

Centers for Medicare & Medicaid Services  
COVID-19 Medicaid & CHIP All State Call

October 20, 2020

3:00 pm ET

- Operator: Greetings, and welcome to the CMCS All-State Medicaid and CHIP Call webinar. During the presentation, all participants will be in a listen-only mode. Afterwards, we will conduct a question and answer session. At that time you may ask questions by using the chat box at the bottom left of your screen, or by pressing star one on your telephone keypad. If at anytime during the conference you need to reach an operator, please press star zero.
- Operator: As a reminder, this conference is being recorded Tuesday October 20th, 2020. I would now like to turn the call over to Jackie Glaze. Please go ahead.
- Jackie Glaze: Thank you, and good afternoon everyone, and welcome to today's All-State Call and webinar. I will now turn to Anne Marie Costello, and she will share the highlights for today's discussion and introduce our speakers. Anne Marie?
- Anne Marie Costello: Thanks, Jackie. Hi, everyone, this is Anne Marie Costello and I'm the Acting Director of the Center for Medicaid and CHIP Services, and I want to welcome and thank you for joining us today. This afternoon, we'll hear from CMCS staff about two telehealth releases CMS issued last week, as well as a brief update on school-based services.
- Anne Marie Costello: Melissa Harris, the Acting Director of the Disabled & Elderly Health Programs Group, will discuss a new supplement to the Medicaid and CHIP telehealth toolkit. The supplement is an update to the original toolkit released in April, and includes a number of new examples and insights into lessons learned from states that implemented telehealth changes during the public health emergency. The supplement is intended to help states strategically think through how they explain and clarify to providers and other stakeholders which policies are temporary and permanent.
- Anne Marie Costello: Then, Kim Proctor, a Technical Director in our Data & Systems Group, will present a preliminary data snapshot, also released last week, that examines the impact of COVID-19 on telehealth utilization among Medicaid and CHIP beneficiaries. The preliminary data show that telehealth use increased dramatically in the early months of the public health emergency. This release highlights another way that CMS is using T-MSIS data to analyze the impact of COVID-19 on service utilization. Just to note, that we will be using the webinar platform for Kim's presentation as she displays her telehealth data slides. Following Kim's presentation, we'll have a brief update of the provision of school-based services.

- Anne Marie Costello: CMS has been contacted by several states recently regarding Medicaid services for children attending school remotely. To address this, Melissa Harris will provide information on types of Medicaid services that are available to students under these circumstances. Then we'll open up the lines for your questions on both the telehealth presentation, as well for your general questions.
- Anne Marie Costello: With that, I'll turn things over to Melissa to start her telehealth presentation. Thank you.
- Melissa Harris: Okay. Thanks, Anne Marie, and hi everyone. This is Melissa Harris, Acting Director of the Disabled & Elderly Health Programs Group, and I want to make sure you're aware that CMS published, on the 14th of October, a supplement to the Medicaid and CHIP telehealth toolkit that we published a couple of months ago. That original toolkit was meant to consolidate and remind states of the flexibilities for using telehealth to deliver Medicaid-covered services that really are available to states at all times, but particularly can be put to use during the public health emergency when the more typical provision of in-person services is so disrupted.
- Melissa Harris: As time passed after the issuance of that initial toolkit, it became clear that we had enough information to warrant issuing a supplement to that toolkit, and that supplement is what was issued on October 14th. And if you go to our Medicaid.gov website, you'll be able to see the actual supplement. And so, I'll hit a couple of highlights for what this supplement contains and then I'll end with some general remarks about telehealth availability.
- Melissa Harris: In this supplement, we have done some more consolidating of all of the frequently asked questions that touch on telehealth that CMS has issued during this public health emergency. When we had released the original toolkit, we had included all of the frequently asked questions issued as of that date. But this supplement condenses all of the newly asked, frequently asked questions as it relates to telehealth and has them all in one place.
- Melissa Harris: And then after that, we go into some information about the actual telehealth modalities that are available. These are the mechanisms that actually allow the information to be conveyed between the practitioner and the individual receiving services. And so in the supplement, you'll see some good information around modalities such as two-way audio and video. There will be a description of what it is, how that modality can be used, any limitations on using that in the context of the delivery of Medicaid-funded services.
- Melissa Harris: We also have some information on audio-only telehealth, including a reminder that this type of modality is available for use during the public health emergency because our colleagues in the Office of Civil Rights, who oversee the HIPAA privacy provisions, have issued a notice of enforcement discretion, not temporarily enforcing the prohibition on this type of telehealth modality during the public health emergency, so that flag is there as we're talking about how audio-only telehealth can be used in the delivery of services. Asynchronous

