Center for Connected Health Policy
The National Telehealth Policy Resource Center

Center for Connected Health Policy

TELEHEALTH & MEDICAID:
A POLICY WEBINAR SERIES

Waivers and State Plan Amendments to Address COVID-19

January 15, 2021

Center for Connected Health Policy
The National Telehealth Policy Resource Center

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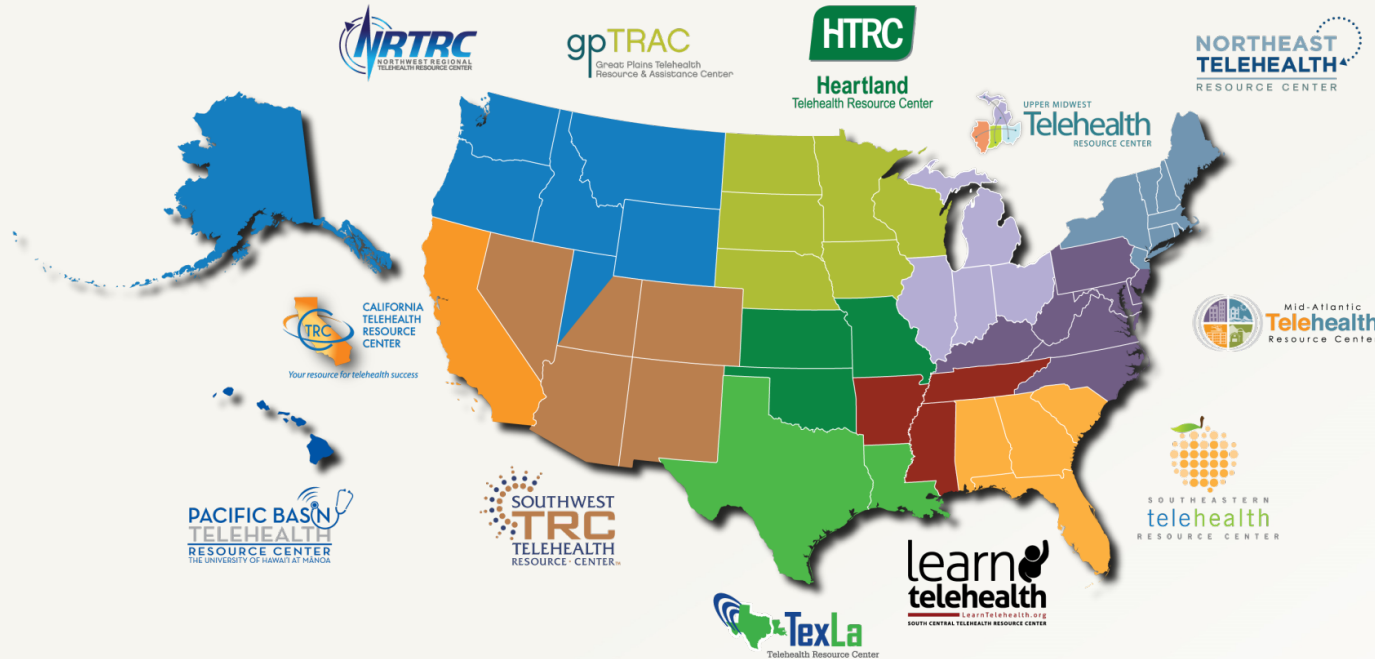The National Telehealth Policy Resource Center

About CCHP

- Established in 2009 by the California Health Care Foundation
- Program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners

NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org

2 National Resource Centers

12 Regional Resource Centers

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Telehealth & Medicaid: A Policy Webinar Series

Image source: American Psychological Association

January 22, 2021: Provider Education & Engagement

January 29, 2021: Patient Education & Engagement

February 5, 2021: What's Next? A Roadmap for Medicaid Telehealth Policy Beyond the Pandemic

Follow the discussion!
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Today's Webinar

Presentation #1: Telehealth in Medicaid

Sheri Gaskins, MBA, Technical Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services (CMS)

Presentation #2: Medi-Cal's Telehealth Policy: Pre-COVID-19, Temporary COVID-19 Flexibilities, and Post-COVID-19

Erica Bonnifield, JD, Health Care Benefits and Eligibility (HCBE) Assistant Deputy Director, California Department of Health Care Services

Presentation #3: NC Medicaid & Telehealth

Shannon Dowler, MD, Chief Medical Officer, North Carolina Department of Health and Human Services

Telehealth in Medicaid

Sheri Gaskins

Technical Director

CMCS/DEHPG/DBC

January 2021

Session Objectives

- Provide a brief overview of Medicaid services

- Discuss how telehealth is incorporated into the Medicaid program

- Learn the reimbursement flexibility for Medicaid services delivered via telehealth

Medicaid in Brief

- States determine their own unique programs within broad federal guidelines
- Each state develops and operates a State plan outlining the nature and scope of services; the State Plan and any amendments must be approved by CMS
- Medicaid mandates some services, states elect to provide additional optional services
- States choose eligibility groups, optional services, payment levels, providers

Medicaid Benefits

- **MANDATORY**
  - Inpatient hospital services
  - Outpatient hospital services
  - EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services
  - Nursing Facility services
  - Home Health services
  - Physician services
  - Rural Health Clinic services
  - Federally Qualified Health Center services
  - Laboratory and X-ray services
  - Family Planning services
  - Nurse Midwife services
  - Certified Pediatric and Family Nurse Practitioner services
  - Freestanding Birth Center services (when licensed or otherwise recognized by the state)
  - Transportation to medical care
  - Tobacco Cessation counseling for pregnant women

- **OPTIONAL**
  - Prescription Drugs
  - Clinic services
  - Therapies – PT/OT/Speech/Audiology
  - Respiratory care services
  - Rehabilitative Services
  - Podiatry services
  - Optometry services
  - Dental Services & Dentures
  - Prosthetics
  - Eyeglasses
  - Other Licensed Practitioner services
  - Private Duty Nursing services
  - Personal Care Services
  - Hospice
  - Case Management & Targeted Case Management
  - TB related services
  - State Plan HCBS - 1915(i)
  - Community First Choice Option - 1915(k)
  - Inpatient Psychiatric Services for Individuals under age 21 (required per EPSDT)

Telehealth

- Telehealth, in short, is described as using technology to deliver services.

- Services are covered in Medicaid and can be delivered using telehealth.

- Examples of technologies are asynchronous store and forward, two-way real time audio/visual communication, telephone, etc.

- Medicaid coverage of services delivered via telehealth not dependent on Medicare rules governing telehealth.

Telehealth

- States have flexibility when covering telehealth:
  - What services to cover,
  - What practitioners to cover,
  - What types of technology to use,
  - Where in the state it will be covered, and
  - How will the services be reimbursed.
- Services must be provided within practitioners' scope of practice.

Telehealth and State Plan Amendments

- The state plan is a document that describes to the Federal government how a state operates its' Medicaid program.

- States are not required to submit a (separate) SPA for coverage or reimbursement of telehealth services, if they decide to reimburse for services the same way/amount that they pay for face-to-face services/visits/consultations.

- States must submit a (separate) reimbursement (attachment 4.19-B) SPA if they want to provide reimbursement for telehealth services differently than is currently being reimbursed for face-to-face services

Telehealth Toolkit

- Provides states with statutory and regulatory infrastructure issues to consider as they evaluate the need to expand their telehealth capabilities and coverage policies. This guide provides a description of these areas and the challenges they present including:
    - Patient populations eligible for telehealth
    - Coverage and reimbursement policies
    - Providers and practitioners eligible to furnish telehealth
    - Technology requirements
    - Pediatric considerations

Examples of Payments for Telehealth

- Distant or originating site fees

- Ancillary costs for the delivery of telehealth services (such as, technical support, necessary equipment)

- CANNOT pay for infrastructure

Telehealth Resources

➢ Telemedicine in Medicaid
   https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html

➢ Telehealth Toolkit for States

   ▪ Medicaid & CHIP Telehealth Toolkit Checklist for states
      https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf

   ▪ State Plan fee-for-service telehealth payments
      https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf

Telehealth

Questions/Comments?

Medi-Cal's Telehealth Policy: *Pre-COVID-19, Temporary COVID-19 Flexibilities, and Post-COVID-19*

Erica Bonnifield

Assistant Deputy Director

Health Care Benefits & Eligibility

Department of Health Care Services

Medi-Cal's Telehealth Policy: *Pre-COVID-19, Temporary COVID-19 Flexibilities, and Post-COVID-19*

DHCS Website:
https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
Medi-Cal Provider Manual:
https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf
All Plan Letter 19-009:
https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
COVID-19 Flexibilities:
https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf

Erica Bonnifield, Assistant Deputy Director
Health Care Benefits & Eligibility, Department of Health Care Services
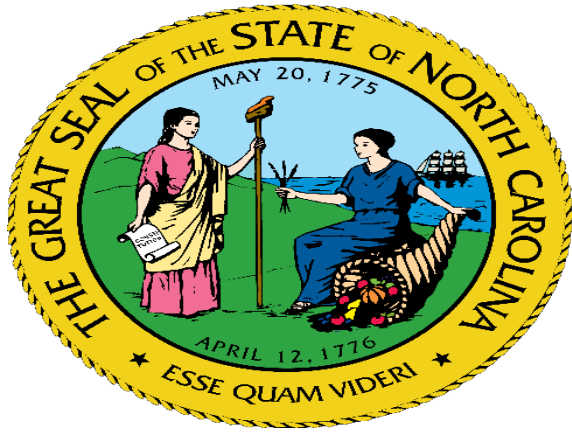
January 2021
Shannon Dowler, MD
CMO NC Medicaid

**NC Medicaid & Telehealth
Moving Mountains, Great Vistas**

WHEN YOU HAVE SEEN ONE MEDICAID STATE, YOU HAVE SEEN...ONE MEDICAID STATE!

