Medicaid Telehealth Policy For Seniors

May 14, 2021

Center for Connected Health Policy
The National Telehealth Policy Resource Center

CENTER FOR CONNECTED HEALTH POLICY (CCHP)

is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.

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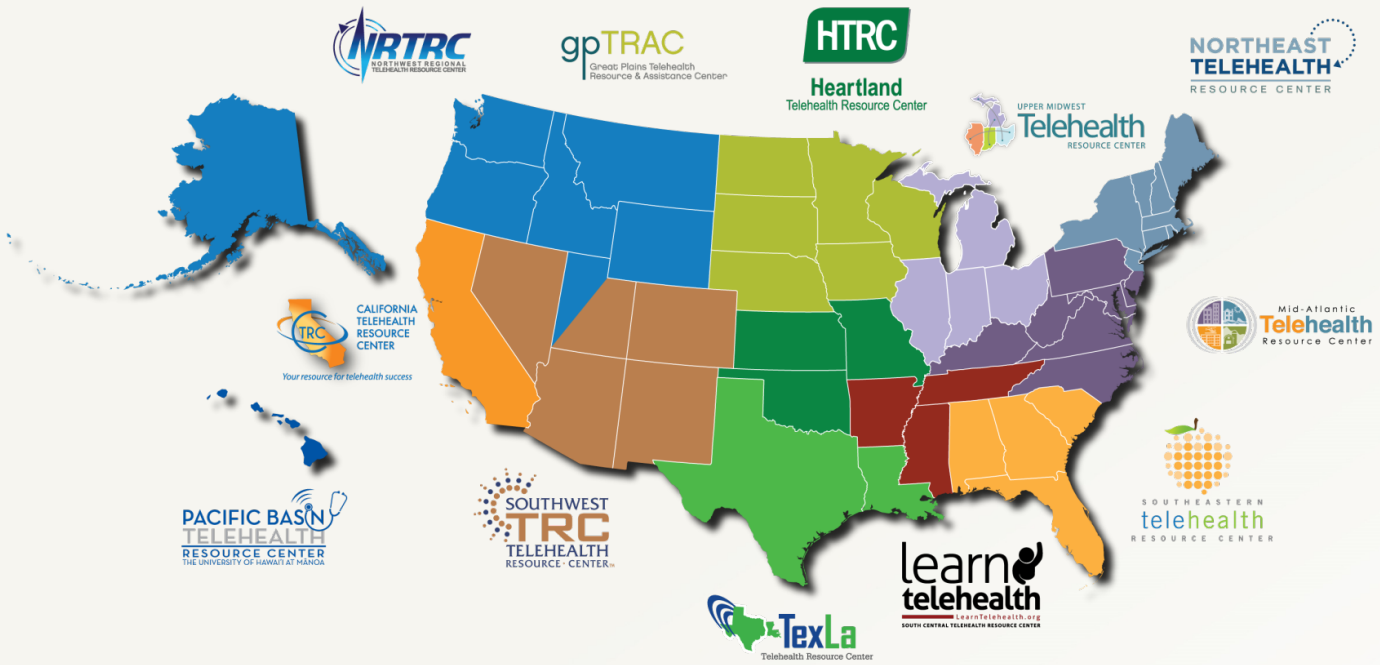
ABOUT CCHP

- Established in 2009 as a 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 on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition

NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org



TTAC TelehealthTechnology.org

Center for Connected Health Policy

2 National Resource Centers

NRTRC	gpTRAC	NETRC
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12 Regional Resource Centers

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Telehealth & Medicaid: A Policy Webinar Series

May 21, 2021: Telemental & Behavioral Health

Image source: American Psychological Association

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TODAY'S WEBINAR

Connecticut Department of Social Services

Kate McEvoy, JD, Director of Health Services, Connecticut Department of Social Services

California Department of Health Care Services

Rene Mollow, MSN, RN, Deputy Director, California Department of Health Care Services, Health Care Benefits and Eligibility

Center for Connected Health Policy
The National Telehealth Policy Resource Center

Connecticut Strategies to Enable Access for Older Adults and People with Disabilities

Center for Connecticut Health Policy Webinar

May 14, 2021

The Overall Approach

Connecticut, which had no applied experience with telehealth prior to the initial declaration of the Public Health Emergency, joined sister states in rapidly deploying, and iteratively expanding, an expansive portfolio of telehealth coverage, at parity with in-person rates, and via audio-visual conferencing and telephone. With respect to older adults and people with disabilities:

- some of this coverage (e.g. authority for remote assessments and various services under home and community-based waivers) was directly targeted; and
- other coverage (e.g. remote provision of skilled therapies, hospice and customized wheelchair assessment) was not specifically targeted but had substantial benefit

Content:

- Public health emergency declarations and authorities
- Member supports
- Provider supports
- Telehealth services, utilization and satisfaction survey data

Public Health Emergency Authorities

Authorities

HUSKY Health has used three federal authorities to flexibly respond to needs of members and providers during the PHE.

Authority Type	Details	Status
Medicaid and Children's Health Insurance Program (CHIP) 1135 waiver	**Increasing Access-to-Care Flexibilities** by removing prior authorization requirements, expanding the ability to serve members in alternate settings such as a shelter or vehicle, waiving or adding flexibilities (settings, signatures, assessments, other) to various requirements for home and community-based 1915(c), 1915(i), and 1915(k) programs, and suspending various provider enrollment requirements to enable enrollment of new providers	CMS has approved many of Connecticut's requests via letters of 3/27/20, 5/12/20, 6/17/20, 8/21/20, and 3/12/21 The approved 1135 authorities expire at the end of the PHE

HUSKY Health has used three federal authorities to flexibly respond to needs of members and providers during the PHE.

Authority Type	Details	Status
Medicaid & CHIP Disaster Relief State Plan Amendments (SPAs)	• **Eligibility** (election of the new Medicaid testing group) • **Coverage** (add flexibility for telehealth, home health, Community First Choice (CFC), and 1915(i) state plan services) • **Reimbursement** (specified temporary rate increases, COVID-19 lab fee codes, telehealth audio-only codes, other) • **Cost sharing** (waiver of HUSKY B copayments for most medical services and prescription drugs) • **Coverage of vaccines**	Medicaid SPAs were approved on 8/13/20 and 2/22/21; CHIP SPA was approved on 8/27/20 The disaster SPAs expire at the end of the PHE

HUSKY Health has used three federal authorities to flexibly respond to needs of members and providers during the PHE.