communication, or store-and-forward information, is also provided. Again, what it means, how it can be used in Medicaid, and any limitations that states and providers need to be aware of. And then we also end with remote patient monitoring. Those are the main modalities that comprise how telehealth can be used to deliver information, again between practitioners and our beneficiaries.

Melissa Harris: States have a lot of flexibility in determining the types of telehealth that make the most sense, and there is no requirement that says the same modality has to be used across the state or across the different Medicaid services. And so, states really are in the driver's seat in determining what types of modalities are going to work in various geographic locations, or for various services, or for various provider groups. And so we hope this information in the supplement will be helpful as you are making decisions, not only about the types of telehealth to utilize right now during the public health emergency, but as Anne Marie said, as you are setting a longer term strategy of how telehealth will be part of your Medicaid program moving forward.

Melissa Harris: And to also help with those conversations, the supplement also includes some assessments and action plans. Templates that have some examples filled in, and are also included in blank form to help you make some decisions about what kind of telehealth you're using right now. What did you use before the public health emergency? What did you newly stand up during the public health emergency? What do you think makes the most sense to continue after the public health emergency? And in the cases of you taking down a telehealth flexibility, who do you need to notify in the cases of continuing a telehealth flexibility? Who do you need to notify, and what information do you need to provide?

Melissa Harris: There's also a comparison tool that lets you look at telehealth in both your fee-for-service and your managed care service delivery mechanisms. Again, you've got discretion to vary the use of telehealth across delivery service options, so what makes the most sense for you and what kind of stakeholder outreach do you need to do in order to be able to carry forward your decisions?

Melissa Harris: And then we also have some communications strategies, again to make sure that you've got the right stakeholders at the table. Obviously, in order to have a really robust telehealth strategy, you need to be making decisions within and across your state agencies. For the Medicaid agency, the agencies that are overseeing programs for people with a mental illness or older adults, or developmental disability. And then you've also got to be communicating those decisions to your providers, to your managed care plans, to your beneficiary groups, family members. And so there is some information in here about stakeholder outreach guidelines, and we also provide some state-specific examples of how some states have done that stakeholder outreach.

Melissa Harris: And then we also end with profiles of a few states that we highlight, that talks about, again, what their telehealth looks like before the public health emergency, and what kind of changes they've made. And then what you'll see under the

heading of notable findings, and those were the most relevant pieces of the telehealth strategies that those states wanted you to know.

Melissa Harris: We hope this is helpful when taken alone and in tandem with the original toolkit that we published a few months ago. As states, you've got a lot of discretion to be making some pretty far reaching decisions about the role of telehealth, both in terms of the technology and the coverage of Medicaid services, and the reimbursement of Medicaid services. We encourage you to take a look at the information in the toolkit and the supplement. And as always, CMS remains available to provide technical assistance on both the coverage and reimbursement policies, and we're available to you at your convenience.

Melissa Harris: With that, I'm going to stop on the toolkit supplement, and turn it over to Kim Proctor in our Data Systems Group. Thanks.

Kim Proctor: Great, thank you so much. Hi, everyone. I'm Kim Proctor, and today I'm going to present a slightly narrowed down version of the telehealth slides that CMS released last week, in conjunction with that telehealth toolkit. But I want to start by saying that we're really excited to release these slides, and we want to thank all the states for all the hard work that they've done over the past few years to submit high quality and timely T-MSIS data. This absolutely would not have been possible without those submissions. To our knowledge, it's the first time CMS has ever been able to release telehealth data for Medicaid and CHIP. I think it's a really big milestone for all of us, and it's really exciting to be able to put this kind of information out so quickly.

