Medicaid Telehealth Policy For Mental & Behavioral Health

May 21, 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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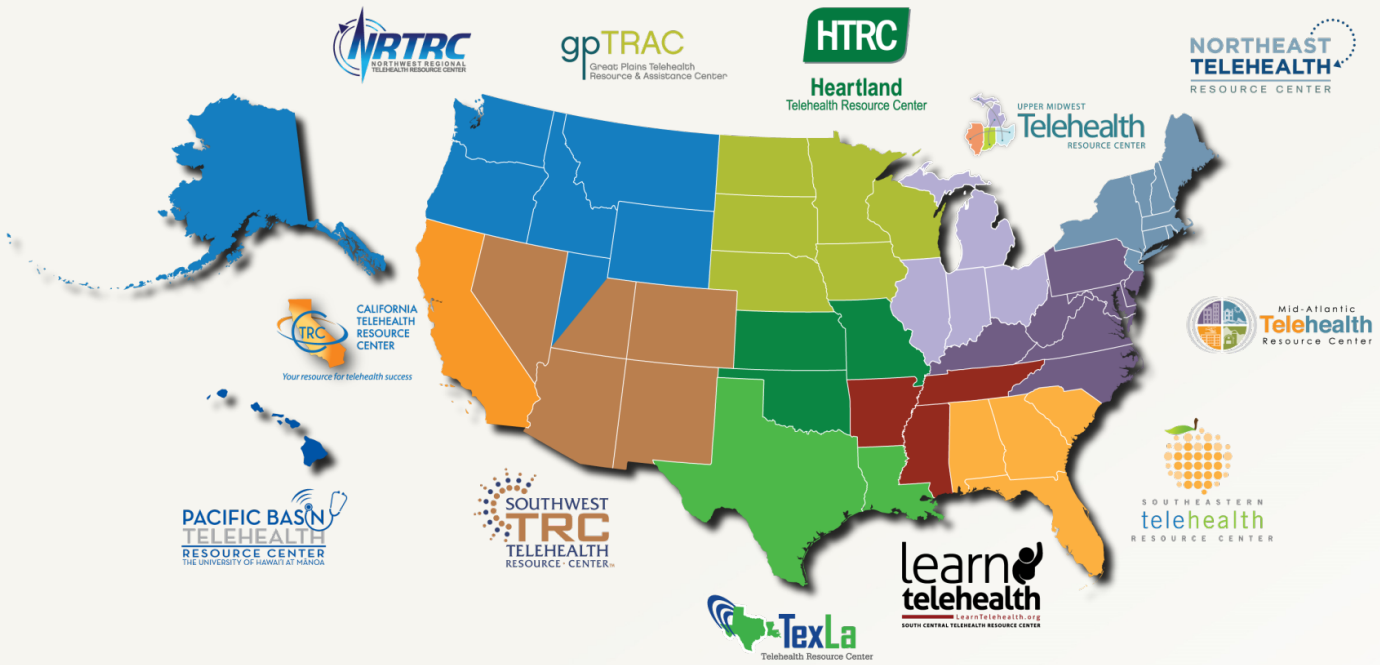
ABOUT CCHP

- 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

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2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

TRC

TELEHEALTH RESOURCE CENTERS

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The National Telehealth Policy Resource Center

Telehealth & Medicaid: A Policy Webinar Series

Stay tuned for information about the Fall Series!

Image source: American Psychological Association

This webinar series was made possible by grant number GA5RH37470 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, U.S. Department of Health & Human Services.

