Center for Connected Health Policy

TELEHEALTH & MEDICAID: A POLICY WEBINAR SERIES

Medicaid Telehealth Policy & Data, Evaluations & Stakeholders

September 24, 2021

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

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Telehealth & Medicaid: A Policy Webinar Series

October 1, 2021: Telehealth & Patients with Disabilities

October 8, 2021: Permanent Policies

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.
States Data, Evaluations, Surveys & Stakeholders

September 24, 2021

Mei Wa Kwong, JD, Executive Director, CCHP

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.
COVID-19 changed everything
### TELEHEALTH POLICY CHANGES IN COVID-19

#### FEDERAL

<table>
<thead>
<tr>
<th>MEDICARE ISSUE</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Limit</td>
<td>Waived</td>
</tr>
<tr>
<td>Site limitation</td>
<td>Waived</td>
</tr>
<tr>
<td>Provider List</td>
<td>Expanded</td>
</tr>
<tr>
<td>Services Eligible</td>
<td>Added additional 80 codes</td>
</tr>
<tr>
<td>Visit limits</td>
<td>Waived certain limits</td>
</tr>
<tr>
<td>Modality</td>
<td>Live Video, Phone, some srvs</td>
</tr>
<tr>
<td>Supervision requirements</td>
<td>Relaxed some</td>
</tr>
<tr>
<td>Licensing</td>
<td>Relaxed requirements</td>
</tr>
<tr>
<td>Tech-Enabled/Comm-Based (not considered telehealth, but uses telehealth technology)</td>
<td>More codes eligible for phone &amp; allowed PTs/OTs/SLPs &amp; other use</td>
</tr>
</tbody>
</table>

#### STATE (Most Common Changes)

<table>
<thead>
<tr>
<th>MEDICAID ISSUE</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modality</td>
<td>Allowing phone</td>
</tr>
<tr>
<td>Location</td>
<td>Allowing home</td>
</tr>
<tr>
<td>Consent</td>
<td>Relaxed consent requirements</td>
</tr>
<tr>
<td>Services</td>
<td>Expanded types of services eligible</td>
</tr>
<tr>
<td>Providers</td>
<td>Allowed other providers such as allied health pros</td>
</tr>
<tr>
<td>Licensing</td>
<td>Waived some requirements</td>
</tr>
<tr>
<td></td>
<td>• Private payer orders range from encouragement to cover telehealth to more explicit mandates</td>
</tr>
<tr>
<td></td>
<td>• Relaxed some health information protections</td>
</tr>
</tbody>
</table>

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• DEA – PHE prescribing exception/allowed phone for suboxone for OUD
• HIPAA – OCR will not fine during this time
PRE-PANDEMIC

- 37 states surveyed
- Concerns over quality, fraud/waste and utilization
- Data gathering varied
- Most states did not assess quality
- Only one state examined cost savings and found there were
- Three states did not track telehealth use

Key Takeaways:
- A few States reported being unable to identify which services are provided via telehealth, limiting their ability to evaluate and oversee telehealth.
- Only a few States have evaluated the effects of telehealth on behavioral health services.
- Despite concerns about fraud, waste, and abuse, many States do not conduct monitoring and oversight specific to telehealth.

Why OIG Did This Review
States are increasingly relying on telehealth to provide behavioral health services to Medicaid enrollees. Before the COVID-19 pandemic, telehealth was an important tool for States to increase access to behavioral health services for enrollees in rural or underserved areas with provider shortages. During the COVID-19 pandemic, States expanded their use of telehealth to help meet the needs of enrollees while also reducing the risks from community spread of the virus. As the Nation confronts the psychological and emotional impact of COVID-19, the use of telehealth will be important in addressing behavioral health needs for Medicaid enrollees.

