Telehealth & Medicaid: A Policy Webinar Series

Winter Webinar Series Report

Center for Connected Health Policy

March 2021

Introduction

The Center for Connected Health Policy's (CCHP) Medicaid telehealth policy webinar series wrapped up its inaugural Winter program on February 5, 2021. *Telehealth & Medicaid: A Policy Webinar Series*, was developed by CCHP staff during fall 2020 after identifying education and resource gaps in Medicaid telehealth policy. The series took place on Friday's between January 15 and February 5, 2021 and exposed thousands of attendees to telehealth policy activities taking place across 10 different Medicaid programs. Attendees also heard from federal agencies, including experts from the Centers for Medicare & Medicaid Services (CMS) and the Medicaid and CHIP Payment and Access Commission (MACPAC). The Winter series was the first of three installments, with Spring and Fall series taking place throughout 2021. The webinar series is supported in part by federal CARES Act funding and the Human Resources & Services Administration (HRSA).

Many Medicaid Programs, One Safety Net

The webinar series was developed in response to an ever-changing and complex landscape for telehealth policy in Medicaid. Because Medicaid programs are administered at the state level, no two Medicaid programs are alike. Under federal law, Medicaid programs are required to provide a set of essential services, which includes a variety of preventive, inpatient, and outpatient healthcare services but excludes services like dental, optometry, or specialty care, among others.[1] States elect to cover optional benefits above and beyond the MEC guidelines. Similarly, Medicaid programs have discretion in determining the scope of their telehealth coverage policies. While states have increasingly moved to reimburse providers for telehealth services in recent years, telehealth coverage policies can range from narrow to expansive.

The need for a Medicaid-focused webinar series became apparent in the wake of the COVID-19 pandemic. Most of the available resources or webinars were not specific to Medicaid and there was a lack of organized updates for Medicaid administrators, policy staff, and providers. As Medicaid programs rapidly expanded their telehealth coverage policies, CCHP received a flurry of requests for technical assistance and resources that could offer clarity. In March 2020, CCHP staff developed a policy tracking tool that captures the COVID-related telehealth policy actions for Medicaid programs in all 50 states and the District of Columbia (DC). The Medicaid webinar series is an extension of this work and offered providers, administrators, and policy staff in Medicaid agencies the opportunity to share insights and best practices with a diverse audience.

Webinar 1: Telehealth Policy and COVID-19

The Winter series theme, *Telehealth Policy and COVID-19*, focused on the rapid telehealth policy developments prompted by the public health emergency (PHE). CCHP reached a total of 1,753 attendees across the four webinars, with the majority of attendees

representing public health agencies, hospitals and doctors' offices, safety net clinics, and non-profit policy and advocacy organizations.

The first webinar took place on January 15, 2021 and gave attendees an overview of the state plan amendments (SPA) and waivers that Medicaid programs leveraged to expand telehealth services during the PHE. The webinar opened with an introduction to how Medicaid programs structure their benefits and services through the state plan provided by Sheri Gaskins, a Technical Director in the Division of Benefits and Coverage at CMS. The SPA is an agreement between each state Medicaid agency and CMS documenting how the state operates its Medicaid program.[1] States are required to submit a SPA to CMS for approval when they are requesting to make changes to their state plan, such as changes to reimbursement or certain covered services.[2] Unlike in Medicare, states are given broad flexibility to design their Medicaid benefits as outlined in their state plan.

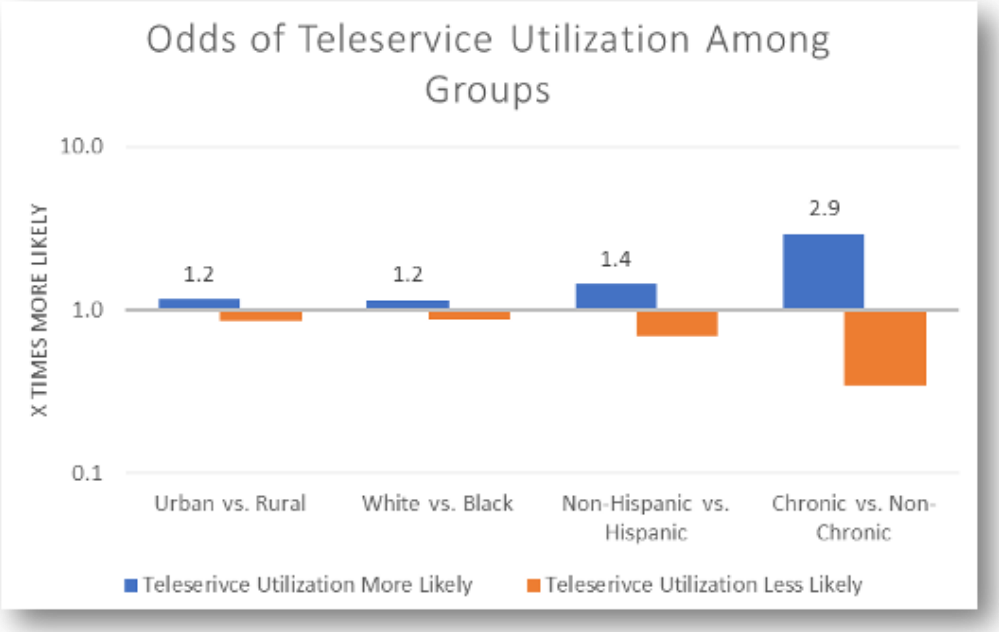
Changes to the state plan were one of the key strategies that Medicaid programs used to expand their telehealth coverage and reimbursement during the PHE. As of February 2021, all 50 states and DC submitted temporary SPA changes to CMS in response to the pandemic. According to CMS, at least 32 of these approved SPAs were related to Medicaid programs' telehealth coverage and reimbursement methdologies.[1] Ms. Gaskins emphasized that Medicaid programs are not governed by the same CMS telehealth regulations that govern Medicare, which granted Medicaid agencies the flexibility to make telehealth policy changes that best serve their populations.

