Center for Connected Health Policy

THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

Medicaid & Telehealth: Summary and Findings from the Spring Webinar Series

Center for Connected Health Policy
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INTRODUCTION

COVID-19 has forever changed many aspects of our lives, including how health care is delivered. With the advent of the pandemic, a quick pivot to the use of telehealth to provide services was made, necessitating in many temporary telehealth policy changes on the federal and state level. Much attention has been paid to federal Medicare telehealth policy changes, but there has been less focus on the actions taken by state Medicaid programs. The Center for Connected Health Policy's (CCHP) Medicaid telehealth policy webinar series was conceived to address this gap in knowledge and also provide a forum for states to share their innovative work on telehealth policy and engage with other state Medicaid programs.

The Spring Series took place every Friday between April 30 and May 21, 2021 and provided attendees updates on telehealth policy activities taking place across nine different Medicaid programs. The Winter Series that took place earlier in the year focused on the changes made in response to COVID-19. The purpose of the Spring Series was to examine specific areas of telehealth policy. CCHP is planning another installment of the series in Fall 2021. The webinar series is supported in part by federal CARES Act funding and the Human Resources & Services Administration (HRSA).

THE SPRING SERIES

CCHP selected four different topics for the Spring Series based on feedback provided by attendees of the Winter Series and policy trends. The four topics were:

- Access and Equity in Medicaid Telehealth Policy
- Medicaid Telehealth Policies for Children and Youth
- Medicaid Telehealth Policies for Seniors
- Telemental Health & State Medicaid Policies

Across the four webinars, nearly 2,000 people registered and nearly 1,000 attended. The majority of attendees represented public health agencies, hospitals and doctors' offices, safety net clinics, and non-profit policy and advocacy organizations. A total of nine states participated as speakers.

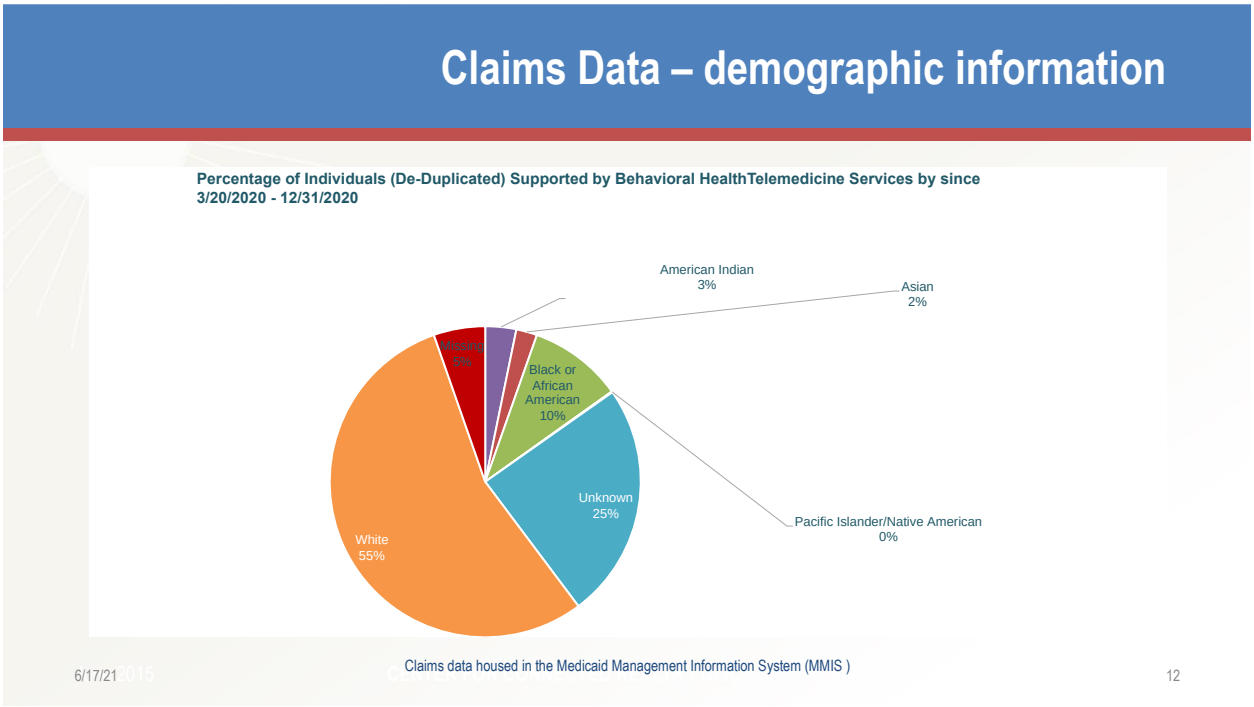
Webinar 1: Access & Equity in Medicaid Telehealth Policy

The first webinar took place on April 30, 2021 and focused on access and equity issues and how telehealth policies address them. Representatives from three state Medicaid programs, Minnesota, New York and Washington, spoke about their experiences and policies.