Authority Type	Details	Status
1915(c) Appendix K waivers	**Requests for flexibilities** around remote assessments and reassessments, additional services, staffing of services, and retainer payments for home and community-based providers	CMS first approved Connecticut's Appendix K submissions on 3/27/20 and approved renewal on 3/24/21 Expire one year from the effective date

Member Supports

To support members during the PHE, HUSKY Health:

- Covers COVID-19 testing, treatment and vaccinations with no cost share
- Extended coverage to 90-day periods for prescription drugs, medical surgical supplies, hearing aid batteries, parenteral/enteral supplies, respiratory equipment and supplies
- Implemented a broad portfolio of telehealth options in support of primary care, behavioral health services, birth to three, physical/occupational/ speech therapy, rehab clinics, autism spectrum disorder services, school-based child health, our long-term services and supports waivers, evaluation in support of customized wheelchairs, speech and language pathology, respiratory care, and dental

Please note that extended coverage and telehealth flexibilities are authorized by Executive Order and are subject to legislative/executive review.




- Through CHNCT, DSS' medical administrative services organization (ASO), is maintaining a 24/7 nurse care line, supporting referrals to providers, and using data to identify people in need of intensive care management
- Through Beacon Health Options, DSS' behavioral health ASO, has implemented a peer staff warm line
- Expanded long-term services and supports under the waivers
- Is ordering and distributing Personal Protective Equipment (PPE) to consumer employers who participate in self-directed care under Community First Choice
- Implemented a specialized Non-Emergency Medical Transportation (NEMT) service for COVID-positive people
- Partnered with DPH, the ASOs and Veyo on vaccine education, outreach, warm reservation line, NEMT for appointments and equity efforts

Provider Supports

Provider Supports

HUSKY Health has supported providers by . . .	• Implementing coverage for telemedicine at the same rates that are paid for in-person visits • Providing administrative flexibilities (e.g. removal of prior authorization) in where and how care can be provided • Continuing to pay 100% of clean claims on a timely, bi-weekly basis • Making payment advances and provider relief payments • Advocating at the federal level for further financial relief

Telehealth

LTSS Telehealth Services

- Permitted specified physical therapy (PT), occupational therapy (OT) and speech & language pathology (SLP) services to established patients via synchronized telemedicine (real time live audio and video technology) Provider Bulletin 2020-23
- For various 1915(c) home and community-based services (HCBS) waivers:
  - Allowed virtual assessments and reassessments
  - Waived the face-to-face requirement
  - Permitted various services (adult day programs, mental health counseling, services for individuals with intellectual disabilities including day supports and group supported employment) to be provided electronically and in some cases telephonically Provider Bulletin 2020-27

- Permitted hospice agencies to provide services via telemedicine or audio-only telephone Provider Bulletin 2020-28
- Permitted behavioral assessments of individuals with Autism Spectrum Disorder to be rendered via synchronized telemedicine (audio and video) Provider Bulletin 2020-47
- Permitted physical therapists, occupational therapists, and assistive technology professionals to conduct customized wheelchair evaluations via synchronized audio and visual telemedicine, so long as one of the licensed professionals is in the member's home while the certified ATP is present by synchronized telemedicine during the evaluation, or vice-versa Provider Bulletin 2020-46

Use of Telehealth

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.						

Race/Ethnicity	2019 Population	2019 Services	2020 Population	2020 Services	Telehealth 2020*	Audio Only 2020*	Audio/Video 2020*	Audio Only Utilization
All Other/Multiple Races/Unknown	30.39%	29.90%	32.21%	31.12%	29.81%	29.20%	29.34%	45.88%
Asian Non-Hispanic	2.77%	2.67%	2.80%	2.61%	2.17%	1.95%	2.07%	42.26%
Black/African American Non-Hispanic	14.66%	14.55%	14.30%	14.04%	13.56%	14.84%	12.85%	51.28%
Hispanic	21.36%	22.07%	20.56%	21.47%	22.37%	26.70%	20.72%	55.91%
White/Caucasian Non-Hispanic	30.82%	30.81%	30.12%	30.76%	32.10%	27.31%	35.02%	39.85%

The 2nd and 4th columns reflect the overall incidence of each group as a segment of the HUSKY Health membership, comparing 2019 and 2020

The 3rd and 5th columns use a denominator reflecting the total of members receiving "telehealth eligible services"(i.e. services were permitted to be billed as telehealth in 2020 with the telehealth modifier) and reflect the racial breakout of members with those services in 2019 and 2020. Again, totals are 100%

The 6th column reflects use of telehealth eligible services that were billed with the telehealth modifier, by each group, for 2020

The 7th (audio only 2020) and 8th (a/v 2020) columns use a denominator reflecting the total membership receiving that type of service, and reflects the racial breakdown of those services

The 9th column represents the % of each racial group that used audio-only services (note that this does not equal 100%)

Experience with Telehealth

- HUSKY Health medical administrative services organization CHNCT conducted surveys to seek feedback on use of telehealth

- Key results of the survey of **801 members** showed the following:

  - 58.2% of respondents reported using “video with audio/telephone” for their appointment, compared to 47.2% of respondents who utilized “audio-only” 79.6% of respondents either “strongly agree/agree” that “overall, [they] liked using telehealth” and 72.0% reported they either “strongly agree/agree” that “telehealth worked just as good for as an in-person appointment”
  - When asked to identify features that members ***liked***, 76.0% indicated that they “did not have to travel to the office” and another 42.9% reported having “less time waiting for the appointment to start”
  - When asked to indicate features they ***did not like***, 64.2% indicated “nothing,” 12.4% noted they “found it too hard to talk to the doctor/felt less personal,” and another 8.4% reported “it was hard to use/had problems connecting”

- Key results of 203 **provider respondents** showed the following:

  - 69.6% of providers used video with audio; 27.0% audio only; and 3.3% advised they didn't offer telehealth
  - 45.8% of providers noticed a decrease in missed appointments
  - 66.0% of providers did not experience any technical difficulty when visiting with their patient during a telehealth visit
  - 73.9% of providers surveyed indicated they found telehealth an adequate replacement for an in-person visit
  - 83.3% said they would continue to use telehealth after the COVID-19 crisis

- Member listening sessions have also been held by Medicaid member advisory bodies including the behavioral health-focused Child & Family Advisory Council

Questions?