The CMS presentation was followed by Erica Bonnifield, Assistant Deputy Director over Health Care Benefits & Eligibility within the California Department of Health Care Services (DHCS). Ms. Bonnifield gave an overview of Medi-Cal's pre-PHE telehealth policy, and additional temporary telehealth policy flexibilities provided during the PHE based upon various state and federal authorities. Similar to other states, California DHCS implemented additional flexibilities for Medi-Cal covered benefits and services provided via traditional telehealth as well as other virtual/telephonic (audio-only) communication modalities, and implemented payment parity for virtual/telephone (audio-only), subject to certain requirements. Lastly, Ms. Bonnifield provided lessons learned from the PHE through anecdotal feedback from the provider and broader stakeholder communities on the impact of temporary flexibilities, and finally announced the release of the Department's post-PHE telehealth policy recommendations.[3] Those recommendations were released publicly on February 2, 2021. CCHP has produced a Fact Sheet on the Medi-Cal telehealth policy recommendations and changes, which can be viewed here.

The first webinar concluded with a presentation by Dr. Shannon Dowler, Chief Medical Officer for North Carolina's Medicaid program. Dr. Dowler gave an engaging overview of the over 100 telehealth policies that North Carolina Medicaid adopted or revised in response to the PHE. Dr. Dowler also presented data from various evaluations that North Carolina Medicaid conducted to assess the impact of the agency's policy changes. Rapid

evaluation was one of North Carolina Medicaid's key strategies to keeping providers and the public informed about the impact of these changes. The Department created a series of dashboards and data visualization tools to track telehealth service utilization on a regular basis. Interestingly, North Carolina Medicaid initially saw a higher utilization rate for audio-only services compared to audio-visual services. This trend decreased as the state scaled up its telehealth expansions and more beneficiaries utilized telehealth.

Table 1. Odds of Teleservice Utilization Among Groups



Source. North Carolina Department of Health. https://www.cchpca.org/sites/default/files/2021-01/CCHP%20Webinar%201%20-%20Waivers%20%26%20State%20Plan%20Amendments.pdf

Dr. Dowler's presentation also highlighted the success and potential challenges of telehealth in a diverse state with a large rural population. The odds that beneficiaries with chronic conditions utilized telehealth during 2020 were nearly 3 times greater than the odds of telehealth service utilization among beneficiaries without chronic conditions. At the same time, rural and Black beneficiaries in North Carolina Medicaid were equally less likely to utilize telehealth services during 2020.[4] Dr. Dowler noted that, among the primary policy changes, she expects reimbursement for federally qualified health centers (FQHCs) to become permanent in North Carolina Medicaid. The data-rich presentation gave attendees a clear understanding of the positive impact that North Carolina's telehealth policies have had on access to care and areas of further study to bridge the digital divide in rural areas of the state. You can view additional data presented during the webinar on CCHP's Resources page using the source link under Table 1.

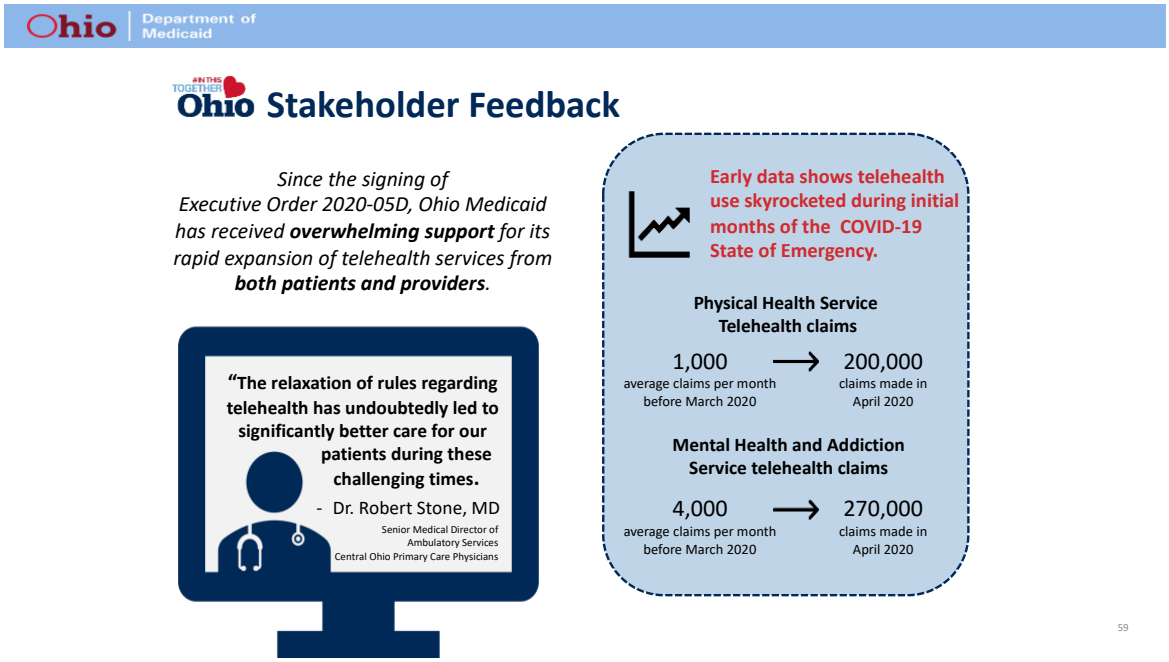
Webinar 2: Provider Engagement and Education During the Public Health Emergency

The second webinar in the series took place on January 22, 2021 and featured presentations on the unique ways that Medicaid programs engaged and educated Medicaid providers about new telehealth policies. Medicaid experts from Nevada and Ohio's Medicaid programs provided a high-level overview of their provider outreach strategies, which included provider resource webpages, a provider outreach hotline, stakeholder meetings, and updated billing and policy guidelines.

