CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

All-State Medicaid and CHIP Call

June 25, 2024

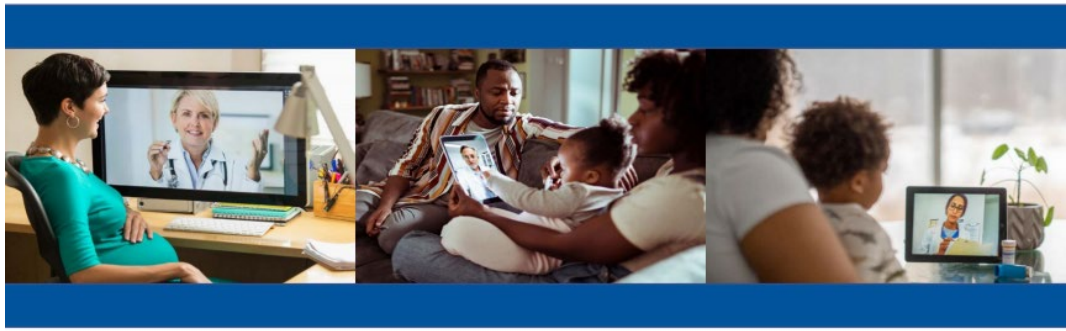
Agenda

- State Medicaid & CHIP Telehealth Toolkit
- Lawfully Present Final Rule
- Open Mic Q and A

Medicaid & CHIP Telehealth Toolkit

Medicaid and CHIP All State Call

June 2024



State Medicaid & CHIP Telehealth Toolkit

February 2024

Background on the Telehealth Toolkit

- The new Medicaid & CHIP Telehealth Toolkit consolidates information from the **State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version** (April 23, 2020)[1], and the **State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1** (October 14, 2020).[2]

- It also provides guidance to states on how they can improve access to telehealth for services covered under Medicaid and CHIP, as required by the **Bipartisan Safer Communities Act (BSCA), 2022, Division A, Title I, Section 11002(a)**:
  - ✓ Flexibilities under Medicaid and CHIP;
  - ✓ Billing best practices;
  - ✓ Strategies for telehealth in value-based care;
  - ✓ Best practices from states during and after the COVID-19 PHE;
  - ✓ Strategies to promote the delivery of accessible and culturally competent care via telehealth, including using telehealth in schools;
  - ✓ Strategies for communications, training, and resources for providers and beneficiaries;
  - ✓ Information about telehealth platforms; and
  - ✓ Evaluation strategies to understand how telehealth affects quality, outcomes, and cost.

[1] https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.

[2] https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.

Background on the Telehealth Toolkit (cont.)

- Additionally, this toolkit includes information on how telehealth can be a helpful tool for maternal health services, accessing out of state providers, transitions for foster-age youth, and more.

Please note: The strategies and state examples provided throughout the toolkit (and this presentation) are meant to illustrate how states have operationalized telehealth and to inform the development of state telehealth policy. Some examples and activities described might not be funded, or might not be eligible for federal matching funds, under title XIX or other federal program(s).

Overview of State Medicaid & CHIP Telehealth Toolkit

- Section 1: Telehealth Overview
- Section 2: Frequently Asked Questions (FAQ)
- Section 3: State Medicaid and CHIP Telehealth Trends
- Section 4: Strategies for Delivering Services via Telehealth to Specific Populations and for Specific Services
- Section 5: Operational Considerations for Implementing Telehealth
- Appendices: Telehealth Tools for States

Section 1: Telehealth Overview

This section of the toolkit provides the following fundamental considerations for state agencies as they explore changes to their existing telehealth policies: telehealth flexibilities in Medicaid and CHIP, state policy considerations, and common telehealth modalities.

Section 1: Telehealth Overview

Highlights of Telehealth Flexibilities in Medicaid and CHIP

For most Medicaid and CHIP benefits, federal laws and regulations do not specifically address telehealth delivery methods or criteria. As such, states have a great deal of flexibility in designing the parameters of service delivery using telehealth.

- **Services:** States have the option to authorize delivery of many Medicaid services through telehealth to expand access to care.
- **Providers:** In addition to provider licensure and credentialing in Medicaid, states should also consider whether a provider's professional scope of services enables him or her to bill for a service provided via telehealth, and whether any changes to the scope of services are warranted.
- **Technology:** States can consider allowing covered services to be delivered via multiple telehealth modalities.
- **Payment:** States should consider whether their Medicaid and CHIP payment rates for services delivered via telehealth are adequate.