Kim Proctor: Before I begin, I just want to highlight, that if you review those publicly released slides, the differences you'll notice are very small. There's a table of contents, a Medicaid and CHIP overview slide, which everyone on this call should be very familiar with, and then we have some slides on claims run-out, which really just caution users to interpret their results with caution, because more information will be coming in. So I think everyone on this call should be aware of those issues, so we don't want to focus on them today, but I just wanted you to know that if you look at that slide deck, that's what you'll see.

Kim Proctor: Okay, so to start on the results, what are we showing? This first slide is just showing you what we capture in T-MSIS in terms of the services delivered via telehealth, using CPT codes, HCPCS codes, place of service codes, and procedure code modifiers. This just shows you this is what we're measuring when we produce these results.

Kim Proctor: Okay. This slide shows our preliminary results, and I really think this is the highlight of the presentation. The results suggest that telehealth dramatically increased from March through April, and it still remains substantially higher than prior year levels, even now. Throughout the public health emergency, we've seen nearly 35 million services delivered via telehealth, which is just a dramatic and drastic increase in the utilization of telehealth. It represents a more than 2,600% increase compared to the same time period from 2019. So, you see this enormous

jump and when you compare it to utilization from prior years, you can really see just how drastic it is. And we do caution users here just to be aware that more claims will come in and so these more recent months, like May and June, they might change slightly in the future, but the story of a drastic increase in the use of telehealth, we expect to stay the same.

Kim Proctor: And then, the next few slides really just try to help unpack some of the variation that we're seeing. We really look at time periods, age groups, and states. This slide is just showing you that, from an age group standpoint, it does appear that working age adults, age 19 to 64, had the most services delivered via telehealth, followed by children, and then the 65 and older population.

Kim Proctor: We do want to caution here, that we're aware that many beneficiaries age 65 and older are probably duals. This doesn't show every service to every person from other health insurance programs, it's just showing Medicaid and CHIP. We know that the utilization for that group might look different if we had a more complete picture, but in terms of Medicaid and CHIP, they had the lowest number of services delivered via telehealth. And then you can also see some of that time relationship here. Telehealth did increase in March, but there's really that explosion in April, and it has still stayed very high in May and June.

Kim Proctor: Okay, and then these next few slides, they show both the variation across age groups, and then also states. We do want to highlight again here, that we know claims lag plays a role. If you're looking at a specific state, there absolutely could be an issue where that state takes a little while to submit their claims to CMS. We do want to highlight that, just keep that in mind.

Kim Proctor: With that said, there still appears to be significant variation across states regarding the amount of services they're delivering via telehealth to these different age groups.

Kim Proctor: This slide is showing children and it's showing that, in this case, Maine appears to have the highest rate per 1,000 beneficiary months, while Vermont has the lowest. And you can just see all of this on the slide, and then what's going on across the different states.

Kim Proctor: And then this slide is going to show adults age 19 to 64, and you're going to see the same thing here. There is substantial variation across states. And even if there's a specific state you're interested in, and you focus on an individual state, you'll even start to see that the results will vary, not only across those states, but also within them across different age groups. Many states have different rates for different groups.

Kim Proctor: For adults age 19 to 64, Missouri appears to have the highest rate, while South Carolina has the lowest rate. And once again, we do want to mention that as more claims are submitted these slides could change.