Nevada Medicaid's presenter, DuAne Young, serves as the Deputy Administrator overseeing telehealth policy in the Department. Mr. Young noted that telehealth in Nevada has been an important service modality for its Medicaid population because the state is primarily rural. Of the 17 counties in Nevada, 15 are defined as rural or frontier with low population density and a lack of participating providers. Because of their unique geography, Nevada leverages participating providers from neighboring states to achieve network adequacy for telehealth services. Nevada Medicaid established a robust online provider resource presence that included webinar trainings, a telehealth resource guide, a COVID-19 email address for providers, and regular provider announcements posted to the Department's provider portal.

Nichole Small, a Health Systems Administrator with Ohio Medicaid, noted that Ohio took a very similar approach to provider outreach. As with most Medicaid programs, updated billing and telehealth resource guides were used to keep providers in both fee-for-service and managed care delivery abreast of policy changes. However, stakeholder feedback was also central to Ohio Medicaid's approach. Ms. Small indicated that provider feedback so far has been overwhelmingly positive.[5]

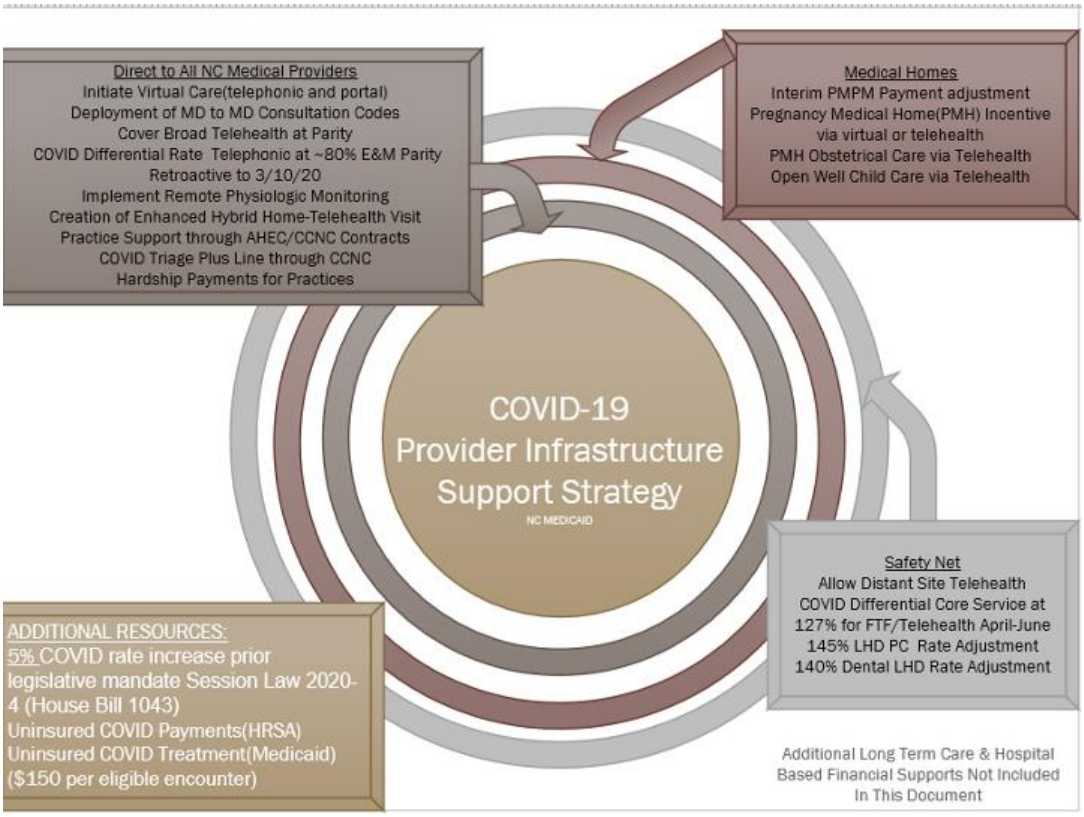
Figure 1. Stakeholder Feedback in Ohio Medicaid



Source. Ohio Department of Medicaid. https://www.cchpca.org/sites/default/files/2021-01/CCHP%20Webinar%202%20-%20Provider%20Engagement%20%26%20Education.pdf