California

Medicaid Expansion ✔

Managed Care ✔

Size: 7.75 million

Figure 1
Medi-Cal Managed Care Models, by County

- COHS
- Two-Plan
- Geographic Managed Care
- Regional
- San Benito
- Imperial
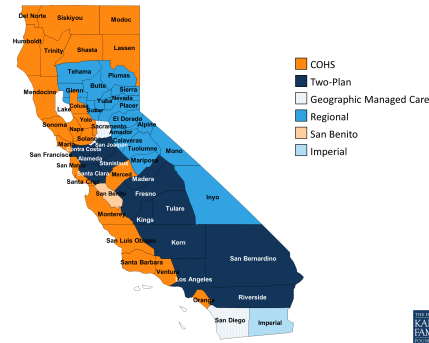
North Carolina

Medicaid Expansion ✗

Managed Care ✗

Size: 2.1 million
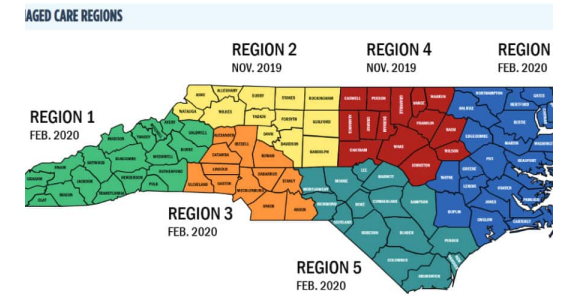
	California	North Carolina
Medicaid Eligibility level for non-pregnant adults	138% FPL	42% for parents only
Total Medicaid Spending	$88B	$14B
Base FMAP	50%	67%
Enrollment (2019)	7.75M	2.1M
1115 Waiver	DSRIP, public hospital incentives program	Healthy Opportunities,
Spending per full benefit enrollee	$5,318	$5,573
State coverage of undocumented children	Yes	No
Medicare-Medicaid Physician Fee Ratio (2016) All Services	0.52	0.78
MCO Enrollment %	81% of beneficiaries	N/A (LME-MCOs not comprehensive coverage)

MOVING from 1 to 100 overnight!

The Department analyzed 367 flexibilities across multiple functional areas. LME-MCO team further updated their recommendation on 16 flexibilities. The summary tables below provide insight into the current round 1 Recommendation status.

Circuit Breaker Recommendations	#	%
Recommended Keep	43	11.7%
Recommend keep with changes	68	18.5%
Consider Keep	4	1.1%
Recommend to not keep	252	68.7%
Grand Total	367	100.0%

Status of Circuit Breaker Recommendations	#	%
Final Recommendation Complete	348	95%
Workstream Recommendation Revised	16	4%
Workstream Recommendation Complete	3	1%
Grand Total	367	100%
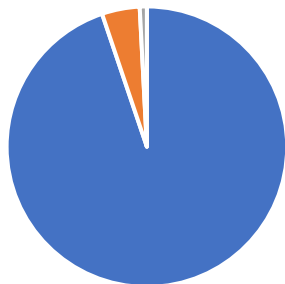
- Final Recommendation Complete
- Workstream Recommendation Revised
- Workstream Recommendation Complete

| Workstream Recommendations	#	%
Benefits	121	33.0%
Recommended Keep	14	3.8%
Recommend keep with changes	39	10.6%
Consider Keep	3	0.8%
Recommend to not keep	65	17.7%
Finance and Rate Setting	20	5.4%
Recommended Keep	6	1.6%
Recommend keep with changes	3	0.8%
Recommend to not keep	11	3.0%
LME-MCO	200	54.5%
Recommended Keep	19	5.2%
Recommend keep with changes	24	6.5%
Consider Keep	1	0.3%
Recommend to not keep	156	42.5%
Member Services	8	2.2%
Recommend to not keep	8	2.2%
Pharmacy	9	2.5%
Recommended Keep	3	0.8%
Recommend to not keep	6	1.6%
Provider Operations	6	1.6%
Recommend to not keep	6	1.6%
Command Center	2	0.5%
Recommend keep with changes	2	0.5%
Contact Center	1	0.3%
Recommended Keep	1	0.3%
Grand Total	367	100.0%

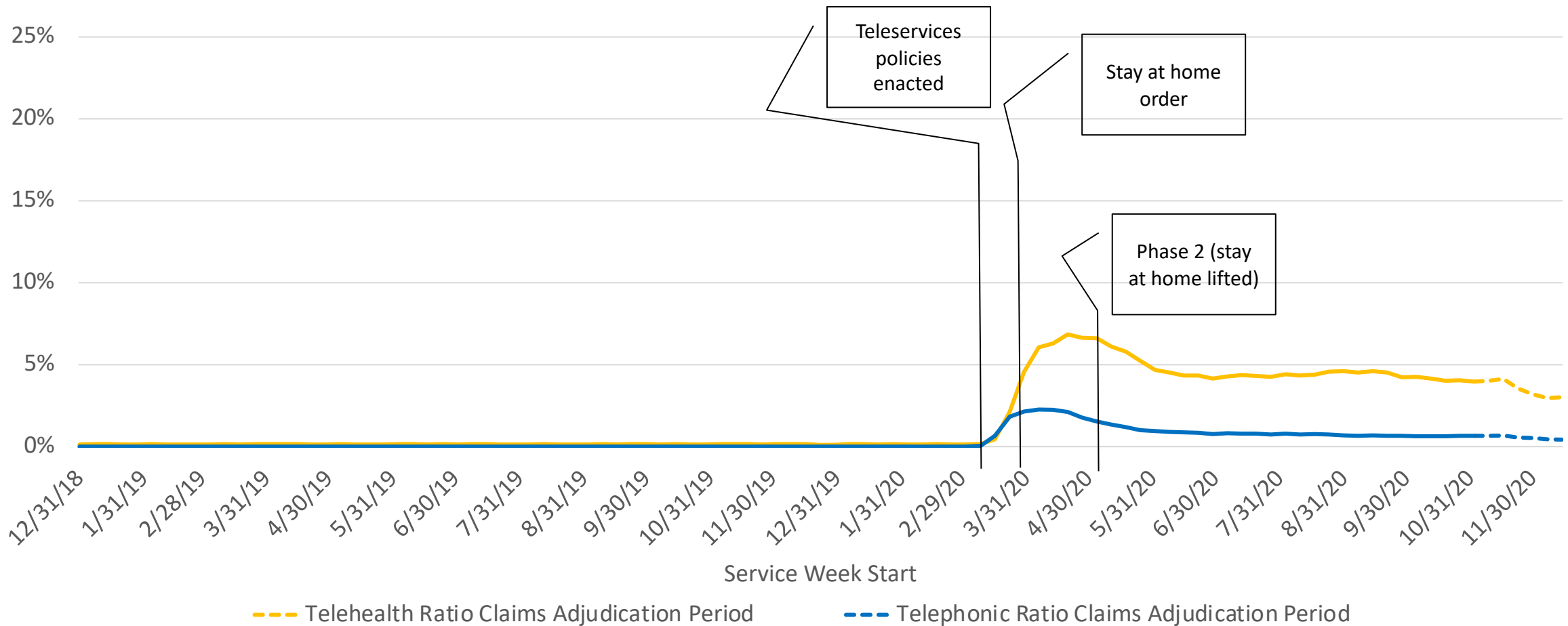# All the while we were tracking the data
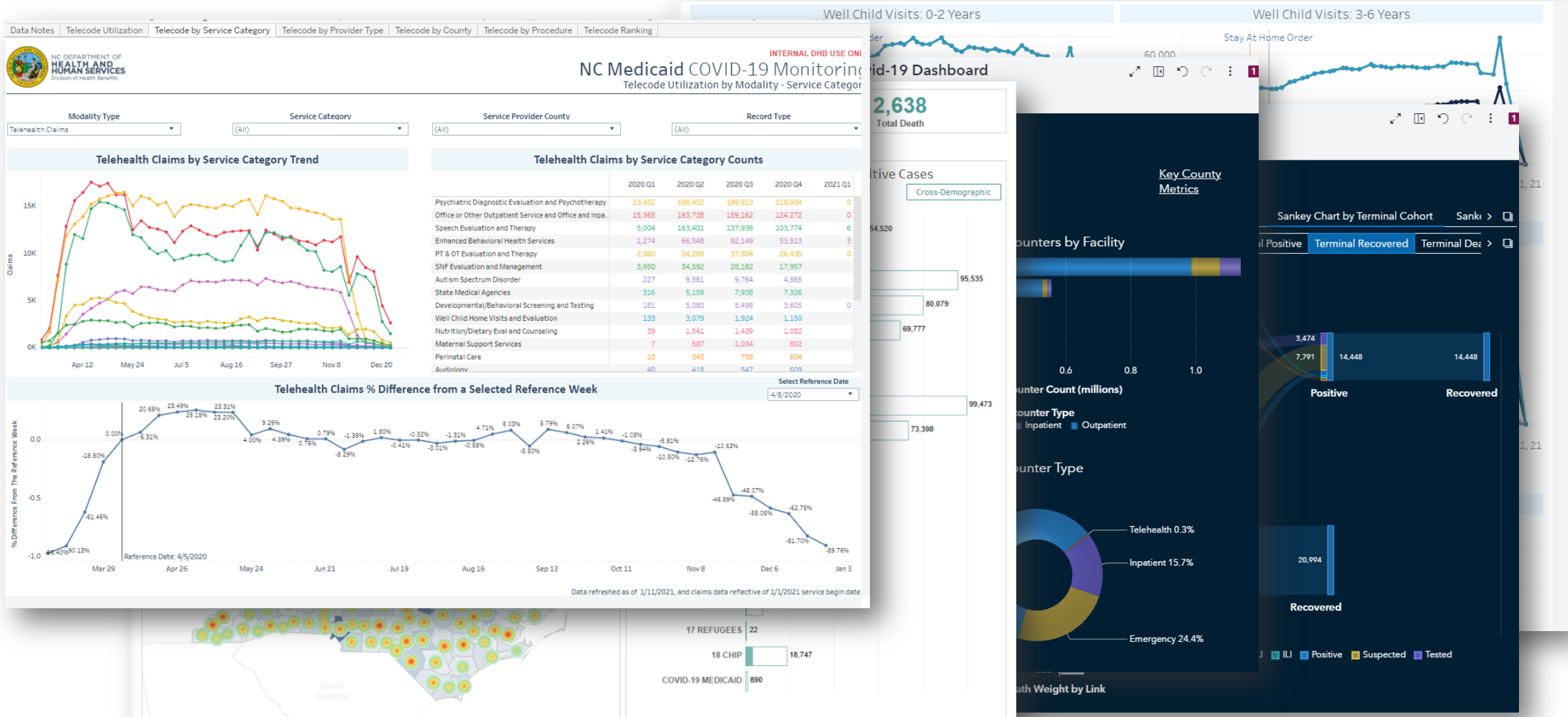
Telehealth, Telephonic, and In-person Claims Volume | 12/31/18 – 12/20/2020

