An Analysis of Behavioral Telehealth Authorization in Scopes of Practice

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KEY FINDINGS

Behavioral telehealth services can expand access to behavioral health professionals (BHPs) for Americans, potentially narrowing the nation's current service gap. In 2017, statutes and administrative rules detailing scope of practice authorization for psychiatrists, advanced practice registered nurses (APRNs), psychologists, marriage and family therapists, licensed professional counselors, addiction counselors, and social workers were extracted from state government websites in all fifty states and D.C., as were state Medicaid statutes, provider handbooks, and fee schedules. These documents were used to summarize and identify variability in telehealth authorization across the country for BHPs.

Key findings include:

- Medicaid often authorizes telehealth services to be provided and reimbursed, even when legal scopes of practice licensure laws do not include telehealth.
- Psychiatrists, psychologists, and APRNs are compensated at a higher rate than other BHPs for the same service codes.
- Twenty-nine states have telehealth parity laws in place for private payers.
- Fourteen states deny out-of-state providers the authority to offer telehealth services within their state, while 18 states have language in place to either allow out-of-state providers to provide behavioral telehealth, or to acquire an expedited state license to do so.

Understanding current laws and policies can provide insight into needed future policies for expanding telehealth, and inform research into the efficacy of existing telehealth policies.

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BACKGROUND

Telehealth use among behavioral health providers (BHPs) has increased substantially over the last decade. In 2008, 87% of U.S. psychologists leveraged non-face-to-face communication technologies with their patients.[1] A growing body of literature has found that patient outcomes for individuals who engage in behavioral telehealth were as beneficial[2-7] as in-person services across patient populations and diagnoses.[8-12] However, a chief barrier to full implementation of behavioral telehealth has been the lack of consistent regulatory oversight governing its use. A 2000 survey found that only three states had statutes regulating behavioral telehealth, while only nineteen states had regulations allowing the electronic provision of mental health services across state lines.[13] Further, a recent study found lack of uniformity across state scopes of practice and behavioral telehealth authorization, including who can practice behavioral telehealth and the extent of clinician roles.[14] For example, only three of twenty-two states with any telehealth laws recognized psychologists specifically, according to a 2010 report from the American Psychological Association.[15]

Variation in the scopes of practice in state laws has influenced the expansion of telehealth coverage. Adler-Milstein et al. found significant associations between state regulations and the adoption of telehealth by providers, in that requiring out-of-state providers to hold additional licensure to deliver telehealth reduced the likelihood of those providers adopting a telehealth program.[16]

This project identified the varying degrees to which states authorize and reimburse telehealth and how that is related to scope of practice regulations within a state. Similar work has been done by the Center for Connected Health Policy (CCHP).[14] The CCHP regularly aggregates state statutes and rules surrounding telehealth authorization for all health professionals, and has a publicly-available database of these policies available by state. The CCHP relies heavily on Medicaid statutes and handbooks for their findings. This study adds a professional-oriented focus. The research conducted by the BHWRC uses many of the same sources as the CCHP, but focuses specifically on which BHPs can provide behavioral telehealth across the country, which services those BHPs can perform, and the variability in expected reimbursement. Further, this study examines whether telehealth training criteria exist as part of scope of practice in a state.

Terminology

With regard to the terminology adopted for this study, "telehealth" refers to the electronic provision of services that promote health, such as live video counseling, while "telemedicine" refers to the provision of medical services via electronic means, such as video consultations with distant specialists.[17] Typically, telemedicine is only authorized for physicians (including psychiatrists), APRNs, and occasionally psychologists. For example, in New Jersey, the specific provision of psychiatric services via telecommunications is referred to as "telepsychiatry." Because the term "telehealth" is broader, and captures the meaning of telemedicine within it, this study refers to these services as "telehealth."