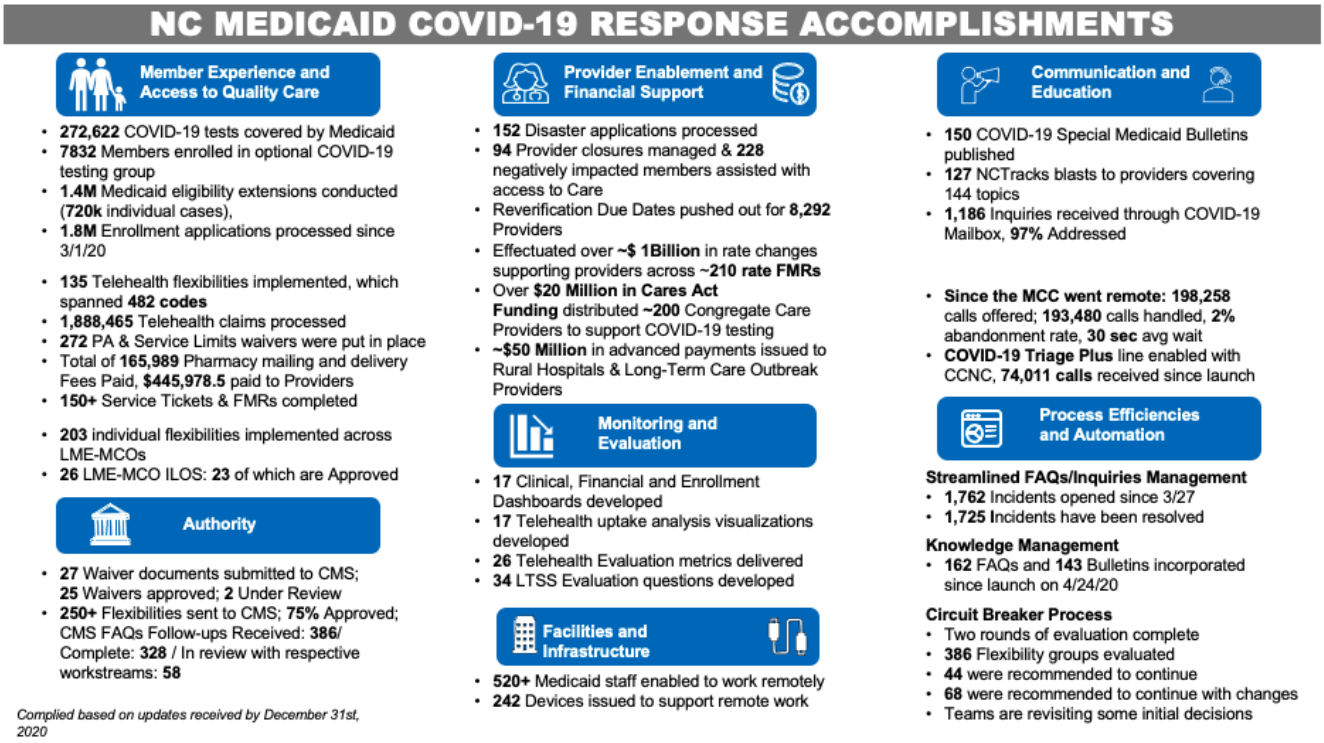
Dr. Shannon Dowler also returned for the second webinar to present North Carolina Medicaid's robust provider outreach strategy. According to Dr. Dowler, what made North Carolina's outreach strategy so effective was transparency and bidirectional communication between the agency and providers. To that end, North Carolina Medicaid hosted over 87 training webinars and a weekly "fireside chat" webinar for the state's Medicaid providers to seek technical assistance on billing and telehealth policy issues. In all, North Carolina's provider outreach webinars reached 37,071 providers. The Department created a provider email address, an online COVID-19 Knowledge Center that includes a searchable database of frequently asked questions for providers, and special incentive payments for telehealth utilization.[6]

Figure 2. COVID-19 Provider Infrastructure Support Strategy



Source. North Carolina Department of Health. https://www.cchpca.org/sites/default/files/2021-01/CCHP%20Webinar%202%20-%20Provider%20Engagement%20%26%20Education.pdf

Figure 3. North Carolina Medicaid Provider Support Outcomes



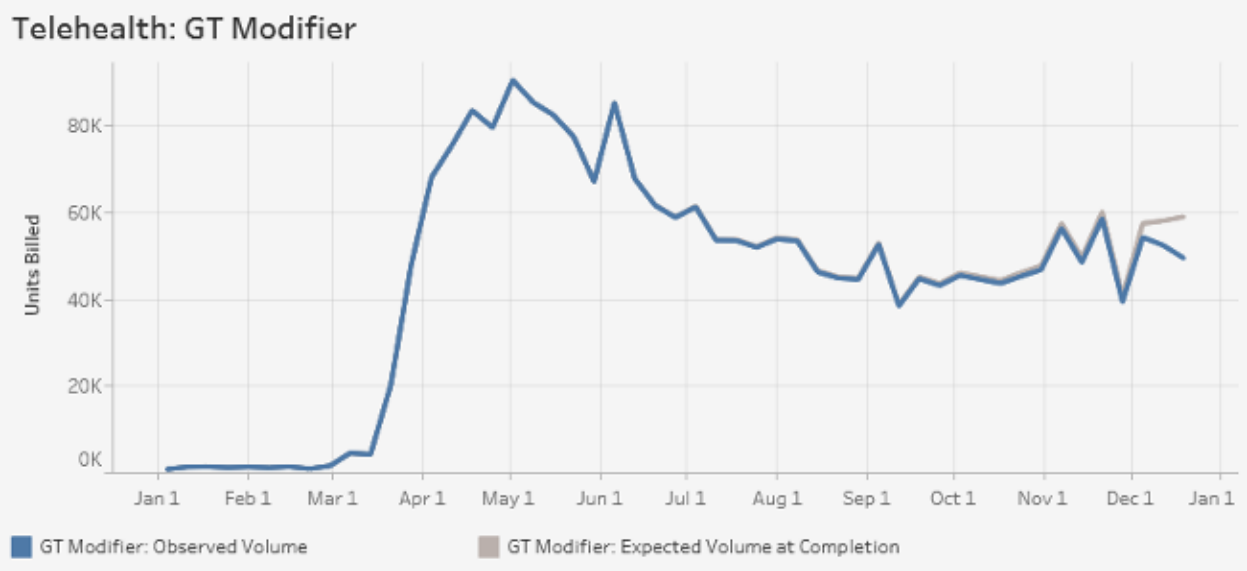
Source. North Carolina Department of Health. https://www.cchpca.org/sites/default/files/2021-01/CCHP%20Webinar%202%20-%20Provider%20Engagement%20%26%20Education.pdf