Dr. Julie Marquardt, Deputy Assistant Commissioner and Deputy Medicaid Director, Health Care Administration and Dr. Neerja Singh, clinical Behavioral Health Director, from the Minnesota

Department of Human Services spoke of the steps Minnesota took on telehealth policy when the pandemic began. Dr. Marquardt noted that in the beginning of the public health emergency (PHE) they had to focus on the immediate needs of their enrollees. One area that definitely rose to the top was related to the provision of behavioral health services. It also became apparent that with the speed the Medicaid program had to move to enact policies so enrollees could receive services, that capturing data might be limited. However, there was the desire to be able to capture data as best as could be done in order to review and assess the impacts. Minnesota Medicaid focused in on physical and behavioral health treatment services to study, leaving aside other services such as long-term services and supports. Minnesota approached it through stakeholder interviews, literature studies, and claims data. Time and resource constraints precluded authentic engagement necessary to gather feedback from enrollees, however, that work is planned as part of the next phase. What they did find from the data was that white populations used telehealth services the most. In surveying providers, they believed that telehealth has improved access to patients, particularly those who may need to travel long distances to receive care. The study was limited in that the efficacy of telehealth was not surveyed, nor patient experience.

Figure 1. Minnesota Medicaid Claims Data – Demographic Information

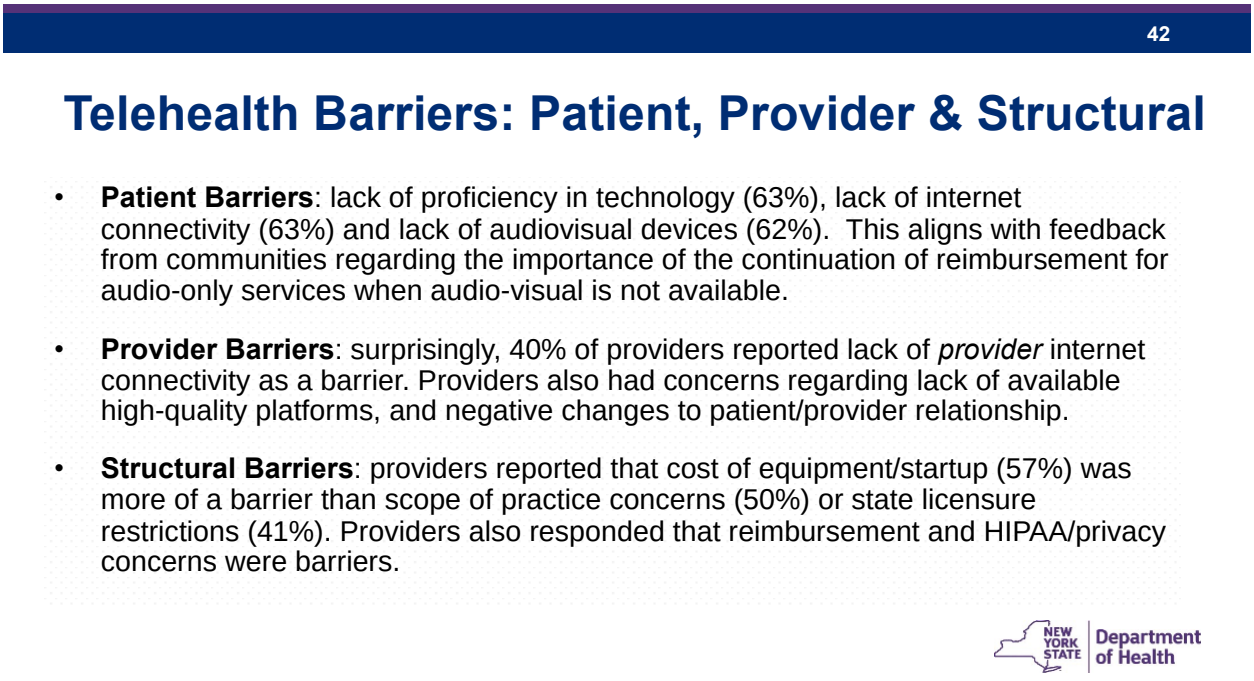


Source. Minnesota Medicaid Management Information System.