Section 1: Telehealth Overview (cont.)

Common Telehealth Modalities

Two-way (bi-directional), real-time audio-video/multi-person calls: Face-to-face interaction between a patient and a provider using audiovisual communication.

Audio-only: Real-time interactive voice-only discussion, generally only requires a working phone.

Asynchronous communications: Also called "store and forward", not real-time interaction; could be a narrative (text-based) description, an image, a video recording, an audio recording, or responses to a survey, among other items.

Remote patient monitoring: Typically involves the deployment and use of technology to capture biometric information about the patient that is automatically shared with a remote provider.

- All modalities can support involvement of more than two parties/call locations.

Section 2: FAQ Highlights

The FAQ section of the toolkit provides information on topics that states commonly consider when implementing telehealth policies.

Section 2: FAQ Highlights

FAQ topics include the following:

- Benefit Flexibilities
- Financing
- Workforce
- Managed Care
- Codes, Modifiers, and Medicaid Systems
- Quality Reporting

Section 3: State Medicaid and CHIP Telehealth Trends

This section describes general trends in state Medicaid and CHIP telehealth policies before, during, and after the COVID-19 PHE, and explores more detailed trends in five states with notable telehealth developments during the same time period.

Section 3: State Medicaid and CHIP Telehealth Trends

- Prior to the COVID-19 PHE in 2020, all 50 states and the District of Columbia authorized delivery of some Medicaid services via telehealth, though states' telehealth policies varied widely.[3]
- During the COVID-19 PHE:
  - States' adoption of service delivery via telehealth accelerated significantly.[4] States used a number of telehealth strategies, including covering specific services within a class of services when provided via telehealth, to increase access to services and expand provider capacity.
    - For example, many states expanded access to certain dental services by covering them when provided via telehealth (commonly known as teledentistry) during the PHE and some states recognized that covering Medicaid services delivered via telehealth by out-of-state providers further increased access to services and expanded provider capacity.[5]
  - Beneficiary utilization of telehealth also increased.[6]

[3] https://www.cchpca.org/2021/04/Historical-State-Telehealth-Medicaid-Fee-For-Service-Policy-ReportFINAL.pdf.
[4] https://aspe.hhs.gov/sites/default/files/documents/190b4b132f984db14924cbad00d19cce/Medicaid-Telehealth-IBUpdate-Final.pdf. U.S. Territories are not included in this analysis.
[5] https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicaid-coverage-access-totelehealth-in-response-to-covid-19/.
[6] https://aspe.hhs.gov/sites/default/files/documents/190b4b132f984db14924cbad00d19cce/Medicaid-Telehealth-IBUpdate-Final.pdf.

Section 3: State Medicaid and CHIP Telehealth Trends (cont.)

- When the COVID-19 PHE ended:
  - According to a survey of 49 states and the District of Columbia, telehealth utilization by Medicaid beneficiaries decreased and/or leveled off in fiscal year 2022 but remained above utilization levels prior to 2020.[7]
  - Two-thirds of the states either expanded or planned to expand telehealth policies in fiscal years 2022 or 2023. The survey results indicated that the most common policies included expansions of allowable telehealth modalities and services allowed to be delivered via telehealth.[8]

[7] https://files.kff.org/attachment/REPORT-How-the-Pandemic-Continues-to-Shape-Medicaid-Priorities-Resultsfrom-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2022-and-2023.pdf.

[8] Ibid.

Section 4: Strategies for Using Telehealth with Specific Populations and Services

This section describes general trends, strategies, and notable examples on how states can leverage the ability to deliver services via telehealth to address health equity among Medicaid and CHIP beneficiaries. It discusses best practices and strategies for improving equitable access to telehealth among specific populations, such as racial and ethnic groups, American Indian and Alaska Native (AI/AN) individuals, individuals with disabilities, and children and youth. It also delves into how states can permit delivery of covered services via telehealth to address maternal mortality and morbidity disparities, and strategies for using telehealth to provide mental health and substance use disorder services.

Section 4: Strategies for Using Telehealth with Specific Populations and Services

Strategies to Ensure the Technological Component of Telehealth is Equitable

- CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."[9]
- While telehealth can be a tool to help encourage equitable access to services, it is important to implement the technological and service components equitably.[10]
- To ensure beneficiaries have knowledge about and access to technology to equitably facilitate care that is available through telehealth, states should consider strategies, such as offering, and encourage their providers and managed care plans to offer, information about how to use telehealth technology.
- States can also use telehealth policy to improve equitable access to, and continuity of, health care services by expanding beneficiaries' options for receiving those services through access to providers who use telehealth to deliver services.