- Dramatic decrease in in-person visits at the outset of the Public Health Emergency
- Steep increases in telemedicine during the same period
- All visit types decrease with claims adjudication

------ General Visits Claims Adjudication Period   ------ Telehealth Claims Adjudication Period   ------ Telephonic Claims Adjudication Period
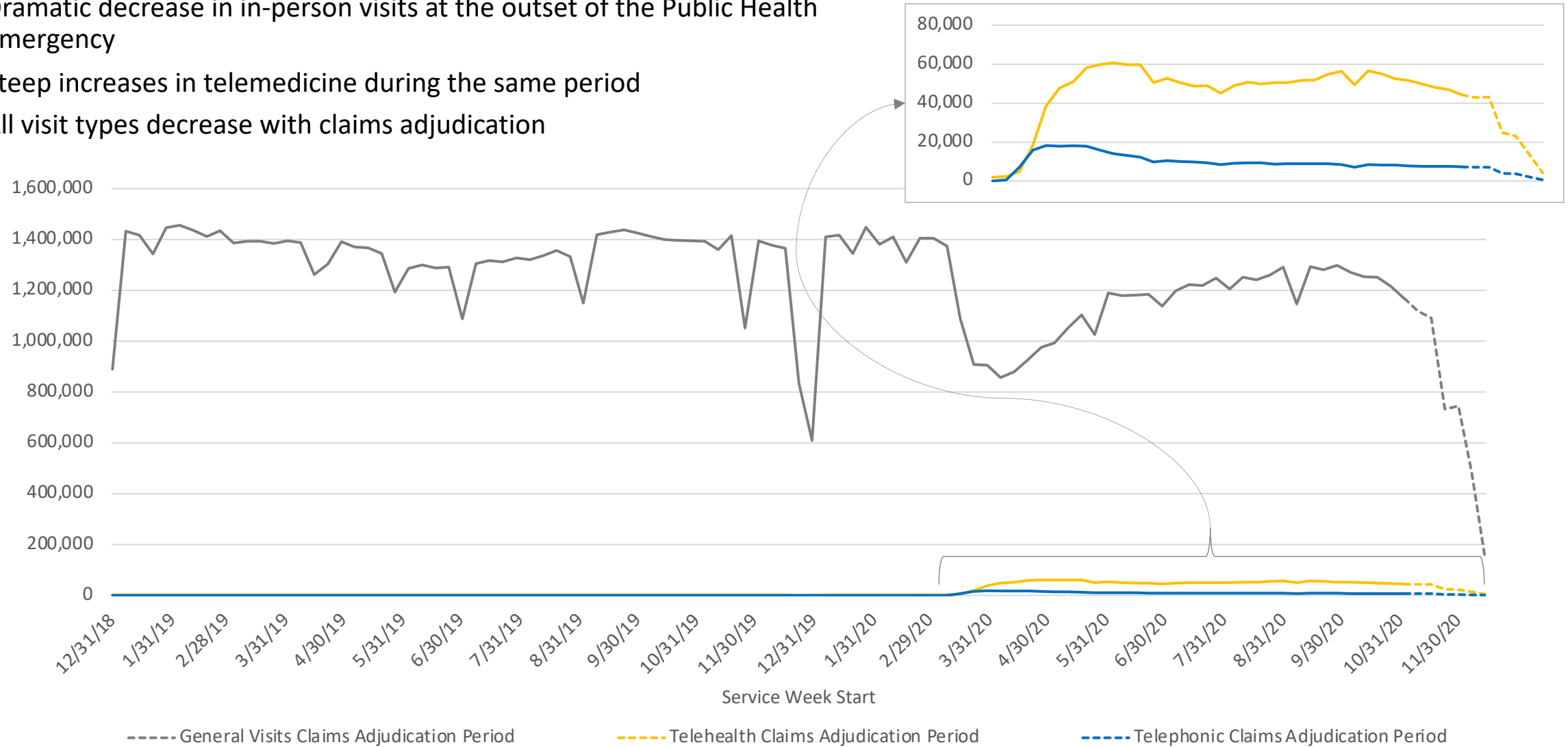
Ratio of Telehealth and Telephonic Claims to General Claims | 12/31/18 – 12/20/2020

Ratios jump after DHB's March 10th implementation telehealth/telephonic policy changes

Teleservices policies enacted

Stay at home order

Phase 2 (stay at home lifted)

Service Week Start

--- Telehealth Ratio Claims Adjudication Period   --- Telephonic Ratio Claims Adjudication Period

% Telehealth[1] for Physical vs. Behavioral Health | 3/09/2020 – 12/13/2020

Compared to other types of care telemedicine made up a much larger proportion of behavioral health visits

- - - LME/MCO % Telehealth Adjudication   - - - FFS % Telehealth Adjudication
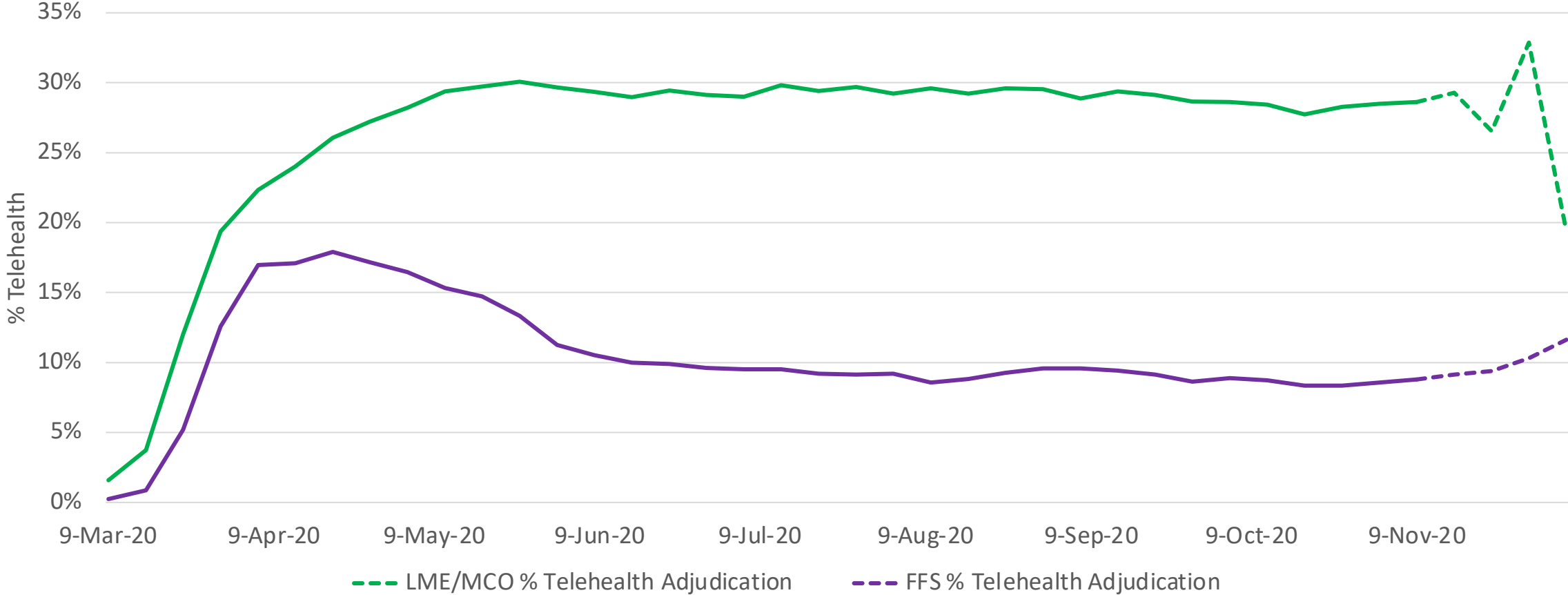
1. Remote encounters that include both audio and video