Telehealth Medicaid Policies for Seniors

René Mollow, MSN, RN
Deputy Director
Health Care Benefits & Eligibility

Telehealth Brief History

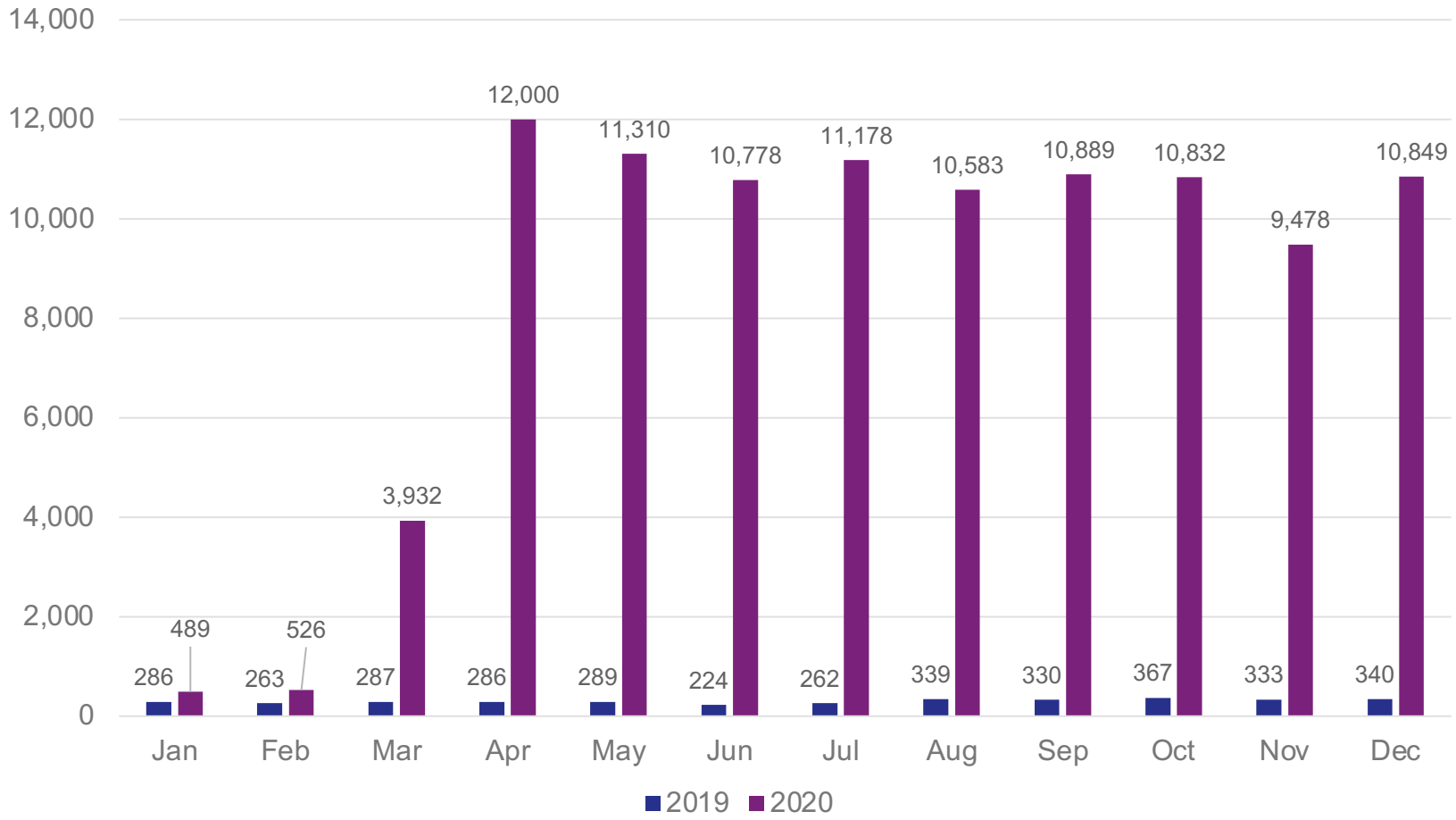
- **Pre-COVID Telehealth Policy**
  - Medi-Cal's telehealth policy was originally established pursuant to Assembly Bill 415, known as the Telehealth Advancement Act of 2011.
  - In 2019 DHCS, following extensive stakeholder engagement and public comment, introduced revised telehealth policy which afforded substantial flexibility to licensed providers to make clinically appropriate decisions regarding the use of synchronous and asynchronous telehealth modalities across both fee-for-service (FFS) and managed care.
- **Temporary COVID-19 PHE flexibilities:**
  - Expand the ability for providers to render all applicable Medi-Cal services that could be appropriately provided by via telehealth modalities – including those historically not identified or regularly provided via telehealth such as home and community-based services, Local Education Agency (LEA) and Targeted Case Management (TCM) services.
  - Allow most telehealth modalities to be provided for new and established patients.
  - Allow many covered services to be provided telephonic/audio only services for the first time.
  - Allow payment parity between in-person, synchronous telehealth, and telephonic services including FQHC/RHCs in both FFS and managed care.
  - Waive site limitations for both providers and patients for FQHC/RHCs.
  - Allow expanded access to good-faith provision of telehealth through non-public technology platforms that would otherwise not be allowed under HIPAA requirements.