[9] https://www.cms.gov/pillar/health-equity.
[10] https://telehealth.hhs.gov/providers/health-equity-in-telehealth.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Using Telehealth to Deliver Services to Specific Populations

Telehealth and Medically Underserved Urban and Rural Communities

- The U.S. Health Resources and Services Administration (HRSA) defines medically underserved populations as populations with economic, cultural, or linguistic barriers to health care.[11] Medically underserved communities exist in both rural and urban areas, and both experience similar barriers related to access to care.
  - For example, both urban and rural communities experience barriers related to lower health literacy, workforce shortages, and limited and unaffordable broadband, all of which can make widespread adoption of telehealth challenging.[12]
- Many states have recognized the benefit of authorizing the delivery of services via telehealth to help overcome challenges related to provider shortages by encouraging telehealth use for current providers and contracting with additional providers, including providers located remotely and in other states, to deliver services.

[11] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups.

[12] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6921587/; https://www.ruralhealthinfo.org/topics/healthcare-access#population-health; and https://www.ruralhealthinfo.org/topics/telehealth.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Telehealth and Racial and Ethnic Groups

- An HHS study of the general population using survey data from the United States Census Bureau revealed similar telehealth utilization rates among racial and ethnic subgroups during the COVID-19 PHE, but the data also indicated that video telehealth use rates were significantly lower among Latino, Asian, and Black individuals than they were among White individuals.[13]
- States should take steps to develop Medicaid and CHIP policies that expand access to telehealth equitably across racial and ethnic groups. This should include considerations around available modalities, culturally and linguistically appropriate service delivery, and efforts to support accessibility. For example:
  - Efforts could include allowing services to be delivered via audio-only telehealth, where clinically appropriate.
  - Additionally, multiple studies have shown promising results for mobile phone and text messaging interventions in reducing health disparities for some racial and ethnic groups, including among Medicaid beneficiaries.[14]

[13] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf.
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8647517/; https://pubmed.ncbi.nlm.nih.gov/28051761/; https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789065; and https://pubmed.ncbi.nlm.nih.gov/23478028/.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Telehealth and AI/AN Individuals

- AI/AN individuals face a disproportionate chronic and behavioral health disease burden, and their access to telehealth is hindered by a lack of internet access, geographic isolation, and resource challenges, among other barriers.[15]
- States should ensure that telehealth policies account for the unique needs of, and barriers faced by, AI/AN individuals.
  - For example, due to the internet access issues that are common among AI/AN individuals, particularly those individuals residing in rural areas, states should consider allowing services to be delivered using audio-only telehealth.
- The Department of Health and Human Services' (HHS) *Preparing Patients for Telehealth in American Indian and Alaska Native Communities* website provides tips on preparing for a telehealth visit with AI/AN individuals.[16]
- States can also work with Tribes and Tribal organizations to better understand the nature and scope for using telehealth for existing Tribal services and programs.[17]

[15] https://minorityhealth.hhs.gov/nahm/health-disparities/ and https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities.

[16] https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities/prepare-patients-for-american-indian-communities.

[17] Information provided by the Tribal Technical Advisory Group (TTAG), Alaska representative. See link for more information about the TTAG: https://www.cms.gov/outreach-and-education/american-indian-alaskanative/aian/tribal-technical-advisory-group.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Telehealth and Individuals with Limited English Proficiency (LEP)

- Individuals with LEP may experience difficulty accessing services via telehealth. For example, digital platforms are not often available in all languages, creating challenges for patients with English as their second language, even if an interpreter is available once they have successfully entered the platform.
- Multiple federal laws and regulations require covered entities (e.g., state Medicaid agencies) to take reasonable steps to provide meaningful access to people with LEP.
  - For example, under Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as well as Medicaid and CHIP regulations, Medicaid and CHIP agencies are required to provide language services, including oral interpretation and written translations, and inform individuals that language services are available and provide taglines in non-English languages on how individuals can access these services.[18]
- HHS' Telehealth.HHS.gov website provides resources and tips—such as creating multilingual patient resources—that states can share with enrolled Medicaid and CHIP providers to promote the delivery of accessible care through telehealth.[19]

[18] 42 C.F.R. § 435.905; 42 C.F.R. § 457.110; and 42 C.F.R. § 457.1207.