- Kim Proctor: And then, the final slide is just showing the same outcome for the 65 and older population. Again, we do want to caution that this population probably received some additional services that were paid via Medicare, but we just still wanted to show what we have from our dataset that you're all submitting to us.
- Kim Proctor: And so here you can see that the rates for this group was lower than for children and for adults age 19-64, but there's also substantial variation here. And Maryland had the highest rate in this case, and South Carolina had the lowest rate.
- Kim Proctor: That really just highlights the data presentation that we released. We really appreciate your time. We look forward to your questions about the slides. And with that, I will turn the presentation back over to Jackie and Melissa for the school-based services overview. Thank you.
- Jackie Glaze: Thank you, Kim. And as communicated, we'll now turn the call back to Melissa Harris, and she would like to share some information with all of you about the types of Medicaid services available to children that are receiving school through remote learning. Melissa?
- Melissa Harris: Thanks, Jackie, and hi, again. It's Melissa. CMS has been contacted by states and other stakeholders to discuss challenges with the provision of needed services when children are attending school virtually. The partnership between Medicaid and the education system has always been critically important in ensuring that Medicaid eligible students receive Medicaid-funded services they've been assessed to need, as well as making sure they receive services and supports authorized under the Individuals with Disabilities Education Act, or IDEA.
- Melissa Harris: When schools are providing in-person learning, students can receive those services and supports from providers that are located physically in the school building. But that arrangement is made further complicated when schools are using virtual learning environments.
- Melissa Harris: We remind states of the statutory provisions in Title XIX authorizing Medicaid-funded home and community based services. And the fact that they are there but they also prohibit Medicaid reimbursement of habilitative services that are the responsibility of the education system, as described in IDEA. But regardless of that prohibition on duplication of IDEA, there are still numerous services that can be authorized in the Medicaid state plan, or through the 1915(c) Home and Community-Based Services waiver that are distinct from habilitative services, and can be provided to Medicaid eligible children, including in remote learning environments.
- Melissa Harris: Obviously, the EPSDT, the Early and Periodic Screening Diagnostic and Treatment requirements, are really a hallmark of the Medicaid program for individuals under the age of 21. And the statute indicates that those services outlined at section 1905(a) of the Social Security Act should be provided to

children when they are medically necessary, even if those services are not made available to adults.

Melissa Harris: One of the key services that is often critical to the success of children during a school day is personal care services, or that hands-on assistance with activities of daily living, such as eating and toileting. These services should be being offered to children, whether they are going to school in-person or going to school remotely from their own home. Outside of EPSDT, there are services in the HCBS coverage authorities that are separate and distinct from habilitative services, and therefore, separate and distinct on the habilitative prohibition on duplicating IDEA responsibilities.

Melissa Harris: During the public health emergency, states can submit an Appendix K for use in their 1915(c) waiver programs, or a disaster-related state plan amendment for services to be implemented under the 1915(i) State Plan, or the 1915(k) Community First Choice State Plan. Those options are available if states want to temporarily modify the service array made available to Medicaid-eligible children.

Melissa Harris: These amendments or these options allow home and community-based services to potentially be used in different ways during the public health emergency, including in remote schooling environments. Again, CMS is available for technical assistance to states on how to, number one, ensure that EPSDT responsibilities are being met. And number two, how to leverage these temporary authorities to meet the needs of children going to school remotely. I know that we all have the same goals of minimizing service disruptions and gaps in care that children might be experiencing, and we are available to either pull the threads of EPSDT or the services available under the Home and Community-Based Services authorities, including their provision in maybe different ways, to try to minimize those gaps and disruptions as much as possible.

Melissa Harris: That's really all I had to say on that, but we are happy to answer any questions. And so, I guess Jackie, I'm going to turn it back to you.

Jackie Glaze: Thank you, Melissa, and thank you Kim, both for your very helpful presentations today. At this point, we're ready to take your questions, any questions that you may have from the presenters today or any general questions. We'll start with the chat function. As you've used it before, just submit your questions through that function, and then we will then move to the questions over the phone lines. Begin submitting your questions now and we'll be prepared to answer those.

Ashley Setala: And Jackie, it looks like we have a couple of questions that have come in on the chat already. The first question is for Melissa on the telehealth toolkit. Does CMS have an Excel version of the comparison tool that states might use?

Melissa Harris: That's a good question, and I imagine you're asking that question so it's a fillable form. I don't think so, but if you want to contact me, if you want to follow up with me, I can link you to the right people who either have that document in a

more fillable form or be able to confirm its lack of availability. Please reach out to me and I will link you with the right people.