Telehealth, Telephonic, and In-person Behavioral Health Encounters Volume 03/09/2020 – 12/13/2020
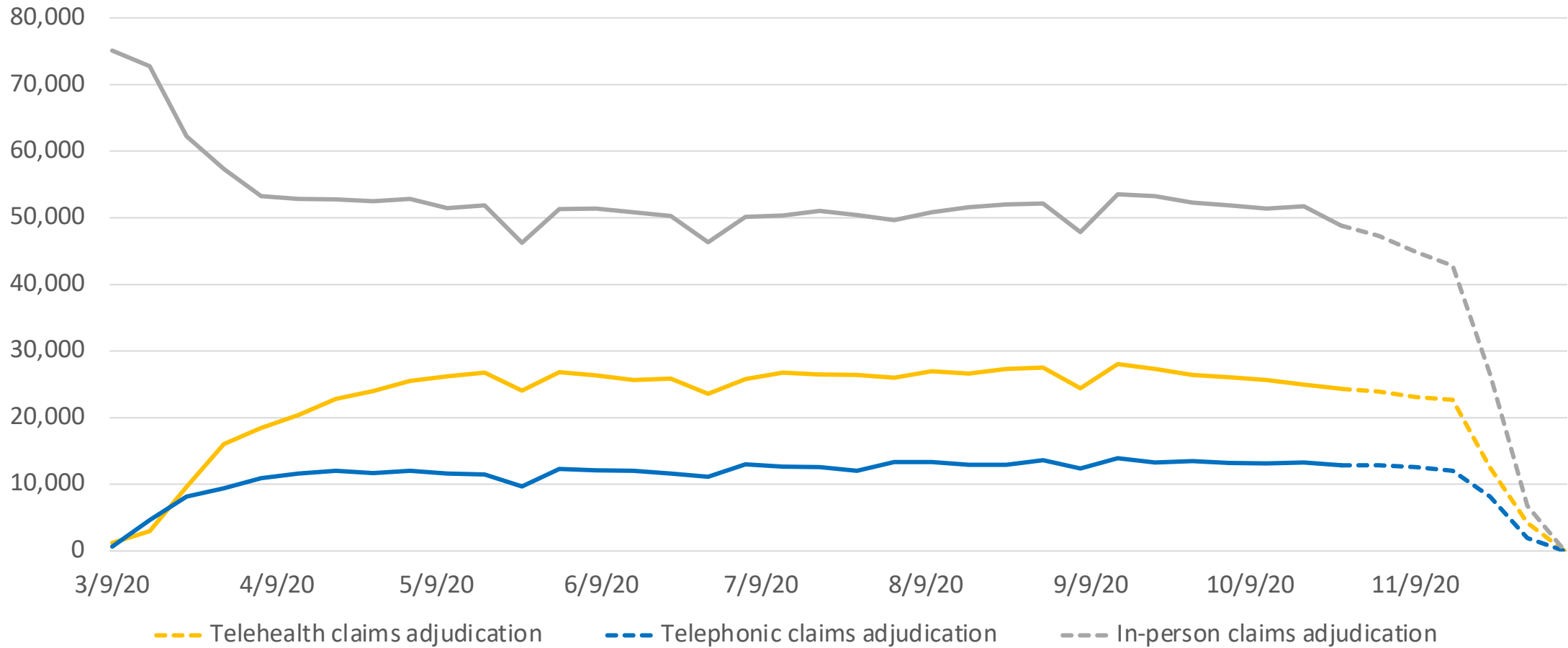
Teleservice Utilization Odds by Geography, Race and Disease Type

The COVID-19 diagnostic population may seek in-person care more readily.

The odds of teleservice utilization among:

- Beneficiaries living in urban geographies is 1.2x greater than utilization odds among beneficiaries living in rural geographies
- White beneficiaries is 1.2x greater than utilization odds among black beneficiaries
- Non-Hispanic beneficiaries is 1.4x greater than utilization odds among Hispanic beneficiaries
- Beneficiaries with a chronic disease is almost 3x greater than utilization odds among beneficiaries without a chronic disease
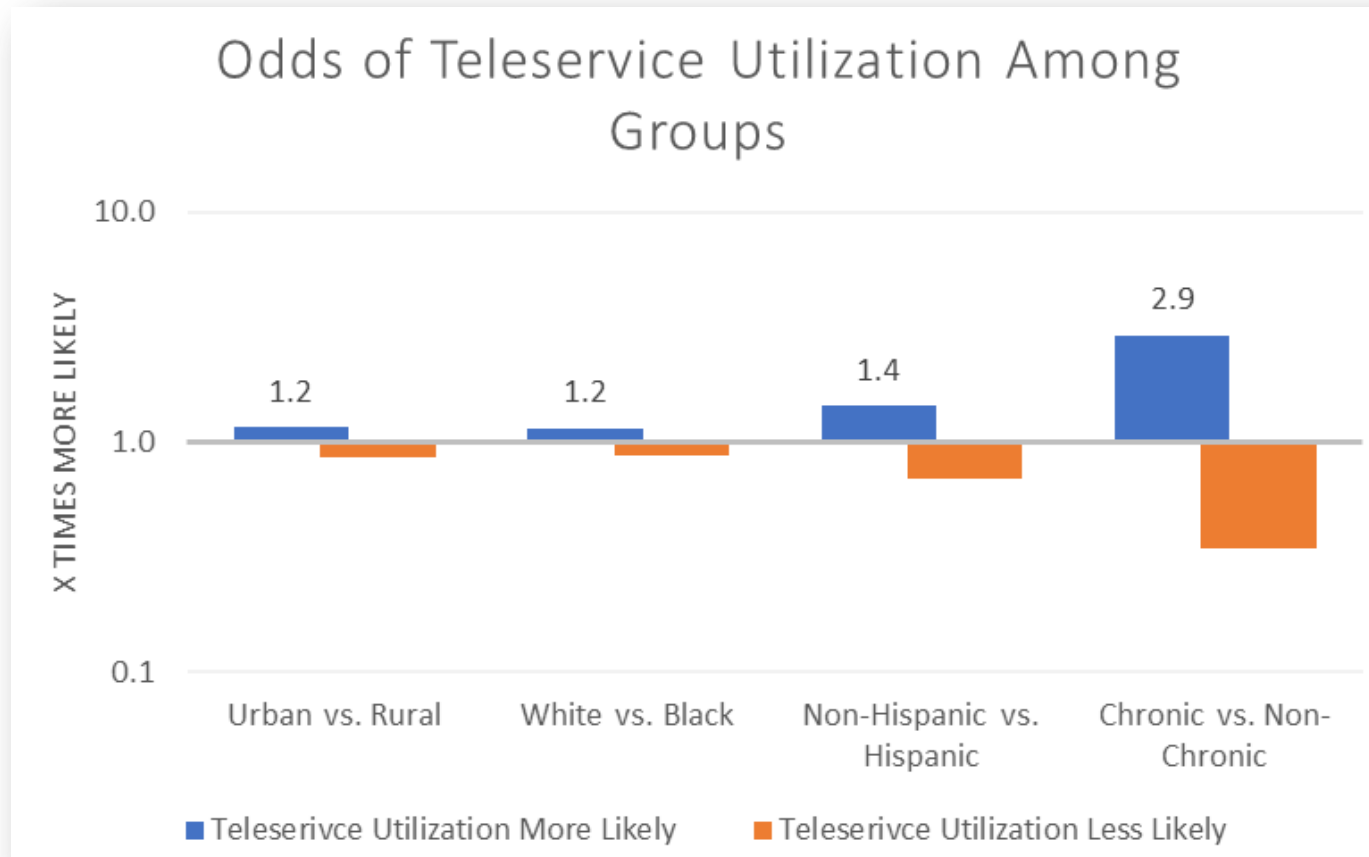
Combined Telehealth/Telephonic to In-person Ratios by Race | 12/31/2019 – 12/20/2020