TODAY'S SPEAKERS

Texas Health and Human Services Commission

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TEXAS
Health and Human Services

Behavioral Health Services in Texas Medicaid

Center for Connected Health Policy
May 21, 2021

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Mental Health (MH) Services

- Outpatient Mental Health Services
- Mental Health Targeted Case Management (MHTCM)
- Mental Health Rehabilitative Services (MHR)
- Inpatient Psychiatric Services
- Health and Behavior Assessment and Intervention (HBAI)

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Outpatient MH Services

- Psychiatric diagnostic evaluation
  - With or without medical services
- Psychotherapy
  - Individual, group and family
- Psychological, neuropsychological and neurobehavioral testing/exam
- Pharmacological management
- Electroconvulsive therapy

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Health and Human Services

Outpatient MH Services Provider Types

- Licensed Practitioners of the Healing Arts (LPHAs) – Physicians, PAs, CNSs, Psychologists, LCSWs, LPCs, and LMFTs
- Licensed Psychological Associates
- Provisionally Licensed Psychologists, Post-Doctoral Fellows, and Pre-Doctoral Psychology Interns

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MHTCM

Services include development of a care plan, making referrals, monitoring and follow-up activities

- **Target population:**
  - All ages with a DSM V mental illness diagnosis
  - Determined via a uniform assessment
- **Types:**
  - Routine services (all ages)
  - Intensive services (20 years of age and younger)

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MHR

To help persons achieve a rehabilitation goal and be a fully integrated and functioning member of the community

- **Includes the following services:**
  - Crisis intervention
  - Medication training and support
  - Skills training and development
  - Psychosocial rehabilitation services (adults only)
  - Day program for acute needs (adults only)

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Inpatient Psychiatric

- Admissions to acute care hospitals and publicly- and privately-operated psychiatric facilities (IMDs) for psychiatric conditions are a benefit of Medicaid for persons:
  - 20 years of age and younger
  - 65 years of age and older
- If delivered through managed care, then services for persons 21 through 64 years of age are eligible for reimbursement for up to 15 days per calendar month
- Admissions to psychiatric facilities must be medically necessary

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HBAI

Health and Behavior Assessment and Intervention Services are:

- For persons 20 years of age and younger
- Provided by Licensed Professional of the Healing Arts (LPHA) co-located with a physician, PA, NP or CNS
- Designed to identify the psychological, behavioral, emotional, cognitive and social factors that are important to prevention, treatment and/or management of physical health symptoms

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Substance Use Disorder Services

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Assessment
- SUD Counseling
- Medication Assisted Treatment (MAT)
- Residential Treatment
- Withdrawal Management

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SBIRT

- For persons 10 years of age and older who have, or at risk of having, an alcohol or substance use disorder.
- Individual, not group, intervention that includes:
  - Screening
  - Brief intervention
    - Positive screen or mild/moderate risk of substance use
  - Referral to treatment
    - More extensive treatment needed or severe risk of substance use

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Assessment

Face-to-face and multi-dimensional to determine the course of medically necessary and clinically appropriate treatment that is conducted by a Qualified Credentialed Counselor

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SUD Counseling

- Provided individually or in a group setting
- Step-down from more intensive services
- Target population:
  - Persons with less severe disorders
  - Persons in early stages of change
  - Persons who are stable but require ongoing monitoring

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MAT

- The use of FDA-approved medications in combination with psychosocial treatment to treat SUDs, particularly alcohol and opioid use disorders
- Recognized best practice for alcohol use disorder and opioid use disorder
- Certain MAT medications are available as a Medicaid pharmacy benefit
- Prescribing of certain MAT medications may be done via telemedicine (presuming all other applicable state and federal laws are followed)

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Residential Treatment Services

- Structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions, as appropriate
- May specialize in the unique needs of a specific population, e.g., adolescents or pregnant or parenting women with children
- May only be delivered by a licensed CDTF

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Withdrawal Management

- Medical and behavioral treatment of persons experiencing or potentially experiencing withdrawal symptoms as a result of ceasing or reducing substance use (formerly known as detoxification)
- May be provided in an inpatient hospital or residential or outpatient setting in a CDTF

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Additional Coverage

Peer Specialist Services

- Benefit for persons 21 years of age and older with mental health or substance use condition
- Must be included in the treatment plan
- Delivered individually or in a group setting
- Includes:
  - Recovery and wellness support
  - Mentoring
  - Advocacy

