Telebehavioral Health: An Effective Alternative to In-Person Care

By Brittany Lazur, MPH, Lily Sobolik, MPP, and Valerie King, MD, MPH

Policy Points

> Telehealth is just as effective as in-person care for certain behavioral health conditions

> States can cover telebehavioral health as as a separate benefit or as a treatment modality, meaning that certain services are covered regardless of how they are delivered

ABSTRACT

In recent years, many states have seen an increase in the prevalence of behavioral health diagnoses and challenges in treatment access. At the same time, the health care delivery system has increasingly relied on telehealth. Given the importance of behavioral health care and the desire of state policymakers to improve outcomes, leaders should consider the effectiveness of various behavioral health treatments delivered via synchronous telehealth.

While the COVID-19 pandemic has prompted numerous, often temporary, telehealth policy changes across the health care field, some states and health care organizations already had robust telehealth policies in place. As health care leaders and organizations consider extending or making these new telehealth policies permanent, they should consider the lessons learned from existing programs.

This brief provides summary findings from a 2019, pre-pandemic review of the evidence of telebehavioral health's effectiveness on key clinical outcomes. It also describes the programmatic structure and relevant telebehavioral health policies of three programs: Texas Medicaid, Massachusetts Medicaid, and the Portland Veterans Affairs Medical Center Rural Telemental Health Program (VA RTMH).

Key Evidence Findings:
- Telehealth is just as effective as in-person care for certain behavioral health conditions;
- Telehealth is not harmful compared with in-person behavioral health care; and,
- The cost of telebehavioral health can be lower than in-person visits, provided that patients have devices they can use.

Key Policy Findings:
- Permanent telebehavioral health policies can be implemented using various means, including treating telehealth as a modality or as a separate program; and
- Administrative or legislative mechanisms can be used to enact authorization for such policies.

BACKGROUND

More than 50% of Americans will be diagnosed with a mental health disorder such as anxiety or depression during their lifetime, with one in five US adults experiencing a mental illness in a given year.[3-5] Approximately 21 million Americans have a substance use disorder (SUD) related to alcohol, opioids, or other drugs.[6] Population-based surveys suggest one in six US children aged two to eight years has a mental, behavioral, or developmental disorder.[7]

> Telebehavioral health, also known as telemental health, is broadly defined as any telehealth services delivered by behavioral health professionals, such as psychiatrists, psychologists, and social workers.[1] Examples of behavioral health services delivered via telehealth include cognitive behavioral therapy, general psychotherapy, behavioral activation, problem-solving therapy, medication management, and training for parents of children with attention-deficit hyperactivity disorder. For the purposes of this brief, telebehavioral health services are limited to live audio-video connections (synchronous) in which patients receive health care at an originating site (e.g., clinical or home setting) from providers located at a distant site.[2]

Despite the ubiquity of mental and behavioral health conditions, access to treatment is often out of reach, particularly for children and adolescents. Sixty-five percent of nonmetropolitan counties in the US do not have a psychiatrist, and there are often shortages of both nonpsychiatric and psychiatric care professionals in rural geographic areas.[8] While primary care clinicians provide substantial amounts of behavioral health care, they often report difficulties obtaining specialist mental health referrals for rural and low-income patients.[9,10] Even with sufficient staffing, providers may be unable to deliver the right services, such as acute and crisis care. Furthermore, only a small proportion of individuals with SUD receive treatment, a reflection of the shortage of SUD treatment providers.[6] This treatment gap is particularly evident among vulnerable populations including racial and ethnic minorities, children, rural communities, and individuals with special health care needs.[7] Tele-

health may have the ability to fill at least some of these gaps in access to care.

The telehealth policy and reimbursement landscape continue to evolve, particularly with changes occurring in the wake of the COVID-19 pandemic. Still, prior to COVID-19, Medicaid fee-for-service provided reimbursement for some forms of live video telehealth in 49 states and Washington, DC.[11]

Evidence on Telebehavioral Health
As Effective as In-Person Care for Common Behavioral Health Conditions

- Studies indicate that there are largely no significant differences between telehealth and in-person care for adults with anxiety,[12-18] depression,[13-22] substance use disorder,[23] and post-traumatic stress disorder[17,18] for the following outcomes:

  • Symptom improvement,

  • Patient satisfaction,

  • Quality of life, and

  • Medication and treatment adherence.