[19] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Telehealth and Individuals with Disabilities

- Accessibility of telehealth interventions may be problematic for some populations of beneficiaries with disabilities, particularly those with visual and hearing disabilities and those with limited or no use of their hands.[20]
  - Research has shown that individuals with a disability are less likely than those without disabilities to own digital devices, particularly desktop and/or laptop computers, a trend that further challenges equitable access to telehealth for beneficiaries with disabilities.[21]

- To help mitigate these issues, states should:
  - Consider tailored training and outreach to beneficiaries with disabilities to ensure they are comfortable accessing and using telehealth technology.
  - Conduct community engagement to inform the design of telehealth policies.
  - Consider encouraging providers to take steps and provide supports—for example, providing resources in different formats, including printed information, audio recordings, or Braille—when using telehealth to provide services to individuals with disabilities.[22]

[20] http://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20FriedenFinalPDF.pdf.
[21] https://www.pewresearch.org/short-reads/2021/09/10/americans-with-disabilities-less-likely-than-those-withoutto-own-some-digital-devices/.
[22] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth#telehealth-forpeople-with-disabilities.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Telehealth and Older Adults

- Telehealth offers a convenient and cost-effective way to deliver health care services to older adults. However, some older adults are not digitally literate or may be less comfortable using a computer or smartphone. Furthermore, some older adults may experience physical or cognitive barriers that reduce their ability to access telehealth (e.g., limitations in hearing, vision, or cognitive impairments).
- States should encourage providers to consider various strategies when providing services via telehealth to older adults.
  - For example, prior to the telehealth appointment, providers could assign a staff member to contact the patient to confirm that their device works (e.g., phones, tablets), the technology works (e.g., internet connectivity), and that the device supports video calls.[23]

[23] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/telehealth-and-older-patients.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Using Telehealth to Deliver Services to Children and Youth

- To maximize the benefits of telehealth for Medicaid- and CHIP-eligible children and youth, states should consider not only the challenges common among all Medicaid and CHIP beneficiaries (e.g., low broadband accessibility), but also the circumstances and challenges unique to this younger population.
  - For example, adolescents may have difficulty finding private spaces to receive sensitive services (e.g., behavioral health) via telehealth.[24]

Expanding Access to Telehealth for Medicaid- and CHIP-Eligible Children and Youth

- Telehealth strategies and policies that could benefit children and youth include:
  - Allowing specific components of well-child visits (a component of the Medicaid program's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for eligible children and youth under age 21) that do not require physical touch to be delivered via telehealth.[25]
  - Issuing specific bulletins with information on EPSDT/well-child visits to clarify the components of a well-child visit that could be delivered via telehealth.[26]

[24] https://publications.aap.org/aapnews/news/14281/Telehealth-taking-center-stage-in-many-practices.

[25] The American Academy of Pediatrics recommends that well-child visits for infants and young children (through 24 months old) be conducted in person whenever possible. See: https://www.aap.org/en/pages/2019-novelcoronavirus-covid-19-infections2/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-duringcovid-19/.

[26] https://nashp.org/states-establish-new-telehealth-policies-to-safeguard-well-child-care-and-immunizations/.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Telehealth and School-Based Services

- School-based services (SBS) can be covered for any student enrolled in Medicaid or CHIP[27] for any covered health services, and using telehealth to deliver these services could further enhance their potential impact.
- SBS play a particularly important role in bridging equity gaps among students in low-income and rural communities where access to health care services may be more limited.
- SBS can specifically support earlier detection of mental health and substance use disorder (SUD) symptoms and implementation of strategies that teach students emotional and behavioral regulation to help lessen the impact of mental health disorders on well-being and academic achievement.

[27] CHIP statutes and regulations allow states to use Title XXI funding for items and services provided to eligible students in school-based settings. Specifically, section 2103(c)(9) of the Act permits states to provide separate CHIP-covered services through school-based health centers. Additionally, the definition of child health assistance at section 2110(a) of the Act and 42 C.F.R. § 457.402 includes services provided in schools. Title XXI funds may also be used for coverage of SBS for Medicaid-enrolled students through a Medicaid expansion CHIP. Medicaid expansion CHIPs follow Medicaid coverage requirements in Title XIX of the Act and implementing regulations. Therefore, states should follow Medicaid requirements and standards for providing SBS to optional targeted low-income students enrolled in a Medicaid expansion CHIP.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Using Telehealth to Deliver Maternal Health Services

- Maternal mortality rates in the U.S. have been on the rise since 2000.[28]
  - In 2019, non-Hispanic Black and non-Hispanic AI/AN women experienced higher pregnancy-related mortality ratios than all other racial/ethnic populations.[29]
- Medicaid covers 42 percent of all births in the United States and 65 percent of births among Black women, in 2019.[30]
- During the COVID-19 PHE, tele-maternity visits spiked nationally, and physicians noted improved attendance in postpartum care via telehealth,[31] and research indicates that telehealth implementation for postpartum care was associated with decreased racial disparities in postpartum care attendance.[32]
- Given the potentially positive impact of receiving services via telehealth on maternal health, Medicaid programs could consider payment for services delivered via telehealth that are critical to the health and well-being of populations that suffer disproportionate maternal morbidity and mortality.