Webinar 3: Patient Engagement & Education During the Public Health Emergency

On January 29, 2021, panelists from Maine, Oklahoma, and Virginia's Medicaid programs detailed their strategies to increase telehealth access during the PHE through service expansions and beneficiary engagement and education. Director of MaineCare, Michelle Probert, and MaineCare Communications Director, Sarah Grant, presented data showing the state saw a 9,000% increase in telehealth utilization immediately following the introduction of expanded telehealth services. This averaged out to 1,000 telehealth encounters billed each week.[7]

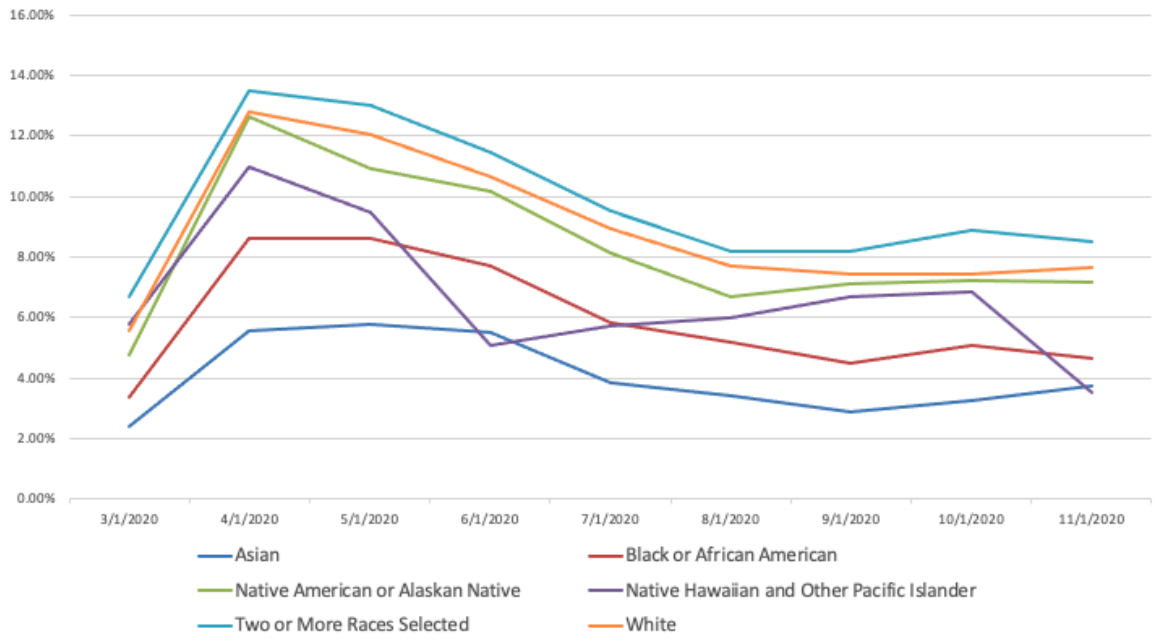
Ms. Probert noted that at one point, 12% of all MaineCare members were utilizing telehealth to receive healthcare services. As with other states, Maine experienced higher telehealth utilization among White beneficiaries compared to Black, Asian, and other racial or ethnic minority groups. However, MaineCare also found that multiracial beneficiaries (e.g., two or more races) consistently had the highest telehealth utilization rate from the onset of the PHE through November 2020. See Tables 2 and 3 and MaineCare's presentation for more data on these trends.[7]

Table 2. Telehealth Utilization in MaineCare Using GT Modifier (January 2020 – January 2021)



Source. Maine Department of Health and Human Services. https://www.cchpca.org/sites/default/files/2021-01/Webinar%203_Patient%20Engage-FINAL.pdf

Table 3. Telehealth Utilization Among MaineCare Beneficiaries by Race/Ethnicity



Source. Maine Department of Health and Human Services. https://www.cchpca.org/sites/default/files/2021-01/Webinar%203_Patient%20Engage-FINAL.pdf

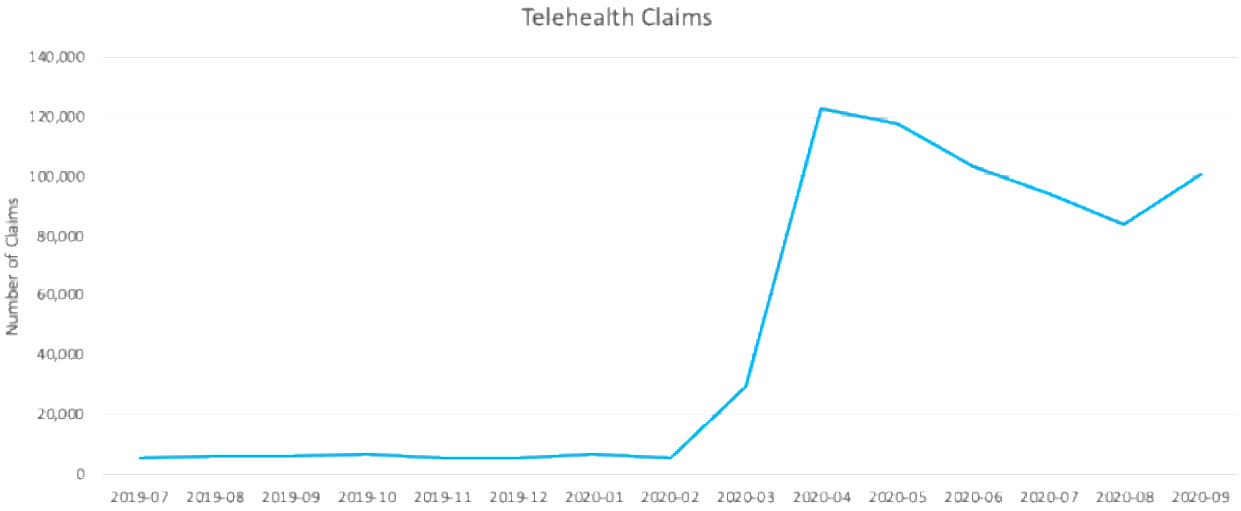
MaineCare's success in promoting telehealth utilization was in part due to their aggressive beneficiary outreach strategy that included a "one-stop-shop" resource website for beneficiaries, direct mailers to 177,531 beneficiaries, and a digital media campaign explaining the new services. MaineCare targeted social media ads using Instagram's "Stories" feature and a video explaining the expanded telehealth benefit to beneficiaries. MaineCare's presenters noted that more robust evaluations of the impact of the beneficiary outreach campaign have not been conducted. However, early indicators from website traffic, media downloads, content views, and overall service utilization suggest it was successful.[7]