- Patients have reported that behavioral health treatment delivered by synchronous telehealth was convenient and reduced barriers to accessing treatment.[15,23]

Greater Improvements in Attention Deficit Hyperactivity Disorder (ADHD) Symptoms

- For children with ADHD, a study showed improvement in symptoms occurred in both synchronous telehealth—in which a patient and provider are connected in real time via teleconferencing—and in-person treatment groups, but the improvement was significantly greater for those participating in the telehealth intervention.[24]

- Telebehavioral health led to decreases in distress among caregivers of children with ADHD.[25]

Neither Worse Than Nor Harmful in Comparison to In-Person Care for Many Behavioral Health Conditions

- No study found behavioral health treatment delivered by synchronous telehealth to be worse than or harmful in comparison to behavioral health treatment delivered in-person.[12-36] However, no

studies evaluated the effects of long-term telebehavioral health treatment, and there were few studies in children.

Costs Vary Greatly by Program, Depending on Staffing, Services, and Technology

- Studies reported mixed findings pertaining to costs and health care utilization for participants in synchronous telehealth and comparison groups across all behavioral health populations studied.[12,13,18,26]

- Studies of people with depression noted direct telehealth costs were lower than costs for in-person care if patients provided their own technology rather than being provided with equipment by clinical providers or the government.[18]

- Telebehavioral health costs less as long as patients have devices that they can use.[18]

Telebehavioral Health Policy Implementation

Telebehavioral Health as a Treatment Modality or Separate Benefit

States can cover telebehavioral health as a treatment modality, meaning that they cover certain services regardless of how they are delivered, or as a separate benefit, where the state specifically defines its coverage of telehealth treatment (e.g., cover telehealth but only for particular conditions or under certain circumstances). Below, we describe examples of both approaches from three states: Texas, Massachusetts, and Oregon. In all three states, the major impetus for developing telebehavioral health programs was to address health professional shortages and reduce treatment barriers related to patient location.[40,41]

While Texas and Massachusetts's Medicaid policies were authorized using different mechanisms, Texas legislatively in 2005[37] and Massachusetts administratively in 2019,[38,39] both states treat telebehavioral health as a treatment modality, not as a distinct, separately covered service.[1*,2*] In contrast, the Portland Veterans Affairs Medical Center (Portland VA) created its telebehavioral health program, Rural Telemental Health (RTMH), in 2009 for patients living in rural areas of Oregon as a separate specialty program.[3*]

There are minimal differences between in-person and remotely delivered services, regardless of modality or separate benefit designation.[38,39,42]

The Texas and Massachusetts Medicaid programs both provide:

- Equal reimbursement;[37,38,43,44]

- Identical patient eligibility requirements;

- Identical prior authorization requirements;[37] and

- No start-up funding or equipment for providers or patients.

Implementation nuances remain for telebehavioral health services:

- Requirement of staff training programs (Mass.);[38,39]

- Presence of a health care professional in mental health emergencies (Texas);[45]

- Specific eligibility exclusions including severe SUD, high risk of suicide or homicide, and dementia (VA RTMH);[4*] and

- Special delivery and eligibility requirements for children (Texas).[45,46]

Minimal Restrictions to Allowed Services

All three programs (Texas, Mass., VA RTMH) permit a wide range of services to be delivered through telebehavioral health including:[4,38,47–50]*

- Diagnosis, evaluation, and treatment;

- Services for new patients; and

- Medication prescribing.

Considerations for prescribing of controlled substances include:

- Compliance with federal and state laws (Texas, Mass., VA RTMH); [4*,38,39,49,51]

- Required periodic in-person visits (Mass., VA RTMH); [4*,38,39]

- Particular restrictions for Schedule II controlled substances (Mass.);[38,39] and

- Exclusion of chronic pain conditions (Texas).[51]

Minimal Restrictions to Allowed Sites

All three programs permitted a patient's home to serve as an originating site for telemedicine, ensuring patients did not have to travel to a practitioner's office or medical facility.[37-39,49,50] The Texas and Massachusetts Medicaid programs had very few, if any, restrictions on patient site location.

Policy considerations for allowed sites include:

- Evaluating a patient's access to emergency services (VA RTMH);

- Requiring a clinical originating site for patients with certain controlled substance prescriptions, like Suboxone (VA RTMH); and

- Contingency planning for technical issues and health crises (Mass., VA RTMH). [4*,38,39]

Minimal Technical Specifications

All three programs provided limited direction on technological requirements and did not provide funding for equipment or technology for patients or providers.[4*,38,39,49]

The broad guidance for providers includes:[4*,38,39,49]

- Compliance with the Health Insurance Portability and Accountability Act of 1996; and

- Secure authentication.