Telehealth Visits

- Telehealth visits were identified based on the presence of a modifier on the claim or encounter
(modifiers 95, GQ and GT)
- Telehealth visits include phone and video healthcare visits
- Telehealth Visits are outpatient visits in fee-for-service or managed care – mental health visits are not included in this chart
- Source of data:
  - MIS/DSS Claims and Eligibility

Telehealth Visits

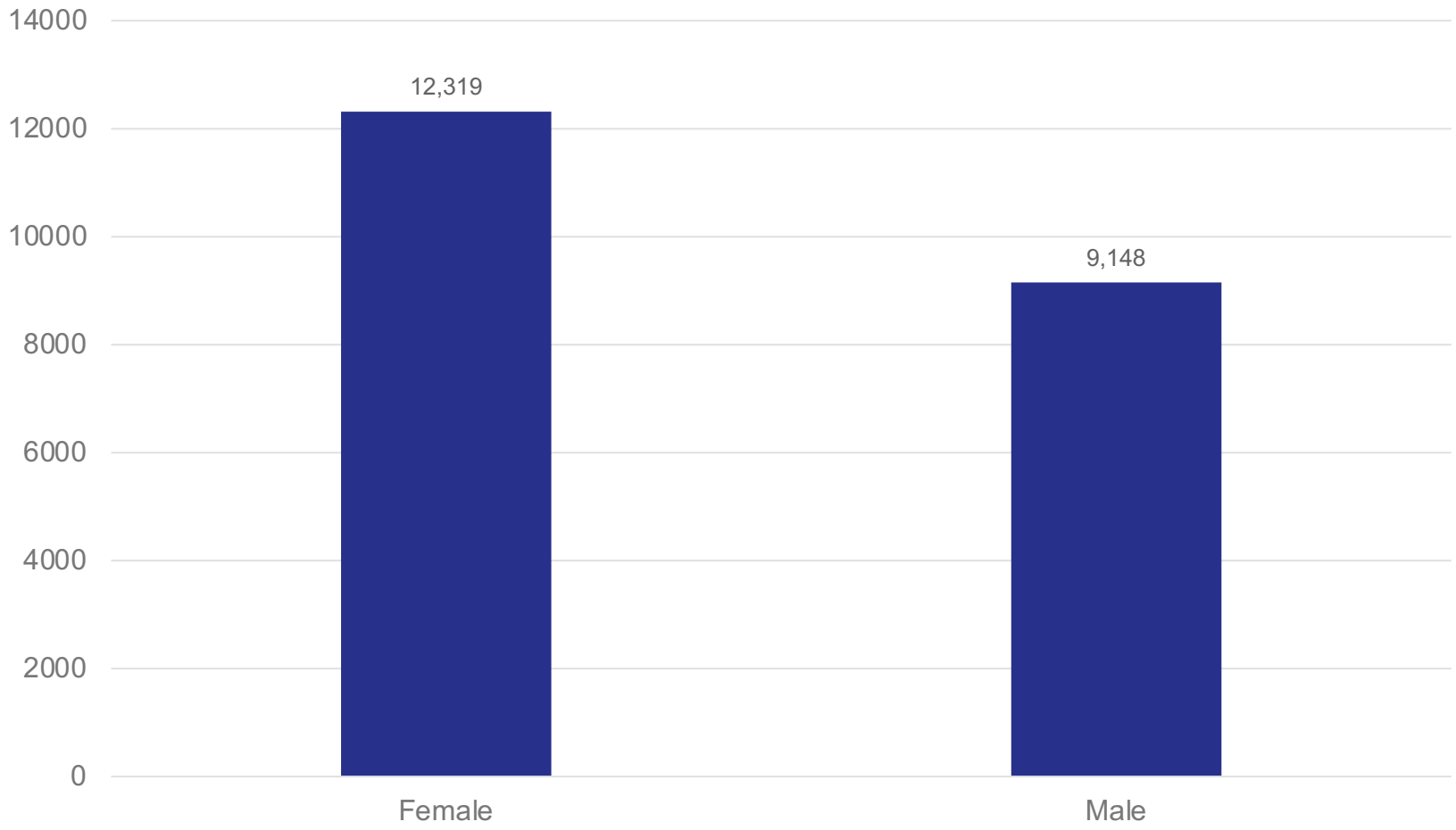
Per 100,000 beneficiaries



Preliminary Data as of 01/2021

Telehealth Visits

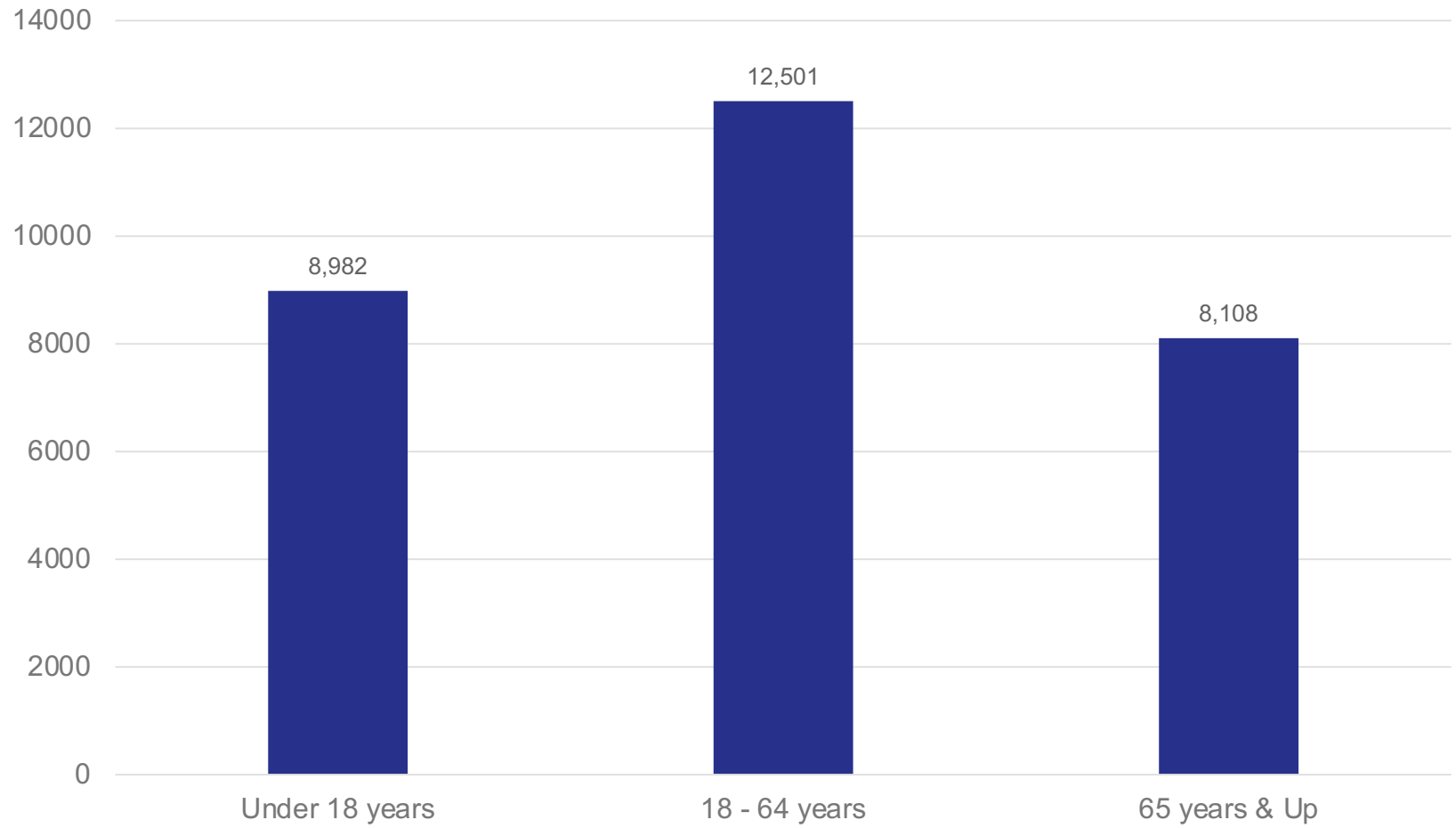
By Sex per 100,000 beneficiaries through 2020