In Oklahoma, a demonstration grant and member satisfaction surveys were two key strategies that the state's Medicaid agency used to engage beneficiaries around telehealth. Deputy State Medicaid Director, Traylor Rains, discussed findings from Oklahoma's member satisfaction survey which showed that roughly 70% of Oklahoma Medicaid beneficiaries reported an interest in receiving care through telehealth. Mr. Rains noted that, in some cases, the results of member and provider satisfaction surveys tend to show a preference for telehealth as a result of telehealth expansions during the PHE. Oklahoma also found that telehealth utilization rates among older adults enrolled in Oklahoma Medicaid were low, so the Health Care Authority is in the process of conducting outreach to nursing homes and assisted living facilities on Oklahoma's telehealth policy and to build capacity to deliver telehealth services in these facilities. Oklahoma is also a Certified Community Behavioral Health Demonstration Grant state, which enabled certain qualified providers to invest in telehealth equipment for eligible members.[8]

The Virginia Department of Medical Assistance Services (DMAS) took a similar approach to beneficiary outreach. Dr. Chethan Bachireddy, Virginia Medicaid's Chief Medical Officer, presented that Virginia Medicaid's Managed Care Organizations (MCOs) conducted outreach to their over 1.6 million beneficiaries through mail, email, text message, and social media, as well as providing certain beneficiaries with iPads or phones to conduct telehealth visits. Virginia Medicaid's beneficiary outreach also emphasized vulnerable populations who might be adversely impacted by the pandemic, such as those with substance use disorders (SUDs) or significant behavioral health needs.

At the onset of the pandemic, Virginia Medicaid introduced new telehealth policies including allowance of home as an originating site, audio-only visits, eConsults, and remote patient monitoring for COVID-19. They engaged extensively with providers through newsletters and seminars about new telehealth flexibilities. Telehealth visits in Virginia Medicaid peaked at just over 120,000 during April 2020 - 15 times higher than prior to the PHE - averaging over 90,000 per month through September (Table 4).[9]

Table 4. Telehealth Utilization Among MaineCare Beneficiaries by Race/Ethnicity



Source. Virginia Department of Medical Assistance Services. https://www.cchpca.org/sites/default/files/2021-01/Webinar%203_Patient%20Engage-FINAL.pdf

Whereas other Medicaid programs saw higher utilization among White beneficiaries, Dr. Bachireddy shared that the relative share of telehealth visits actually increased by 8% among Black/African American beneficiaries from March to September 2020. Dr. Bachireddy noted that it's possible that the telehealth flexibilities, extensive provider engagement, and beneficiary outreach campaign were effective in ensuring more equitable use of telehealth services.[9]

Webinar 4: What's Next? A Roadmap for Medicaid Telehealth Policy Beyond the Pandemic

The Winter series wrapped up with the final webinar on February 5, which hosted an expert panel featuring panelists from MACPAC and Medicaid administrators from Arizona, Colorado, and Oregon. A looming question for telehealth policy experts in both the Medicaid and Medicare spheres is around which telehealth expansions or flexibilities will become permanent after the PHE ends. Experts came together for the final webinar to discuss how their states will approach those policy decisions and which services or flexibilities might become permanent.

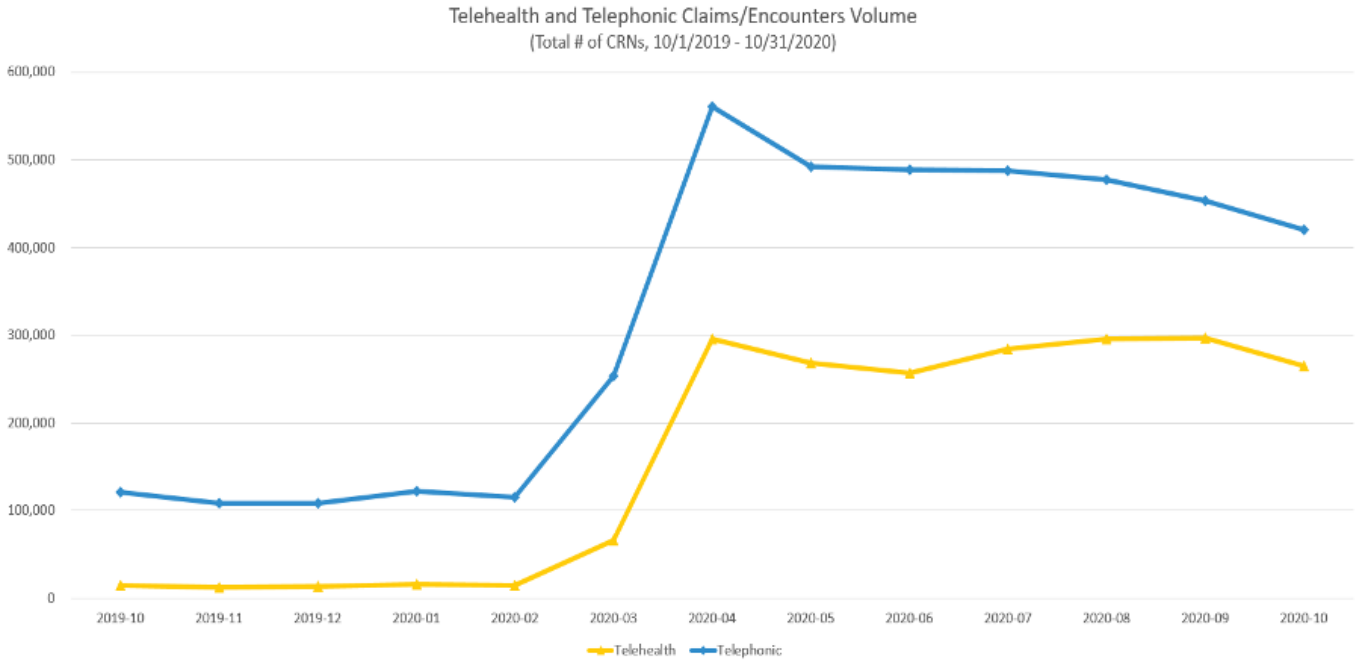
Joanne Jee, Principal Analyst with MACPAC, laid the foundation for the webinar by discussing MACPAC's role in providing analysis to and advising states, Congress, and the U.S. Department of Health and Human Services on federal Medicaid and CHIP policy. MACPAC is federally-designated by the Government Accountability Office to be responsible for providing analysis and technical assistance to Congress on Medicaid and Children's Health Insurance Program (CHIP) issues. MACPAC also develops telehealth resources and reports for health policy audiences on healthcare access, service utilization,