[28] Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison," To the Point (blog), Commonwealth Fund, Dec. 1, 2022. https://doi.org/10.26099/8vem-fc65.

[29] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

[30] https://www.commonwealthfund.org/blog/2021/improving-access-telematernity-services-after-pandemic.

[31] https://www.urban.org/sites/default/files/publication/103126/maternal-telehealth-has-expanded-dramatically-during-the-covid-19-pandemic_5.pdf.

[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9726646/.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Using Telehealth to Deliver Behavioral Health Services

- The Surgeon General issued an Advisory to Protect Youth Mental Health specifically citing the need for expanded access to behavioral health services via telehealth, and the majority of Americans view the country as being in a mental health crisis, with young adults the most affected.[33]
- Telehealth's demonstrated ability to maintain or enhance access to behavioral health treatment without negatively impacting patient outcomes or satisfactions has led most states to take steps to maintain or further expand coverage for behavioral health delivered via telehealth.[34]

[33] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf and https://www.kff.org/other/press-release/new-kff-cnn-survey-on-mental-health-finds-young-adults-in-crisis-morethan-a-third-say-their-mental-health-keeps-them-from-doing-normal-activities/.

[34] https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:%7E:text=In%20particular%2C%20states%20report%20that,telehealth%20utilization%20among%20Medicaid%20enrollees.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Behavioral Health Services Delivered to Children and Youth via Telehealth

- Children and youth have experienced an alarming and consistent increase in the prevalence of anxiety, depression, and other behavioral health challenges in recent years, and suicide remains a leading cause of death among young people.[35]
- All state Medicaid programs include some form of coverage and payment for mental health services delivered via telehealth, which has helped mitigate, but not resolve, the well-documented pediatric behavioral health workforce shortage.[36]
- When implementing new, or expanding upon existing, telehealth coverage and payment policies for mental health and SUD services delivered to children and youth specifically, states should consider:
  - **Consent** laws, regulations, procedures, and policies for pediatric populations.[37]
  - **Provider licensure and credentialing** requirements for pediatric providers to evaluate whether they present barriers to telehealth delivery in their states.

[35] https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.

[36] https://mailchi.mp/cchpca/its-finally-here-the-updated-50-state-telehealth-laws-reimbursement-policies-reportspring-2019-edition; and https://bipartisanpolicy.org/report/filling-gaps-in-behavioral-health/.

[37] The age of consent is the age at which children can provide their own consent without the parent or legal guardian and can vary by type of service.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

OUD Services and MAT Delivered via Telehealth

- Telehealth has played an increasing role in service delivery for beneficiaries with opioid use disorder (OUD).
  - One study showed the increased use of telehealth for OUD services, including medications for OUD, during the COVID-19 PHE was associated with a reduced overdose risk and increased length of stay for individuals in treatment.[38]
- Incorporating telehealth to treat OUD for Medicaid beneficiaries may include the delivery of Medication-assisted treatment (MAT).[39]
- Permitting mid-level practitioners to deliver Medicaid and CHIP services via telehealth is an important strategy for improving access to buprenorphine, as nurse practitioners and physician assistants have been central to the increase in buprenorphine prescription growth among Medicaid beneficiaries.[40]

[38] https://www.cms.gov/newsroom/press-releases/increased-use-telehealth-opioid-use-disorder-services-duringcovid-19-pandemic-associated-reduced.

[39] When the MAT medications prescribed are controlled substances, the prescriber must comply with the federal Controlled Substances Act. See Sections 1262-1263 of the Consolidated Appropriations Act, 2023, Consolidated Appropriations Act, 2023, Pub. L. No. 117-328 (2022), https://www.govinfo.gov/app/details/PLAW-117publ328.

[40] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increaseaccess-to-opioid-treatment-via-telehealth#Policy%20Recommendations.