Preliminary Data as of 03/2021

Telehealth Visits

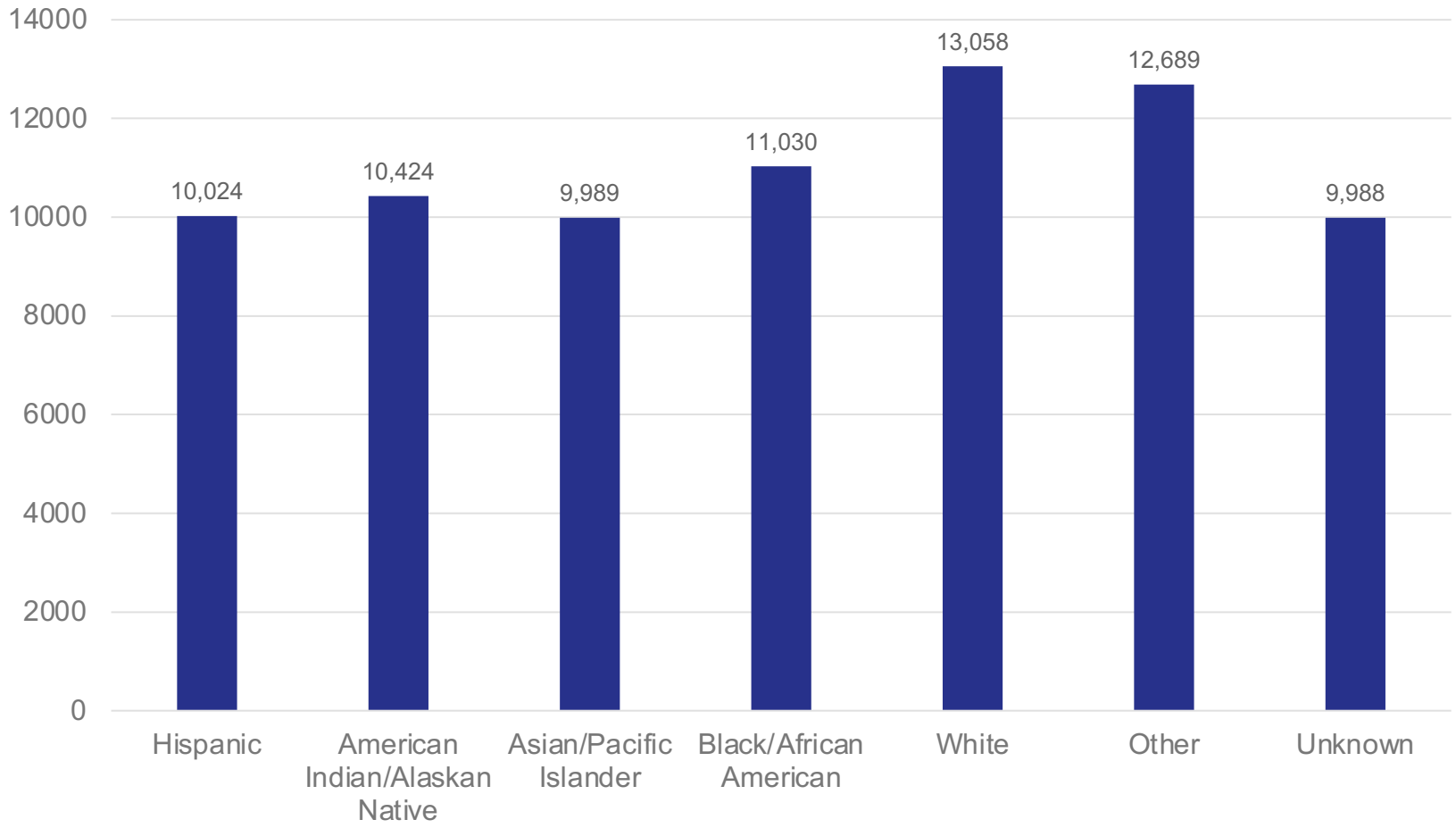
By Age Group per 100,000 beneficiaries through 2020