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Court-Ordered Services

- Court orders are considered the determination of medical necessity
- MCOs must pay for court-ordered services and cannot deny, reduce or controvert court orders
- MCOs cannot apply their own utilization management criteria via prior authorizations or concurrent or retrospective reviews

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Telemedicine and Telehealth Services

Existing Medicaid Coverage

Telemedicine and Telehealth Service Services

- Psychiatric diagnostic evaluations
- Psychotherapy
- Prolonged psychotherapy
- Evaluation and management services
- Inpatient consultations

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Existing Medicaid Coverage

Modalities for Telemedicine and Telehealth Services

- Synchronous audiovisual interaction
- Asynchronous store and forward technology, including in conjunction with a synchronous audio interaction
- Other forms of audiovisual telecommunication technologies that allow the distant site provider to meet the in-person standard of care.

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Existing Medicaid Coverage

Modality Exceptions for Managed Care

- Health benefit plans, including Medicaid Managed Care Organizations (MCOs), may provide reimbursement for telemedicine or telehealth services provided as:
  - Audio-only telephone consultations.
  - Text-only email messages.
  - Fax transmissions.

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Existing Medicaid Coverage

Recent Changes to Managed Care Coverage

- Medicaid MCOs may not deny reimbursement for covered services solely because they were delivered remotely.
- All medically necessary Medicaid-covered benefits provided via telemedicine or telehealth services must also be considered for reimbursement.

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COVID-19 Policy Flexibilities

New Synchronous Audio-Visual Services

- Peer specialist services
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Substance use disorder counseling
- Mental health rehabilitation
- Targeted case management

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COVID-19 Policy Flexibilities

New Audio-Only Services

- Psychiatric diagnostic evaluations
- Psychotherapy services
- Evaluation and management services
- Peer specialist services
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Substance use disorder counseling
- Mental health rehabilitation
- Targeted case management

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Utilization Trends

- Prior to the federal Public Health Emergency, the most common primary diagnoses for telemedicine and telehealth service claims and encounters were Attention-Deficit Hyperactivity Disorder (ADHD), schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder.
- During the Public Health Emergency, telemedicine and telehealth services continued to be utilized at high levels for the treatment of mental health conditions.
- COVID-19 reporting dashboards for Medicaid and CHIP are available on the HHSC website.

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Post-Public Health Emergency

- Legislation introduced to make permanent COVID-19 policy flexibilities for telemedicine and telehealth services.
- Planning underway at HHSC to make clinical appropriateness recommendations for telemedicine and telehealth services used to treat mental health conditions.

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Health and Human Services

Thank You!

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Kansas Medicaid Telemedicine Coverage for Behavioral Health Services

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Telehealth waivers from the Centers for Medicare & Medicaid Services (CMS)

- Kansas closely aligned with Medicare allowances on telemedicine guidance prior to the Public Health Emergency although we did deviate in some respects—as with allowing statewide coverage versus restrictiveness in rural areas, e.g. Temporary policy changes were made during the Coronavirus pandemic, however, based on CMS guidance.
- CMS issued temporary measures to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the COVID-19 Public Health Emergency.
- These changes were adopted on a code specific basis which allowed providers to:

➢Conduct telehealth with patients located in their homes.

➢Bill for telehealth services (both video and audio-only) as if they were provided in person

General Rules/Reminders for Kansas Providers made with this “expansion”:

Services have to be provided via real-time interactive (synchronous) audio-video unless telephonic contact specifically allowed (as with some codes during the Pandemic).

Distant site is defined as a site at which the health care provider is located while providing healthcare services by means of telemedicine. The distant site claim must contain place of service 02 (telemedicine distant site). (CMS replaced the GT modifier with place of service 02 several years prior.)

Originating site is defined as a site at which a patient is located at the time healthcare services are provided by means of telemedicine. Providers physically present at the originating site are allowed to submit claims using the Code of Q3014 (telemedicine originating site facility fee).

Services provided via telemedicine are reimbursed at the same rate as a face-to-face service. Providers are responsible to ensure the codes are covered by Kansas Medicaid and additionally via telemedicine.