Section 4: Strategies for Using Telehealth with Specific Populations and Services (cont.)

Delivering Services via Telehealth to Address Behavioral Health Provider Shortages

- Access to behavioral health services is hampered by documented provider workforce shortages, and behavioral health workforce challenges in Medicaid are exacerbated by the greater reluctance of some providers to accept Medicaid compared to other payers.[41]
- States should consider integrating telehealth as a strategy to extend the behavioral health workforce.
  - For example, states may cover qualifying community-based mobile crisis intervention services and may incorporate telehealth into this service delivery option.[42] States may include highly trained and specialized practitioners, such as psychiatrists, as part of the mobile crisis team that connects virtually via telehealth to other members of the mobile crisis team on scene to provide screening and assessment and/or to stabilize the beneficiary and de-escalate the crisis.

[41] https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortagesfindings-from-a-survey-of-state-medicaid-programs/.

[42] Section 9813 of the American Rescue Plan amends Title XIX of the Social Security Act to add a new section 1947, which authorizes the state option to cover qualifying community-based mobile crisis intervention services. https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf.

Section 5: Operational Considerations for Implementing Telehealth

This section discusses operational considerations for states for telehealth policy implementation, including approaches for evaluating telehealth, considerations for integrating telehealth into value-based care models and measuring its impact on value, and strategies and approaches for conveying information about telehealth to providers and beneficiaries.

Section 5: Operational Considerations for Implementing Telehealth

Evaluation Strategies for Services Delivered Using Telehealth

- The rapid increase in telehealth utilization poses important research questions regarding health care quality, cost, and outcomes, as well as questions regarding whether telehealth has made a positive impact on access, equity, and beneficiary experience.
- Two-thirds of states responding to a Kaiser Family Foundation survey on State Fiscal Years 2022 and 2023 reported that assessment initiatives were either in place or that they planned to assess telehealth quality.[43]
- To comprehensively evaluate telehealth, both qualitative and quantitative research is needed, as well as consistent data sets. States and providers should consider promising practices when reporting telehealth on claims and analyzing related data.
  - For example, states could adopt a billing and coding approach that is standard and consistent across several or all services, so that it is easy for providers to understand, more likely to be known and adopted, less prone to error, and easy to apply in creating queries and reports. Several states use a single POS 10 to indicate that services are delivered to a beneficiary's home via telehealth.[44]

[43] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-telehealth/.

[44] https://www.cchpca.org/2022/10/Fall2022_ExecutiveSummary8.pdf.

Section 5: Operational Considerations for Implementing Telehealth (cont.)

Telehealth and Value-Based Care (VBC) Models

- Under VBC arrangements, providers are rewarded based on quality measures that demonstrate specific evidence of performance.[45]
- Delivering services via telehealth can be a helpful component of a VBC model's design to support an increase in provider capacity and reduce health care costs, particularly when there are barriers with accessing care in general and with accessing care at an appropriate acuity level.
  - For example, states can reduce the inappropriate use of emergency department services by designing VBCs that provide financial incentives to utilize more appropriate care pathways with some service delivery through telehealth. Recognition of and payment for both direct care provided to beneficiaries and interprofessional consultation can be implemented as part of a VBC payment strategy.[46]

[45] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.
[46] https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-ImproveAccess-Quality?searchresult=1.

Section 5: Operational Considerations for Implementing Telehealth (cont.)

Strategies for Communicating Telehealth Information to Providers and Beneficiaries

- When states proactively communicate with interested parties regarding the development of, or revision to, telehealth service delivery and payment requirements, it can help support awareness of the telehealth changes or updates and buy-in from providers who are willing to adopt new methods of delivering care but who may need assistance using telehealth technologies, for example.

Conveying Information to Providers about Telehealth

- Providers have found it easier to search for and comprehend policies about which services may be delivered via telehealth, as well as billing instructions for those services, when the information is organized by clinical area or provider specialty.
  - Louisiana, for example, includes information about the Medicaid services that can be delivered via telehealth, as well as related telehealth modality and coding requirements, in its provider billing manuals, informational bulletins, and MCO manual.[47]

[47] https://www.lamedicaid.com/provweb1/Providermanuals/manuals/PS/PS.pdf; https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2019/IB19-11/IB19- 11_Revised_5.18.22.pdf; https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-1_revised20220520.pdf; and https://ldh.la.gov/assets/medicaid/MCO_Manual_2022-05-10_published.pdf.

Section 5: Operational Considerations for Implementing Telehealth (cont.)