This data brief provides insight into State evaluations and oversight of telehealth for behavioral health services as of January and February 2020, before the expansion of telehealth due to the COVID-19 pandemic. It provides a useful foundation to inform the Centers for Medicare & Medicaid Services (CMS) and State decisions on how to evaluate the impacts of telehealth on access, cost, and quality of behavioral health services and to strengthen oversight of program integrity. Evaluating the effects of telehealth on access, cost, and quality is particularly important in helping States make decisions about how best to use telehealth and about which populations benefit most from these services. Understanding States’ efforts to oversee telehealth can help States protect their Medicaid programs. Further, States’ expansion of telehealth during the COVID-19 pandemic has been largely on a temporary basis. As States consider making telehealth expansions permanent, States can use information in this data brief to help determine which services best support enrollees. This data brief is a companion report to a data brief that describes the challenges States reported with using telehealth to provide behavioral health services to Medicaid enrollees.1

How OIG Did This Review
States commonly provide behavioral health services to Medicaid enrollees through managed care organizations. We conducted a survey of State Medicaid Directors from 17 States that provide behavioral health services via telehealth through managed care organizations. We also conducted structured interviews with other stakeholders. While we asked about efforts specific to managed care, the respondents focused on States’ efforts to evaluate and oversee the use of telehealth more generally.
Prior to the pandemic, some states did report on/track telehealth utilization data.
Increasingly seeing states specifically focus on gathering/analyzing telehealth data
  - Many states extending emergency flexibilities contingent on forthcoming data evaluations, meetings, and reports

Using a variety of means
  - Surveys/reports
  - Advisory Groups/Stakeholder engagement
  - Pulling data from claims

Some Medicaid programs may encounter issues gathering data
  - Utilization data vs outcomes research
The following are slides from Rene Mollow, MSN, RN, Deputy Director of Health Care Benefits & Eligibility, California Department of Health Care Services presentation on CCHP’s Spring Medicaid Webinar Series

Medicaid Telehealth Policy for Seniors

PPT for Webinar
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
The following are slides from Catherine Ivy, Deputy Executive Director, Georgia Department of Community Health presentation on CCHP’s Spring Medicaid Webinar Series

Medicaid Telehealth Policies for Children and Youth

PPT for Webinar
After PHE

- DCH began a survey in June of 2020 to look at the efficiency of telehealth during the PHE.
  - What provisions should remain under telehealth/telemedicine?
  - What worked?
  - What didn’t work?
  - Opportunities missed?
Survey Results

Telehealth Feedback

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>138</td>
<td>911</td>
</tr>
</tbody>
</table>
Provider Participation

**Survey Respondent Type** | **Number participated**
--- | ---
Behavior Health | 266
FQHC | 1
Other | 13
Pediatrician | 3
Physician (Non-pediatrician) | 5
Therapy Services | 51
Did not Identify | 571

**NUMBER PARTICIPATED**

- Did not Identify: 63%
- Behavior Health: 29%
- Other: 1%
- FQHC: 0%
- Pediatrician: 0%
- Physician (Non-pediatrician): 1%
- Therapy Services: 6%
Survey Results - Comments

- 101 providers out of 910 providers submitted comments
- 35 Members, Parents, Caregiver, etc. provided comments
- Enjoy and appreciate the services to Doesn’t meet the needs for my child
Survey Takeaways

• Telehealth is a useful tool when applied correctly
• Each specialty and service will need to be reviewed to determine if it is in the best interest of the member to provide the service in this manner.
• Establish or refine protocols for rendering telehealth
  – OCR HIPAA requirements
  – Health and Safety requirements
  – Exclusions to the service
  – Ability for all members and providers to participate
• **Nevada SB 5** – Requires Dept. to establish an electronic tool to analyze certain data concerning access to telehealth and creation of a data dashboard for analysis of data related to telehealth access by different groups and populations.

• **Maryland HB 123/SB 3** – Requires a report on the impact of providing telehealth services, shall consider both audio-only and audio-visual technologies.

• **Minnesota HF 33** – Requires study on the impact of telehealth expansion and payment parity on the coverage and provision of health care services under public health care programs. The study must review and make a number of recommendations relating to specified issues such as payment parity and audio-only policy impacts.
STATE ACTIONS – STAKEHOLDER ENGAGEMENT: CONVENINGS

- **California AB 133** – Convening stakeholders to provide recommendations on establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program.

