Center for Connected Health Policy

THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

State Telehealth Policy: Summary and Findings from the Summer 2022 Webinar Series

Center for Connected Health Policy
August 2022

This report was made possible by Grant #U6743496
from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

INTRODUCTION

Thrust into the forefront of healthcare with the advent of COVID-19, telehealth policy has taken a prominent place in discussions and actions on both the state and federal level. However, the telehealth policy landscape is complicated and ever-evolving with many trying to keep pace with multitude of changes and issues. For the Summer 2022 edition of the Center for Connected Health Policy's (CCHP) webinar series, the focus was more on state policy issues that have been of great interest to many. The Summer Series took place every Friday in the month of June.

THE SUMMER SERIES

While previous series have almost always focused on Medicaid policy, the Summer Series took a different track by examining other telehealth policy issues that are in the jurisdiction or have a significant impact on state policy. The webinars were:

- Webinar #1: **Telehealth in School-Based Programs** – June 3, 2022
- Webinar #2: **Telehealth and Licensure** – June 10, 2022
- Webinar #3: **Private Payer Telehealth Laws** – June 17, 2022
- Webinar #4: **Telehealth and Substance Use Disorders** – June 24, 2022

Across the four webinars, over 5,000 people registered and over 2,100 attended. The majority of attendees represented state or federal offices, public health agencies, hospitals and providers' offices, safety net clinics, and non-profit policy and advocacy organizations. The diversity of topics reflected the variety of attendees.

WEBINAR #1 – TELEHEALTH IN SCHOOL-BASED PROGRAMS

Prior to the pandemic, school-based telehealth had received significant interest for a variety of reasons. Whether it was shortages of school nurses, budget cuts, or the increased health concerns children faced, particularly around mental health issues, administrators and policymakers alike believed that telehealth could be an invaluable tool to addressing the health care needs in a school setting. The telehealth discussion and use took on increased importance during the pandemic as schools were close down and children were educated from home. However, while there was a fix for the education side of things, ensuring students who were receiving health services at school became another issue. The first webinar explored these challenges as well as providing different examples of the models that exist.

Christine Guinn, NAME Governmental Affairs Committee Chair & Deputy Bureau Chief, Exempt Services and Program Bureau, Medical Assistance Division, New Mexico Human Services Department

Ms. Guinn is not only with the New Mexico Human Services Department, she is also the Governmental Affairs Chair for the National Alliance for Medicaid in Education (NAME). Ms.

Guinn began her talk with a little bit of background on NAME. NAME is an organization that champions collaboration, integrity and growth for school-based Medicaid. Members are from State Medicaid Agencies, State Education Agencies, Local Education Agencies, professional organizations and billing/consulting companies. Ms. Guinn then provided an overview on the federal role on school-based health. She noted that in 2014, the Centers for Medicare and Medicaid Services (CMS) issued a letter to State Medicaid directors that allowed for more flexibility for school-based Medicaid. Schools would be able to seek out reimbursement for all covered services provided to children who were enrolled in Medicaid, regardless of whether the services are provided at no cost to other students. Previously Medicaid reimbursement was prohibited if the same services were provided free of charge to the general student population unless specifically included in a student's individual education plan (IEP) or individualized Family Service Plan (IFSP). Pre-COVID-19 telehealth use in schools encountered issues such as having reliable connectivity, lack of equipment and lack of eligibility for reimbursement, for example, the school not being an eligible originating site. However, COVID-19 changed this and waivers to reimbursement were sought, COVID Relief funds were used to address connectivity and equipment access issues and focusing on ensuring IEP services were provided regardless of a school's ability to bill Medicaid. Ms. Guinn noted that school-based Medicaid programs are administered in a variety of ways across the country. However, collaboration and cooperation between Medicaid and the Education agency is very important. She noted that in her own program the two state agencies share a common staff person who is aware of pertinent policy changes in both departments that will impact the program and thus be able to keep all parties updated and informed.

