Medicaid & Telehealth: Summary and Findings from the Fall 2021 Webinar Series

Center for Connected Health Policy
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INTRODUCTION

Though progress has been made in combating COVID-19, it continues to impact the nation on many levels from politics to education and most significantly on health care. At the time this summary report is being written, there are concerns that a winter surge may still occur. Nonetheless, we've also seen states end their public health emergencies or allowed their telehealth policy waivers to expire, though the federal public health emergency (PHE) is still in place.   With the telehealth policy landscape still evolving, the Center for Connected Health Policy's (CCHP) held a third round of its popular Medicaid Telehealth Policy Webinar Series to not only look at what may have been made permanent in the face of expiring PHEs and waivers, but also to examine other topics that could or should have a significant impact on how telehealth policy is shaped. The Fall Series took place every Friday between September 17 and October 8, 2021 with seven different states participating.

THE FALL SERIES

The Fall series focused in on elements that were shaping or impacting permanent telehealth policies. While we ended with three states relaying what policies they had made permanent and why, the previous topics touched upon issues that policymakers have raised in preceding months as being significant factors in their discussions and decisions for more permanent telehealth policies. The four topics were:

- Webinar #1: **Telehealth & Medicaid: Medicaid & Audio Only** – September 17, 2021
- Webinar #2: **Telehealth & Medicaid – Medicaid Telehealth Policy & Data, Evaluations, & Stakeholders** – September 24, 2021
- Webinar #3: **Telehealth & Medicaid – Telehealth & Patients with Disabilities** – October 1, 2021
- Webinar #4: **Telehealth & Medicaid – Medicaid Telehealth Permanent Policies** – October 8, 2021

Across the four webinars, nearly 4,000 people registered and over 1,500 attended. The majority of attendees represented state or federal offices, public health agencies, hospitals and doctors' offices, safety net clinics, and non-profit policy and advocacy organizations. The diversity of topics reflected the variety of attendees.

WEBINAR #1 – MEDICAID & AUDIO-ONLY

The first webinar's subject is one of the most discussed items on both the federal and state level – what to do with audio-only? Prior to the pandemic, audio-only in most jurisdictions would not have been considered telehealth. However, faced with people who were unable to access live video delivered services for a multitude of reasons, federal and state policymakers allowed the use of audio-only. Currently, policymakers are debating whether to let those policies remain fully or partially, or roll them back completely.

Nissa L. James, Ph.D., Health Care Director for the Department of Vermont Health Access spoke first. Dr. James relayed that in responding to the pandemic and developing temporary telehealth policies, the Department consulted with their partners to determine what Medicaid providers needed most to ensure care could still be delivered for Medicaid members during the federal COVID-19 PHE . A multi-disciplinary team was assembled to assess clinical appropriateness, access to care, quality of care and patient safety concerns in the face of the circumstances of the PHE.

Vermont Medicaid developed a temporary policy for coverage and reimbursement of health care services delivered by an audio-only modality in response to Medicaid provider and member needs; Vermont Medicaid already had broad coverage for health care services delivered through telemedicine (two-way, real-time, audio and video/visual interactive communication). The Department created a list of services that could be delivered via an audio-only modality when medically necessary and clinically appropriate; in order to receive reimbursement, claims for health care services delivered through audio-only also needed to be submitted with a specific modifier (V3) so that audio-only health care service delivery could be identified in Medicaid claims data. The Department held a live webinar within a week of the Emergency declaration to discuss these temporary changes with Medicaid providers and practices, answer questions, and release informational tools.

In the first seven months of the Emergency, use of audio and video/visual interactive communication occurred more frequently than use of the audio-only modality (roughly an average of 5 to 1). In 2021, compared to those same months in 2020, overall use of audio and video/visual interactive communication and audio-only was less. In fact, the ratio of audio-only compared to live audio and video visits widened to roughly an average of 7 to 1. Vermont Medicaid continues to engage with their stakeholders on solidifying more permanent policies. Outside factors on these decisions include actions on the federal level as well as legislative changes.

Dr. Sara Salek, Chief Medical Officer for the Arizona Health Care Cost Containment System (AHCCCS) which administers the state's Medicaid program noted that pre-pandemic, the program was already reimbursing for some services provided via audio-only, 13 codes that include case management and ongoing support services. Like Vermont, Arizona Medicaid also held stakeholder forums and created a temporary telephonic code set where coverage and reimbursement would occur if the service was provided via audio-only. The data the program gathered showed that for behavioral health services, case management interactions of 15 minutes was the most billed service. For physical health services, clinic visits/encounters and established patient outpatient visits were the most frequently billed service. In looking at post-pandemic coverage for audio-only, Arizona Medicaid examined member preference, clinical appropriateness, Healthcare Common Procedure Coding System (HCPCS) code description/availability, health care access for in-person care, and broadband access. That has led to a permanent adoption of a smaller allowed audio-only list of services than what was seen during the early months of the pandemic, but was greatly expanded from what existed pre-

pandemic. Like Vermont, some of AHCCCS' changes and actions are also impacted by legislation.

