislature. Act No. 99, ENROLLED HOUSE BILL No. 5414. Legislature.MI.gov. <http://www.legislature.mi.gov/documents/2019-2020/publicact/htm/2020-PA-0099.htm>. Published June 24, 2020. Accessed September 4, 2020.
15. State of Michigan 100 Legislature. Act No. 101, ENROLLED HOUSE BILL No. 5416. Legislature.MI.gov. <http://www.legislature.mi.gov/documents/2019-2020/publicact/htm/2020-PA-0101.htm>. Published June 24, 2020. Accessed September 4, 2020.

16. Michigan Legislature. The Insurance Code of 1956, Section 300.3476 Telemedicine services; provisions; definitions. Legislature.MI.gov. [http://www.legislature.mi.gov/\(S\(zq4k3fergqxmcyf4ple4ela\)\)/mileg.aspx?page=GetObject&objectname=mcl-500-3476#:~:text=\(1\)%20An%20insurer%20that%20delivers,as%20determined%20by%20the%20insurer](http://www.legislature.mi.gov/(S(zq4k3fergqxmcyf4ple4ela))/mileg.aspx?page=GetObject&objectname=mcl-500-3476#:~:text=(1)%20An%20insurer%20that%20delivers,as%20determined%20by%20the%20insurer). Updated June 24, 2020. Accessed December 14, 2020.
17. Michigan Department of Health and Human Services. Telemedicine: Policy, Billing & reimbursement. Michigan.gov. https://www.michigan.gov/documents/mdhhs/Telemedicine_2019_671338_7.pdf. Published 2019. Accessed December 14, 2020.
18. Michigan Department of Health and Human Services, Medical Services Administration. MSA Bulletin 20-15. Michigan.gov. https://www.michigan.gov/documents/mdhhs/MSA_20-15-SBS_689471_7.pdf. Published May 5, 2020. Accessed December 14, 2020.
19. Michigan Legislature. Public Health Code, Section 333.16284 Telehealth service; consent required; exception. Legislature.MI.gov. [http://www.legislature.mi.gov/\(S\(5xxpzsqxo5deggpvbwqqynme\)\)/mileg.aspx?page=getObject&objectName=mcl-333-16284#:~:text=333.16284%20Telehealth%20service%3B%20consent%20required%3B%20exception.&text=16284.,indirectly%20obtaining%20consent%20for%20treatment](http://www.legislature.mi.gov/(S(5xxpzsqxo5deggpvbwqqynme))/mileg.aspx?page=getObject&objectName=mcl-333-16284#:~:text=333.16284%20Telehealth%20service%3B%20consent%20required%3B%20exception.&text=16284.,indirectly%20obtaining%20consent%20for%20treatment). Updated March 29, 2017. Accessed December 14, 2020.
20. Michigan Department of Licensing and Regulatory Affairs. Michigan Register Issue No. 16, R.338.2407 Telehealth. Michigan.gov. https://www.michigan.gov/documents/lara/MR16_091520_702353_7.pdf. Published September 15, 2020. Accessed December 14, 2020.

Appendix A

Michigan Telebehavioral Health Policies for Private Insurers and Medicaid Before and During the COVID-19 Emergency

Policy	Pre-COVID Michigan Laws/Regulations		Current Michigan Laws/Regulation		Proposed Change Mechanisms	
	Private	Medicaid	Private	Medicaid	Private	Medicaid
Audio-Only Telehealth	Michigan Insurance Code, Section 500.3476(2)(b)	N/A	Enrolled House Bill No. 5412	Michigan Medical Services Administration Bulletin 20-13	Legislators amend Insurance Code to mandate audio-only coverage	Plan and/or waiver amendment to authorize audio-only telehealth after pandemic
Telehealth Service Parity	Michigan Insurance Code, Section 500.3476(1)	N/A	Enrolled House Bill No. 5413	Michigan Medical Services Administration Bulletin 20-15	No changes recommended	Eliminate list of pre-approved telehealth services, allowing all services to be billed via telehealth at provider's discretion of clinical efficacy and patient feasibility
Telehealth Reimbursement Parity	N/A	Michigan MDHHS Slide Deck: "Telemedicine: Policy, Billing & Reimbursement"	Executive Order No. 2020-86	Michigan Medical Services Administration Bulletin 20-15	Legislators amend Insurance Code to mandate audio-only coverage	No changes recommended
Verbal Consent for Telehealth Initiation	Michigan Public Health Code Section 333.16284 & R.338.2407	N/A	Executive Order No. 2020-86	Executive Order No. 2020-86	To highlight legal leniency, legislators amend Public Health Code and/or regulators amend rule	Voluntarily continue allowance for written consent and announce allowance via bulletin

- Green Policy exists and is codified in statutes and/or regulations
- Yellow Policy exists but is temporary in nature and may revert after the state of emergency
- Red Policy does not exist, or policy is expressly prohibited by statutes and/or regulations

Appendix B:

Federal Telebehavioral Health Policies for Medicaid and Medicare Before and During the COVID-19 Emergency

Policy	Pre-COVID Michigan Laws/Regulations		Current Michigan Laws/Regulation		Proposed Change Mechanisms	
	Private Insurers	Medicaid	Private Insurers	Medicaid	Private Insurers	Medicaid
Audio-Only Telehealth	Health Insurance Portability and Accountability Act	Section 1834 (m)(1) of the Social Security Act	Notification of Enforcement Discretion	New authorities under 1135 Waiver	Medicaid is flexible based on state plans No changes recommended	Federal statutory amendment and rulemaking to extend audio-only allowances contained in CARES Act after the state of emergency
Telehealth Service Parity	N/A	Section 1834 (m)(1) of the Social Security Act	N/A	N/A	Medicaid is flexible based on state plans No changes recommended	No changes recommended
Telehealth Reimbursement Parity	N/A	Section 1834 (m)(2)(A) of the Social Security Act	N/A	N/A	Medicaid is flexible based on state plans No changes recommended	No changes recommended
Verbal Consent for Telehealth Initiation	N/A	N/A	N/A	CMS Clarification: "CMS Flexibilities to Fight COVID-19"	Medicaid is flexible based on state plans No changes recommended	No changes recommended

Green Policy exists and is codified in statutes and/or regulations

Yellow Policy exists but is temporary in nature and may revert after the state of emergency

Red Policy does not exist, or policy is expressly prohibited by statutes and/or regulations