Nichole Small, Section Chief, Policy Management & Development and Meredith Schram, Health Systems Administrator, Ohio Department of Medicaid

Ohio Medicaid builds upon one of the elements that Ms. Guinn cited as important for a school-based Medicaid program to work successfully: collaboration between state agencies. Ohio's Medicaid and Education Agencies have built a very collaborative relationship over the years, most recently over how telehealth is used in a school setting. Ms. Small and Ms. Schram noted that Ohio Medicaid's Virtual School-Based Health was available to all students, not just those with an IEP, allowed for any medically necessary service, allowed for any eligible provider to provide that service and the Medicaid program worked closely with the Education Agency to resolve any issues. Ms. Small noted that Ohio Medicaid had greatly expanded its policies in response to COVID-19 and made many of these expanded policies permanent. She noted their data for common health conditions students enrolled in Medicaid were being treated for were mental/behavioral health. From January 2020 to February 2022, nearly 10,000 students have received services via telehealth from their schools. Ms. Schram provided information on a pilot program that was conducted in the Switzerland of Ohio school district. The pilot was to facilitate the use of telehealth to treat behavioral health and was launched in March 2020. In the first year of the pilot, 103 telehealth appointments were completed. Depression and anxiety were the most common conditions treated. Phase 2 of the project is ongoing.

Andrea Shore, Chief Program Officer, School-Based Health Alliance & Melanie Wild-Lane, Executive Director, Connecticut Association of School-Based Health Centers

Ms. Shore of the School-Based Health Alliance explained that a school-based health center is a shared commitment between a school, community and health care organization to support students' health, well-being and academic success by providing preventative, early intervention, and treatment services when the student is in school. She noted most school-based health centers were a traditional model where there is a fixed site on school campus and the provider is also onsite and may provide some services via telehealth. The National School-Based Health Care Census in 2016-2017 shows telehealth exclusive models made up about 12% of the school-based health centers. When looking at school-based health centers that incorporate telehealth, some also deliver care to satellite schools with the provider rotating through the schools at regular intervals to deliver in-person care. Reimbursement for telehealth in schools come from a variety of sources of both public and private payers as well as grants. If Medicaid is allowed for telehealth delivered services, along with reimbursement for those services and depending upon the program's policies, schools may also be able to receive an originating site fee if the student is on campus at the time of the telehealth interaction.

Ms. Wilde-Lane spoke next, talking about school-based health centers (SBHC) in Connecticut. Currently, these centers provide services in 29 communities, serving over 44,000 students. The SBHCs are fully-licensed primary care facilities and bill both Medicaid and commercial payers. As many other states also experienced, Connecticut's students faced increased mental health issues with the closure of schools during the pandemic. Telehealth visits for mental health conditions increased dramatically in those early months of COVID-19. There were, however, challenges as well such as missed appointments, blocked numbers, guardians not answering, and concerns from students over privacy. Programs worked with families to resolve these issues and telehealth use became stable. Legislation was passed to at least temporarily extend the telehealth exceptions from the pandemic to 2023. However, the state continues to study the use of telehealth.

<u>WEBINAR #2 – TELEHEALTH & LICENSURE</u>

State licensure of health care professionals has always been a major issue when discussing the use of telehealth. Many telehealth proponents saw the need to be licensed in every state the provider was operating in as a barrier to greater utilization of the technology. While much discussed prior to COVID-19, policy changes were slow with the most significant being the establishment of state licensure compacts. However, with COVID-19, the discussions took on more urgency as well as realization that not everyone was aware of the ways this issue has been addressed in the past and the impact on providers and patients.

Lisa A. Robin, Chief Advocacy Officer, Federation of State Medical Boards

Ms. Robin provided background information on the Federation of State Medical Boards (FSMB), an over 100-year old organization that represents all 70 of the state medical and osteopathic

boards across the United States. The FSMB has examined the issue of state licensure or licensure portability. Several years ago, it drafted model language for an interstate compact that would allow states to retain sovereignty on issues traditionally reserved for state jurisdiction but would allow for a more expedited process to obtain a license. Applying only to physicians, the Interstate Medical Licensure Compact (IMLC) is active in over 30 states and is in the process of onboarding several more. To be IMLC Eligible, the applicant must meet certain qualifications such as graduating from an accredited medical school and having a full and unrestricted license to practice medicine in a IMLC member state. From April 2017 – May 2022, more than 23,000 applications issued and more than 35,000 licenses issued. Ms. Robin also reported on the development a Physician Assistant licensure compact and that model legislation was expected to be finalized by the end of June 2022. Other work that FSMB is doing is adopting policy regarding the appropriate use of telehealth technologies in the practice of medicine. In this policy it was noted that there should be certain exceptions to licensure for practice across state lines, such as follow-up visits for a patient the physician has treated previously in-person.