Telemedicine does not include communication that consists solely via E-mail or a facsimile transmission.

Documentation requirements are the same as face-to-face services.

During the Public Health Emergency:

Expansion of codes allowed for telemedicine service delivery did not change or modify current coverage.
Allowed Provider types and specialties remained unchanged.

Existing National Correct Coding Initiatives (NCCI) edits/limitations were not waived.

Reminder given on the use of the Q3014 code when applicable. The place of service code should reflect where the beneficiary is actually located. If “home” is allowed as an acceptable originating site, Providers would need to be physically present in order to bill for the Q3014 code.

Any telemedicine service (including any allowed telephone contact) required a verbal consent from the patient (to be followed up by written approval in the medical record).

If a member is seen in the same physical location where the service is being billed as a telemedicine distant site, no reimbursement was allowed for the originating site code of Q3014.

Via Governor Executive Order, out-of-state physicians were allowed to provide telemedicine when treating patients in Kansas without a Kansas license provided the physician holds an unrestricted license in the state in which they practice. This allowance was not extended to any other licensed provider.

Though originally, policies were set to expire at the time the original Executive order expired on May 1, 2020, it became evident the Public Health Emergency was going to extend for a lengthy period of time. In order to alleviate/minimize Provider "angst", the policies related to the expansion/changes with telemedicine delivery were modified to read that they were in place until rescinded. A commitment was given to provide a minimum of 60 days prior to any "roll back" on these telemedicine policies.

Additionally, instructions were given that treatment plans should be reviewed and updated as needed to correspond with the service location and/or changes in the service delivery mode.

Given the Kansas demographics, Kansas has covered telemedicine for a select number of behavioral health codes since 2004.

Prior to 2004 and as a spring board to the allowance of telemedicine, the Community Mental Health Center System was provided with grant funding to purchase/install needed technology for a tele-video system for some of the Centers. This helped these Centers connect with contacts such as their own satellite offices, court rooms, law enforcement, etc. (One CMHC, for example, covers 20 counties in the Northwest Corner of Kansas which encompasses more than half of these counties designated as "frontier").

Kansas Demographics

Population—2.9 million with 14% covered by Medicaid/CHIP.

Monthly average caseload for the Medicaid population is around 408,000.

Kansas is NOT a Medicaid expansion state per Legislative decision not to adopt at this point in time.

Kansas consists of 105 counties in which 66 of those meet the definition of medically underserved.