Preliminary Data as of 03/2021

Telehealth Visits

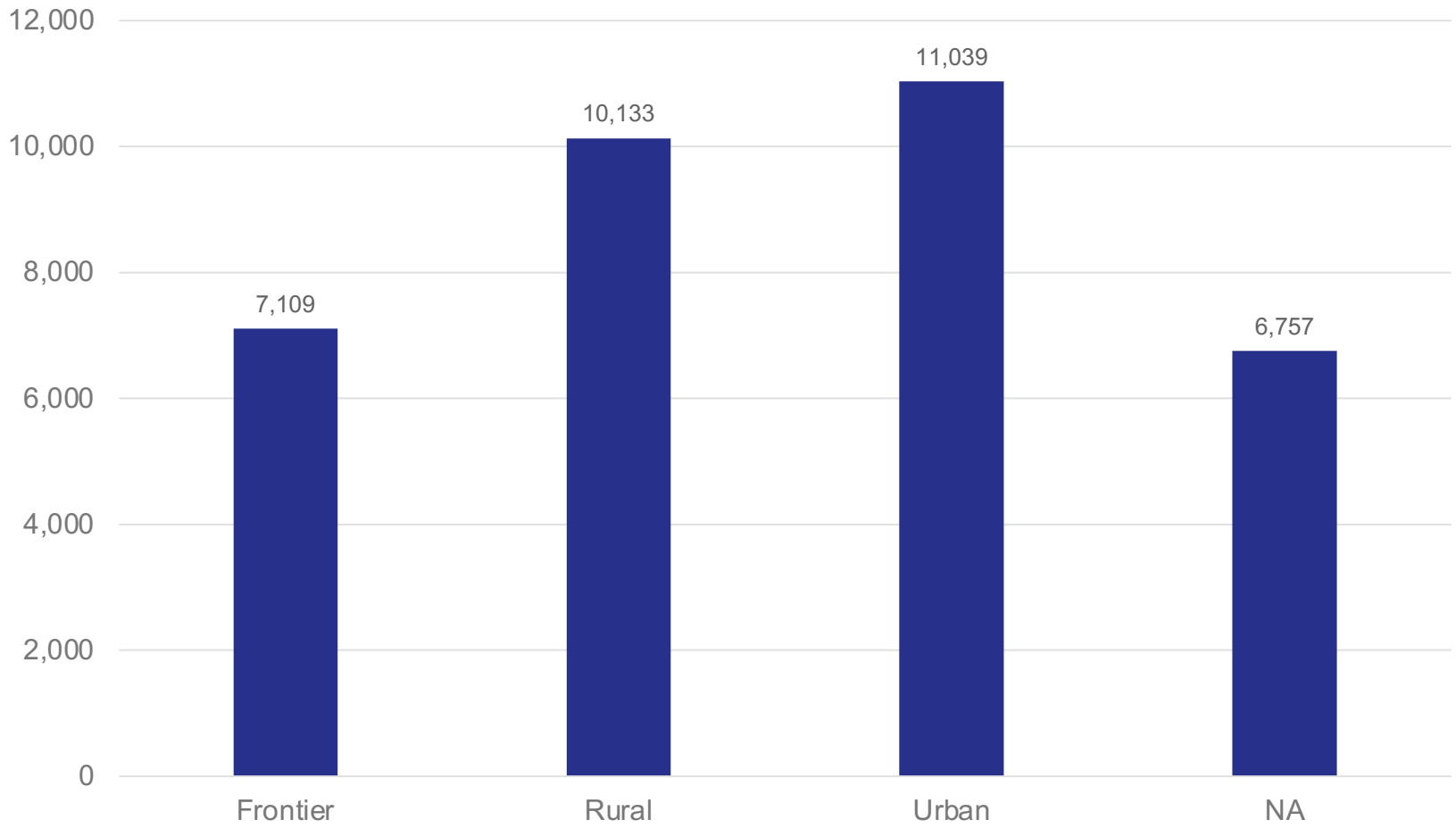
By Race/Ethnicity per 100,000 beneficiaries through 2020



Preliminary Data as of 03/2021

Telehealth Visits New

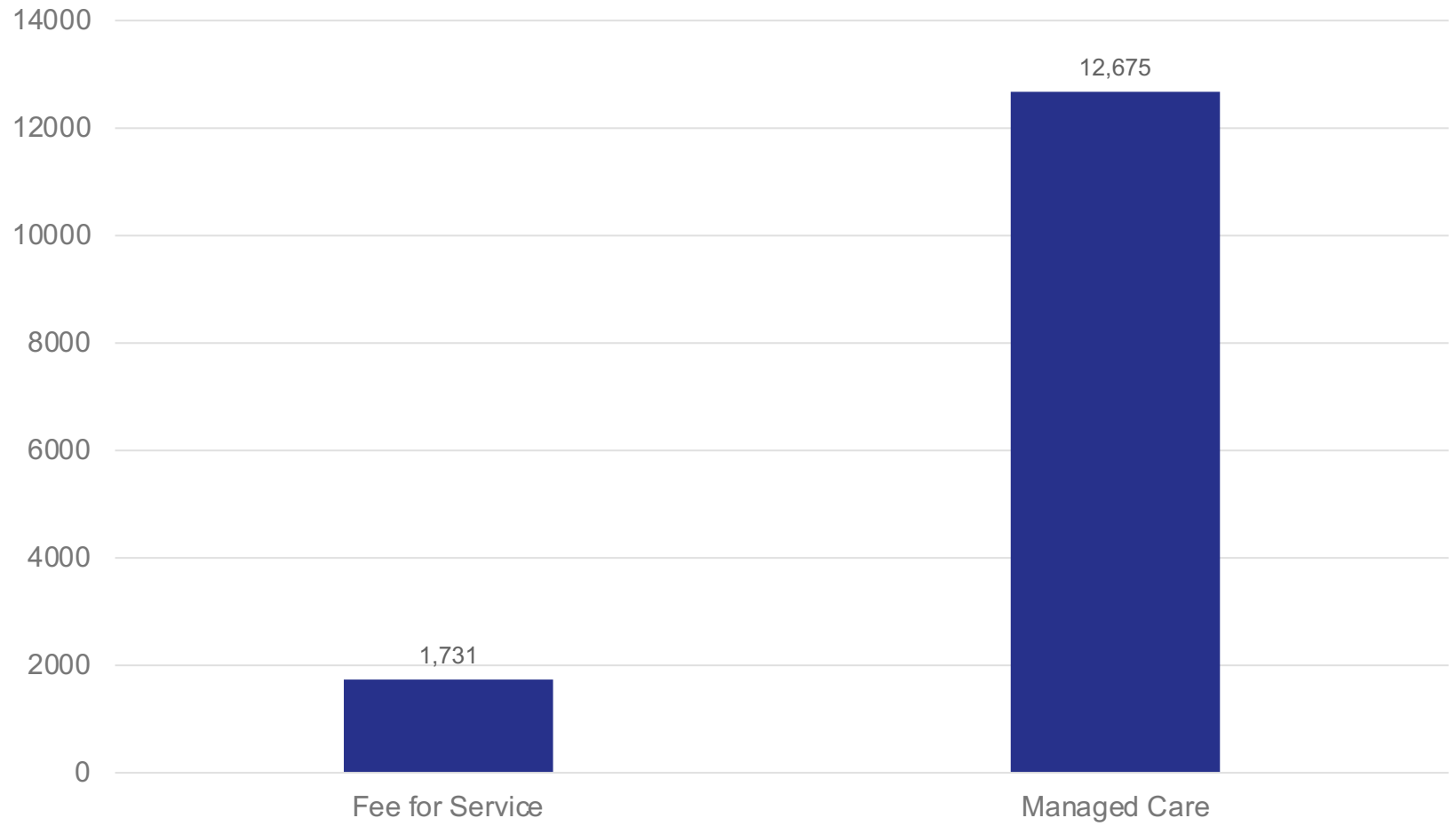
By Location per 100,000 beneficiaries through 2020