and financing. Ms. Jee provided an overview of the history of Medicaid telehealth policy, emphasizing the states have substantial flexibility within Medicaid rules to cover telehealth services. States have substantial flexibility within federal Medicaid rules to cover telehealth. Ms. Jee also pointed out that, prior to the PHE, most states had some sort of coverage of telehealth and that many states leveraged existing federal Medicaid flexibilities to expand telehealth coverage and use in their programs during the PHE.[10]

In her presentation, Ms. Jee cited CMS's data snapshot showing that telehealth utilization in Medicaid and CHIP between March and July 2020 increased 2,846% from the same period in 2019, based on preliminary data. Ms. Jee noted that state approaches to a host of factors in designing their post-COVID telehealth policies will be of interest to policy community. These include for example payment, network adequacy, qualify and outcomes, and preventing fraud.[10]

Dr. Sara Salek, Chief Medical Officer for the Arizona Medicaid Program, the Arizona Health Care Cost Containment System (AHCCCS), provided an in-depth overview of the telehealth expansions implemented in Arizona's Medicaid program. These included the addition of over 150 new procedure codes to the existing telehealth services list and a temporary code list for covered audio-only services. Arizona also required managed care organizations to reimburse telehealth and audio-only services at the in-person rate and provide telehealth coverage for all contracted services. As a result, Arizona saw an audio-only claims and encounters increase from just over 100,000 in February 2020 to around 550,000 in April 2020. During that same period, telehealth claims and encounters climbed to 300,000 (Table 5).[11]

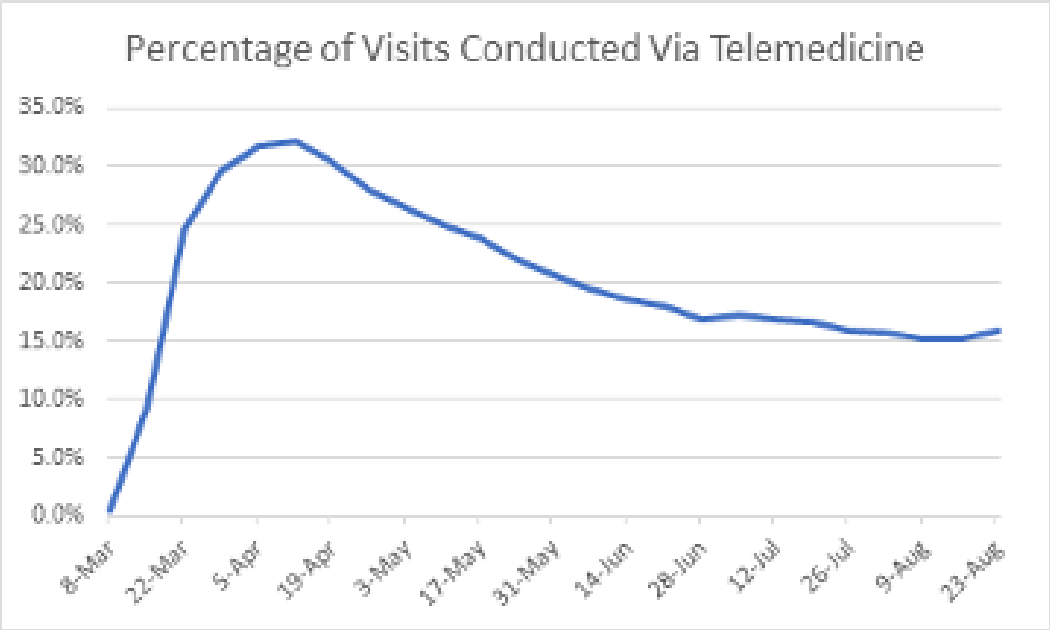
Table 5. Telehealth and Telephonic Claims/Encounters Volume



Source. Arizona Health Care Cost Containment System. https://www.cchpca.org/sites/default/files/2021-02/Webinar%204%20-%20What%27s%20Next%20FINAL.pdf