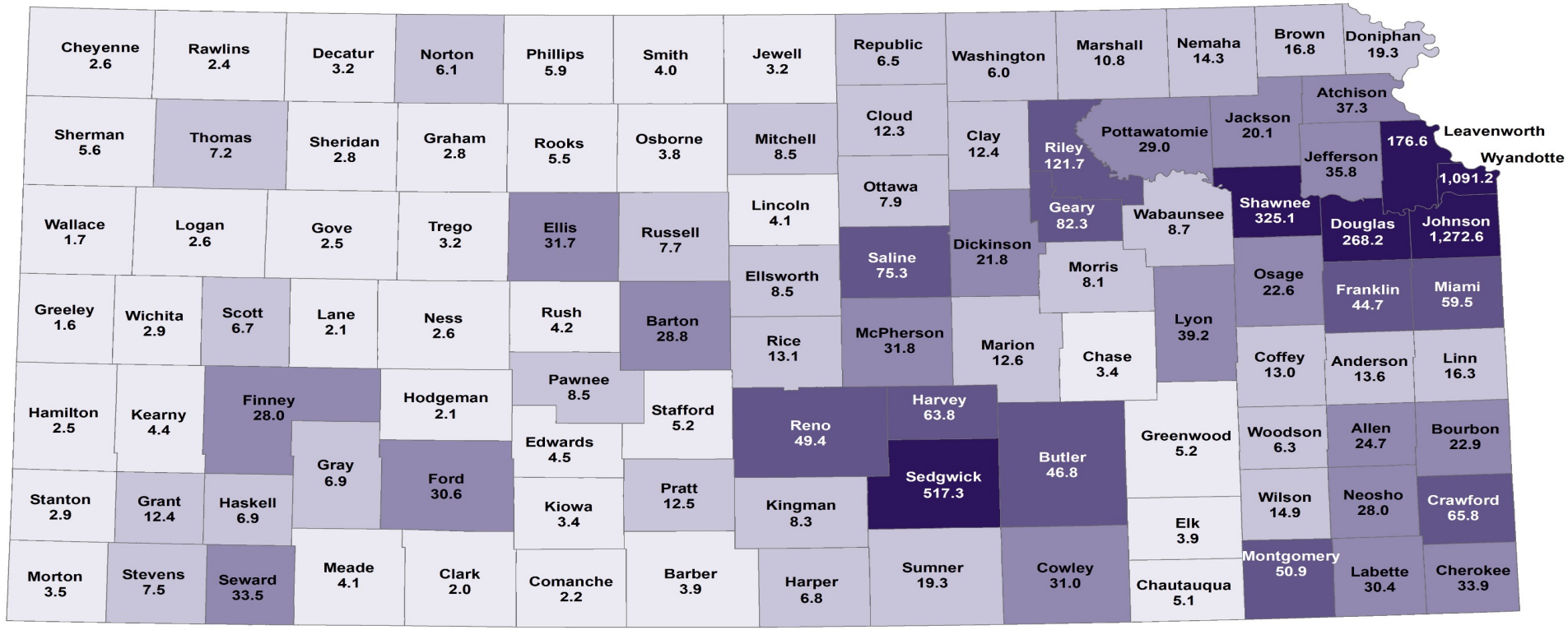
The annual budget for the Kansas Medical Assistance Program is $3.8 Billion.

Kansas has an area of 82,278 square miles and is the 15th largest state by area but 34th in the most populous of the 50 states. Kansas has a length of 213 miles and a width of 410 miles.

About 26% of Kansas live in rural areas but we also have frontier areas. (See map on next slide.)

The Medicaid Program encompasses about 98% of individuals with coverage via three Managed Care Organizations.

Population Density Classifications in Kansas by County, 2019



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2019.