Telehealth exists primarily in four forms: live video, store and forward, telemonitoring, and online prescribing.[2] In live video, a patient communicates with a provider via video conferencing technology, and the provider provides real-time assessment and treatment for the patient's conditions. Live video includes diagnosis and therapy, which are instrumental to behavioral telehealth. Most behavioral telehealth services take the form of live video telehealth.[18]

During store and forward, otherwise known as "asynchronous telehealth/telemedicine", health information is sent from one location to be interpreted by a provider in another location.[2] This could be as simple as a clinic sending an x-ray to a distant specialist for her/his opinion, or as complex as sending a patient's lab results and full medical history to a distant provider for a consultation. Store and forward is not used as frequently for behavioral telehealth.

Telemonitoring, also known as "telecare," is the remote monitoring of a patient's condition through use of electronic medical devices that transmit important health data back to a provider.[17] Telemonitoring is typically only used for chronic medical conditions, and the laws don't mention it having any behavioral health applications.

Finally, online prescribing permits providers to fill out prescriptions for patients without meeting the patient in person and is typically permitted after the provider has established a doctor-patient relationship with the patient, so as to prevent over-prescribing or drug-seeking behavior. Online prescribing is important for behavioral telehealth, but is limited both by the state's authorization of the practice, as well as the state's prescriptive authority laws.

METHODS

Researchers at the University of Michigan Behavioral Health Workforce Research Center conducted a study focused on analyzing regulatory, licensing and certification, and service authorization

variables within state scopes of practice for a subset of ten behavioral health occupations in 2016.[19] In 2017, the state statutes and administrative rules that outline scopes of practice for psychiatrists, psychologists, advanced practice registered nurses (APRNs), licensed professional counselors, marriage and family therapists, social workers, and addiction counselors were further analyzed to look specifically at telehealth authorization. The Center also collected and compiled each state's Medicaid provider manuals, Medicaid fee schedules, and other relevant statutes/rules for telehealth and telemedicine authorization and provision. These sources were all available online through state government websites.

Because private payer data is difficult to obtain and may not be representative of the entire health marketplace for a given state, state Medicaid programs are the focus of this study. Medicaid reimbursement opportunities provide a consistent incentive for state behavioral health providers to participate in telehealth practices, as opposed to private payer plans, which would only incentivize telehealth should they choose to cover it. Medicaid coverage also signifies that the state recognizes the utility of telehealth and have chosen to invest tax dollars into providing it to its citizens.

Study Analyses

Our analyses are separated into three distinct categories: telehealth authorization for all health providers by state, telehealth authorization for behavioral health providers by state, and reimbursement for behavioral telehealth providers.

The first analysis describes telehealth authorization nationwide, not limited to BHPs, revealing which of the four basic telehealth services are authorized for providers in each state, as well as whether interstate telehealth is allowed. This analysis draws from both Medicaid statutes and handbooks, as well as individual professional licensing statutes and rules for its data. The focus is whether each state's providers, as a whole, are able to offer certain telehealth services – not whether BHPs in particular can offer them. This means that if any single provider is explicitly authorized to perform a form of telehealth, then it is considered allowable by the state.

The second analysis is focused on BHP telehealth authorization. Two separate sub-analyses are summarized: 1) a state-by-state summary of occupations that are authorized to provide telehealth according to their licensing laws/rules; and 2) a state-by-state summary of occupations that are authorized to provide telehealth services according to the state's Medicaid program. The inclusion criteria for each analysis are different. For the state licensing laws/rules analysis, a BHP is considered authorized to provide telehealth services if the law or rule mentions this method as

within the professional's scope of practice. For the Medicaid-centered analysis, a BHP is considered authorized to provide telehealth services if the BHP is allowed to provide the services by Medicaid provider handbooks and/or statutes *and* the BHP is able to bill independently for telehealth services. Billing authority is a barrier to providing behavioral telehealth; without reliable reimbursement, BHPs are reluctant to offer behavioral telehealth services.[20] As such, lack of billing authority was treated in our analysis as a de facto denial of authorization, as it can have the same effect for service provision. Discrepancies in authorization between the two analyses are highlighted.