Looking ahead, Arizona has extended their telehealth flexibilities through September 2021 and is in the process of finalizing the telehealth and audio-only codes to be included in AHCCCS' permanent telehealth policy. Dr. Salek indicated that AHCCCS expects to finalize those decisions by July 2021. Dr. Salek noted that although they will need to evaluate quality of care and other factors, AHCCCS intends to maintain all the temporary telehealth codes in their permanent policy. A pending parity bill introduced in the Arizona legislature will directly impact private health insurance telehealth coverage; although this bill does not directly pertain to AHCCCS, it will have an indirect impact on AHCCCS telehealth coverage if passed.[11]

Table 6. Percentage of Visits Conducted via Telemedicine at a Percentage of all Telemedicine-Eligible Visits (March – August 2020)



Source. Colorado Department of Health Care Policy & Financing. https://www.cchpca.org/sites/default/files/2021-02/Webinar%204%20-%20What%27s%20Next%20FINAL.pdf

Colorado's Medicaid program introduced a slate of telehealth expansions in March 2020, including coverage for audio-only and live chat; permitting physical and occupational therapists and pediatric behavioral health providers to deliver telehealth services; and pay parity for all services. Colorado also expanded its list of eligible telehealth providers to include FQHCs and rural health clinics (RHCs). Colorado's Medicaid Director, Dr. Tracy Johnson, indicated that the Department has begun evaluating the impact of these telehealth expansions and found substantial increases in utilization as a result. Most notable, telemedicine visits accounted for over 30% of all telemedicine-eligible visits at its peak in mid-April 2020 (Table 6). In June 2020, Colorado made these changes permanent through the state legislature.[12]

Based on this initial data, Colorado has observed that children and adults with SUDs, chronic conditions, and disabilities have become the drivers of telehealth utilization. However, Colorado has also seen higher utilization in urban parts of the state compared to rural parts. This mirrors what other states featured in the webinar series found as well and Dr. Johnson noted that this may have implications for health equity. Beyond the PHE, Colorado will continue to evaluate the impact of both the temporary and permanent changes to understand its impact on utilization and the state's reimbursement methodology. On March 9, 2020, the Colorado Department of Health Care Policy & Financing released a comprehensive analysis of telemedicine utilization in Medicaid during the PHE.[13] Dr. Johnson also noted that Colorado Medicaid will assess future coverage and capability for eConsults.[12]

Lori Coyner, Director of the Oregon Health Authority (OHA), shared a similar experience in Oregon's Medicaid program. After a series of telehealth flexibilities were introduced in Oregon, telehealth visits in April 2020 peaked at roughly 40 times higher than pre-pandemic levels. As in Colorado, Oregon moved quickly to update its permanent telehealth coverage for 2021 with some of these flexibilities. As of January 2021, the OHA has permanently expanded the originating site to the patient's home, removed the existing patient-provider relationship requirement, and now reimburses telehealth services at the in-person rate.[14]

Ms. Coyner stated that Oregon's future telehealth strategy beyond the PHE includes centering health equity in access to telehealth services and improving alignment of payer's telehealth policies across public and private payers. One of the ways that Oregon will address health equity beyond the pandemic is by ensuring that non-English speaking beneficiaries or those with hearing or language disability have access to interpreters during the telehealth visit. Oregon now requires providers and the state's coordinated care organization network to reimburse for interpretation services and at the same rate as if the service were provided in person.[14]

Conclusions

Medicaid administrators often point out that when you have seen one Medicaid program, you have seen one Medicaid program. When you consider the patchwork of telehealth coverage across states and their diverse responses to the PHE, it becomes important to compare policies and share best practices across state lines. Through the Winter series, several high-level themes emerged from each state's telehealth experience:

- Utilization Growth: Telehealth visits increased significantly in Medicaid programs following the introduction of flexibilities and new coverage. Presenters shared data that showed large growth in telehealth visits through the early months of the pandemic in Spring 2020, with visits typically peaking in April 2020, but then dropping there afterward. Some Medicaid administrators think utilization will continue to be higher than pre-pandemic levels, but will be lower than the utilization rate seen during COVID-19.
- Health Equity: Nearly all of the Medicaid administrators who participated in the webinar series indicated that the COVID-19 pandemic exacerbated disparities in access to healthcare services and many communities do not have the necessary technology or broadband to utilize telehealth. Because Medicaid programs provide coverage to medically underserved and at-risk populations, health equity will remain a high priority for these programs as they develop their telehealth policies. It is important to keep in mind that disparities in access to telehealth services are a reflection of other existing inequities, namely the digital divide. Ensuring that future or permanent Medicaid telehealth expansions reach rural and underserved patients

will depend on other initiatives such as broadband access and infrastructure development at the state and federal level.

- Evidence-Based Policy: Medicaid programs emphasized that monitoring and evaluation will continue to guide decision-making on telehealth policy during and beyond the PHE. In particular, Medicaid programs will continue to track the impact of temporary policy on utilization, monitor the digital divide, evaluate the quality of audio-only services, and measure beneficiary satisfaction with telehealth services.
- Permanent Changes: Across all four webinars, Medicaid administrators indicated that some temporary telehealth policies would become permanent. States like Colorado, Oregon, and North Carolina have already made certain flexibilities permanent, while others await CMS guidance on audio-only services or optional services such as physical therapy and dentistry.

The Winter webinar series was successful in reaching diverse public health audiences and creating a platform for Medicaid agencies to share their experiences with telehealth policy during the pandemic. Furthermore, CCHP received overwhelmingly positive feedback from attendees and stakeholders for the Winter series. Attendees noted in webinar evaluation surveys that the webinars were engaging and well-organized, and that they filled a crucial gap in synthesizing and explaining Medicaid policies. Telehealth & Medicaid: A Policy Webinar Series will return this Spring for four new webinars on April 30, May 7, May 14, and May 21, 2021. We invite our diverse network to stay tuned for more information about topics and presenters for the Spring series.

Please visit CCHP's Events page to learn more about the Spring series and register for future webinars.

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