State: 35.6

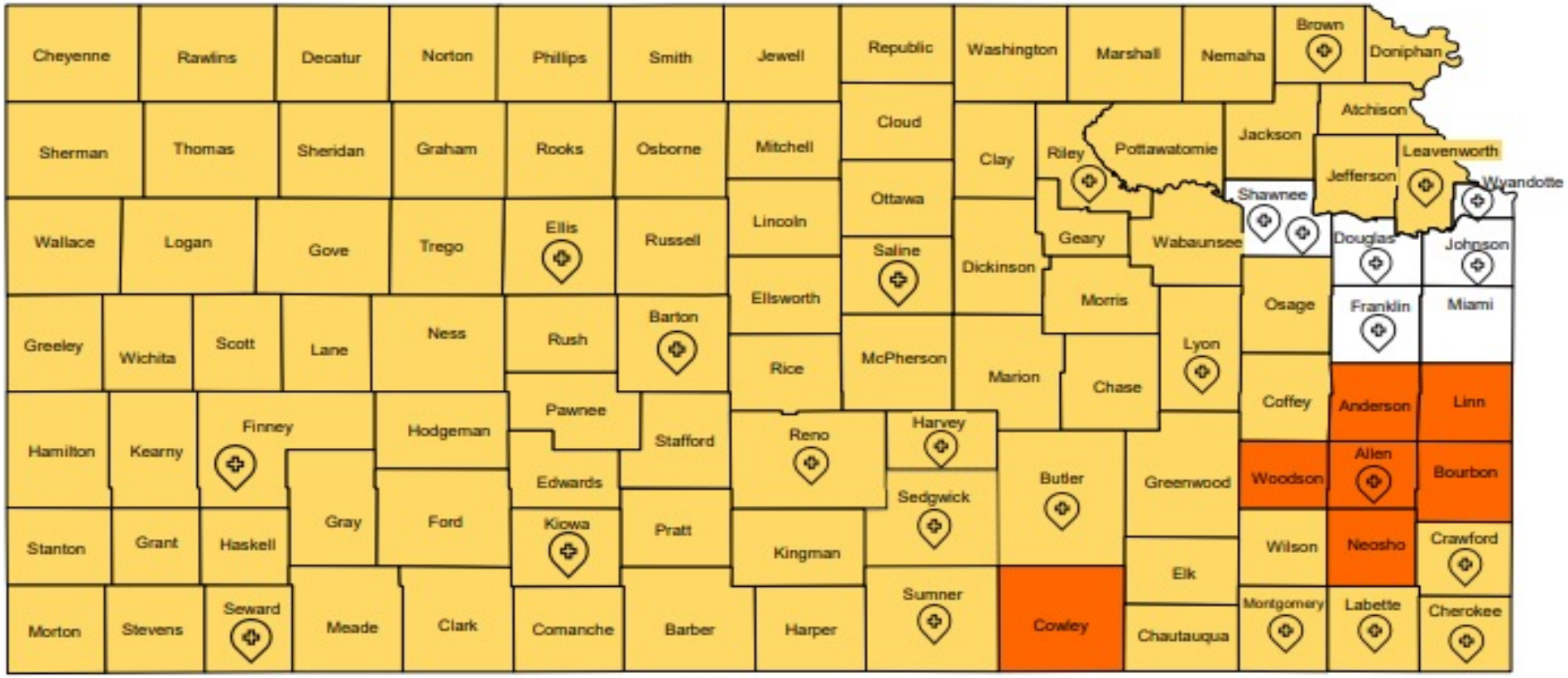
Population Density by Classification* (persons per square mile)

- Frontier (less than 6.0 ppsm)
- Rural (6.0 - 19.9 ppsm)
- Densely-settled Rural (20.0 - 39.9 ppsm)
- Semi-Urban (40.0 - 149.9 ppsm)
- Urban (150.0 ppsm or more)

* Kansas Department of Health and Environment classifications.

Mental Health Professional Shortage Areas
Geographic and Low-Income County-Level Designations December 2020

KANSAS
PRIMARY CARE AND RURAL HEALTH



County-level Mental Health HPSA Score of 18 or higher

County-level Mental Health HPSA Score of 17 or lower

Not eligible for County-level Mental Health HPSA score

Community Mental Health Center Location

Data Sources: Health Resources & Services Administration Data Warehouse, December 2020
Association of Community Mental Health Centers of KS, Inc., 2018

Data Note: HPSA scores shown are listed in Data Warehouse as of December 2020.
Updates to HPSAs made after this date are not reflected.

Initially (in 2004), telemedicine coverage was only for the Mental Health services of consultation, office visits (evaluation and management codes), individual psychotherapy, and pharmacologic management. Over time, the allowed services were expanded to include additional Mental Health and Substance Use Disorder services.

With the Pandemic, telemedicine allowance was expanded further for Behavioral Health Providers. In Kansas, the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE/DHCF) holds the distinction of being the State Medicaid Authority; however, our sister agency of the Kansas Department for Aging and Disability Services (KDADS) is designated as the State Mental Health Authority. As a result of this partnership, agreement was reached between the two Agencies as to this expansion specific for Behavioral Health services. The expansion included input from the Association of Community Mental Health Centers and the two statewide SUD Associations.

In addition to expansion of telemedicine services for Behavioral Health codes, expansion included some codes allowed for telephonic contact and some for the home setting without a Provider's presence.

Consideration was given for appropriateness of the service being delivered via this mode, helping beneficiaries stay connected to their Providers, preserving the network of Providers, and most of all providing support during this time of stress and uncertainty.