The third analysis is focused on BHP reimbursement for telehealth services. For each type of BHP, Medicaid fee schedules from all 50 states and D.C. were utilized to estimate the average reimbursement for psychiatric diagnostic evaluations and for one hour of individual psychotherapy using telehealth. Services provided via telehealth use the same billing code as in-person services (referred to as the Current Procedural Terminology (CPT) code) but have a modifier attached – typically the letters "GT," although this is set to change in 2017 to the numeric modifier "95".[21] In this case, the CPT codes for psychiatric diagnosis and one hour of psychotherapy are 90791 and 90837, respectively. We also explored the current state of parity laws across the country with regard to how behavioral telehealth is reimbursed. Telehealth parity laws affect all forms of telehealth, not just behavioral telehealth, so those results speak to the current policy environment among the states, similar to the results of the first analysis. A full list of study variables is included in the Appendix.

RESULTS

Telehealth Authorization for All Health Providers Across States

When looking at types of telehealth authorized by state, all but three states (Connecticut, Massachusetts, and Rhode Island) authorize and reimburse for at least one form of telehealth. The most common form of authorized telehealth is live video (n=47). States are more likely to authorize online prescribing (n=34) than telemonitoring (n=24) or store-and-forward services (n=20). Ten states authorize all four common forms of telehealth (Alaska, Arizona, Hawaii, Kentucky, Mississippi, Missouri, Nebraska, Vermont, Virginia, and Washington) and Arkansas will be joining that list when their new telemonitoring law is enacted in 2018 (Table 1).

Eighteen states permit out-of-state providers to deliver telehealth services, while fifteen states prohibit interstate telehealth practice (Table 1). The prohibition language most commonly used is,

"a provider must have a valid license from [this state] in order to provide telehealth services to [this state's] citizens." This serves as a barrier to out-of-state service provision, because it takes years to earn the experience and education necessary to become a licensed healthcare provider in any state. Some states, however, offer an expedited path to licensure within the state, either through the Interstate Medical Licensure Compact (limited only to physicians), the Nurse Licensure Compact (limited to nurses), or through other reciprocity/endorsement mechanisms. States that offer fast-tracks to in-state licensure were considered, by our analysis, to allow interstate telehealth.

Another common authorization phrase for out-of-state providers is, "out-of-state providers can provide telehealth services to citizens in this state, provided they are duly licensed in their own state, have no limitations on their license, and do not set up offices within this state." This seems to allow for specialist, out-of-state consultations and services, while also limiting competition from out-of-state providers. This would also, theoretically, improve rural access to BHPs by connecting patients to providers through telehealth, both inside and outside of the state.

Table 1. Types of Telehealth Authorized by State (n = 51)

	Live Video	Store and Forward	Telemonitoring	Online Prescribing	Interstate
Alabama	X		X		X
Alaska	X	X	X	X	
Arizona	X	X	X	X	
Arkansas	X	X	Starting 2018	X	NO
California	X	X		X	
Colorado	X	X	X		
Connecticut					
Delaware	X			X	
D.C.	X				
Florida	X			X	
Georgia	X				NO
Hawaii	X	X	X	X	NO
Idaho	X			X	
Illinois	X	X	X		X
Indiana	X		X	X	
Iowa	X				
Kansas	X		X		
Kentucky	X	X	X	X	NO
Louisiana	X		X	X	X
Maine	X		X	X	X
Maryland	X			X	X
Massachusetts				X	
Michigan	X				NO
Minnesota	X	X	X		X