> The US Department of Veterans Affairs (US VA) has an encrypted, web-based app, VA Video Connect, which is a web link that creates a virtual medical room.[52] Additionally, the US VA has recently piloted partnerships with public and private organizations, e.g., American Legion, Veterans of Foreign Wars, and Walmart, that will provide on-site access at five to 10 locations nationally to technology and private space for telehealth visits.[53-55]

Considerations for States Thinking About Continuing New Telebehavioral Health Policies Established During COVID

The establishment of permanent telebehavioral health policies, developed prior to COVID-19 by the Texas and Massachusetts Medicaid programs and Portland VA RTMH program, provides important lessons for states and health care organizations to consider when planning for their own long-term implementation of similar policies. States should consider these findings in the context of their unique regulatory environments.

Program Reporting

Texas and Massachusetts Medicaid staff emphasized that the assessment of remotely delivered services is critical, and both programs have a modifier code to denote remote delivery of services.[38,39,49] In Texas, the first external evaluation is underway and will report cost savings; recommend future data collection elements; and develop a methodology to evaluate the cost-effectiveness, clinical efficacy, and utilization of remotely delivered services.

Texas Medicaid regularly administers stakeholder surveys and has regular, standardized legislative reporting on its remote delivery services, which includes:[37]

- Number and type of health care providers using remotely delivered services;

- Provider geographic and demographic makeup;

- Provider expenditures;

- Common primary diagnoses for services; and

- Patient utilization.

Texas Medicaid staff noted some current data collection limitations and suggested states consider the following program improvements:

- Mandating the use of modifier codes (i.e., additional information to payers related to the specific service provided) to ensure consistency and

- Implementing codes for the place of treatment to track patient location.

Oversight Requirements

Among all three programs, there were no differences in audit or oversight requirements for remotely delivered and in-person services.[38,39] Remotely delivered services were simply included in any regular audit activities and were not overseen separately.

Staffing Requirements

Staffing requirements among the three programs depended on the scope and type of service included in the telebehavioral health program. Policies that treated telebehavioral health as a delivery modality were usually implemented with existing staffing. However, separate telebehavioral health programs required distinct staffing.

Key Takeaways

In light of the restrictions on in-person access to health care resulting from COVID-19, many states and health care organizations may consider making temporary telebehavioral health policies permanent. A pre-pandemic review of the evidence and policies from three existing programs provides key considerations for policymakers:

- Telehealth is just as effective as in-person care for certain behavioral health conditions, and

- Telebehavioral health policies can be implemented permanently using different structures, including treating it as a modality or as a separate program.

These findings are promising for the adoption of permanent policies. In addition to the evidence on effectiveness, policymakers should consider implementation nuances and the underlying motivations and expectations behind such policies. Cost savings and increased service utilization are of particular interest, however, the evidence in these two areas is unclear and requires additional research. A large expansion of telebehavioral health services could provide the needed impetus, and volume, to properly explore their impact on costs and service utilization.

NOTES

1. Uscher-Pines L, Bouskill KE, Sousa J, Shen M, Fischer SH, RAND Corporation. *Experiences of Medicaid programs and health centers in implementing telehealth.* 2019. https://www.rand.org/pubs/research_reports/RR2564.html. Accessed November 18, 2019.

2. Bennett A, Lazur B, King V. *Telehealth in the home: evidence, policy, and practice* Portland, OR: Oregon Health & Science University; 2018.

3. Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry.* 2007; 6(3): 168-176.

4. Centers for Disease Control and Prevention. *Learn about mental health.* https://www.cdc.gov/mentalhealth/learn/index.htm. Accessed January 28, 2020.

5. Substance Abuse and Mental Health Services Administration. *Key substance use and mental health indicators in the United States: results from the 2015 national survey on drug use and health.* 2015. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm. Accessed January 28, 2020.

6. Huskamp HA, Busch AB, Souza J, et al. How is telemedicine being used In opioid and other substance use disorder treatment? *Health Aff (Millwood).* 2018; 37(12): 1940-1947. doi: https://dx.doi.org/10.1377/hlthaff.2018.05134.