Legend:
- Black Tele Claims Adjudication Period
- White Tele Claims Adjudication Period
- Asian/Pacific Islander Tele Claims Adjudication Period
- Native America/Alaska Native Tele Claims Adjudication Period
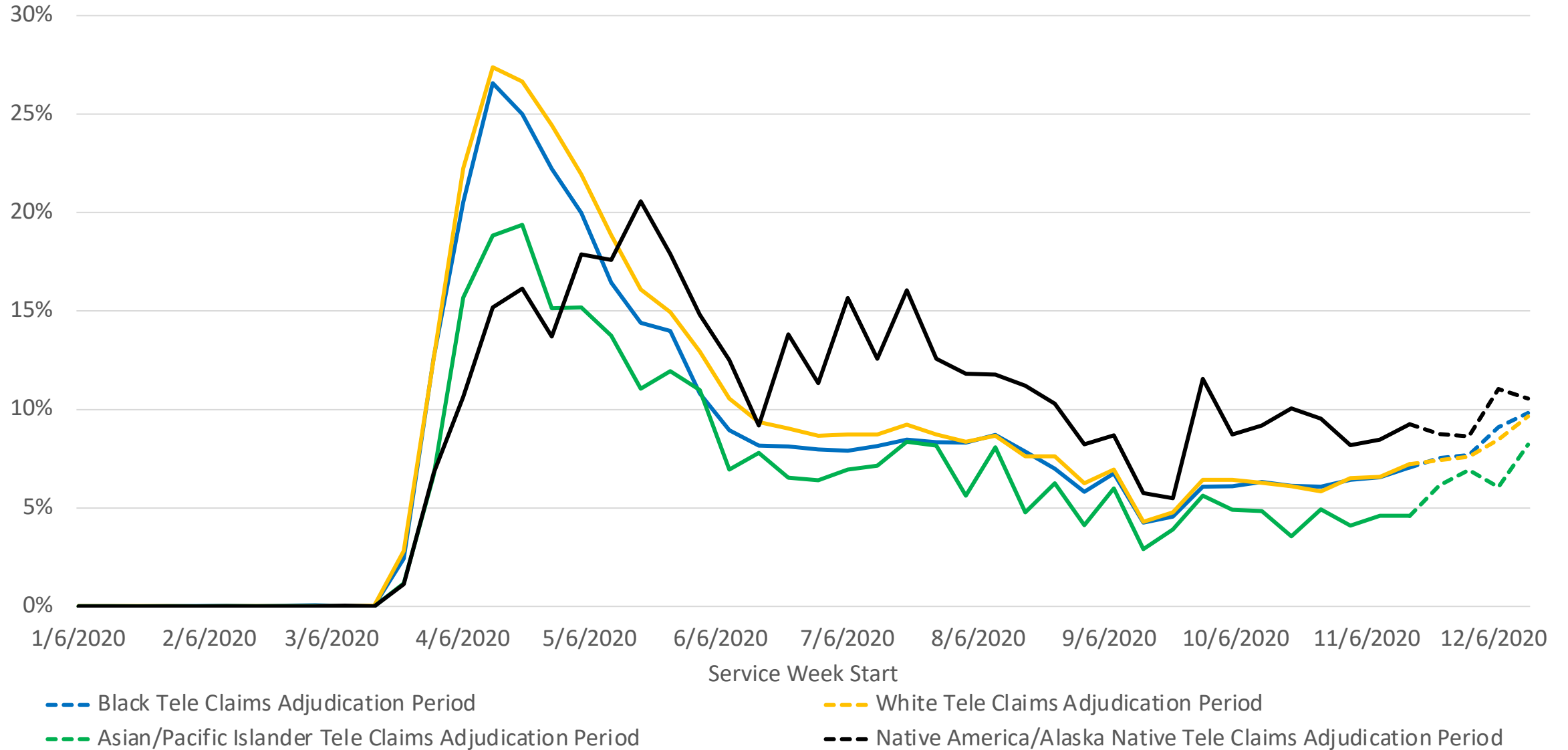
Claims per Beneficiary by Race |12/30/19 – 10/18/20

- The chart on the left compares claims per 1000 beneficiaries by race. The White and American Indian subgroups have a disproportionately high volume of claims relative to their share of the NC Medicaid population.

- The chart on the right shows this same metric broken out for telehealth, telephonic, and in-person modalities.

Total claims per Beneficiary Last 90 Days

Race	Total claims per Beneficiary
White	221
Black	163
American Indian	212
Asian/Pacific Islander	142

Legend: Asian/Pacific Islander, American Indian, Black, White

Modality	Asian/Pacific Islander	American Indian	Black	White
Telehealth Claims per 1000 Beneficiaries Last 90 Days	5	15	6	9
In-Person Claims per 1000 Beneficiaries Last 90 Days	136	193	154	209
Telephonic Claims per 1000 Beneficiaries Last 90 Days	1	3	3	3

Rurality, Broadband and Telehealth | 3/9/2020 – 11/20/2020

- Counties' rates of primary care and OB services that were telehealth:
  - decrease as the percent of counties' populations living in rural areas increases
  - increase as the percent of counties' populations with broadband access increases
- These relationships do not hold for behavioral health telehealth services
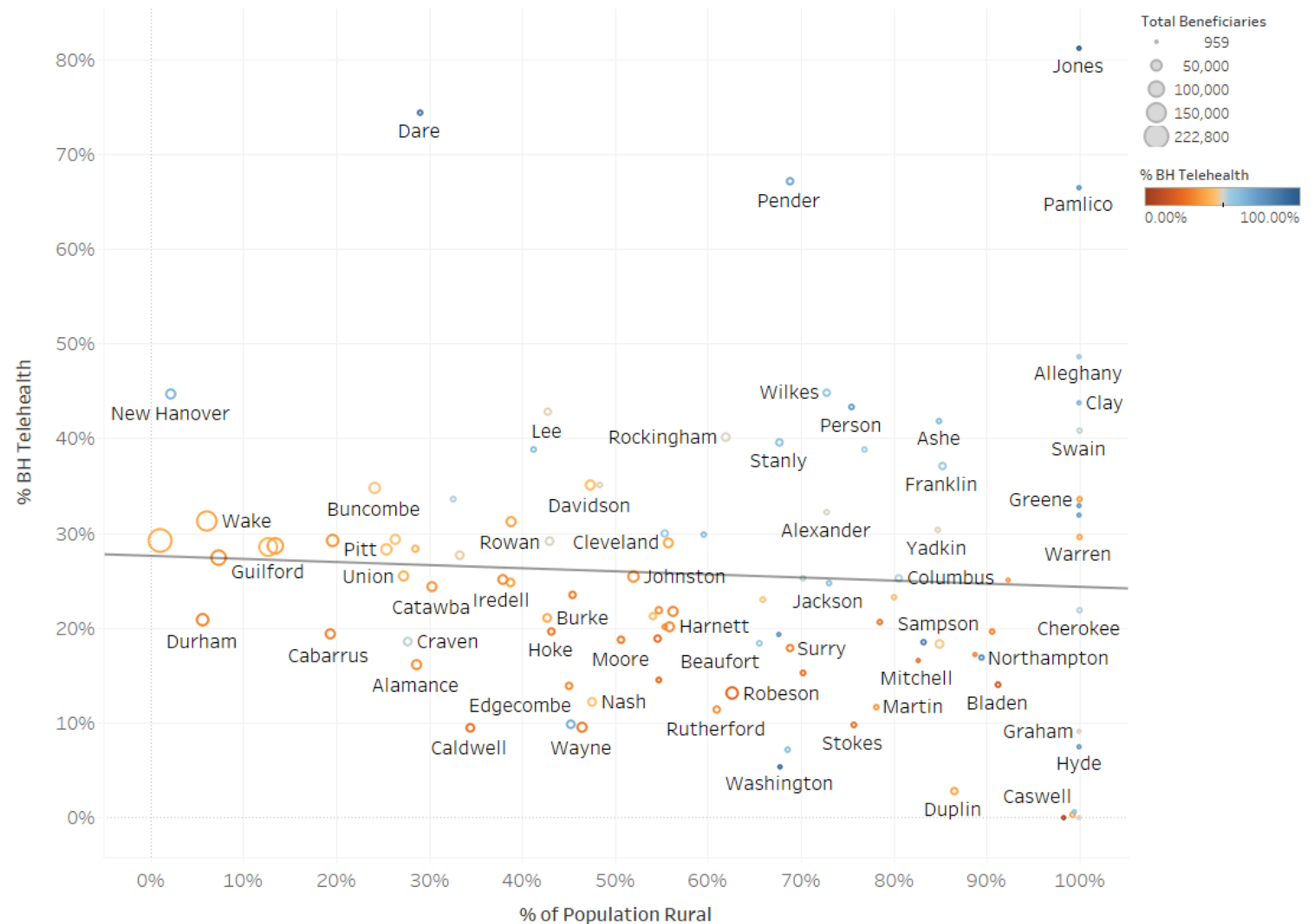
Providers engaged in teleservices were slower to bill

Claims submission speed for providers submitting teleservice claims during the first three months of the COVID-19 period was slower than the speed at which those same providers submitted claims 180 days prior.