Mississippi	X	X	X	X	X
Missouri	X	X	X	X	NO
Montana	X	X			
Nebraska	X	X	X	X	NO
Nevada	X	X		X	NO
New Hampshire	X			X	
New Jersey	X				NO
New Mexico	X	X		X	X
New York	X		X		
North Carolina	X				
North Dakota	X			X	
Ohio	X	X		X	X
Oklahoma	X			X	NO
Oregon	X		X		X
Pennsylvania	X				X
Rhode Island					NO
South Carolina	X		X	X	NO
South Dakota	X		X		X
Tennessee	X	X		X	NO
Texas	X		X	X	X
Utah	X		X	X	X
Vermont	X	X	X	X	NO
Virginia	X	X	X	X	NO
Washington	X	X	X	X	X
West Virginia	X			X	X
Wisconsin	X				X
Wyoming	X			X	X
TOTAL	**48**	**20**	**24**	**32**	**18**

X: Service Authorized; NO: Service Prohibited; Blank cell indicates the service is not addressed in the scope of practice

Telehealth Authorization for Behavioral Health Providers Across States

The data collected from state scopes of practice revealed psychiatrists to be the BHP most commonly authorized to perform telehealth, followed by social workers, and then psychologists. Addiction counselors are the least likely BHP to have authorization (9 states). However, none of the over 1000 statutes and rules used in this analysis explicitly prohibit telehealth by any BHP. Instead, telehealth is mostly unmentioned. This would, theoretically, allow BHPs to practice telehealth, so long as the services provided are within their legal scope of practice. However, Table 2 only considers BHPs as authorized to perform telehealth services if the service is explicitly mentioned in their respective scope of practice statutes and rules.

Only nine states do not authorize any of their BHPs to perform telehealth: Alabama, Florida, Indiana, Kansas, Michigan, Rhode Island, South Dakota, Washington, and Wisconsin. Like with Table 1, these states did not mention telehealth within the BHP scopes of practice laws and rules,

but did not outright prohibit it. In contrast, only three states allow all of the BHPs for which we collected data to provide telehealth services: Delaware, Kentucky, and Nevada. Twenty states authorize at least three BHPs to perform telehealth.

Table 2. Providers Authorized by State Licensing Laws/Rules to Provide Telehealth

	MD	APRN	Psych	MFT	LPC	AC	SW
Alabama							
Alaska							X
Arizona	X	X	X	X	X		X
Arkansas	X			X	X		X
California	X	X					
Colorado	X	X	X				X
Connecticut	X	X	X				
Delaware	X	X	X	X	X	X	X
D.C.				X			
Florida							
Georgia	X			X	X		X
Hawaii	X						
Idaho	X	X	X	X	X	X	
Illinois		X	X	X	X	X	
Indiana							
Iowa	X	X	X	X	X		X
Kansas							
Kentucky	X	X	X	X	X	X	X
Louisiana	X	X	X		X	X	
Maine	X		X				
Maryland			X				
Massachusetts	X		X				X
Michigan							
Minnesota	X						X
Mississippi	X	X	X				
Missouri		X					
Montana	X						
Nebraska	X	X	X	X	X	X	
Nevada	X	X	X	X	X	X	X
New Hampshire	X	X	X			X	
New Jersey	X		X				
New Mexico	X						X
New York			X				
North Carolina	X						
North Dakota							X
Ohio		X	X		X		X
Oklahoma	X						X
Oregon	X			X	X		
Pennsylvania	X						X
Rhode Island							
South Carolina	X						X

South Dakota							
Tennessee	X	X	X				
Texas	X						X
Utah							X
Vermont			X				
Virginia							X
Washington							
West Virginia	X						
Wisconsin							
Wyoming	X			X	X	X	X
TOTAL	**31**	**17**	**21**	**13**	**14**	**9**	**21**

X: Authorized; Blank cell indicates the service is not addressed

MD: physician, APRN: advanced practice registered nurse, Psych: psychologist, MFT: marriage and family therapist, LPC: licensed professional counselor, AC: addiction counselor, SW: social worker

In contrast, the data collected from Medicaid documents nationwide reveal a different authorization pattern for telehealth use among BHPs. All professions show more instances of authorization via Medicaid laws (Table 3) than scope of practice/licensure laws (Table 2), save for addiction counselors, whose authorization is unchanged.