The next speakers were from New York, Kendra Muckle, Division of Program Development and Management and Megan Prokorym of the Office of Primary Care and Health Systems Management, Health Care Transformation Group. Ms. Prokorym noted that New York was already working on modernizing their telehealth policies when the pandemic occurred. COVID-19 expanded these policies even more and New York began to look at how to operationalize

these changes to reduce barriers and increase access. They utilized workgroups to focus in on evaluating services and identifying opportunities to utilize telehealth but also looked at claims data to look at what services their high need populations needed. A dashboard New York created is useful to assess where to targets efforts to increase utilization. The Medicaid program's goal is to address health disparities. Another barrier to utilizing telehealth New York encountered is connectivity, which is something both patients and providers cited as an issue, and digital literacy. New York has created an in-home facilitator pilot meant to assist members who have difficulty utilizing technology.

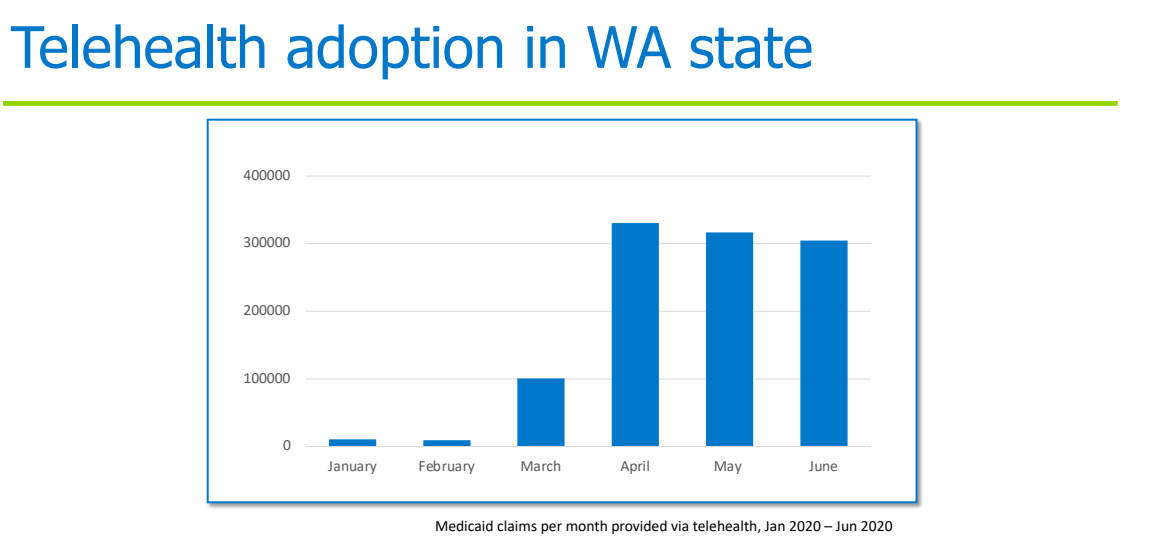
Figure 2. New York Medicaid Identified Telehealth Barriers



Source: New York Department of Health

The final speaker for this webinar was Dr. Christopher Chen, Medical Director for Washington Medicaid. Dr. Chen noted that similar to the other Medicaid programs, Washington Medicaid had a fairly broad, flexible approach to telehealth policy before the pandemic. When COVID-19 hit, the policies were expanded. Additionally, to provide direct support to patients and providers, the program obtained 2000 HIPAA compliant platform licenses for providers and also donated 6,000 cell phones to clients in need. Dr. Chen also spoke of the West Coast compact that several states including California, Colorado, Nevada and Oregon have joined to work on issues related to telehealth. The guiding principles of this group touch upon Access, Confidentiality, Equity, Standard of Care, Stewardship, Patient Choice and Payment/Reimbursement. For access and equity, Dr. Chen stressed the need not to inadvertently create or exacerbate disparities. He also touched upon the concept of telehealth and value and that Washington state has a target percentage of healthcare purchasing linked to value according to the HCP-LAN framework.