Janet P. Orwig, Executive Director, PSYPACT

Ms. Orwig is the Executive Director for PSYPACT which is a licensure compact that includes 34 states as members. PSYPACT is for licensed psychologists. There is also a Counseling Compact with 10 state members and a Social Worker Compact is underdevelopment (expected to be ready in 2023). Arizona was the first state to pass legislation for PSYPACT in 2016. The Compact became active in 2019 when the minimum number of states to activate it was achieved. The Compact is designed to regulate the day-to-day practice of telepsychology across state boundaries and/or the temporary in-person, face-to-face practice of psychology for up to 30 days annually. PSYPACT has allowed or increased access to care, facilitating continuity of care and allowed providers to readily know legal requirements. PSYPACT is overseen by a Commission where each Compact Member state has one representative. For PSYPACT, when telepsychology is employed, the practice of psychology takes place where the practitioner is located and licensed. Comparing 2020 to 2021, PSYPACT saw a tripling of applicants.

Brian Hasselfeld, Medical Director, Digital Health and Telemedicine, Office of Johns Hopkins Physicians Primary Care Physician, Internal Medicine and Pediatrics, Johns Hopkins Community Physicians

Dr. Hasselfeld provided a practitioner's view on the licensure issue. He noted that during the pandemic, telehealth has been generally used to substitute for in-person care. While telehealth was used quite often for mental and behavioral health, it was also used for advanced specialties like genetics, anesthesia/pre-operative medicine, neurology and neurosurgery. Patient testimonials note support for telehealth as it continues to be personal and efficient, providing benefits both during the pandemic and beyond. Dr. Hasselfeld next spoke about an article he co-authored titled, "A Process for Developing a Telehealth Equity Dashboard at a Large Academic Health System Serving Diverse Populations." For the dashboard, they measured disparities in the domains of race and ethnicity, language, age and payor. Populations more

likely to have audio-only visits were Black/Asian American and American Indian patients as well as those who had Spanish as their preferred language. Patients with Medicaid or Medicare were 3-4 times more likely to have audio-only visits compared to those who had commercial payor coverage. Telehealth appears to be an important access point to care, with privately insured patients using telehealth for 20% of their encounters whereas it was 19% and 25% for Medicare and Medicaid, respectively, highlighting the importance of telehealth to the historically underserved Medicaid population. Providing this care via telehealth is made even more complicated by licensure. Approximately 10% of the telehealth visits from March 2020-June 2021 for Johns Hopkins were out-of-state encounters. Waivers put in place by states on licensure assisted in overcoming this challenge, but not all states had the same waivers in place and they were temporary. Many of these temporary waivers have already expired and Johns Hopkins is already seeing the impact. The patient needs to remain at the center and preventing care based upon state geographic boundaries is not meeting the needs of the patient.

Heidi Ross, Vice President, Policy and Regulatory Affairs, National Organization for Rare Disorders

The National Organization for Rare Disorders (NORD) is a patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them. NORD is committed to the identification, treatment and cure of rare disorders through programs of education, policy and advocacy, research and patient services. A rare disease is defined as one that affects less than 200,000 Americans. At this time, there are more than 7,000 known rare diseases, two-thirds of which have a genetic component. Approximately 90% of rare diseases do not have an Food and Drug Administration (FDA) approved treatment. About half of those with a rare disease are children. Rare disease patients were seriously impacted by COVID-19, not only because of the potential harm from infection, but they faced high cancellations of medical appointments and challenges accessing treatment, care and accessing medications. Telehealth became a lifeline but issues like licensure created challenges and barriers for patients. Fortunately, many states did issue waivers adjusting their state licensure requirements, but as these temporary licensure policies expire or are rolled back, many rare disease patients find themselves again struggling to access care. Several bills in Congress have been introduced to address this issue, but thus far, they have not moved significantly forward.

<u>WEBINAR #3 – TELEHEALTH & STATE PRIVATE PAYER LAWS</u>

Over the past 10 years, telehealth private payer laws have been adopted by states. While these laws receive a lot of attention when first introduced and passed, often times, very little is written about what happens next. This webinar focused on the evolutionary cycle of a telehealth private payer law by looking at its beginning, implementation and the impact it has on the group the policy is directed at: the payer. (NOTE: this webinar was not funded with federal funds, but other unrestricted funds).

Representative David Bentz, Delaware House of Representatives, 18th District

State Representative David Bentz from the Delaware House of Representatives (18th District) was not yet an elected official but was a staffer at the time Delaware's private payer law was going through the legislative process. Representative Bentz noted that at the time there was a strong interest in telehealth by proponents and advocates, but it was really a collaborative effort to create the Delaware Telehealth Coalition that began to move an actual bill forward. Delaware, at the time in 2015, was one of the few states that specifically required parity in coverage and payment. HB 69 passed in May of 2015. COVID-19 however, has increased utilization of telehealth in the state beyond what was envisioned in 2015. It has been a learning experience for providers and patients alike. Certain emergency waivers have been requested by telehealth advocates to be made permanent. Policymakers in the state continue to develop and work with the policy to ensure access to services for Delaware's residents.