With regard to Medicaid billing, eight states explicitly permitted BHPs to be reimbursed by Medicaid for telehealth services, but did not permit the BHPs to bill for services themselves. For instance, in Missouri, though more BHPs are authorized to engage in telehealth according to the Medicaid provider handbook, only physicians, APRNs, and psychologists can bill MO HealthNet – the Missouri Medicaid program. In similar states, BHPs must be part of a treatment team in which the primary care physician is authorized to bill Medicaid.

Psychiatrists, the most likely profession to be authorized by Medicaid to provide and bill independently for behavioral telehealth, are authorized to perform this service in all states except Massachusetts and Rhode Island, where no BHPs were authorized by Medicaid to provide and independently bill for behavioral telehealth. APRNs are the second most likely profession to be similarly authorized (43 states), followed by psychologists (37 states) and social workers (30 states). Again, addiction counselors are the least likely BHP to be authorized by Medicaid (9 states).

Seven state Medicaid programs authorize all of the BHPs included in the study to provide and independently bill Medicaid for behavioral telehealth services: Arizona, Connecticut, Kansas, Maine, Oklahoma, Oregon, and Wyoming. Interestingly, none of these states explicitly authorize all BHPs to perform telehealth services in their respective scope of practice laws and rules. Thirty-six state Medicaid programs authorized at least three BHPs to perform behavioral telehealth.

Table 3. Providers Authorized to Provide and Bill Medicaid for Telehealth

	MD	APRN	Psych	MFT	LPC	AC	SW
Alabama	X						
Alaska	X	X					
Arizona	X	X	X	X	X	X	X
Arkansas	X	X	X	X	X		X
California	X	X	X				X
Colorado	X	X	X				
Connecticut	X	X	X	X	X	X	X
Delaware	X	X	X	X	X		X
D.C.	X	X					
Florida	X						
Georgia	X	X	X				
Hawaii	X	X	X	X	X		X
Idaho	X	X	X				X
Illinois	X	X					
Indiana	X	X	X	X	X		X
Iowa	X						
Kansas	X	X	X	X	X	X	X
Kentucky	X	X	X	X	X		X
Louisiana	X	X	X		X		X
Maine	X	X	X	X	X	X	X
Maryland	X	X					
Massachusetts							
Michigan	X	X					
Minnesota	X	X	X	X	X		X
Mississippi	X	X	X				X
Missouri	X	X	X				
Montana	X		X		X	X	X
Nebraska	X	X	X				
Nevada	X	X	X		X		X
New Hampshire	X	X	X				X
New Jersey	X	X					
New Mexico	X	X	X		X		X
New York	X	X	X				X
North Carolina	X	X	X				X
North Dakota	X	X	X		X	X	X
Ohio	X		X				
Oklahoma	X	X	X	X	X	X	X
Oregon	X	X	X	X	X	X	X
Pennsylvania	X	X	X				
Rhode Island							
South Carolina	X	X					
South Dakota	X	X	X		X		X
Tennessee	X						
Texas	X	X	X	X	X		X

Utah	X	X					
Vermont	X	X	X				X
Virginia	X	X	X		X		X
Washington	X	X	X	X	X		X
West Virginia	X	X	X				X
Wisconsin	X	X	X				
Wyoming	X	X	X	X	X	X	X
TOTAL	**49**	**43**	**37**	**15**	**22**	**9**	**30**

X: Authorized; Blank cell indicates the service is not addressed

MD: physician, APRN: advanced practice registered nurse, Psych: psychologist, MFT: marriage and family therapist, LPC: licensed professional counselor, AC: addiction counselor, SW: social worker