7. So M, McCord RF, Kaminski JW. Policy levers to promote access to and utilization of children's mental health services: a systematic review. *Adm Policy Ment Health.* 2019; 46(3): 334-351. doi: https://dx.doi.org/10.1007/s10488-018-00916-9.

8. Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. *Am J Prev Med.* 2018; 54(6 suppl 3): S199-S207. doi: 10.1016/j.amepre.2018.01.004.

9. Cook NL, Hicks LS, O'Malley AJ, Keegan T, Guadagnoli E, Landon BE. Access to specialty care and medical services in community health centers. *Health Aff (Millwood).* 2007; 26(5): 1459-1468. doi: 10.1377/hlthaff.26.5.1459.

10. Rust G, Daniels E, Satcher D, Bacon J, Strothers H, Bornemann T. Ability of community health centers to obtain mental health services for uninsured patients. *JAMA.* 2005; 293(5): 554-556. doi: 10.1001/jama.293.5.554-c.

11. Center for Connected Health Policy. *State telehealth laws and reimbursement policies.* 2019. https://www.cchpca.org/sites/default/files/2019-10/50%20State%20Telehealth%20Laws%20and%20Reibmursement%20Policies%20Report%20Fall%202019%20FINAL.pdf?utm_source=Telehealth+Enthusiasts&utm_campaign=1c42d90c8e-EMAIL_CAMPAIGN_2019_10_21_11_19&utm_medium=email&utm_term=0_ae00b0e89a-1c42d90c8e-353242231. Accessed October 25, 2019.

12. Morriss R, Patel S, Malins S, et al. Clinical and economic outcomes of remotely delivered cognitive behaviour therapy versus treatment as usual for repeat unscheduled care users with severe health anxiety: a multicentre randomised controlled trial. *BMC Med.* 2019; 17(1): 16. doi: 10.1186/s12916-019-1253-5.

13. Pande RL, Morris M, Peters A, Spettell CM, Feifer R, Gillis W. Leveraging remote behavioral health interventions to improve medical outcomes and reduce costs. *Am J Manag Care.* 2015; 21(2): e141- 151.

14. Khatri N, Marziali E, Tchernikov I, Shepherd N. Comparing telehealth-based and clinic-based group cognitive behavioral therapy for adults with depression and anxiety: a pilot study. *Clin Interv Aging.* 2014; 9: 765-770. doi: 10.2147/CIA.S57832.

15. Crowe T, Jani S, Jani S, Jani N, Jani R. A pilot program in rural telepsychiatry for deaf and hard of hearing populations. *Heliyon.* 2016; 2(3): e00077. doi: 10.1016/j.heliyon.2016.e00077.

16. Berryhill MB, Culmer N, Williams N, et al. Videoconferencing psychotherapy and depression: a systematic review. *Telemed J E Health.* 2019; 25(6): 435-446. doi: 10.1089/tmj.2018.0058.

17. Varker T, Brand RM, Ward J, Terhaag S, Phelps A. Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: a rapid evidence assessment. *Psychol Serv.* 2019; 16(4): 621-635. doi: 10.1037/ser0000239.

18. Veazie S, Bourne D, Peterson K, Anderson J. *Evidence brief: video telehealth for primary care and mental health services.* VA ESP Project #09-199. 2019.

19. Chong J, Moreno F. Feasibility and acceptability of clinic-based telepsychiatry for low-income Hispanic primary care patients. *Telemed J E Health.* 2012; 18(4): 297-304. doi: 10.1089/tmj.2011.0126.

20. Hungerbuehler I, Valiengo L, Loch AA, Rossler W, Gattaz WF. Home-based psychiatric outpatient care through videoconferencing for depression: a randomized controlled follow-up trial. *JMIR Ment Health.* 2016; 3(3): e36. doi: 10.2196/mental.5675.

21. Moreno FA, Chong J, Dumbauld J, Humke M, Byreddy S. Use of standard Webcam and Internet equipment for telepsychiatry treatment of depression among underserved Hispanics. *Psychiatr Serv.* 2012; 63(12): 1213-1217. doi: 10.1176/appi.ps.201100274.

22. Scogin F, Lichstein K, DiNapoli EA, et al. Effects of integrated telehealth-delivered cognitive-behavioral therapy for depression and insomnia in rural older adults. *J Psychother Integr.* 2018; 28(3): 292-309. doi: 10.1037/int0000121.