- Virtual or in-person provider trainings are a critical component in educating providers on telehealth policies and ensuring the implementation of these policies is successful. Provider trainings and resources are especially helpful when they are comprehensive and easily accessible.
  - For example, North Carolina has a Provider Telehealth Education website that includes links to recorded, on-demand, and upcoming telehealth trainings provided by a range of organizations, such as the North Carolina Area Health Education Centers, the Mid-Atlantic Telehealth Resource Center, and Community Care of North Carolina.[48]
- Finally, states could consider establishing a coordinated support process and system for providers under both fee-for-service and managed care.

[48] https://www.ncdhhs.gov/about/department-initiatives/telehealth/provider-telehealth-education.

Section 5: Operational Considerations for Implementing Telehealth (cont.)

Conveying Information to Beneficiaries on Telehealth Availability and Requirements

- In order for telehealth to be an effective tool in reducing health disparities and expanding access to services, beneficiaries may need help understanding the telehealth options available to them, and education on ways to access and use the technology required to conduct a telehealth visit.
- States could consider directly offering educational opportunities to beneficiaries on a regular basis in order to keep beneficiaries apprised of evolving coverage policies.
  - For example, Maine maintains a telehealth website within the Member Resources section of its Medicaid website that addresses topics that may be of concern to Medicaid beneficiaries. It includes general information on what telehealth is and when and how it can be used, as well as more specific guidance on how beneficiaries can request an appointment for services delivered via telehealth.[49]
- States could also rely on established partnerships with managed care plans, providers, or other third parties to engage beneficiaries around telehealth utilization and to disseminate training and education.

[49] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs_doc/Telehealth/Telehealth-QuestionsAnswers.pdf.

Appendices: Telehealth Tools for States

- State Checklist
- Comparison Tool—Fee-for-Service/Managed Care Telehealth Policies
- State Medicaid Telehealth Assessment/Action Plan
- State Medicaid Telehealth Communication Strategies

Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens

Medicaid and CHIP All State Call

June 2024

Description of Lawfully Present Final Rule Provisions

1. Eligibility for DACA Recipients in Marketplaces and BHP

2. Other “Lawfully Present” Definition Changes for Marketplace and BHP

3. Additional Technical Changes, including “Qualified Noncitizen” Definition

4. Marketplace Special Enrollment Period Eligibility

Summary of the Final Rule: Marketplace and BHP Coverage

- CMS published the Lawfully Present Final Rule, *Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program* (CMS-9894-F), which appeared in the May 8, 2024 Federal Register.
- Effective November 1, 2024, this Final Rule:
  - Changes the definition of "lawfully present" to include Deferred Action for Childhood Arrivals (DACA) recipients for purposes of determining eligibility for coverage through the Marketplace, including advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs), and the Basic Health Program (BHP).
  - Makes other technical changes to eligibility for certain other noncitizens applicable for Marketplace and BHP coverage.

Summary of the Final Rule: Medicaid and CHIP

CMS is not finalizing the "lawfully present" definition for Medicaid and CHIP at this time: There are no Medicaid and CHIP changes in this final rule for DACA recipients.

- CMS is taking more time to evaluate and carefully consider the comments regarding our proposal with respect to Medicaid and CHIP, and specifically, to continue evaluating the potential impact of our proposed definition of "lawfully present" on State Medicaid and CHIP agencies.
- This Final Rule does not change or expand eligibility for DACA recipients in Medicaid or CHIP.
- States that have elected the option to cover "lawfully present" children and/or pregnant individuals in Medicaid and CHIP should continue to reference and implement the "lawfully present" definition set forth in the State Health Official Letters #10-006 and #12-002.
- Low Income DACA Recipients Likely Eligible for Marketplace Coverage with APTCs and CSRs or BHP Coverage: DACA recipients can qualify for Marketplace coverage with APTC and CSRs, and BHP coverage, even if their household income is below 100% of the Federal Poverty Level (FPL), if they meet all other eligibility requirements.
- CMS has finalized an updated definition of "qualified noncitizen," and made some other technical changes, discussed in further detail on Slide 41.

Technical Changes For Medicaid and CHIP

Qualified Noncitizen Definition: Finalizes and adds detail to existing "qualified noncitizen" definition for Medicaid and CHIP, based on 8 U.S.C. 1641(b) and (c) and other federal statutes that treat certain noncitizens as refugees. The definition is codified at 42 CFR 435.4 for Medicaid and at 42 CFR 457.320(c) by cross-reference for CHIP.