Telehealth Reimbursement for Behavioral Health Providers

Aside from psychiatrists, Medicaid fee schedules often did not include separate prices for BHPs. It is possible that the service is reimbursed at the same rate regardless of the professional providing it, but this was not specified in the data. States with varying reimbursement amounts by profession consistently reimburse psychologists and psychiatrists at a higher level than APRNs, marriage and family therapists, licensed professional counselors, addiction counselors, and social workers for the same service code. Marriage and family therapists are paid equally to licensed professional counselors in most states (median = $103.25 for diagnosis and $94.63 for an hour of psychotherapy). Some states reimburse professionals at a different percent of the standard fee schedule rate. For instance, Delaware reimburses psychologists at 98% of the rate paid to physicians, APRNs at 100%, and marriage and family therapists, professional counselors, and social workers at 75% (Table 4).

Table 4. Medicaid Telehealth Pay Rates for Common Psychiatric Services by Provider

	Psychiatric Diagnostic Evaluation (90791)	Psychotherapy, 60 Minutes (90837)*
M.D. (n)	51	51
Mean	$122.85	$114.76
Median	$115.27	$109.04
S.D.	$45.59	$42.57
APRNs (n)	11	12
Mean	$104.28	$101.07
Median	$106.16	$93.68
S.D.	$19.53	$32.63
Psychologist (n)	11	10
Mean	$111.42	$98.56
Median	$120.56	$98.95
S.D.	$27.77	$20.93
MFT (n)	5	5
Mean	$102.43	$91.78

Median	$103.25	$94.63
S.D.	$17.78	$16.57
LPC (n)	5	5
Mean	$102.43	$91.78
Median	$103.25	$94.63
S.D.	$4.72	$16.57
AC (n)	3	3
Mean	$105.67	$91.25
Median	$103.25	$94.63
S.D.	$4.72	$13.09
SW (n)	6	6
Mean	$105.33	$93.28
Median	$107.18	$97.71
S.D.	$17.42	$15.27

* Missouri reimbursed for code 90834 (Psychotherapy, 38 to 62 minutes) instead of 90837
MD: physician, APRN: advanced practice registered nurse, Psych: psychologist, MFT: marriage and family therapist, LPC: licensed professional counselor, AC: addiction counselor, SW: social worker

Parity requires one set of services be covered equally to another set of services and is frequently discussed with regard to behavioral health service delivery. States with telehealth parity laws in place that include Medicaid must reimburse telehealth at the same rate as in-person services. Other forms of parity laws include private payer parity and state-run health plan parity, where private insurance plans and state-run plans must both cover and reimburse telehealth services the same as they would for in-person services.

Medicaid parity is the most common form of telehealth parity in the country, with thirty-four states having a Medicaid parity law, followed by private payer parity laws in twenty-nine states, and state plan parity laws in ten states. Nine states have all three parity laws: Arkansas, Georgia, Mississippi, Montana, Oregon, Tennessee, Vermont, Virginia, and Washington. Seventeen states have no telehealth parity laws. Nevada was unique, in that it has a parity law in place for its worker's compensation program – no other state explicitly covers worker's compensation (Table 5.)

Table 5. Telehealth Parity Laws by State

	Medicaid	**Private Payer**	**State Plans**
Alabama			
Alaska	X	X	
Arizona	X	X	
Arkansas	X	X	X
California	X	X	
Colorado	X		
Connecticut			
Delaware	X	X	

D.C.	X	X	
Florida			
Georgia	X	X	X
Hawaii	X	X	
Idaho			
Illinois			
Indiana	X	X	
Iowa			
Kansas	X		
Kentucky	X	X	
Louisiana	X	X	
Maine	X	X	
Maryland	X	X	
Massachusetts			
Michigan	X	X	
Minnesota	X	X	
Mississippi	X	X	X
Missouri	X	X	
Montana	X	X	X
Nebraska			
Nevada	X	X	
New Hampshire	X		X
New Jersey			
New Mexico	X	X	
New York	X	X	
North Carolina			
North Dakota			
Ohio			
Oklahoma	X	X	
Oregon	X	X	X
Pennsylvania			
Rhode Island	X	X	
South Carolina			
South Dakota			
Tennessee	X	X	X
Texas	X	X	
Utah	X		
Vermont	X	X	X
Virginia	X	X	X
Washington	X	X	X
West Virginia			
Wisconsin			
Wyoming	X		
TOTAL	34	29	10