Preliminary Data as of 03/2021

Telehealth Visits

By Delivery System per 100,000 beneficiaries through 2020



Preliminary Data as of 03/2021

Pathway Forward

Post COVID-19, DHCS is recommending broad changes to allow the continuation of additional Medi-Cal covered benefits and services to be provided via telehealth modalities.

- Approach is both reasonable and balanced to ensure equity in availability of modalities across the delivery systems while protecting the integrity of the Medi-Cal program.

- Use of the various telehealth modalities continue to provide beneficiaries with increased access to critically needed subspecialties and could improve access to culturally appropriate care.

- Ensure adherence to HIPAA Privacy Rule for appropriate uses and disclosures of information.

Telehealth Post COVID-19

- Recommend to allow the following for all 1915(c) waivers via traditional two way interactive audio-visual telehealth
  - Waiver intake (e.g., initial assessments, level of care determinations, care plan development, home environmental assessments)
  - Case management / Care Coordination
  - Ongoing re-assessments (e.g., scheduled and ad hoc re-assessments, LOC re-determinations, care plan updates, home environmental re-assessments)

- Recommend to allow the following for all 1915(c) waivers via store and forward/e-consults and audio-only telehealth
  - Case management / Care Coordination

Telehealth Post COVID-19 (cont.)

- Allow specified FQHC and RHC providers to establish a new patient, located within its federal designated service area, through synchronous telehealth and make permanent the removal of the site limitation.

- Expand synchronous and asynchronous telehealth services to 1915(c) waivers, the TCM Program and the LEA Medi-Cal Billing Option Program (LEA BOP) and add synchronous telehealth and telephone services to Drug Medi-Cal.

- Require payment parity between in-person, face-to-face visits and synchronous telehealth modalities, when those services meet all of the associated requirements of the underlying billing code(s), including for FQHC/RHCs.
  - Payment parity is required in both FFS and managed care delivery systems, unless plan and network provider mutually agree to another reimbursement methodology.

Telehealth Post COVID-19 (cont.)

- Expand the use of clinically appropriate telephonic/audio-only, other virtual communication and remote patient monitoring for established patients only.
  - These modalities would be subject to a separate fee schedule and not billable by FQHC/RHCs.

- Provides that the TCM Program and the LEA BOP will follow traditional certified public expenditure (CPE) cost-based reimbursement methodology when rendering services via applicable telehealth modalities.

Telehealth Post COVID-19 (cont.)

Flexibilities DHCS is <u>not</u> recommending:

- Telephonic/audio-only modalities as a billable visit for FQHC/RHCs reimbursed at the Prospective Payment System rate.
- Telephonic/audio-only modalities to establish a new patient.
- Payment parity for telephonic/audio-only modalities, virtual communications for delivery systems allowed to bill such services
- Continuing COVID-19 PHE telehealth policies for Tribal 638 clinics as the federal government sets policy for Indian Health Services.

DHCS would like to engage with interested FQHC/RHC stakeholders relative to using telephonic/audio-only modalities, e-consults, virtual communication modalities (e.g., e-visits) and/or RPM in the context of an Alternative Payment Methodology.

CMS Guidance on Medicare during COVID 19

- CMS has added 144 telehealth services covered through the end of the PHE such as
  - Initial inpatient and nursing facility visits
  - Discharge day management services,
  - Medicare telehealth services at renal dialysis facilities and at home.
  - Medicare telehealth services for certain emergency department visits at home.
  - Medicare telehealth services for certain physical and occupational therapy services at home.
  - Some services delivered via audio only devices.
  - Virtual check-ins and E-visits.

Program of All Inclusive Care for the Elderly (PACE) COVID 19 Flexibilities

- Critical, medically necessary services can be delivered by the PACE Organizations (POs) via an in-person visit or via telehealth
- Adult Day Health Care (ADHC) can provide basic services to participants through telehealth or other remote services
  - Basic services include: occupational therapy, physical therapy, speech therapy, medical services, nursing services, nutrition services, psychiatric or psychological services, social services, and recreation or planned social activities.
- When using telehealth flexibility DHCS requested POs send notification to the PACE Policy Unit for tracking purposes

Home and Community-Based Alternatives Waiver COVID 19 Flexibilities

- Temporarily modify licensure or other settings requirements allowing telehealth as an alternative option to face-to-face interactions for medically necessary services by waiver service providers and waiver agencies.
- A covered health care provider can use any non-public facing remote communication product that is available to communicate with patients.

Assisted Living Waiver COVID 19 Flexibilities

- Medically necessary services can be delivered by home health agency (HHA) providers and CCAs via telehealth, as deemed appropriate by the HHA provider or Care Coordination Agencies (CCA).
- The Office of Civil Rights (OCR) exercises enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth.