Figure 3. Telehealth Adoption in Washington State



Source: Washington State Health Care Authority

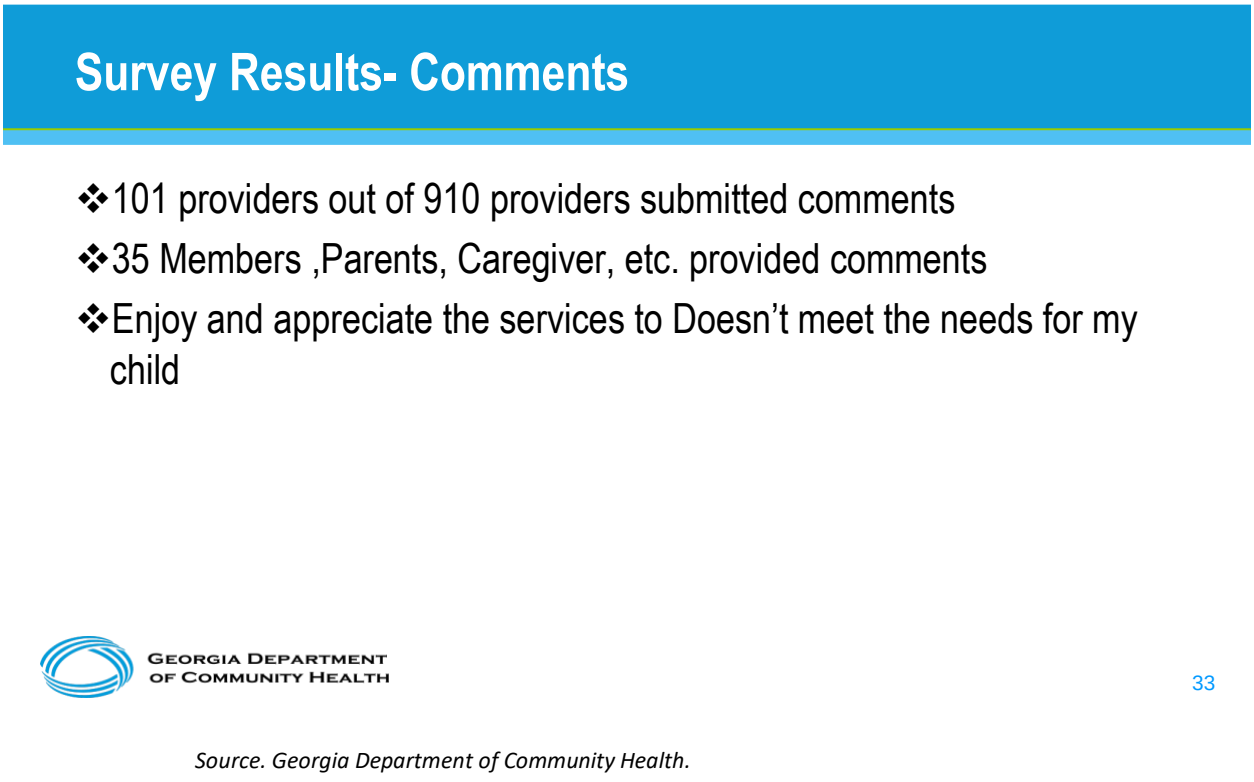
Webinar 2: Children & Youth

The second webinar in the series took place on May 7, 2021 and featured presentations on Medicaid programs and telehealth delivered services to children and youths. Representatives from Georgia and Kansas spoke.

Catherine Ivy, Deputy Executive Director, Georgia Department of Community Health and Rebecca Dugger, Director Program and Community Support, Division of Medicaid noted that their telehealth policies covered all Medicaid populations including children and youths. Before the pandemic, Georgia Medicaid was also covering services delivered in a school setting through local education agencies. In response to COVID-19, Georgia Medicaid expanded the availability of telehealth-delivered services to their enrollees. Significantly, the program allowed the home to be an eligible originating site and waived the need for a pre-existing relationship and allowing some flexibilities with platforms used and providers operating across state lines. These relaxations were particularly important for children needing general pediatric and pediatric therapy services as well as behavioral health services. In June of 2020, the Georgia Department of Community Health began collecting provider and member experiences using a web-based survey to look at the efficiency of telehealth during the PHE. Respondents included providers, patients and parents and caregivers. While there were many positive comments regarding the use of telehealth, there were also concerns noting some services were not best suited for delivery over technology and some patients, including young children, may not be

able to fully benefit from a telehealth encounter and parents reported that they generally respond better to an in-person interaction.