23. Lin LA, Casteel D, Shigekawa E, Weyrich MS, Roby DH, McMenamin SB. Telemedicine-delivered treatment interventions for substance use disorders: a systematic review. *J Subst Abuse Treat.* 2019; 101: 38-49. doi: 10.1016/j.jsat.2019.03.007.

24. Myers K, Vander Stoep A, Zhou C, McCarty CA, Katon W. Effectiveness of a telehealth service delivery model for treating attention-deficit/hyperactivity disorder: a community-based randomized controlled trial. *J Am Acad Child Adolesc Psychiatry.* 2015; 54(4): 263- 274. doi: 10.1016/j.jaac.2015.01.009.

25. Vander Stoep A, McCarty CA, Zhou C, Rockhill CM, Schoenfelder EN, Myers K. The Children's Attention-Deficit Hyperactivity Disorder Telemental Health Treatment Study: caregiver outcomes. *J Abnorm Child Psychol.* 2017; 45(1): 27- 43. doi: 10.1007/s10802-016-0155-7.

26. Fairchild RM, Ferng-Kuo SF, Laws S, Rahmouni H, Hardesty D. Telehealth decreases rural emergency department wait times for behavioral health patients in a group of critical access hospitals. *Telemed J E Health.* 2019; 25(12): 1154-1164. doi: 10.1089/tmj.2018.0227.

27. Hughes M, Gorman JM, Ren Y, Khalid S, Clayton C. Increasing access to rural mental health care using hybrid care that includes telepsychiatry. *Rural Ment Health.* 2019; 43(1): 30-37.

28. Myers K, Vander Stoep A, Lobdell C. Feasibility of conducting a randomized controlled trial of telemental health with children diagnosed with attention-deficit/hyperactivity disorder in underserved communities. *J Child Adolesc Psychopharmacol.* 2013; 23(6): 372-378. doi: 10.1089/cap.2013.0020.

29. Pruitt LD, Vuletic S, Smolenski DJ, Wagner A, Luxton DD, Gahm GA. Predicting post treatment client satisfaction between behavioural activation for depression delivered either in-person or via home-based telehealth. *J Telemed Telecare.* 2019; 25(8): 460- 467. doi: 10.1177/1357633X18784103.

30. Reynolds GO, Saint-Hilaire M, Thomas CA, Barlow DH, Cronin-Golomb A. Cognitive-behavioral therapy for anxiety in Parkinson's disease. *Behav Modif.* 2019:145445519838828. doi: 10.1177/0145445519838828.

31. Rockhill C. Telepsychiatry intervention is better for ADHD symptoms than usual treatment augmented by telemedicine consultation. *Evid Based Ment Health.* 2015; 18(4): e9. doi: 10.1136/eb-2015-102151.

32. Rockhill CM, Tse YJ, Fesinmeyer MD, Garcia J, Myers K. Telepsychiatrists' medication treatment strategies in the Children's Attention-Deficit/Hyperactivity Disorder Telemental Health Treatment Study. *J Child Adolesc Psychopharmacol.* 2016; 26(8): 662- 671. doi: 10.1089/cap.2015.0017.

33. Tse YJ, McCarty CA, Stoep AV, Myers KM. Teletherapy delivery of caregiver behavior training for children with attention-deficit hyperactivity disorder. *Telemed J E Health.* 2015; 21(6): 451- 458. doi: 10.1089/tmj.2014.0132.

34. Vander Stoep A, Myers K. Methodology for conducting the children's attention-deficit hyperactivity disorder telemental health treatment study in multiple underserved communities. *Clin Trials.* 2013; 10(6): 949- 958. doi: 10.1177/1740774513494880.

35. Xie Y, Dixon JF, Yee OM, et al. A study on the effectiveness of videoconferencing on teaching parent training skills to parents of children with ADHD. *Telemed J E Health.* 2013; 19(3): 192- 199. doi: 10.1089/tmj.2012.0108.

36. Yeung A, Martinson MA, Baer L, et al. The effectiveness of telepsychiatry-based culturally sensitive collaborative treatment for depressed Chinese American immigrants: a randomized controlled trial. *J Clin Psychiatry.* 2016; 77(8): e996- e1002. doi: 10.4088/JCP.15m09952.

37. Texas Health and Human Services Commission. *Telemedicine, telehealth, and home telemonitoring services in Texas Medicaid.* 2018. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb-789-telemedicine-telehealth-hts-medicaid-dec-2018.pdf. Accessed September 30, 2019.