- Special consideration was given to the Crisis Intervention Service since some beneficiaries accessing this service would not be established patients and the nature of this service. Billing for the service was contingent upon KDADS approval of the individual protocol utilized at a specified Community Mental Health Center upon review of their plan. If approval was authorized, an approval start date was given and provided to the CMHC for their records. Additionally, this approval notification was to be routed to all three of the MCOS and the Medicaid Agency.

Important links

HHS:

- https://www.hhs.gov/hipaa/ select HIPAA and COVID-19 link for additional information
- https://www.hhs.gov/coronavirus/telehealth/index.html

CMS:

- List of Telehealth Services for Calendar Year 2021 (ZIP)

Kansas:

- https://www.kmap-state-ks.us/ Publications specific to telemedicine updates due to the pandemic can be found at this link. Select COVID–19 Provider Information and then select Telemedicine.
- See https://www.kmap-state-ks.us/Documents/Content/Provider/COVID%2019%20.pdf for code expansion, settings, and conditions with that expansion.

Important links cont'd

With the onset of the PHE, both MH and SUD services were expanded further.

- https://www.kmap-state-ks.us/public/providermanuals.asp_All provider manuals can be found at this link. There is a reference in the Mental Health manual to the General Benefits manual which addresses telemedicine services.
- See https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Gen%20benefits_19203_19079.pdf

Under telemedicine section for a list of codes allowed prior to the Public Health Emergency.

- https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Mental_Health_20263_20214.pdf

- https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/SUD_manual_19109_172003.pdf

- Fran Seymour-Hunter, Interagency Liaison KDHE, Division of Health Policy
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MassHealth:
Telehealth Evolution

May 2021

Context

MassHealth in **March 2019** introduced coverage for behavioral health services delivery via video telehealth

In **March 2020**, MassHealth introduced a broad telehealth policy:

- Allows all clinically appropriate, medically necessary MassHealth-covered services to be delivered via telephone and and live video telehealth modalities
- Paid at parity with in-person services
- Allows preventive visits to occur via telehealth
- Specific remote patient monitoring bundle for COVID care
- Does not impose specific requirements for technologies used, but required member consent to any privacy risks
- Expanded to support CMS Acute Hospital Care at Home program

Experience

Observed **peak utilization in April and May of 2020**, with gradual decrease over 2020 and then stability

Telehealth only made up for a **proportion of decreased utilization**

Some data **on member experience** emerging

- Satisfaction with telehealth on par/above satisfaction with in-person care
- Strong preference for telephone-only services in some contexts
- Majority of members “very likely” to use telehealth in the future
- Some variability by demographic characteristics
- Experience with behavioral health and physical health

Moving Forward: Considerations

Continuing current policy, also exploring:

- Addition **of remote patient monitoring services** for chronic disease
- Introduction of coverage for **provider-to-provider e-consultations**
- Continuation of **hospital at home programming** post-PHE, as well as other mobile health interventions

Moving Forward: Considerations

Legislation signed into law in Massachusetts in early 2021 contains several provisions relevant to MassHealth telehealth policy:

- MassHealth must maintain parity between rates for certain services delivered via telehealth and rates for those services delivered in-person, according to the following schedule:
  - The **first 90 days** following termination of the Governor's Emergency Declaration for ALL services rendered via all telehealth modalities, and
  - **Through December 31, 2022** for chronic disease management and primary care services rendered via all telehealth modalities,
  - **Permanently** for all behavioral Health (BH) services rendered via audio-video or audio-only telehealth

Moving Forward: Considerations

Patient and provider preferences have shifted: many like telehealth and have become accustomed to its use

Providers have invested in **telehealth infrastructure**; will likely seek opportunities to continue to utilize

Equity considerations: disparities in access to broadband, minutes, devices; role of telephone-only telehealth; implications for time away from work/families

Evidence base around **quality of care delivered via telehealth** still emerging, especially around specific clinical and/or population-based experience (eg behavioral health, care for children and youth, non-English-speaking members, etc)

Statewide discussions about **future state of primary care delivery**, including a movement from the provider community towards global budgeting for primary care with implications for telehealth