- **Arizona HB 2454** – Telehealth Advisory Committee on Telehealth Best Practices shall adopt telehealth best practice guidelines and recommendations regarding the health care services appropriately provided through an audio-only telehealth format. Prior to issuing recommendations, shall analyze medical literature and national practice guidelines to consider comparative effectiveness.

- 2020 Vermont Medicaid convened a meeting to discuss audio-only. [Report](#)
STATE ACTIONS –EXISTING STATE GROUPS/SURVEY

• **Maine Telehealth and Telemonitoring Advisory Group** meets once a year to evaluate technical difficulties related to telehealth and made recommendations to the department to improve telehealth services statewide.

• **Texas e-Health Advisory Committee** advises on development, use, and long-range plans for telehealth.

• **DC Telemedicine Program Evaluation Survey** – As a condition of participation, Medicaid providers delivering services via telemedicine are required to respond to requests for information in the form of a telemedicine program evaluation survey from the Department of Health Care Finance. The survey aims to evaluate the utilization of telemedicine services among the Medicaid beneficiaries.
One Year Off Mute: An Evaluation of Telemedicine in Colorado Medicaid

Tracy Johnson
Medicaid Director

Tamara Keeney
Research & Analysis Manager
Today's Agenda

• Highlight key findings from HCPF's telemedicine evaluation
  ➢ Who used telemedicine? Which services were used?

• Explore how changes in telemedicine utilization have potentially impacted emergency department visits

• Learn how no-show rates changed during the pandemic and the subsequent expansion of telemedicine

• Discuss current work on e-Health Entities
# Telemedicine Policy Changes

<table>
<thead>
<tr>
<th></th>
<th>Pre-Pandemic Period</th>
<th>Pandemic Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Modality</strong></td>
<td>Audio/visual (video)</td>
<td>Audio/visual (video), audio only, live chat</td>
</tr>
<tr>
<td><strong>Provider Type</strong></td>
<td>Federally Qualified Health Center (FQHCs), Rural Health Clinics (RHCs), Indian Health Services (IHS) could <strong>NOT</strong> bill a separate encounter</td>
<td>FQHCs, RHCs, IHS <strong>CAN</strong> bill a separate encounter</td>
</tr>
<tr>
<td><strong>Payment Parity</strong></td>
<td>In-person paid same as telemedicine.</td>
<td>In-person paid same as telemedicine.</td>
</tr>
</tbody>
</table>

**Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Services (IHS)**
Evaluation Approach

Goal
Evaluate impacts of telemedicine expansion to inform future policy changes (both PHE and non-PHE specific)

Methods
• Analyzed fee-for-service telemedicine utilization dashboard and emergency department dashboard
• Fielded and analyzed member survey
• Interviewed providers
• Literature review and contracted work

Time Period
• Report online is through August 22nd, 2020
• Presentation’s data is updated through March 14th, 2021
Utilization Analysis

Who used telemedicine? Which services were accessed? What does utilization look like for adults vs children?
Utilization Dashboard

Outpatient and Professional Services Eligible for Telemedicine

Eligibility Category
- Adults: $79,765,752
- Children: $70,695,118
- Retrospectively Eligible: $46,326,973
- Children in Foster Care: $9,649,263
- Members with Disabilities: $5,932,433
- Pregnant Adults: $2,377,161
- Adults Over 65: $818,549
- Partial Dual Eligibles: $209,658
- Non-Citizens - Emergency Serv.: $4,486

Age Group
- 0-15: $79,321,854
- 16-24: $39,164,444
- 25-29: $22,539,192
- 30-34: $16,143,104
- 35-39: $19,941,432
- 40-44: $19,595,551
- 45-49: $6,968,369
- 50-54: $37,578
- 55+: $252,860