38. Tsai D. MassHealth all provider bulletin 281: *Access to behavioral health services through use of telehealth options.* 2019. https://www.mass.gov/files/documents/2019/01/23/all-provider-bulletin-281.pdf. Accessed October 29, 2019.

39. Tsai D. MassHealth managed care entity bulletin 10: *Access to behavioral health services through use of telehealth options.* 2019. https://www.mass.gov/files/documents/2019/01/23/managed-care-entity-10.pdf. Accessed October 29, 2019.

40. MassHealth-executive office of health and human services. *MassHealth expands access to behavioral health care for members through telehealth.* 2019. https://www.mass.gov/news/masshealth-expands-access-to-behavioral-health-care-for-members-through-telehealth. Accessed October 29, 2019.

41. Rural Health Information Hub. *Rural telemental health (RTMH) program.* 2018. https://www.ruralhealthinfo.org/project-examples/916. Accessed November 25, 2019.

42. Texas Legislature Online. Senate bill 1107, *Relating to telemedicine and telehealth services.* 2017. https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB01107F.pdf#navpanes=0. Accessed September 30, 2019.

43. Texas Secretary of State. Texas administrative code, title 1, part 15, chapter 355, subchapter g, rule 355.7001, *Reimbursement methodology for telemedicine, telehealth, and home telemonitoring services.* 2017. https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=196382&p_tloc=&p_ploc=1&pg=11&p_tac=&ti=1&pt=15&ch=355&rl=7001. Accessed September 30, 2019.

44. Texas Statute. Government code, title 4, subtitle i, chapter 531, subchapter a, section 531.0217, *Reimbursement for certain medical consultations,* subsection 2d. 2019. https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm. Accessed September 30, 2019.

45. Texas Medicaid & Healthcare Partnership. Texas Medicaid provider procedures manual October 2019: *Behavioral health and case management services handbook.* 2019. http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Behavioral_Health.pdf. Accessed September 30, 2019.

46. Texas Legislature Online. Senate bill 670, *Relating to telemedicine and telehealth services.* 2019. https://capitol.texas.gov/tlodocs/86R/billtext/pdf/SB00670F.pdf#navpanes=0. Accessed September 30, 2019.

47. Code of Massachusetts Regulation. 101 CMR 306.00: *Rates of payment for mental health services provided in community health centers and mental health centers.* 2019. https://www.mass.gov/files/documents/2019/05/20/jud-lib-101cmr306.pdf. Accessed October 29, 2019.

48. Code of Massachusetts Regulation. 101 CMR 346.00: *Rates for certain substance-related and addictive disorders programs.* 2019. https://www.mass.gov/files/documents/2019/07/01/jud-lib-101cmr346.pdf. Accessed October 29, 2019.

49. Texas Medicaid & Healthcare Partnership. *Texas Medicaid provider procedures manual* October 2019: telecommunication services handbook. 2019. http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Telecommunication_Srvs.pdf. Accessed September 30, 2019.

50. Texas Secretary of State. Texas administrative code, title 1, part 15, chapter 354, subchapter a, division 33, rule 354.1432, *Telemedicine and telehealth benefits and limitations.* 2017. https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=354&rl=1432. Accessed September 30, 2019.

51. Texas Secretary of State. Texas administrative code, title 22, part 9, chapter 174, subchapter b, rule 174.5, *Issuance of prescriptions.* 2017. https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=186660&p_tloc=&p_ploc=1&pg=11&p_tac=&ti=22&pt=9&ch=174&rl=1. Accessed September 30, 2019.

52. U.S. Department of Veterans Affairs. *VA video connect.* https://mobile.va.gov/app/va-video-connect#AppDescription. Accessed November 18, 2019.

53. Elliott VL, Congressional Research Service. Department of Veterans Affairs (VA): *A primer on telehealth.* 2019. https://fas.org/sgp/crs/misc/R45834.pdf. Accessed November 18, 2019.

54. U.S. Department of Veterans Affairs. *VA, Walmart open telehealth locations to serve veterans in rural areas.* 2019. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5374. Accessed December 13, 2019.

55. U.S. Department of Veterans Affairs. ATLAS: *offering veterans VA care closer to home.* https://connectedcare.va.gov/partners/atlas. Accessed November 21, 2019.

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About the Center for Evidence-based Policy

The Center for Evidence-based Policy (Center) is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.