X = Parity Law Exists

We found no evidence in state scope of practice statutes and regulations or Medicaid manuals that additional education or training is required of BHPs before telehealth services can be provided.

However, seven states require a telehealth license/certificate/permit before a provider can deliver telehealth services: Alabama, Louisiana, Maine, New Mexico, Ohio, Oregon, and Texas. In most of these cases, the license/certificate/permit was only required of out-of-state providers. In-state providers could typically provide services without needing an extra credential.

DISCUSSION

The findings of this study support the idea that because telehealth is perceived as the provision of a service a BHP is already authorized to perform, save through a new medium, state lawmakers are not as inclined to regulate it. This would theoretically give the free market and individual professionals the freedom to experiment with service innovations. This could explain the delay in telehealth statutes and regulations across the country. However, without authorizing telehealth services in scope of practice laws or in Medicaid manuals, BHPs may not be willing to engage in telehealth services for fear of violating their license or not getting reimbursed. This could potentially hinder behavioral telehealth uptake within a state.

Surprisingly, addiction counselors were not well-represented with regard to telehealth authorization in Medicaid documents or state licensing laws. This may be due to the unique nature of addiction counseling as a field within behavioral health. First, only about half of states have a license track for addiction counselors - the rest only offer certifications.[19] Without a state-issued license to practice in the state, many addiction counselors would not qualify for Medicaid reimbursement, based on the language commonly used in Medicaid provider manuals. Second, unlike other BHPs who are required to complete a master's degree and thousands of hours of postgraduate practice experience before licensure, addiction counselors tend to have several tiers of credentials in each state. The "lowest" credential often allows applicants with a high school diploma to receive an addiction counselor certification, as long as they have the required professional experience. Because of this variation within the field, it's difficult to compare success of incorporating addiction counselors in behavioral telehealth across states.

The difference in reimbursement rates between psychiatrists and other BHPs reflects the in-person service reimbursement disparities between BHPs. Sound economic arguments are made for both the status quo and for equal reimbursement regardless of profession. Psychiatrists, psychologists, and APRNs often maintain that the services they provide, while coded with the same CPT code, are of higher quality due to their advanced education and medical specialty. This additional training and education allows these BHPs to command higher reimbursement rates from Medicaid and

private payers.[22] Other BHPs, however, contend that the psychotherapy services they provide are equal in quality, save for not being able to prescribe psychotropic medication[23] and should receive the same reimbursement rate as physicians, psychologists, and APRNs. The merit behind each argument is outside the scope of this study. However, it seems clear that Medicaid reimbursement rates are tiered in a way that offers physicians, psychologists, and APRNs greater remuneration than professional counselors, marriage and family therapists, social workers, and addiction counselors.

Since seventeen states lack a Medicaid parity law, the data in Table 4 might be an overestimate of the amount BHPs are receiving for behavioral telehealth services. Parity laws tend to increase statewide utilization of telehealth services by making them more economically viable for providers to offer.[18] Not only would we expect providers in states without Medicaid parity laws to be less likely to offer telehealth services,[18] but the lack of equal coverage by law would likely allow private plans, state plans, and Medicaid to reimburse for telehealth services at a lower rate than in-person services. On the other hand, private insurance plans generally reimburse at a higher rate than Medicaid and Medicare for the same services.[24] If the same pattern holds true for behavioral telehealth services, then our findings may underestimate the average amount of reimbursement for BHPs providing behavioral telehealth services across the country. More research is needed, particularly with regard to private payer claims data.