Lookback Period (Sept.-Dec. 2019)
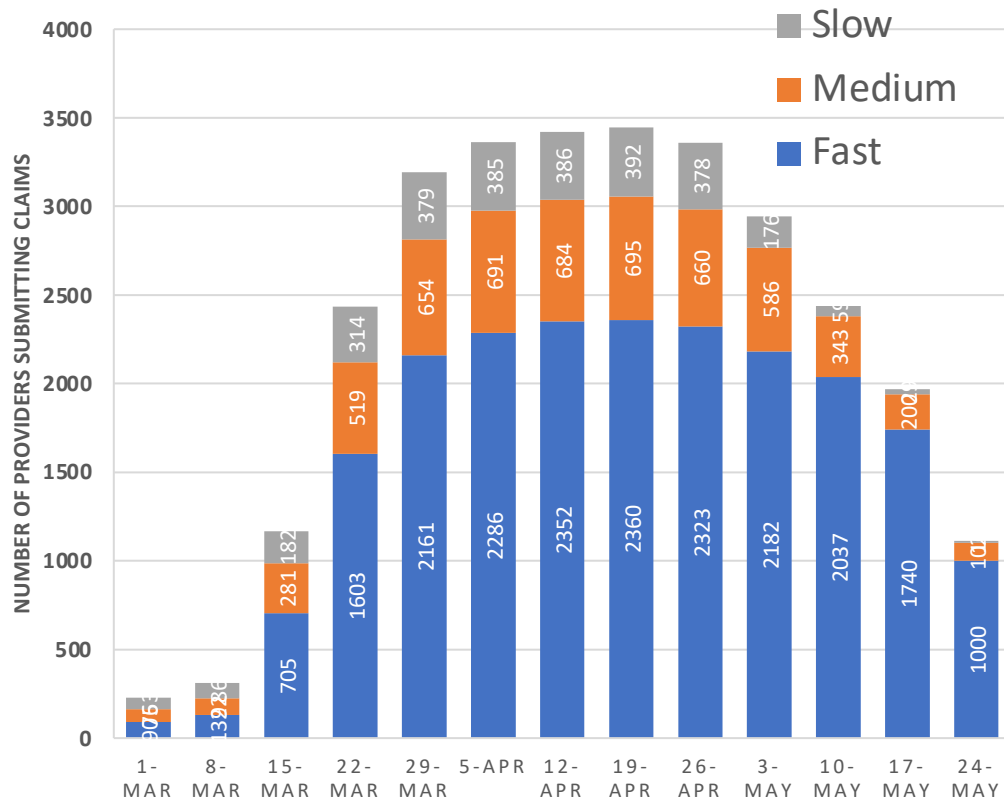
COVID-19 Period (March-May 2020)
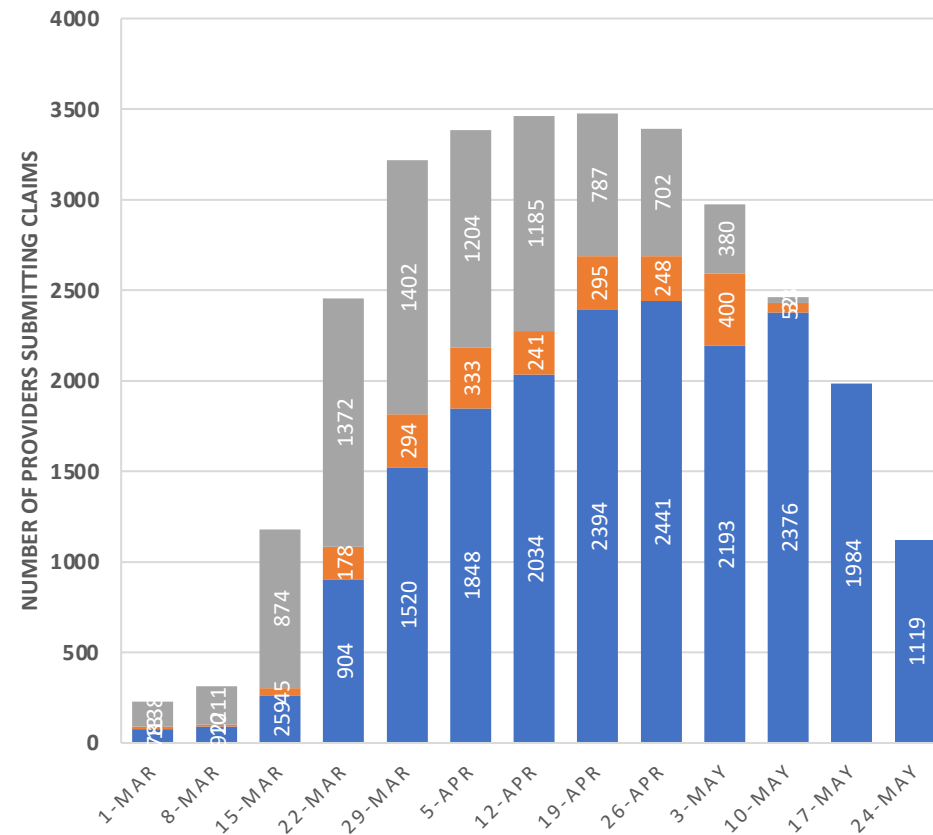
Beneficiary Survey Findings

- Of respondents whose most recent visit was virtual individual therapy (n=145) 59% said that they would like to continue virtual therapy if given the option to return in person.[1]

  - Black or African American respondents were less likely to want to continue virtual individual therapy (44%, 24 of 54, p<.00001) compared to White respondents (73%, 48 of 66).[1]

- 84% of respondents (n=186) reported no technical difficulties at their last virtual appointment.[1]

- When comparing self reported outcomes from February 2020 (before transition to telehealth) to April 2020 (transition to primary telehealth model), self reported outcomes remain similar.[2]

1. Intercept survey implemented by Carolina Outreach, a statewide behavioral health provider
2. Patient-reported outcomes survey implemented by Access Family Services, statewide behavioral health agency

Using Teleservices to Close Care Gap

Primary care practices that adopted telemedicine at higher rates saw a much larger proportion of their patients during the first five months of the Public Health Emergency.

Level of Uptake (number of teleservice claims during the pandemic so far)	No. of Practices	No. of Patients Receiving Primary Care During Pandemic	Est. % of Panel Accessing Practice During Pandemic
HIGH (300+)	132	339,476	76%
MED (50-299)	482	320,402	62%
LOW (1-49)	740	192,349	48%
NONE	393	56,666	29%
Grand Total	**1,747**	**908,893**	**58%**

A Second Visit Was Less Likely After Teleservices
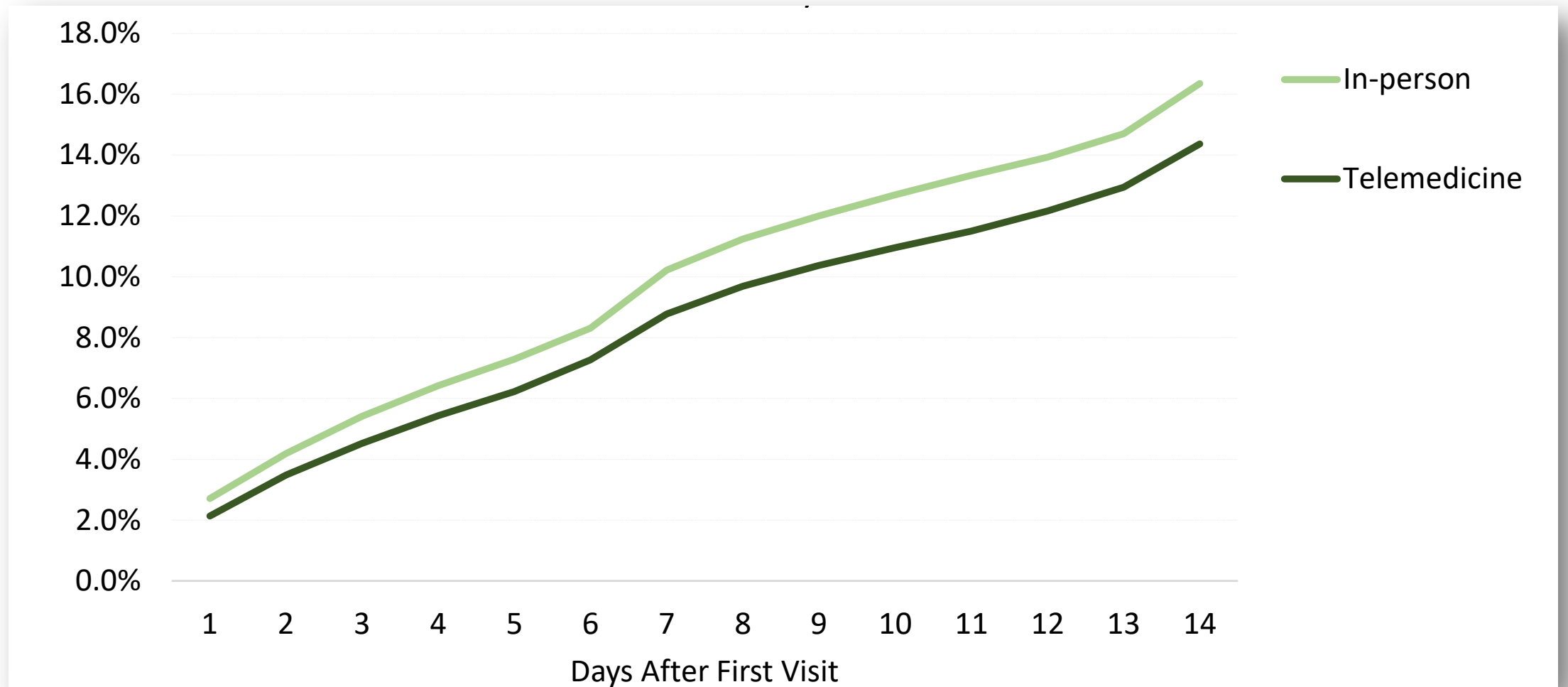
Total Cost of Care in Two Weeks Following Primary Care Visit