Mary Shelton is the Director of Behavioral Health Operations for The Division of TennCare, Tennessee's Medicaid program. TennCare is 100% managed with three statewide managed care organizations (MCOs): Amerigroup, UnitedHealthcare and BlueCare Tennessee. As with other states, when the pandemic began, a quick pivot was made in the behavioral health program towards telehealth. In deciding to allow audio-only to provide services, TennCare considered the availability and limitations of data and equipment for its members, understanding that at least in the beginning, treatment models would not necessarily be the same, but also knowing providers needed to continue to be connected to their patients. There was some hesitation allowing audio-only but eventually it was allowed for outpatient behavioral health services. Instructions on what would be covered were sent out to providers. In deciding on more permanent policies, the Tennessee state legislature played an important role, passing language that allowed audio-only services in behavioral health when no other options were available.

WEBINAR #2 – MEDICAID & TELEHEATH POLICY & DATA, EVALUATIONS AND STAKEHOLDERS

As policymakers make their decisions on what temporary telehealth policies to keep, they are increasingly looking for data, surveys and evaluations and engaging stakeholders to determine what would be worth making permanent. Never before have so many state Medicaid programs at the same time been utilizing these different channels to help them craft their telehealth policies. We heard from Colorado Medicaid on their extensive work that they have done so far.

Dr. Tracy Johnson, Medicaid Director and **Tamara Keeney**, Research and Analysis Manager, both from Colorado Medicaid presented on the state's evaluation of the use of telehealth during the pandemic. Their presentation covered highlights of the evaluation the program ran, how telehealth impacted emergency department visits, the effects of telehealth on no-show rates and subsequent expansion of telehealth and to discuss current work on e-Health entities. Ms. Keeney went first and explained that some of the changes Colorado Medicaid made in response to the pandemic was to allow audio-only and live chat to be a means of providing services and allowing federally qualified health centers (FQHCs) and rural health clinics (RHCS) to bill telehealth interactions as separate encounters. Their evaluation methodology included analyzing fee-for-service telemedicine utilization, a member survey, provider interviews and a literature review and contracted work. Their report covered data through August 2020 and was published in March 2021.

As expected, utilization peaked in the early days of the pandemic before dipping and then rising again during COVID-19's second wave at the end of 2020 before dipping again. Even with the dips, telehealth use was approximately around 15% on average throughout the period studied. Children were the top utilizers of telehealth, mostly for therapy services (physical, occupational, speech). There were more variations in what adults used telehealth for including services for opioid dependence, anxiety and hypertension. Older adults were less likely to utilize

telehealth. Adults aged 60 or older averaged 7% of the telehealth visits while other age groups averaged around 15%. Older adults also tended to rely more on audio-only. Urban utilization of telehealth was much higher than rural, likely due to connectivity issues. Emergency room visits dropped during 2020 in comparison to 2019. Respiratory conditions were more prevalent in emergency room visits in 2019 than in 2020, but 2020 saw an increase in nonspecific chest pain when compared to 2019. Pediatric upper respiratory infections in emergency room visits were considerably down in 2020 compared to the previous year. There are other factors that contribute to these numbers beyond telehealth use such as limiting emergency room visits due to COVID-19 fears or children not having as much contact with each other to pick up respiratory infections, but Colorado Medicaid did note that telehealth visits were likely also a contributing factor to these lower emergency room numbers.

Dr. Johnson spoke next to discuss the departments research on no show rates. First, she thanked the [Farley Center](#) for conducting the analysis. In looking at no-show rates, Colorado Medicaid's data showed that telehealth helped contribute to reducing racial/ethnic disparities in no-show rates for primary care. These disparities were also reduced when looking at medically complex patients. As with previous speakers, actions by the Colorado Legislature have directed some of the department's current work including creating a definition for "e-Health Entities" which are providers/organizations that lack a brick-and-mortar location and primarily/exclusively provide services via telehealth technology. Dr. Johnson described their approach of examining the current models of telehealth entities and how they deliver services and have settled on a definition as "Practice that provides services only through telemedicine and does not provide in-person services to Colorado Medicaid members."