- Kirsten Jensen: Melissa, this is Kirsten Jensen, and actually we don't have it in that form for states to use, unfortunately.
- Melissa Harris: Thanks for that confirmation.
- Ashley Setala: Okay. The second question is for Kim on the telehealth data presentation. The data presented was categorized on the basis of telehealth services per 1,000 Medicaid member months. Is there any information on the proportion of total Medicaid services that were delivered via telehealth for each population?
- Kim Proctor: For this presentation, we don't have those types of summary utilization measures to actually quantify what proportion was delivered via telehealth. I can tell you that we work to construct those measures, so I think in a future presentation that might be something we'd be able to show. We did do a foregone care release for services for children 18 and under. And we do show those, for example, the proportion of outpatient mental health services delivered via telehealth compared to just total levels from the prior year.
- Kim Proctor: We're very interested in measuring the proportion of services delivered in this way, we just don't have that ready at this time, but I would expect something like that in the future.
- Ashley Setala: Okay, great. Another question for Kim. Is it possible to see in the data which modality was used? Audio-only versus audio and video?
- Kim Proctor: The way we can break it apart is, this slide. Okay, so we can break apart this slide. We can show the services delivered across these different categories. The reason why we didn't report that, is because we put this presentation out so quickly that we didn't have enough time to fully analyze exactly what we were seeing in the data. This is something we are looking at, but we want to do additional data quality analysis and we want to dig into state data a little bit better before we publish something like that. But this is the capacity that we have to look at and that is something we are continuing to monitor.
- Ashley Setala: Okay, great. And then we have a question, not related to either of today's presentations, but related to eligibility. In regards to the PHE, when someone transfers their assets and is found during a redetermination or reported as a change, if we are not to reduce their benefits, how do we address the period of ineligibility?
- Sarah DeLone: I think that we probably don't have Gene Coffey ... I can't tell if it's just an asset eligibility question ... This is Sarah DeLone ... Or if it's about a transfer of asset and the application of the penalty. I think the best though might be to reach out to



the state lead, for that person so we can be sure to hook you up with our division of Medicaid eligibility policy experts and Gene Coffey in particular.

Ashley Setala: Okay. And then, another question for Melissa on the school-based services. Can you provide any additional clarification on the ability of non-habilitative services to be used with remote learning? Or should they request TA calls for further specifics?

Melissa Harris: Well, I'll start with an easy yes to the second half of that question in terms of requesting individualized technical assistance. I think the details of the services that are available right now in a given state's program, be it a state plan or a waiver, I think will really be helpful for us to provide the right guidance on what's available currently that you might be able to tweak a little bit in terms of growing the scope of providers who are delivering a service, or adding a temporary service that looks like a little bit of a spin on an original service. That kind of individualized technical assistance really can't be overstated in terms of its importance.

Melissa Harris: Speaking generally, the habilitative service that has the statutory prohibition on duplication of IDEA responsibilities, is one service in the menu package found in 1915(c) and then through reference in 1915(i). And so there could be some states there in the other services that are found in the 1915 authorities. You'll find personal care there. Again, you'll find some other services like homemaker and home health aide. And so it's always such a gray area between, where does EPSDT start and stop for a service under the state plan like home health and personal care? And where does that type of service that can be authorized under a 1915(c) waiver or a 1915(i) state plan authority also start and stop?

Melissa Harris: And so there could be some differences in the way the services are described, the differences in the provider capacity, or the provider network that's delivering those services. Obviously, our first conversation would be around EPSDT to see how a state is complying with those requirements right now.

Melissa Harris: But we understand that these circumstances are not the norm, and so even to bolster a state's adherence to EPSDT, we might need to temporarily bring some new providers to the table. Or, separate and apart from EPSDT, we might just need to look at the scope of home and community-based services that are provided or need to be temporarily added to try to minimize some of those service disruptions.

Melissa Harris: But an awful lot of that is going to depend on the specifics of what's available in the state in the near term. And so that's really where the individual state TA comes in. And we've got a couple of divisions that this would span, because a conversation can so quickly migrate from EPSDT into home and community-based services. So it would probably make sense to have a few people from CMS on the phone who can handle the questions from both of those angles. But that's something that we know is of time sensitivity, and we will do our best to accommodate schedules and provide the needed technical assistance.