Mike Rhoads, Deputy Commissioner of Health and Life Insurance, Oklahoma Department of Insurance

For nearly three decades Oklahoma residents have been receiving services via telehealth. Due to the rurality of the state, providers have had to have a long history of being innovative. It also has one of the first telehealth private payer laws having passed it in 1997. Since then, there have been changes and adoptions of other policies to expand the use of telehealth such expanding eligible modalities and reimbursement parity. Oklahoma also has a Project Echo project sponsored by the Oklahoma State University Health Sciences where it is providing virtual clinics for rural primary care providers in underserved populations. At this time, there have been no complaints filed with the Department regarding issues with private payers on telehealth. However, prior to the pandemic there was a decline in telehealth utilization partially due to infrastructure issues such as connectivity. Issues like connectivity continue to persist, but the state is working on it.

Kevin P. Beagan, Deputy Commissioner, Massachusetts Division of Insurance

Massachusetts passed an initial telehealth private payer law in 2012. Under the 2012 law, carriers were not required to cover telehealth services; the law only outlined what telehealth included, if carriers did choose to cover telehealth. The law did not comment on levels of reimbursement or whether carriers could place restrictions on the telehealth platforms used. As the law went into place, providers and carriers did not develop contracts to include telehealth services, and there was limited availability through dedicated telehealth networks.

At the beginning of COVID-19, the availability of telehealth use changed immediately. Under emergency orders issued by Massachusetts Governor Charlie Baker, carriers were required to reimburse providers for services delivered via telehealth through any available platform at a rate that was at least that of the rate of reimbursement for in-person services. Certain telehealth standards were also required in the emergency orders, such as proscribing carriers from imposing prior authorization barriers that would limit access to medically necessary health services via telehealth.

In 2020, Massachusetts passed legislation to align permanent policies with some of the temporary emergency orders issued in response to COVID-19. The implementation of these new laws led the Division of Insurance to hold information sessions to clarify the rules via regulations. One of the more complex parts of the law requires carriers to reimburse behavioral health services provided via telehealth at the same level as reimbursement for in-person visits, but it allows other services to be reimbursed at less than 100% parity after a specified period.

While the Division works to finalize regulations, it instructed carriers that if they wished to reimburse telehealth at less than 100% of in-person services, they needed to file an implementation plan with the Division to document how they were providing adequate advance notice to consumers and providers. Thus far, only one carrier has filed such a plan to reimburse certain non-behavioral health, non-primary care, and non-chronic care services at 80% of the in-person reimbursement level. This one carrier may need to amend its telehealth policies if different from what is required under the final regulations.

In May 2022, draft regulations were released, containing: definitions for telehealth terms, what telehealth information is required in directories, how a carrier determines what types of care are appropriate for telehealth, and appropriate coding and billing. The Division is considering further changes to the draft regulations based on feedback received from interested parties via public comment.

Chelsey Matter, Executive Director of Government Programs Health Integration, Blue Cross Blue Shield of North Dakota

Telehealth in North Dakota also has a long history. Blue Cross Blue Shield of North Dakota (BCBSND) issued its first medical policy on telehealth in the 1990s. A coverage parity mandate was passed in 2017. Pre-pandemic, BCBSND had 2,000 – 3,000 telehealth visits per year (behavioral health and infertility were a good portion of those visits). With COVID-19, those numbers increased to 2,000 – 7,000 visits ***per week***. Now, the average visits per week are 1,500. As in many other states, in response to the pandemic, executive orders were issued addressing coverage during the pandemic. At this time, legislative policymakers are studying the effects of potential policy changes and when is it appropriate to use telehealth and for what. In the meantime, BCBSND continues to tweak their policies to service the needs of their enrollees. Ms. Matters noted that input needs to be solicited from all stakeholders, including patients and that BCBSND will continue to work collaboratively with state policymakers on these important issues.