WEBINAR #3 – TELEHEALTH & PATIENTS WITH DISABILITIES

During the pandemic, it became increasingly clear that telehealth and how it is used to treat patients with disabilities has been one area that needed more attention. COVID-19 impacted everyone and limited their ability to access health services. This exacerbate issues for populations that were already facing challenges accessing appropriate care. Two non-Medicaid programs from North Carolina and Kentucky helped shed light on what they were doing to address the needs of patients with disabilities and approaches other programs may wish to consider taking.

Jan Withers, Director of the Division of Services for the Deaf and Hard of Hearing at the North Carolina Department of Health and Human Services provided an overview of the importance of communication equity in health care. She noted that hearing loss is a hidden disability that is often overlooked or misunderstood. While effective communication may be a simple goal, how to achieve it can be complicated. Meeting the communication needs of patients with hearing loss is not a one-size fits all matter. For some Deaf patients American Sign Language (ASL) may be their primary language while English is their second language. Hard of Hearing patients may benefit from Communications Access Real-time Translation (CART), but some deaf patients may not. DeafBlind patients have another layer of complexity that needs to be considered when communicating with them. For many adults with adult-onset hearing loss, there may be delays

in addressing hearing loss as it has a "slow boil effect" or some may deny that there is an issue. Over 90% of people with adult-onset hearing loss could benefit from hearing aids, but only 16% actually use them which impact their ability to communicate effectively with their healthcare providers. Additionally, many Deaf, Hard of Hearing and DeafBlind patients lack resources and knowledge to effectively advocate for themselves. Health care providers may lack the knowledge and resources to ensure how these patients can access services and resources. North Carolina looked at the experience of these populations with telehealth and found that some reasons for poor experience was poor video quality and communication accommodation issues. Also noted, given the pandemic, the provider may have been wearing a mask during the telehealth interaction, which prevented some patients from effectively understanding all information relayed (e.g., difficulty in lip reading or hearing the provider through the barrier). Barriers to accessing telehealth appointments for the Deaf, Hard of Hearing and DeafBlind community also included connectivity and equipment access, but also lack of instructions on how to utilize the technology. Laws in place are clear that auxiliary services or aids for communication accessibility must not only be provided but also result in effective communication. For discussions of policy around telehealth, subject matter experts for people with disabilities need to be included in future discussions to ensure the information is accurate, up to date, and sufficiently detailed to be effective.

Ivanora Alexander, the Executive Director for the Office for Children with Special Health Care Needs (OCSHCN) in Kentucky's Cabinet for Health and Family Services discussed the program's long-standing provision of services via telehealth to their enrollees who may have special needs. The program has statewide locations and numerous partnerships and collaborations it has built up over the years to provide access to services, some include specialty medical clinics that incorporate care coordination (18 locations across Kentucky), early intervention service coordination, audiology services, and occupational, physical and speech therapy. They have also had telehealth delivered services in place for almost a decade starting with neurology clinics in 2013. In response to the pandemic, OCSHCN also had to adjust in delivery of their services. In a one-year period they have seen their telehealth visits increase to over 400% in comparison to the same period before the pandemic. Accommodations made for COVID-19 allowed services to occur in the patient's home rather than traveling to a facility. However, the transition to telehealth was not without its issues including families/patient's limited understanding of video-based visits, inequity in technology, and not having all specialties being provided via telehealth. To address these barriers, OCSHCN worked with the families and community groups to provide information and education on telehealth and video visits. Through grant funding, they developed a lending library of technology that families could access to borrow tablets and procure an internet connection. The department did ongoing work with providers to expand the number of specialties utilizing telehealth. OCSHCN also made sure to check-in with families on surveys to determine what their experience with telehealth was like. Of the parents surveyed 95% rate the telehealth visit as good or excellent to an in-person office visit. When asked if they would like to access other types of services via telehealth, 88% said definitely or probably. Parents noted that telehealth helped reduce concerns about exposure to COVID-19, reduced the need to miss work/school and stress from traveling to appointments. However, issues noted were that the child and/or parent/caregiver

did not interact as well with the provider over telehealth or they experienced technical issues during the visit. OCSHCN will continue to consider expansion of telehealth policies and check-in with their patient and families on what other services could benefit from being offered via telehealth.

WEBINAR #4 – MEDICAID TELEHEALTH PERMANENT POLICIES

The last webinar for the Fall Series focused on what policies three states, Arizona, North Carolina and Oregon, had made permanent and how did they reach those decisions, The speakers presented each state's unique approaches to evaluating and deciding on their permanent policies, but the common thread through all their decisions was ensuring that their Medicaid beneficiaries could access the care they needed.