- Ashley Setala: Okay, great. And it looks like we have one more question in the chat. If a state considered continuing a telehealth modality such as audio-only, would this be something CMS would consider approving via a different waiver application and update to a state plan? Or something else?
- Melissa Harris: That's also a really great question. This is Melissa. And because the question was specific to audio-only, it invokes the fact that CMS is not alone federally in making decisions about the extent to which that modality is available, both during and outside the public health emergency.
- Melissa Harris: We at CMS will also be taking our cues from our colleagues at the Office of Civil Rights. And the way they have structured their guidance around enforcement discretion, they will need to provide additional guidance about when that enforcement discretion ends. And so, at what point does their underlying prohibition on using audio-only modalities kick back in?
- Melissa Harris: And so, once our colleagues in OCR make that determination and audio-only telehealth is not approvable anymore, the ability for CMS to authorize it for Medicaid services also becomes questionable. And so I don't want to leave any door falsely open or falsely closed. I will just say that we will have to be taking our cues from our OCR colleagues.
- Melissa Harris: Right now, there is enforcement discretion and so you've got the ability under a disaster-related state plan amendment, for example, to use audio-only capabilities for state plan services. Likewise, you can use the Appendix K for audio-only capabilities for 1915(c) waiver services. If you've got all of your services funneled under an 1115 demonstration, we can put you in contact with our state demonstrations group to make sure you've got the right shout-out to audio-only modalities in your 1115. That's a pretty easy conversation from the vantage point of the public health emergency.
- Melissa Harris: When that ends, and to the extent OCR lifts their enforcement discretion, I think it's going to be a different conversation. And the ability of CMS to move forward with approvals of audio-only might look very different. But that's something that we will all need to tackle when we understand what the moving pieces are. And to the extent the state wants to build any kind of permanent telehealth flexibility into their Medicaid program, you won't be limited to disaster-related state plan amendments or Appendix Ks. You'll be able to embed those flexibilities in your underlying state plan and your underlying 1915(c) waiver.
- Melissa Harris: But there's an asterisk by the audio-only modality because of the linkage to HIPAA and to our colleagues in the Office of Civil Rights. So we do need to be cautious there.
- Ashley Setala: Okay. And I think that's everything in the chat at this point. So, Jackie, I think we're ready to move to the phone.

Jackie Glaze: Thank you, Ashley. Christie, we're now ready to open up the phone lines, so can you give instructions to the audience on how they submit their questions?

Operator: Certainly. To ask a phone question, press star, then the number one on your telephone keypad. And you do have a question from Tricia Roddy.

Tricia Roddy: Hi, this is Tricia Roddy. I'm in the car, so hopefully you can hear me. Melissa, I just heard your comments around the Office of Civil Rights. And I think actually, putting that into a Q&A for states would be incredibly helpful. Stakeholders in Maryland are not interpreting the Office of Civil Rights as a barrier for CMS approval. So, in terms of the telehealth guidance and toolkits that came out, they are very much not seeing what you just stated. It would be really appreciative if you would send out some clarification, in terms of exactly what you just stated over the phone.

Melissa Harris: Thanks for that, Tricia. We'll go back and look at the FAQs and I just had the toolkit supplement in front of me. Let me scroll down to the page that's talking about audio-only. I think we do have ... Yes, it's on page 19 of the toolkit supplement. In the limitations column, we do have a note about OCR having issued enforcement discretion, which is made available during the public health emergency. I think the invisible ink there to continue that sentence is, and so what happens after OCR takes down their enforcement discretion?

Melissa Harris: The real answer today is, I don't know what that means for CMS. I don't want to presume that we will continue to have the authority to authorize audio-only technology if OCR says doing that would violate HIPAA. I don't want anyone's expectations such that CMS is going to be able to authorize something that has been from our colleagues viewed as a HIPAA violation.

Melissa Harris: I know OCR is aware that there's been an awful lot of use of audio-only during the public health emergency. How that is informing what decisions they might make moving forward, is something that we will also be watching with interest. But I think it is wise to make sure that the potential time-limited nature of this audio-only flexibility is known amongst stakeholders, and we'll go back and look at the way we've described it in the FAQs, as well. Thanks for that.

Tricia Roddy: Thank you.

Operator: Once again, if you would like to ask a question, press star one. And there are no further questions at this time.