Device Codes
- 99213 - OFFICE/OUTPATIENT VISIT EST
- 99214 - OFFICE/OUTPATIENT VISIT EST
- 99215 - OFFICE/OUTPATIENT VISIT EST
- 99238 - SPEECH THERAPY, IN THE HOME
- 99212 - OFFICE/OUTPATIENT VISIT EST
- 92070 - SPEECH/HEARING THERAPY
- 99329 - OCCUPATIONAL THERAPY, IN THE HOME
- 99380 - THERAPUTIC ACTIVITIES
- 99316 - ADAPT BEHAVIOR TREATMENT
- 01631 - HICP-SVS OF 3/5 PATH, EA 10MM

Primary Diagnosis Codes
- AUTISTIC DISORDER: $15,908,985
- DEVELOPMENTAL DISORDER OF SPEECH: $75,232,662
- UNRESP LACK OF EXPECTED NORMAL PHYS: $9,299,186
- MIXED RECEPTIVE-EXPRESSION LANGUAGE: $16,565,646
- DELAYED MILESTONE IN CHILDHOOD: $54,987,176
- SPECIFIC DEVELOPMENTAL DISORDER: $4,259,318
- OPIOID DEPENDENCE, UNCOMPLETED: $3,496,230
- GENERALIZED ANXIETY DISORDER: $3,029,125
- EXPRESSIVE LANGUAGE DISORDER: $2,918,729
- ANXIETY DISORDER, UNSPECIFIED: $2,825,463
- ANXIETY DISORDER, UNSPECIFIED: $2,814,078
- MAJOR DEPRESSIVE DISORDER, REC: $2,629,281
- PHONETICAL DISORDER: $2,594,443
- MORBID (SEVERE) OBESITY DUE TO EX: $2,179,613
- ESSENTIAL (PRIMARY) HYPERTENSION: $2,102,962
- FEEDING DIFFICULTIES: $2,056,782
- ATTENTION-DEFICIT HYPERACTIVITY DIS: $1,849,745
- CONTACT W AND EXPOSURE TO OTH: $1,753,990
- COVID-19: $1,596,906
- TYPE 2 DIABETES MELLITUS WITHOUT: $1,589,265

Benefit Category
- Professional Services: $88,625,695
- FQHC, RHC, IH: $79,897,960
- Home Health: $5,563,515
- Outpatient Hospital: $3,954,078
- Imaging: $21,054
- Physician Administered Drug: $8,080
- Emergency Department: $0

Billing Provider Type
- Federally Qualified Health Center: $68,889,041
- PT/OT/SL Home Health: $53,424,931
- Clinic - Practitioner: $18,704,332
- Non-Physician Practitioner - Group: $25,644,568
- Rehabilitation Agency: $10,589,455
- Pediatric Behavioral Therapists: $8,305,360
- Hospital - General: $4,563,873
- Speech Therapist: $991,166

Trend over time (Actuals)

Access updates slides bimonthly here: https://hcpf.colorado.gov/provider-telemedicine
Utilization Growth

Percentage of Eligible Fee-for-Service Visits Conducted Via Telemedicine
March 8, 2020 - March 14, 2021

Source: Department of Health Care Policy & Financing, Analysis of Fee-For-Service Claims
Utilization: Children

- Children are top utilizers of telemedicine due to the types of services utilized
- Average visits per utilizer: 7.7
- Dominated by therapies (physical, occupational, speech)

Top Five Diagnoses Associated with Telemedicine Visits for Children

<table>
<thead>
<tr>
<th>Top Telemedicine Diagnoses by Visit Count</th>
<th>Top Telemedicine Diagnoses by Utilizer Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mixed Expressive-Receptive Language Disorder</td>
</tr>
<tr>
<td>2</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>3</td>
<td>Developmental Disorder of Speech and Language</td>
</tr>
<tr>
<td>4</td>
<td>Unspecified Lack of Expected Normal Development</td>
</tr>
<tr>
<td>5</td>
<td>Specific Developmental Disorder of Motor Function</td>
</tr>
</tbody>
</table>

Source: Colorado Department of Health Care Policy & Financing, Analysis of Fee-For-Service Claims
Utilization: Adults

- More variation in visit types
- Average visits per utilizer: 3.1
- Mix of chronic disease management and behavioral health