Lori Coyner, Senior Medicaid Policy Advisor for the Oregon Health Authority (OHA), which oversees the state's Medicaid program, discussed the changes they have made to their telehealth policies. Ms. Coyner noted that the Oregon Health Plan covers one million Oregonians for physical, oral and behavioral health care. The OHA has a strategic goal to eliminate health inequities in the state by 2030. This goal would mean Oregonians can reach their full health potential and well-being and not be disadvantaged by race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Telehealth is one of the tools to help achieve this equality but it may also inadvertently cause inequities. In the early days of the pandemic, telehealth use increased dramatically and it still remains high. Approximately 40% of the telehealth visits in Oregon Medicaid is done through audio-only. Part of this high audio-only use is connectivity issues, including broadband, data limits/cost and equipment access. While telehealth can help increase access and help facilitate greater access to culturally and linguistically responsive care, it can possibly cause inequities due to broadband issues, digital literacy and decreased in-person access. OHA has an internal policy framework that aligns under its vision to eliminate health inequities, coordinate with other staff working on telehealth, identify issues in need of resources or attention and communicate high-level goals and vision with stakeholders. This framework helped formed the current policy which includes no restrictions on originating or distant sites, allowing telehealth to be used for new and established patients and payment parity. Patient consent is required and providers must ensure meaningful access. Recent state legislation also made some of the temporary COVID-19 policies, permanent such as including audio-only and payment parity. For 2022, OHA is looking at strengthening patient choice and options and consent requirements.

Dr. Shannon Dowler, MD, Chief Medical Officer for North Carolina Medicaid noted that before the pandemic, she was a telehealth skeptic. But like with all other states, North Carolina had to pivot in the early days of the pandemic to allow for wider utilization of telehealth and she became convinced in those early months of the use and ability of the technology to deliver health services effectively, with certain parameters in place. In deciding what temporary telehealth policies to make permanent, North Carolina Medicaid looked at all of the flexibilities

it had provided which generally fell into four general categories: the clinical policy, eligibility and type of provider, compliance/regulatory issues and finance. In total, there were 387 flexibilities examined that spread across multiple function areas. In doing this deep dive into the policies and impacts, North Carolina Medicaid found that consistently a second visit was less likely after telehealth(real time audio and visual) was used compared to a visit that took place in-person or by telephone only. Total cost of care in two weeks following a primary care visit were comparable or it was very slightly more expensive with telehealth. Overall, North Carolina realized that it had grossly overestimated the fiscal impact of telehealth and there were unexpected benefits they had not considered. Hospital visits two weeks after a primary care visit tended to be lower when telehealth was used compared to in-person or telephonic. Probability of consistent medication use for Substance Use Disorder and Severe Mental Illness when telehealth was used was higher than in-person. However, while telehealth live video showed great returns, North Carolina struggled more with audio-only services. While there were some positives to audio-only such as accessibility, there were concerns over quality, fraud and risk of inappropriate clinical care. There were also some services that simply could not be done via audio-only such as some components of wellness visits. There were also some policies they implemented that they believe would provide great benefits, but did not receive as much uptake as they would have hoped such as their hybrid home-telehealth model. Overall, North Carolina Medicaid's foray into telehealth made necessary by COVID-19 was a success and they continue to monitor and discuss other potential policies that would benefit their beneficiaries.

The last speaker for the Fall 2021 series was **Dr. Sara Salek**, Chief Medical Officer for the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is the largest single health insurer in Arizona, covering over two million individuals and their families. Unlike North Carolina, Arizona had extensive telehealth policies within its Medicaid program pre-pandemic and had only recently updated them months before COVID-19 hit. When the pandemic arrived, AHCCCS sprang into action and among its policies, created a temporary audio-only code set that allowed for 94 different Healthcare Common Procedure Coding System (HCPCS) codes to be delivered via audio-only and approximately 150 HCPCS codes for interactive audio-video and store and forward services. For 2020, the most common primary diagnosis served through telehealth was behavioral health. Recent legislation also impacted Medicaid's policies around telehealth such requiring the adoption of telehealth best practice guidelines. For other permanent policies, from the temporary audio-only code set, 24 codes out of 94 (25%) are being recommended to be made permanent. AHCCCS is also planning for pay parity for telehealth services delivered via interactive audio-video, store and forward, as well as audio-only for behavioral health services.

CONCLUSION

The Fall Medicaid Webinar Series truly highlighted the different approaches states are taking in deciding what telehealth policies to change/make permanent as we approach almost two years of the COVID-19 pandemic. More than ever before, the process on how telehealth policy is being decided has drawn interest and scrutiny. Medicaid programs have responded with higher levels of engagement with stakeholders and closer examination of data that focuses not only on

utilization, but impacts and outcomes. A constant theme throughout all the presentations was a conscious expression of the impact these policies, adopted or not, would have on Medicaid beneficiaries and a desire to minimize potential disruptions of services to people.