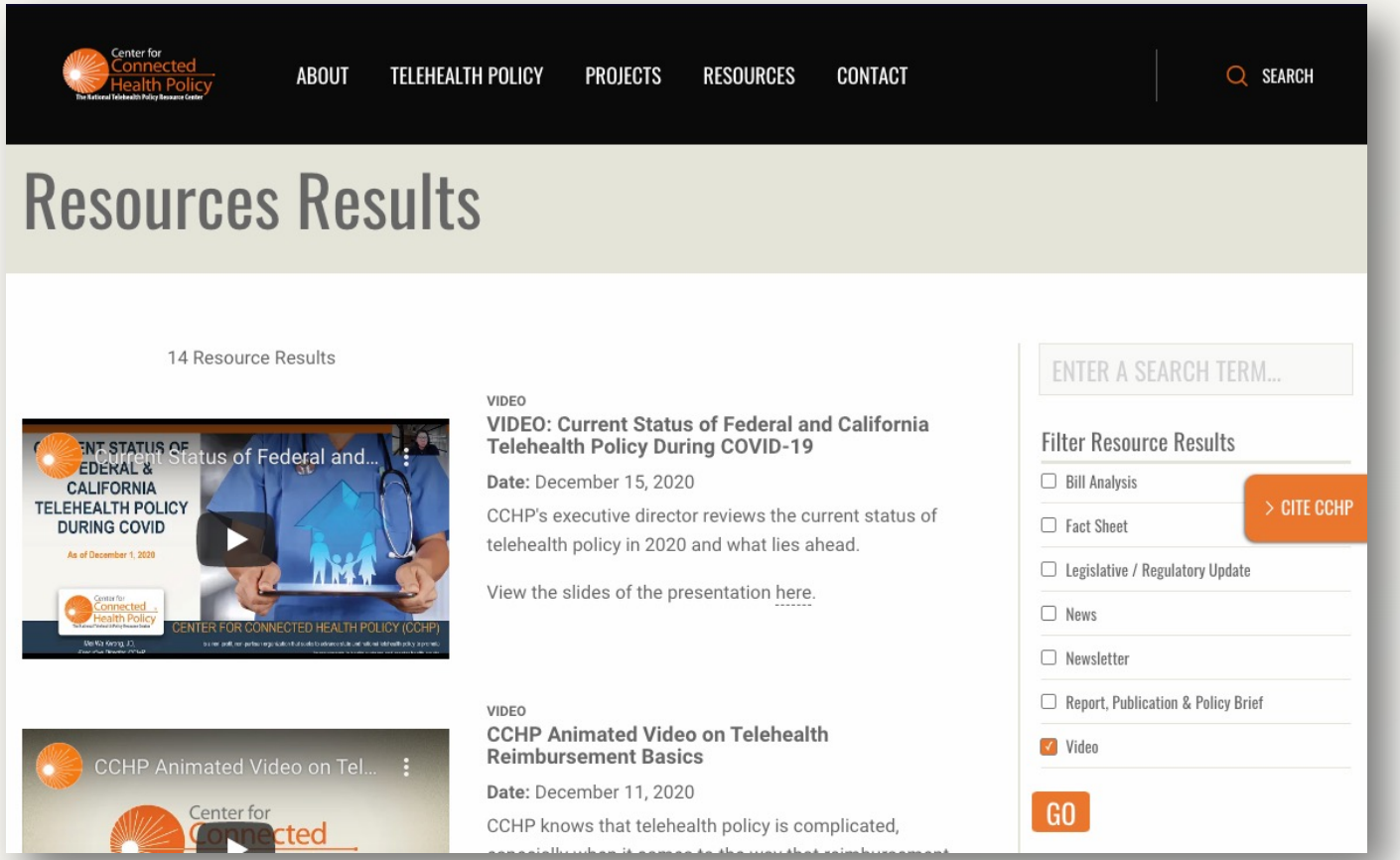
Questions?

Panel Q&A

Please submit questions using the Q&A function.

Thank You!

Webinar Recordings and Resources



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