- Noncitizens treated as refugees under this updated definition include, but are not limited to, victims of trafficking, Iraqi and Afghan special immigrants, Amerasian immigrants, certain Afghan evacuees, and certain Ukrainian parolees.
- Updated definition includes the recent Consolidated Appropriations Act, 2024, amendments to 8 U.S.C. § 1641(b)(8) and 8 U.S.C. § 1613(b)(3) to allow immediate eligibility for individuals who lawfully reside in the United States in accordance with a Compact of Free Association (commonly referred to as "COFA migrants") for coverage in a separate CHIP, if they meet all other eligibility requirements in the state.

The revised definition of "Qualified Noncitizen" in the final rule is intended to promote clarity and does not change or expand eligibility to any new category of noncitizens.

NOTE: The "qualified noncitizen" definition is used to determine eligibility for Medicaid and CHIP in all states, D.C., and the territories. Qualified noncitizens are also covered by Marketplaces and BHP under the "lawfully present" definition. (see paragraph (1) at 45 CFR 155.20, cross-referenced at 42 CFR 600.5 for a BHP)

Operational Considerations for Medicaid & CHIP

- State Medicaid/CHIP agencies can comply with the final rule without making any new eligibility system changes:
  - The revised definition of "lawfully present" **does not apply** to Medicaid or CHIP.
  - DACA recipients and other noncitizens impacted by the Final Rule continue to be **not** lawfully present for purposes of Medicaid or CHIP eligibility.
- The revised definition of "qualified noncitizen" does apply to Medicaid and CHIP but does not expand eligibility. It is intended to provide clarity and transparency to the public.
  - State agencies should confirm that their policy and operational guidance aligns with the final rule.
- Medicaid and CHIP agencies that rely on Hub indicators to verify immigration status, can accurately verify immigration status for noncitizens with no updates to their systems.
- DACA recipients and noncitizens impacted by the Final Rule should apply for Marketplace or BHP coverage directly with the Marketplace or BHP, rather than at the state Medicaid or CHIP agency.

Operational Considerations for Updating Eligibility, Verification, and Enrollment Processes – Overview

- For DACA recipients, Hub indicator values will be returned as follows, indicating that the individual does not have a lawfully present immigration status and is not a qualified noncitizen:

Lawful Presence Verified	Qualified Noncitizen	Five-Year Bar Apply	Five-Year Bar Met	U.S. Citizen Code
N	N	X	X	X

- Other noncitizens impacted by the final rule may have LPV=N or LPV=P returned by the Hub.
- Although these values are accurate for purposes of Medicaid and CHIP eligibility, they are not accurate for Marketplace and BHP eligibility.
- **Marketplaces and BHPs will need to implement new functionality or update existing processes in order to use more granular information returned by DHS SAVE through the Hub** in order to correctly identify and verify DACA recipients and other noncitizens impacted by the Final Rule as eligible for Marketplace or BHP coverage. This information includes ESC codes, Major Codes, COA codes, and EAD codes.

Key Takeaways

- Starting November 1, 2024, DACA recipients and other noncitizens impacted by the Final Rule are considered eligible to enroll in Marketplace and BHP coverage, and for financial assistance, if otherwise eligible.

- This Final Rule does not change or expand eligibility for DACA recipients and other noncitizens impacted by the Final Rule in Medicaid or CHIP.

  - DACA recipients continue to not be eligible for full Medicaid or CHIP, but remain eligible for limited coverage of treatment of an emergency medical condition under Medicaid, if they meet all other eligibility requirements in the state plan.

- DACA recipients and other noncitizens impacted by the Final Rule should apply at HealthCare.gov or with approved EDE entities (e.g., QHP issuers and web-brokers) to enroll in Marketplace coverage. DACA recipients and other noncitizens impacted by the Final Rule can work with an agent, broker, or assister when applying through these channels.

- DACA recipients and other noncitizens impacted by the Final Rule who apply for Marketplace coverage between November 1, 2024 and November 30, 2024 can enroll in Marketplace coverage as soon as December 1, 2024.

- The revised Medicaid and CHIP definition of “qualified noncitizen” does not make any changes or expansions to Medicaid or CHIP eligibility but provides additional clarity and transparency to states and stakeholders.

Resources

- Final Rule "*Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program*" (CMS-9894-F)

- Lawfully Present Final Rule *Fact Sheet*

- State Health Official Letter, #10-006, "*Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*"

- State Health Official Letter #12-002 "*Individuals with Deferred Action for Childhood Arrivals*"

Open Mic Q and A