Figure 4. Georgia Medicaid Survey Results



Source. Georgia Department of Community Health.

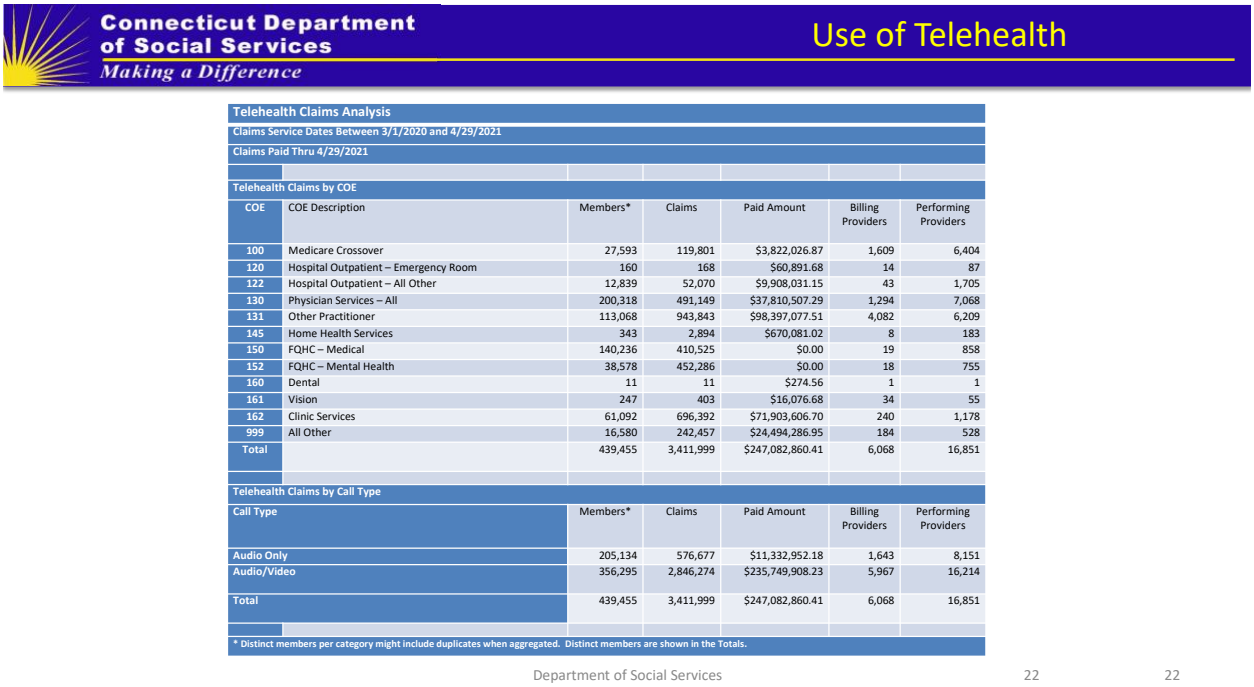
Fran Seymour-Hunter, Interagency Liaison and Brenda Kuder, Contract Nurse Consultant are from the Kansas Department of Health and Environment. Kansas has reimbursed for medical school-based services since 1997. They began allowing telehealth to be used in school-based settings in January 2019. Initially it was limited to speech-language and audiology, but was expanded in response to COVID-19. Currently, they provide additional services such as occupational and physical therapy and preventive medicine counseling. The services must be medically necessary. Telehealth in schools was well-received by both the student and the family. Kansas found it very important to keep lines of communications open among the various agencies to identify necessary services and keep providers updated on any changes.

Webinar 3: Telehealth in Medicaid and Seniors

On May 14, 2021, panelists from Connecticut and California's Medicaid programs detailed their policies to address the needs of seniors in Medicaid via telehealth.

Kate McEvoy, Director of Health Services, Connecticut Department of Social Services noted that prior to the pandemic, they did not have any applied experience with telehealth but had to rapidly expand and deploy in the face of COVID-19. Connecticut utilized the flexibilities provided by the federal government in response to the pandemic to expand their own Medicaid policies related to telehealth. The flexibilities were authorized by executive order and included a broad portfolio of primary care, behavioral health, physical/occupational/speech therapy and other services. Additionally, various home and community-based services such as virtual assessments and reassessments were allowed to be provided via telehealth. While Connecticut Medicaid did allow for audio-only services, the majority of their claims have been live video.