Costs were about 25% higher for ABD when initial visit was telehealth
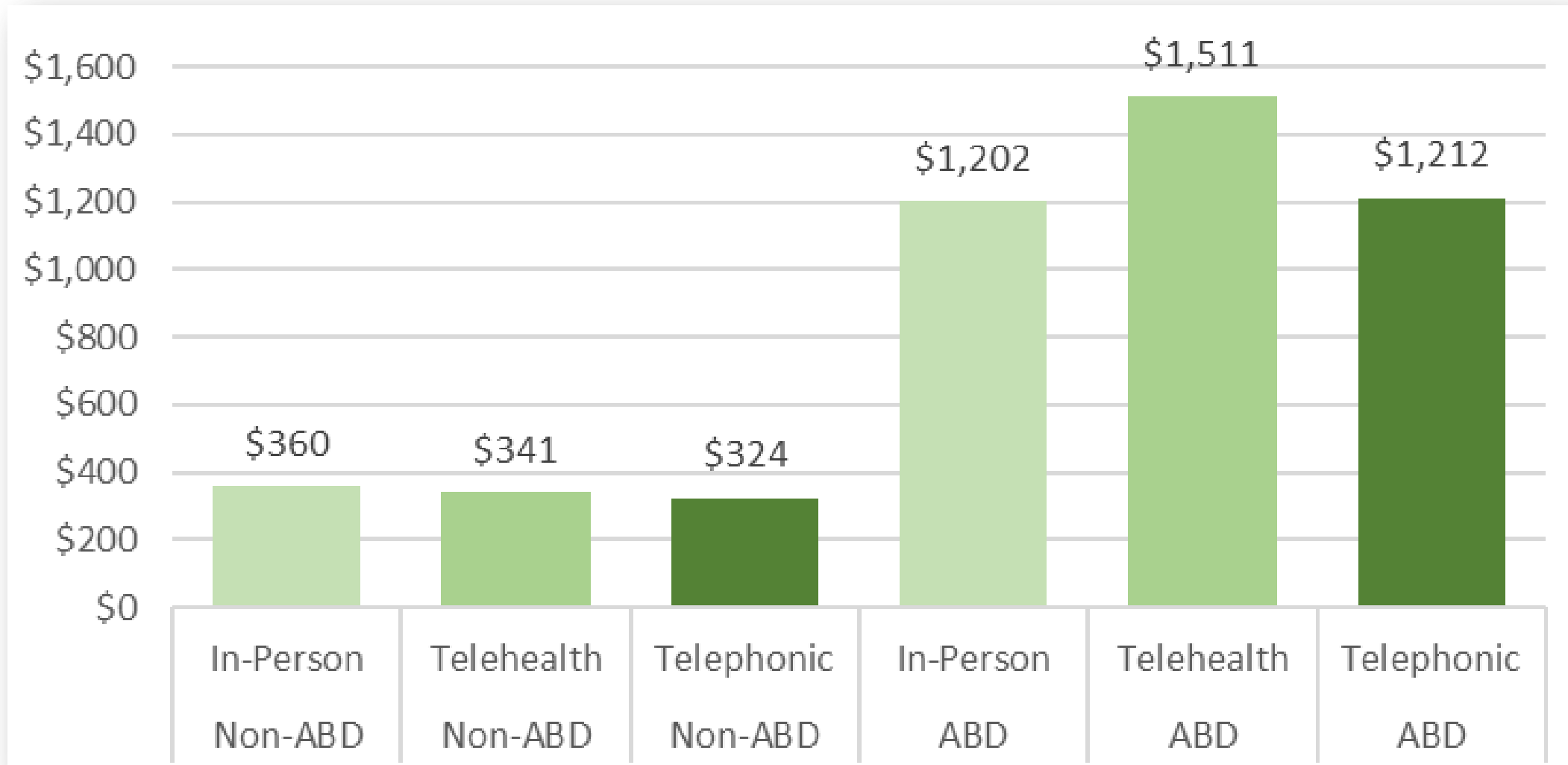
% Using Hospital Within Two Weeks of Primary Care Visit

Admissions were lowest for both ABD and non-ABD populations when initial visit was telehealth

Non-ABD: In-person 2.2%, Telehealth 1.5%, Telephonic 2.4%

ABD: In-person 4.8%, Telehealth 3.2%, Telephonic 4.0%

Legend: In-person, Telehealth, Telephonic
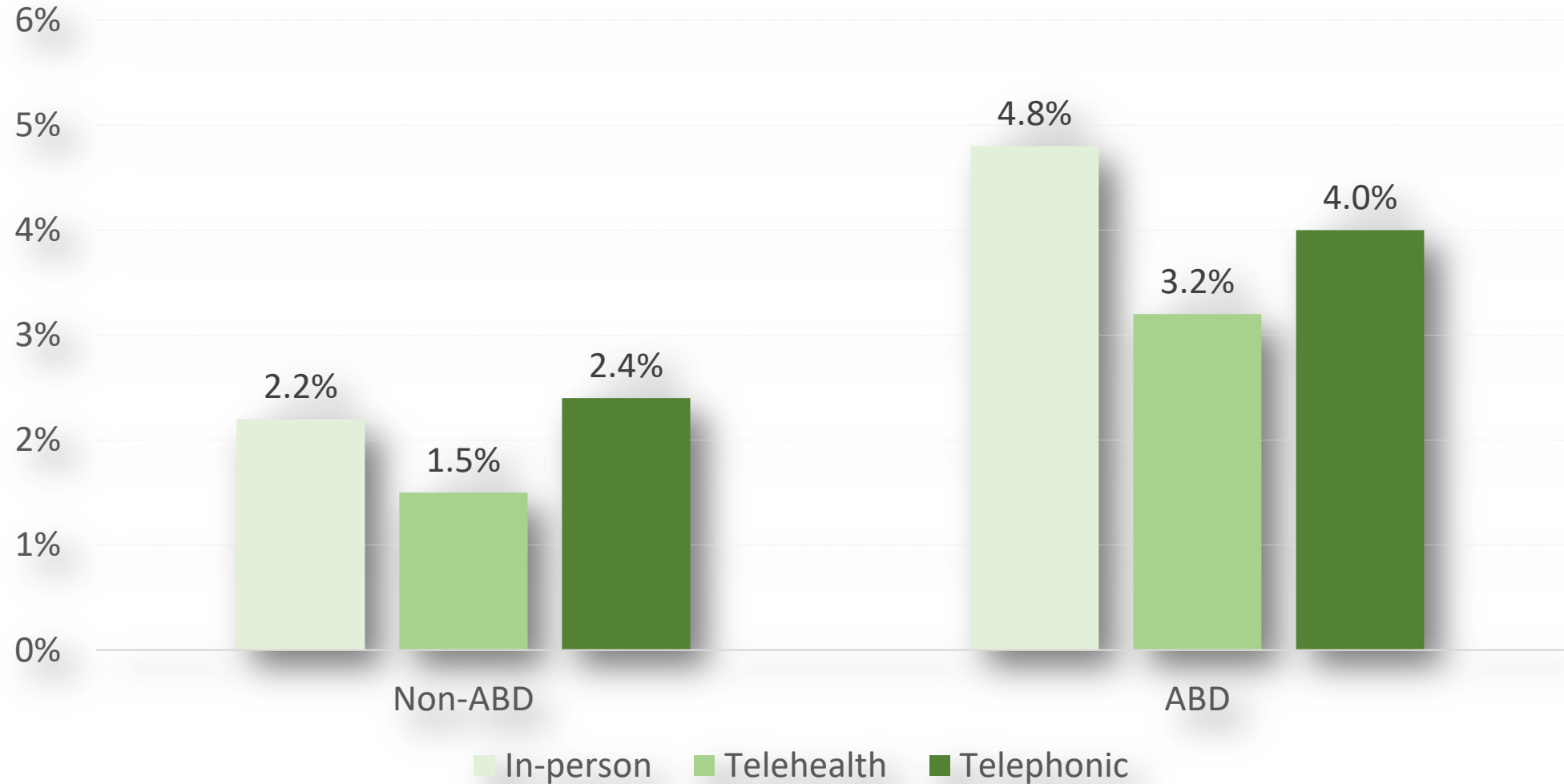
Medication use from June-August was higher for beneficiaries that received some services during March - May