DHCS Next Steps

- **Budget Proposal:** The budget includes $94.8 million total funds ($34.0 million General Fund) to implement remote patient monitoring services as an allowable telehealth modality in fee-for-service (FFS) and managed care delivery systems.

- **Advancing Trailer Bill Language (TBL):** The TBL, with an effective date of July 1, 2021, which includes the following:
  - Add virtual communication, telephonic/audio-only and RPM as allowable modalities under Medi-Cal
  - Allow DMC providers to deliver all allowable SUD services via synchronous and telephonic/audio only modalities
  - Expand the definition of a FQHC and RHC visit to include synchronous interaction and include the ability of these providers to establish patients through synchronous telehealth.
  - Use of telehealth to meet network adequacy standards in Medi-Cal managed care health plans, County mental health plans, dental managed care plans and DMC-ODS
  - Revise Alternate Access Standards submission and review process and to postpone the network adequacy sunset provision until 2026

DHCS Next Steps (cont.)

- **Submission of State Plan Amendments (SPAs):** as necessary, submit any needed SPAs for necessary federal approvals, with an effective date of July 1, 2021.

- **Submission of 1915(c) Home and Community Based Services (HCBS) Waivers:** will amend existing 1915(c) HCBS waivers, with an effective date of July 1, 2021, to allow for telehealth and other virtual communication modalities and amendment waiver contracts, as necessary.

- **Promulgating CA Regulations:**
  - TCM
  - SMH
  - DMC

DHCS Next Steps (cont.)

- **Developing and Issuing Policy Guidance:** Through calendar year 2021, develop and issue clear policy guidance for Medi-Cal providers across delivery systems.
  - Updates to various sections of the Medi-Cal Provider Manual and other policy/procedure documents.
  - Creation of new and amendments to existing provider and patient education materials.
  - Execution of contract amendments, as appropriate across various delivery systems

- **Initiating Stakeholder Engagement**

DHCS Telehealth Links

- Medi-Cal and Telehealth website: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
- DHCS Telehealth Trailer Bill and Fact Sheet: https://www.dhcs.ca.gov/Pages/LGA.aspx
- DHCS Telehealth Public Proposal: https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Policy-Proposal-2-1-21.pdf

Thank you!

Panel Q&A

Please submit questions using the Q&A function.

Thank You!

Connecticut Department of Social Services

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California Department of Health Care Services

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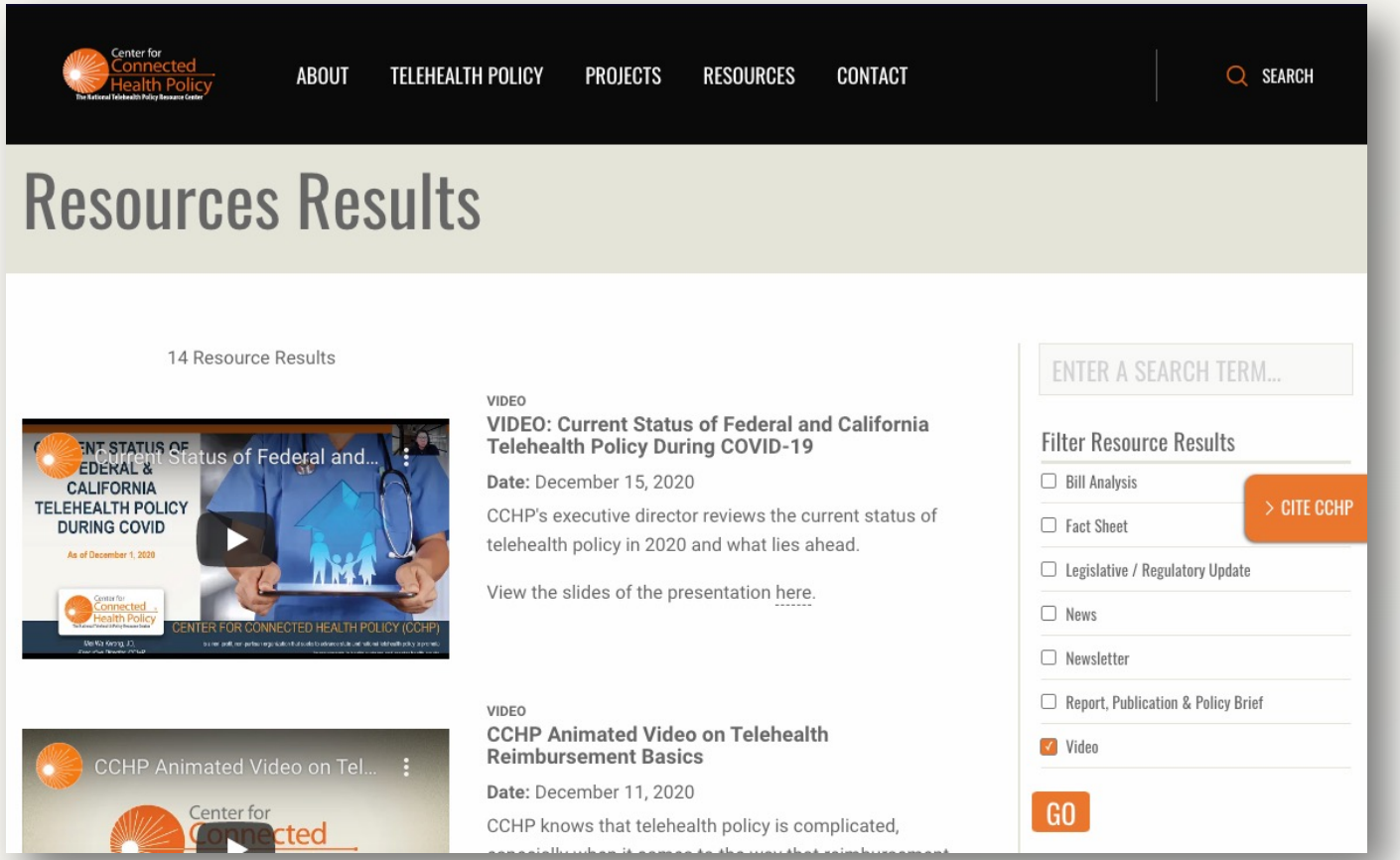
Webinar Recordings and Resources



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Thank You!

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