Figure 5. Connecticut Medicaid Claims Analysis



Telehealth Claims Analysis
Claims Service Dates Between 3/1/2020 and 4/29/2021
Claims Paid Thru 4/29/2021

Telehealth Claims by COE

COE	COE Description	Members*	Claims	Paid Amount	Billing Providers	Performing Providers
100	Medicare Crossover	27,593	119,801	$3,822,026.87	1,609	6,404
120	Hospital Outpatient – Emergency Room	160	168	$60,891.68	14	87
122	Hospital Outpatient – All Other	12,839	52,070	$9,908,031.15	43	1,705
130	Physician Services – All	200,318	491,149	$37,810,507.29	1,294	7,068
131	Other Practitioner	113,068	943,843	$98,397,077.51	4,082	6,209
145	Home Health Services	343	2,894	$670,081.02	8	183
150	FQHC – Medical	140,236	410,525	$0.00	19	858
152	FQHC – Mental Health	38,578	452,286	$0.00	18	755
160	Dental	11	11	$274.56	1	1
161	Vision	247	403	$16,076.68	34	55
162	Clinic Services	61,092	696,392	$71,903,606.70	240	1,178
999	All Other	16,580	242,457	$24,494,286.95	184	528
Total		439,455	3,411,999	$247,082,860.41	6,068	16,851

Telehealth Claims by Call Type

Call Type	Members*	Claims	Paid Amount	Billing Providers	Performing Providers
Audio Only	205,134	576,677	$11,332,952.18	1,643	8,151
Audio/Video	356,295	2,846,274	$235,749,908.23	5,967	16,214
Total	439,455	3,411,999	$247,082,860.41	6,068	16,851

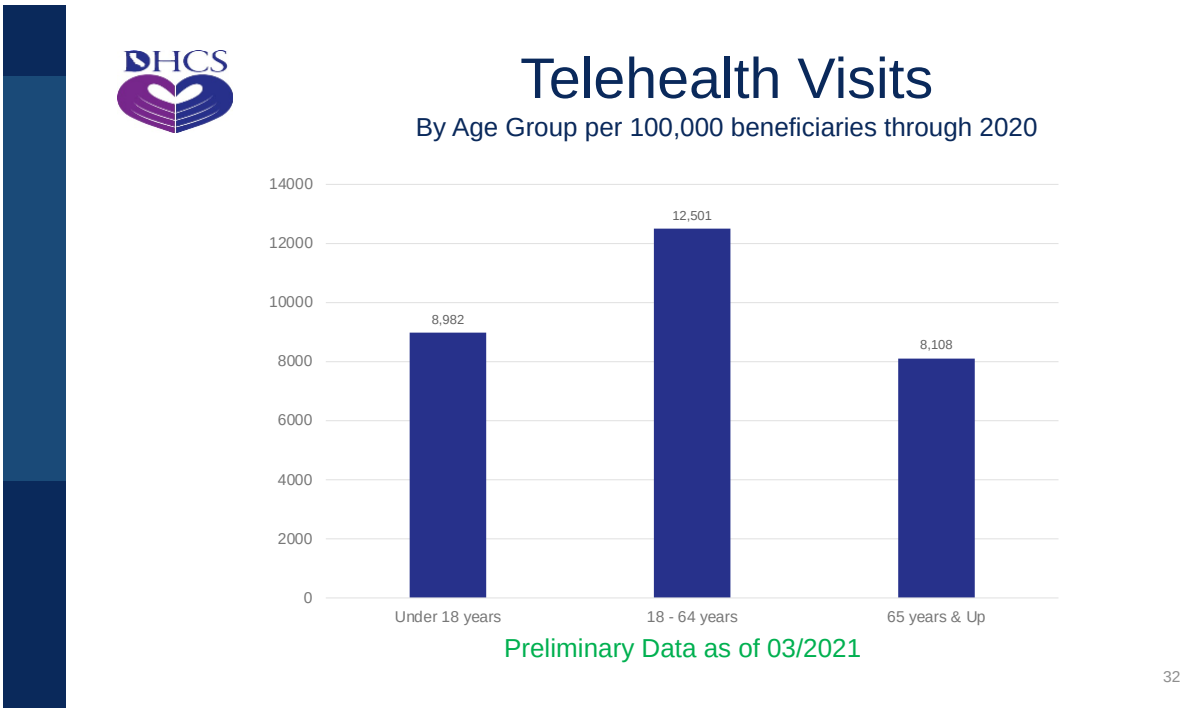
* Distinct members per category might include duplicates when aggregated. Distinct members are shown in the Totals.