Future research could look into how parity laws have affected behavioral telehealth services in a state. If longitudinal claims data are available for a state's Medicaid population, a study could be conducted that compares how often behavioral health service claims had the "GT" telehealth modifier before and after a Medicaid parity law was enacted. While not necessarily causative, the correlation could speak to how an increase in reimbursement for telehealth services could increase the provision of that service. Similarly, if longitudinal private claims data were accessible, then a before-and-after survey could be used to track the effect of private payer parity laws for behavioral telehealth.

This study shows that, while behavioral telehealth has expanded rapidly in the last ten years, state policies regulating the service still vary. Expansion of telehealth parity laws have been shown to increase telehealth provision in states, but there are discrepancies in authorizing language for health providers in general, and BHPs specifically. Without aligning scope of practice language within licensing statutes and rules with the authorizing language of state Medicaid programs, it is

possible that states have been inadvertently discouraging BHPs from practicing behavioral telehealth. Providing more explicit' authorization to perform behavioral telehealth services, along with a guarantee of reliable compensation for these services, may prompt increases in behavioral telehealth utilization across the country to help offset access to care barriers for those who live in areas with few BHPs.

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APPENDIX

Variable Name	Variable Description	Possible Values
phys	Are psychiatrists authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
aprn	Are advanced practice registered nurses authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
psych	Are psychologists authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
mft	Are marriage and family therapists authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
lpc	Are licensed professional counselors authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
ac	Are addiction counselors authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
sw	Are social workers authorized to provide telehealth/telemedicine and bill for the service with state Medicaid?	Yes, No, NA
def	Statute/rule language for how the state defines telehealth/telemedicine	String
serv	Statute/rule language for which services (live video, store and forward, telemonitoring, and online prescribing) the state authorizes	String
live_video	Does the state authorize live video telehealth/telemedicine?	Yes, No, NA
store_forward	Does the state authorize store and forward telehealth/telemedicine?	Yes, No, NA
telemonitor	Does the state authorize telemonitoring?	Yes, No, NA
online_rx	Does the state authorize online prescribing?	Yes, No, NA
diag_code	What code/description did the state use for a psychiatric diagnosis?	String
diag_cost_XXX	How much was each occupation reimbursed for providing a psychiatric diagnosis?	$XX.XX
couns_code	What code/description did the state use for an hour of individual	String

	counseling?	
couns_cost_XXX	How much was each occupation reimbursed for an hour of individual counseling?	$XX.XX
inf_consent	Is informed consent explicitly required before providing telehealth/telemedicine services?	Yes, No
tele_req	Training, education, or certification requirements necessary before providing telehealth/telemedicine services in this state	String
tele_inst	Can out-of-state providers offer telehealth/telemedicine services to citizens within this state?	Yes, No, NA
tele_inst_req	Statutory/rule language about how out-of-state providers are authorized (or not authorized) to provide telehealth/telemedicine services to citizens within the state	String
prof	Statutory/rule language delineating which occupations are authorized to provide telehealth/telemedicine within the state	String
parity_year	What year has a telehealth/telemedicine parity law been passed in the state?	Integer
parity_medicaid	Does the state have a law requiring Medicaid to cover and reimburse telehealth/telemedicine the same as it would for in-person services?	Yes, No, NA
parity_private	Does the state have a law requiring private payers to cover and reimburse telehealth/telemedicine the same as it would for in-person services?	Yes, No, NA
parity_state	Does the state have a law requiring state health plans to cover and reimburse telehealth/telemedicine the same as it would for in-person services?	Yes, No, NA
parity_other	Does the state have a law requiring another party to cover and reimburse telehealth/telemedicine the same as it would for in-person services?	Yes, No, NA
notes	Additional information about telehealth/telemedicine in the state which does not fit in the other variables	String
link	Hyperlinks to reference documents	Hyperlink