Jackie Glaze: We'll give it another minute or two and to see if any questions come through and then we'll wrap up.

Ashley Setala: It looks like we have a couple of other questions that have come in, in the chat. Can CMS weigh in on the ability of FQHCs to establish patients via asynchronous modalities?

- Melissa Harris: This is Melissa, and I'm pretty sure I cannot weigh in on that. I don't think anyone would want me to. That is probably something, and I believe we may have lost our Division of Benefits and Coverage folks, that is a good conversation or a good question that would probably be best to ask of our subject matter experts. And so I would encourage you to reach out to Kirsten Jensen and her Division of Benefits and Coverage folks. They are becoming pretty masterful at threading the needle between telehealth flexibilities and coverage categories like FQHCs that bring their own technicalities to the table. And so I apologize that I don't know how to answer that question myself, but they will be your best bet.
- Jackie Glaze: And I'll also say, just to add to Melissa, you can also reach out to your state lead and they can help make the connection to Kirsten Jensen's team.
- Melissa Harris: Yeah. Thank you, Jackie.
- Ashley Setala: And then we have someone asking for some clarification about the issue with audio-only and HIPAA compliance. It says, providers have used telephones to communicate with patients for years and there have been codes for that. Can you explain why this is different?
- Melissa Harris: I don't have a lot of technical understanding of what about audio-only is viewed as a violation of HIPAA. But again, HIPAA is the federal expectations for privacy and protecting the confidentiality of identifying information, healthcare information. And my assumption is, that there is a risk in audio-only technologies that, that kind of privacy expectation is jeopardized. But I don't know much beyond that.
- Melissa Harris: And so, we have, in any real piece of Medicaid guidance that we issue that runs up against HIPAA provisions, we in CMS are very deferential to the Office of Civil Rights because they really have the expertise and the oversight of HIPAA provisions. And so I don't want to try to migrate into their territory.
- Melissa Harris: But I reiterate that I think they understand how popular it has become, particularly during the public health emergency. To the extent it was being used before the public health emergency, I think you're probably not alone there. We had to be educated ourselves about, as we were in the new early days of the public health emergency, what it meant to be authorizing audio-only telehealth and why we were able to do so, because of this enforcement discretion.
- Melissa Harris: I imagine there's a bit of an opening for some additional clarification on the role of audio-only moving forward, both inside and outside of the public health emergency. But that kind of clarification would need to come from our Office of Civil Rights colleagues.
- Ashley Setala: Okay. And then we have one more question for Kim on the telehealth data. Is there any explanation as to why Maine, Missouri, and Maryland have high telehealth rates for their respective subpopulations?

- Kim Proctor: This is a great question, and it's one that people on our team also had. We do not have an explanation. And we do want to caution people that there are a lot of different reasons why utilization rates could be different. For some states, the restrictions to stay at home were more severe, where maybe you have used a telehealth visit, and the spread of COVID was more significant and more severe.
- Kim Proctor: There could be actual just state level variation that has really nothing to do necessarily with telehealth utilization and has entirely to do with something else. At this point, there are so many variables going into what's happening, we did not feel like we could tell a real causal story about what was happening.
- Kim Proctor: What we did do is, we did say, are there any major data quality issues for these states that appear to very high or low? And we did a very preliminary analysis of that, and we did not see anything that suggested it is a significant data quality issue driving those results.
- Kim Proctor: So, in this case, I think that's the kind of question we would need more time. Not only for more claims, but to really understand the variance across states and actual environment to explain that kind of answer. But it is a great question and something we would love to be able to look into as time progresses.
- Jackie Glaze: Thanks for the questions. I'll circle back to Christie to ask if there's any questions in the phone queue.
- Operator: We currently have no questions.
- Jackie Glaze: Thank you. In closing, I want to thank Melissa and Kim for their excellent presentations today. And invitations for the next call are forthcoming that will include the topic. In the meantime, if you do have questions, please reach out to us. You can always reach out to your state leads. We're here to assist you. Thanks again, everyone, for participating and joining our call today, and we hope that you have a great afternoon. Thank you.
- Operator: Thank you. This does conclude today's conference call. You may now disconnect.