Source: Connecticut Department of Social Services

Rene Mollow, Deputy Director of Health Care Benefits and Eligibility at the California Department of Health Care Services spoke next. Ms. Mollow provided an overview of the Department's telehealth policies before the pandemic and what temporary steps were taken in response to COVID-19. Those specific to seniors included flexibilities allowed to the Program for All Inclusive Care (PACE) that allowed all medically necessary services to be provided via telehealth and that Adult Day Health Care basic services can be provided through telehealth or other remote services. Additionally, Home and Community-Based Alternative Waiver flexibilities provided during COVID-19 included allowing telehealth to be used as an alternative to face-to-face interactions and using non-public facing remote communication projects to communicate with patients. Home Health Agencies were also allowed to utilize telehealth to

provide services. Ms. Mollow noted that California was in the midst of determining what flexibilities will be made permanent.

Figure 6. California Medicaid Preliminary Data



Source: California Department of Health Care Services.

Webinar 4: Telemental and Behavioral Health Services in Medicaid

The final webinar in the Spring series focused on Medicaid telehealth policies and telemental and behavioral health services, one of the specialties which most payers cover if technology is used to provide services. The topic delivered a robust discussion among the panelists that included representatives from Texas, Kansas and Massachusetts Medicaid.

Erin McManus, MPAff, Senior Policy Advisor and Tamra Boyd-Ostrout, LMSW, Behavioral Health Policy Analyst, Medical Benefits, Medicaid/CHIP Services Department provided an overview of Texas Medicaid's approach to covering mental and behavioral health services, including services related to substance use disorders (SUD). For telehealth, psychiatric diagnostic evaluations, psychotherapy and evaluation and management services are covered among others. Synchronous audio-visual interactions, synchronous audio interactions coupled with asynchronous store-and-forward technologies, or any other technology that meets the in-person standard of care may be used for service delivery. In Managed Care, audio-only telephone consultations and text-only email messages may optionally be covered. COVID-19 flexibilities included peer specialist services as well as SUD counseling and targeted case

management if provided via telehealth. Audio-only was also allowed for some services. Legislation has been introduced to make some of these flexibilities permanent.

Fran Seymour-Hunter from the Kansas Department of Health and Environment returned to talk about Kansas Medicaid's coverage of telemedicine and behavioral health services. Ms. Seymour-Hunter noted that initially telemedicine coverage for mental health services only covered consultation, office visits (E&M codes), individual psychotherapy and pharmacologic management. Pre-pandemic, additional MH services were added along with SUD services. With the advent of COVID-19, though general conditions for reimbursement (such as allowed Provider types and specialties) remained the same, some services were expanded to allow for telemedicine delivery. Kansas also allowed some services to be provided via telephonic contact along with some services being allowed in the home without the required presence of a provider with the beneficiary. Anticipating that some individuals might require Crisis Intervention services during the Public Health Emergency period, special allowance was given for this service to be provided via telemedicine to beneficiaries who were not established patients. In order for a Provider to appropriately bill for telemedicine crisis intervention services, the State Mental Health Authority had to review and provide approval of the individual crisis protocol to be utilized.

Wrapping up the final webinar for the Spring series was Massachusetts Medicaid where we heard from Clara Filice, MD, MPH, MHS, Deputy Chief Medical Officer. Dr. Filice noted that MassHealth introduced telehealth coverage for behavioral health services in March 2019. Exactly one year later the pandemic hit and MassHealth greatly expanded its telehealth policy including allowing the use of audio-only phone as a modality of delivering services. Dr. Filice noted that they saw peak utilization during April and May of 2020 but there was a gradual decrease and then utilization levels stabilized. Overall, a subset of members surveyed through community health centers had a satisfactory or better than in-person care experience and reported that they would like to continue using telehealth in the future. MassHealth is currently exploring other options for telehealth such as remote monitoring and e-consult. State legislation passed in early 2021 requires MassHealth to maintain parity rates between certain services on a specific schedule and permanently for behavioral health services whether they are rendered via live video or audio-only.

CONCLUSION

The Spring 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. 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 Fall with four new webinars in September 2021. We invite our diverse network to stay tuned for more information about topics and presenters for the Spring series.

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