Any Antipsychotic fills June - Aug among those with pre-use
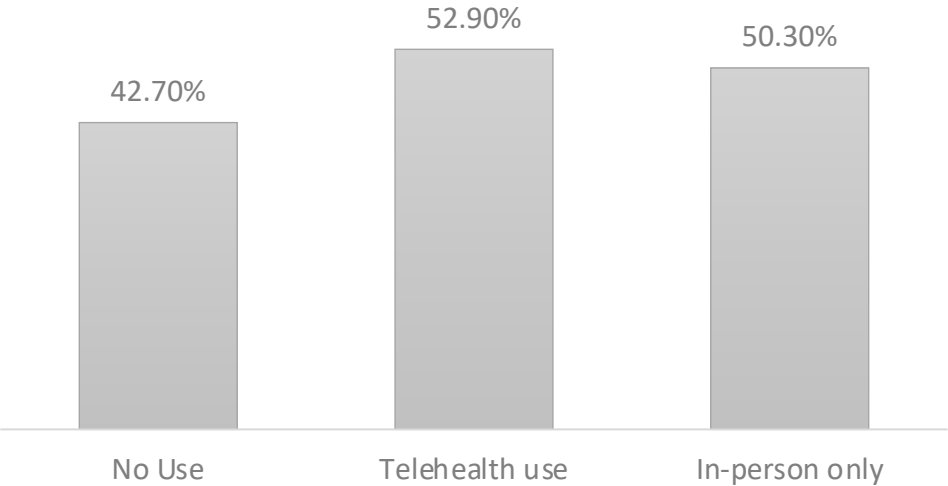
Any MOUD fills June - Aug among those with pre-use

Antipsychotic fills:
- No Use: 42.70%
- Telehealth use: 52.90%
- In-person only: 50.30%

MOUD fills:
- No Use: 46.00%
- Telehealth use: 64.80%
- In-person only: 63.40%
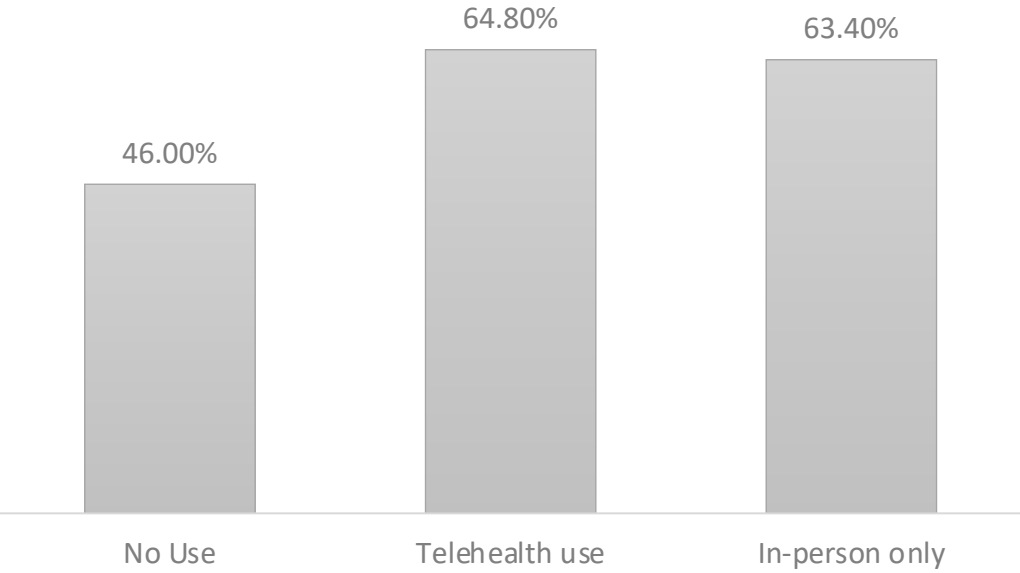
Results were sustained in propensity-weighted models

- In doubly-robust IPTW models (first stage=3 categories of use during Mar-May), we find:
  - No difference among service use during March-May on very poor outcomes (death, overdose, use of crisis services)
  - Higher rates of antipsychotic adherence for those who were on antipsychotics prior to the PHE:
    - <u>Telehealth only beneficiaries had 9.1% point higher probability of an antipsychotic fill, compared to beneficiaries that did not receive services</u>
    - In-person only beneficiaries had a 6.1% point higher probability of an antipsychotic fill, compared to beneficiaries that did not receive services
  - Higher rates of MOUD for those who were on MOUD prior to March:
    - <u>Telehealth only beneficiaries had 16.0% point higher probability of an MOUD fill, compared to beneficiaries that did not receive services</u>
    - In-person BH users had a 20.8% point higher probability of an MOUD fill, compared to beneficiaries that did not receive services

Further Analyses

1. Working with North Carolina's Health Information Exchange and State Lab data to observe teleservice health outcomes

2. Fielding a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey with a sampling approach that will allow responses to be stratified by teleservice utilization by the following demographic categories:
   a) Child | Adult
   b) Race (Black | White | General)
   c) Ethnicity (Latinx | Not Latinx | General)

3. Examining the impact of primary care providers' telehealth uptake on COVID-19 rates within their patient panel coupled with an examination of the degree to which receiving care via telehealth is a factor in beneficiaries contracting COVID-19

4. Partnering with the Sheps Center for Health Services Research on a metanalysis of teleservice findings in provider surveys implemented during the first several months of the COVID-19 period, as well as a follow-up survey of providers' experience with teleservices
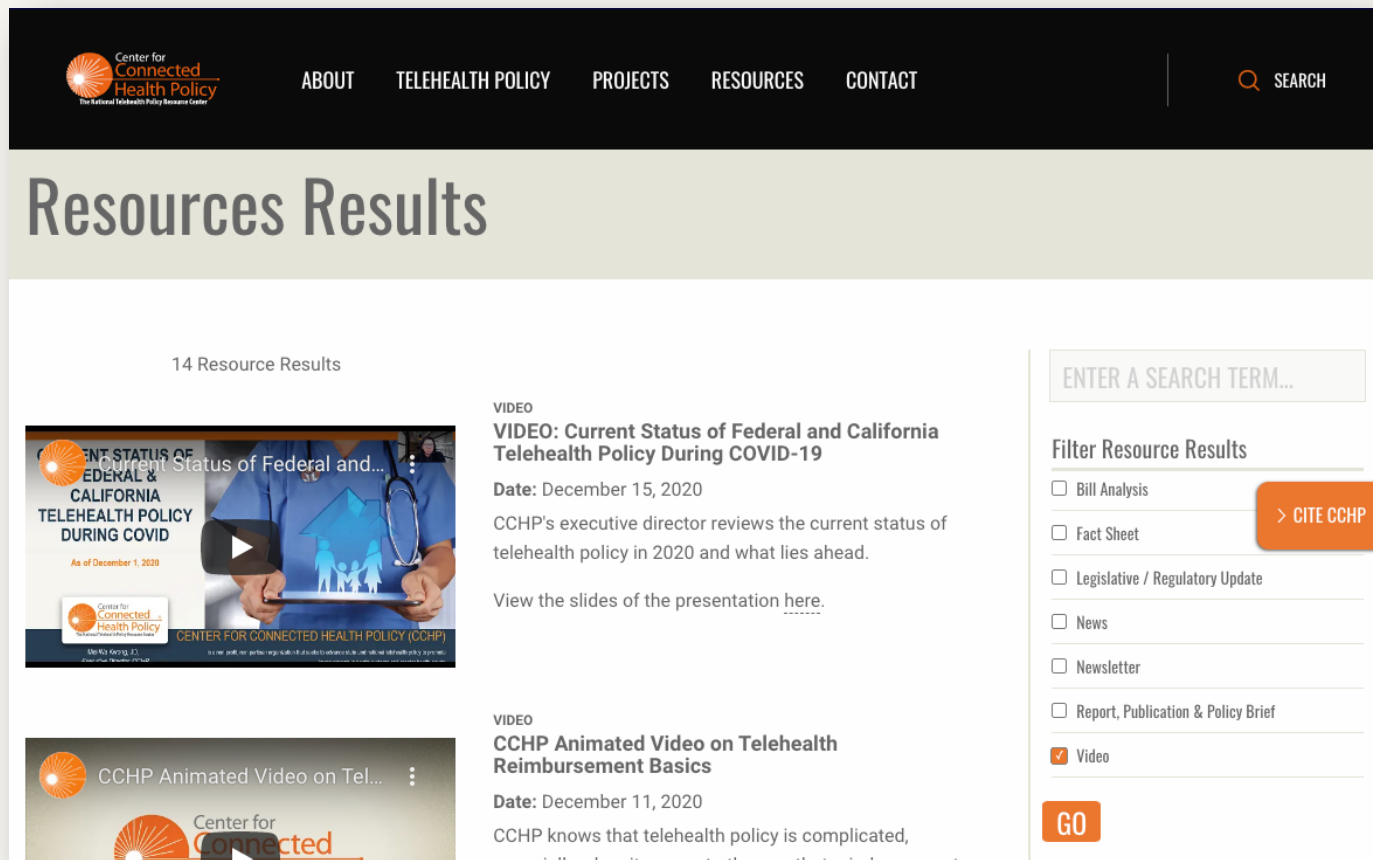
The Digital Divide

Panel Q&A

Please submit questions using the Q&A function.

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