<u>WEBINAR #4 – TELEHEALTH & SUBSTANCE USE DISORDERS</u>

Robert Baillieu, Physician and Senior Clinical and Practice Advisor, SAMHSA/CSAT/OD

Dr. Baillieu noted that telehealth is defined as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration." Research from the past several years indicates that racial and ethnic minority groups are experiencing higher rates of depression, substance use, and self-reported suicidal thoughts. Similarly, the evidence also shows an increase in drug-related mortality during the COVID-19 public health emergency, with most overdose deaths involving one or more illicit drugs. Further to this, there are challenges in accessing treatment with many communities lacking local treatment providers or programs. In March 2020, the Secretary of Health and Human Services, with the concurrence of the Drug Enforcement Agency (DEA) Administrator, designated a telehealth exception that applied to all schedule II-V controlled substances. The DEA also granted a temporary exception that allowed practitioners to prescribe controlled substances in states in which they were not registered. These changes were made in response to the COVID-19 pandemic. SAMHSA has been working to help expand the use of telehealth beyond the aforementioned actions including providing grants, technical assistance and education. Telehealth has the potential to improve service delivery and access, particularly for underserved populations but will need to be used in a manner that promotes individualized, patient centered care. In this way, telehealth is a form of service delivery that has potential to expand access and to foster new paradigms of care.

Patricia Gann, Deputy Director, Division of Aging, Adult and Behavioral Health Services, Elizabeth Pitman, Division Director, Division of Medical Services, Jennifer Shuler, Nurse Practitioner, Division of Aging, Adult and Behavioral Health Services, Arkansas Department of Human Services

Even before COVID-19, Arkansas' Department of Human Services Medicaid program had already ensured that their telehealth policies would allow for the use of the technology to treat SUD. However, even with this forward thinking, like other states, Arkansas still needed to make certain adjustments to their telehealth policies to allow for greater flexibility and utilization. Some of the COVID-19 changes allowed for more providers to be able to utilize telehealth to provide services and allowing for telehealth to be used as a means to provide more services. In 2021, the Arkansas state legislature made some of the temporary pandemic policies permanent such as allowing the home to be an eligible originating site and audio-only technology to be used when appropriate. Arkansas Medicaid reimburses for medication assisted therapy (MAT) to treat opioid use disorder (OUD). Providers are encouraged to use telehealth when in-person services are not readily accessible. Arkansas Medicaid went into depth as to the policies they have on OUD including provider eligibility and billing codes. There are specific telehealth rules that providers utilizing technology need to follow. For example, remembering to code properly with the appropriate modifier.

Jeffrey Hom, Medical Director of the Division of Substance Use Prevention and Harm Reduction, Philadelphia Department of Public Health

Dr. Hom explained that the Philadelphia Department of Public Health's innovative work on SUD was spurred by such factors as having one of the highest death rates for unintentional overdoes among the 10 largest US cities. There is also a high rate of prescribing opioids in the region. Heroin and fentanyl have also provided to be factors for drug abuse in the city. In 2017, the Mayor convened a task force that made recommendations in five strategic areas: prevention and education, treatment, overdose prevention and harm reduction, criminal justice and data and surveillance. Among some of the actions taken included making naloxone more available by requiring pharmacies to carry it and having "naloxone towers" which are free standing kiosks where naloxone kits can be accessed free of charge 24/7. There has also been a conscious expansion to access to buprenorphine through mentorship programs, decriminalization of buprenorphine possession and access to it in the City's jail. Health systems have also committed to training their primary care providers in prescribing buprenorphine. Treatment capacity has increased in the city, but low barrier options were still needed which is where telehealth came into play. In the early days of the pandemic, telehealth was used to fill in gaps created by disruptions in treatment access and decarceration. In those early days, they learned that same-day access to medication treatment and close touch from experienced navigators were very important. Working with Penn Medicine, a project funded by grants called CareConnect Warmline was started. Callers into the warmline would be connected to Substance Use Navigators and be able to have same day access to buprenorphine. The project was intended to ensure patients did not lose access to medication. There have been 184 total encounters with a little less than half as non-prescription encounters and 98 buprenorphine encounters. Of the patients triaged to telehealth, 100% receive buprenorphine. Almost all of the patients were able to pick up their initial prescription within 7 days. The pilot shows great promise and Dr. Hom noted that he saw telehealth as an important component of Philadelphia's efforts to ensure low-barrier access to evidence-based treatment for its residents. However, challenges to continue the project exist unless telehealth policies are in place to ensure sustainability.

CONCLUSION

From the variety of topics, it is clear that a multitude of issues still face telehealth policy on the state level, not just those within the Medicaid program. Some states or cities have taken innovative approaches to use telehealth to address specific health care needs, but could be frustrated by policies that will be rolled back, or have already been, when the PHE is declared over. Without further changes to policies, some advances made may be lost and patients will lose access to needed services.