### Top Five Diagnoses Associated with Telemedicine Visits for Adults

<table>
<thead>
<tr>
<th>Top Telemedicine Diagnoses by Visit Count</th>
<th>Top Telemedicine Diagnoses by Utilizer Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Opioid Dependence</td>
<td>Essential (Primary) Hypertension</td>
</tr>
<tr>
<td>2 Generalized Anxiety Disorder</td>
<td>Anxiety Disorder, Unspecified</td>
</tr>
<tr>
<td>3 Anxiety Disorder, Unspecified</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>4 Major Depressive Disorder, Recurring</td>
<td>Contact With and Exposure To Other Communicable Viruses</td>
</tr>
<tr>
<td>5 Essential (Primary) Hypertension</td>
<td>Type Two Diabetes</td>
</tr>
</tbody>
</table>

Source: Colorado Department of Health Care Policy & Financing, Analysis of Fee-For-Service Claims
Older Adults

• Utilization analysis
  ➢ Ages 60+ were least likely age group to utilize telemedicine
  ➢ Averaging around 7% of visits via telemedicine vs 15% for all other age groups
  ➢ Most common visits: hypertension, diabetes, COPD, chronic pain

• Provider interviews and literature review
  ➢ High reliance on phone only
  ➢ Potential improvements to video technologies to accommodate needs of older adults
Utilization: Urban vs Rural

Urban vs Rural FQHC Telemedicine Utilization, July 2019 - August 2021

Source: Colorado Department of Health Care Policy & Financing, Claims Analysis
Emergency Department Analysis

How did increased access to telemedicine impact emergency department utilization?
Emergency Department Trends

Emergency Department Visits Per 1,000: April 2019

Source: Colorado Department of Health Care Policy & Financing
Emergency Department Trends

Emergency Department Visits Per 1,000: April 2019 vs April 2020

Source: Colorado Department of Health Care Policy & Financing
Emergency Department Trends

Emergency Department Visits Per 1,000: April 2019 vs April 2020 vs April 2021

Source: Colorado Department of Health Care Policy & Financing
### Emergency Department Trends

<table>
<thead>
<tr>
<th>Rank</th>
<th>Diagnosis Group</th>
<th>Count of Visits</th>
<th>Diagnosis Group</th>
<th>Count of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abdominal pain</td>
<td>64,502</td>
<td>Abdominal pain</td>
<td>48,311</td>
</tr>
<tr>
<td>2</td>
<td>Other upper respiratory infection</td>
<td>48,343</td>
<td>Nonspecific chest pain</td>
<td>23,796</td>
</tr>
<tr>
<td>3</td>
<td>Other lower respiratory disease</td>
<td>31,687</td>
<td>Superficial injury, contusion</td>
<td>20,687</td>
</tr>
<tr>
<td>4</td>
<td>Superficial injury; contusion</td>
<td>29,722</td>
<td>Other injuries and conditions due to external causes</td>
<td>19,212</td>
</tr>
<tr>
<td>5</td>
<td>Nonspecific chest pain</td>
<td>28,253</td>
<td>Alcohol-related disorders</td>
<td>18,480</td>
</tr>
<tr>
<td>6</td>
<td>Sprains and strains</td>
<td>25,936</td>
<td>Sprains and strains</td>
<td>17,998</td>
</tr>
<tr>
<td>7</td>
<td>Other injuries and conditions due to external causes</td>
<td>23,603</td>
<td>Other upper respiratory infection</td>
<td>16,092</td>
</tr>
<tr>
<td>8</td>
<td>Headache, including migraine</td>
<td>21,820</td>
<td>Other lower respiratory disease</td>
<td>15,487</td>
</tr>
<tr>
<td>9</td>
<td>Spondylosis; other back problems</td>
<td>20,859</td>
<td>Skin and subcutaneous tissue infections</td>
<td>15,461</td>
</tr>
<tr>
<td>10</td>
<td>Fever of unknown origin</td>
<td>20,252</td>
<td>Spondylosis; other back problems</td>
<td>15,009</td>
</tr>
</tbody>
</table>

Source: Colorado Department of Health Care Policy & Financing
## Emergency Department Trends

<table>
<thead>
<tr>
<th>Rank</th>
<th>3/15/19 – 3/14/20</th>
<th>3/15/20 – 3/14/21</th>
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Source: Colorado Department of Health Care Policy & Financing
Emergency Department Trends

Number of ED Visits for Acute Pediatric Upper Respiratory Infections, 19/20 vs 20/21

Source: Colorado Department of Health Care Policy & Financing
Emergency Department Trends

Number of ED Visits for Acute Pediatric Upper Respiratory Infections, 19/20 vs 20/21

- Fear of exposure to Covid during ED visit
- Fewer cases: children out of school and daycare, social distancing, masking, etc
- Visits happening elsewhere (telemedicine)

Source: Colorado Department of Health Care Policy & Financing
Emergency Department Trends

Number of ED Visits for Acute Pediatric Upper Respiratory Infections, 19/20 vs 20/21

Source: Colorado Department of Health Care Policy & Financing
No-Show Rates
No Show Research Project

• Research question: Did increased access to and utilization of telemedicine lead to a reduction in no-show rates? Did it have equal impact across populations?

• Data Sources
  • Denver Health appointment and EHR data

• Partnership with the Farley Health Policy Center at the University of Colorado

• Funded by the Colorado Office of State Budget and Planning
Telemedicine reduced racial/ethnic disparities in no-show rates for primary care

No-Show Rates for Scheduled Primary Care Appointments by Race/Ethnicity Category
Pre- and Post-Pandemic

- In-person Pre-Pandemic
  - Hispanic: 20.65%
  - Non-Hispanic White: 20.29%
  - Non-Hispanic Black: 26.44%
  - Non-Hispanic Multiple/Other: 20.29%

- In-person Post-Pandemic
  - Hispanic: 18.79%
  - Non-Hispanic White: 18.90%
  - Non-Hispanic Black: 19.16%
  - Non-Hispanic Multiple/Other: 16.99%

- Telemedicine Post-Pandemic
  - Hispanic: 10.89%
  - Non-Hispanic White: 10.86%
  - Non-Hispanic Black: 12.69%
  - Non-Hispanic Multiple/Other: 10.45%
Telemedicine reduced disparities in PC no-show rates for medically complex patients

![Bar chart showing no-show rates for scheduled primary care appointments by risk tier pre- and post-pandemic.](chart)

- **In-person Pre-Pandemic**: 19.59% Tier 1, 21.93% Tier 2, 25.98% Tier 3, 21.79% Tier 4
- **In-person Post-Pandemic**: 18.81% Tier 1, 19.92% Tier 2, 21.79% Tier 3, 14.33% Tier 4
- **Telemedicine Post-Pandemic**: 11.06% Tier 1, 10.64% Tier 2, 11.08% Tier 3, 11.08% Tier 4
Current Department Work

Legislation enacted that gives the Department the authority to set rules designed to guide provider entities that operate exclusively or predominately via telemedicine.

• Create definition for e-Health Entities
• Better utilization monitoring
• Create policy that supports member access and appropriate care while supporting the medical home
Approach

Brick-and-mortar clinic/organization with telemedicine completely integrated

Brick-and-mortar clinic/organization with separate telemedicine division with a telemedicine provider service

No brick-and-mortar clinic, only telemedicine service
Draft Definition

Electronic Health (e-Health) Entity:

Practice that provides services only through telemedicine and does not provide in-person services to Colorado Medicaid members.
Future Evaluation

- Behavioral health
- Telemedicine models
- Race/ethnicity and language utilization trends
- Big outstanding question: quality of telemedicine services
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Full Evaluation:
Panel Q&A

Please submit questions using the Q&A function.
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Ivanora Alexander  
Executive Director  
Office for the Children with Special Health Care Needs  
Kentucky Cabinet for Health and Family Services

Jan Withers  
Director, Division for Services for the Deaf and Hard of Hearing  
North Carolina Department of Health and Human Services
Please don’t forget to fill out your evaluation form!

Thank you and have a great day!