CMS CMCS Medicaid and CHIP All-State Call
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Coordinator: Good afternoon, and thank you for standing by. Your lines are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star followed by the number 1 to ask a question. Please unmute your phones and state your first and last name when prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time. It is now my pleasure to turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you, and good afternoon, everyone and welcome to today's all-state call. On today's call, we will be discussing two important topics. First, Betsy Conklin from our Medicaid Benefits and Health Programs Group will provide an overview of the Telehealth Toolkit that was updated and released in February of 2024. The Toolkit - the Telehealth Toolkit 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, which is BSCA of 2022, Division A, Title I, Section 11002, small A.

Secondly, Annie Hollis from our Children and Adult Health Programs Group will provide an overview of the final rule clarifying the eligibility of deferred action for childhood arrivals, which is DACA, recipients, and certain other noncitizens, which was released in May 3rd of 2024. The final rule modifies the definition of lawful presence applicable to eligibility for enrollment in the

Qualified Health Plan through the Health Insurance Marketplace and Basic Health Program.

Before we get started, I want to let everyone know that we will be using the webinar platform to share slides today. If you're not already logged in, I would suggest that you do so that you can see the slides for today's presentation. You can all submit any questions that you have into the chat at any time during our presentation. With that, I'm pleased to introduce and turn things over to Betsy Conklin. So, Betsy, I'll turn to you.

Betsy Conklin: Thanks, Jackie. Good afternoon, everyone. My name is Betsy Conklin, and I'm a Technical Director in the Division of Benefits and Coverage. As Jackie mentioned, I'll be giving an overview of our new state Medicaid and CHIP Telehealth Toolkit, which was issued this past February. I did want to note that the toolkit is meant to be a resource for states and interested parties, and as a result, it's very long and detailed.

So, for this presentation, I'm going to try to keep it at a very high level. But of course, please feel free to ask questions at the end of the presentation today, or you can reach out to your state lead at any time to request technical assistance. Next slide, please.

During the COVID-19 Public Health Emergency, or PHE, CMS issued two telehealth toolkits with an emphasis on how telehealth could be helpful during a PHE. This new toolkit consolidates information from those existing toolkits and makes the information more general, that is, relevant for non-PHE times. We also added information on how states can to improve access to telehealth for Medicaid and CHIP services, which was required by the Bipartisan Safer Communities Act.

The toolkit discusses the telehealth topics listed here, including telehealth flexibilities under Medicaid and CHIP and strategies to promote the delivery of accessible and culturally competent care, for example. Next slide, please. Along these lines, the new toolkit includes sections dedicated to discussing how telehealth can be useful, could be a useful tool for maternal health services, accessing out-of-state providers and more. Next slide, please.

This is the high-level outline of the sections in the toolkit that I'll be discussing today, including the telehealth overview in Section 1 through operational considerations in Section 5. Next slide, please. Section 1 gives a general overview of telehealth as it relates to Medicaid and CHIP, including telehealth flexibilities, state policy considerations, and common telehealth modalities.

Next slide, please. Generally speaking, federal laws and regulations don't specifically address telehealth for most Medicaid and CHIP benefits, so states really have a great deal of flexibility in how they use telehealth. States can generally choose which services can be delivered via telehealth, the specific providers who can use telehealth, the telehealth modalities that can be used, and the payment rates for services delivered via telehealth.

Next slide, please. There are four main modalities that are used to deliver services via telehealth. The most common of which is two-way real-time audio-video. This is typically what people think of when they think of telehealth, basically the provider and patient interacting with video and audio using computers or smartphones, for example. The other three modalities include audio-only, asynchronous communication, and remote patient monitoring. If you're interested in learning more on this topic, we describe these four modalities in detail in the toolkit, including the potential uses and limitations for each modality.

Next slide, please. Section 2 on FAQ highlights provides information on common telehealth topics. The FAQs largely reflect the FAQs that were included in the previously released toolkits, so they were revised to be relevant for non-PHE times. The new toolkit also added four new FAQs.

Next slide, please. The FAQ topics in this section include those listed here, including benefit flexibilities, financing, and managed care, for example. If you're interested in learning specific details about our telehealth policies, this is a good section of the toolkit to review. Next slide, please.

Section 3 of the toolkit describes trends in states' telehealth policies before, during, and after the PHE. It also goes into detailed trends in five states, which I won't go over today, but you can find in the toolkit itself if you're interested in learning more.

Next slide, please. In terms of general telehealth trends over the past few years, prior to the PHE, all 50 states NDC authorized delivery of some Medicaid services via telehealth, but the policies varied widely. During the PHE, states ramped up their use of service delivery via telehealth, and they used a number of different strategies to do this. Beneficiary utilization of telehealth also increased during this time period. Next slide, please.

When the PHE ended, survey results indicate that beneficiary utilization decreased or leveled off, but remained above utilization levels pre-PHE. Additionally, two-thirds of states either already expanded or are planning to expand their telehealth policies, the most common of which includes expansion of allowable telehealth modalities and services that can be delivered via telehealth. Next slide, please.

Section 4 is by far the longest section of the toolkit, and it goes into detail about how states can leverage delivery of services via telehealth to address health equity. It describes best practices and strategies for improving equitable access to telehealth among specific populations, and describes how states can use telehealth to address maternal mortality and strategies for using telehealth to provide mental health and substance use disorder or SUD services.

Next slide, please. The first part of Section 4 gives an overview of how states can ensure that the technological component of telehealth is equitable with the CMS definition of health equity in mind. It's important when states are considering telehealth policies that they implement the technological and service components equitably.

For example, states can offer and encourage providers and managed care plans to offer information on how to use telehealth technology. States can also use telehealth to improve equitable access to health services by expanding providers who can deliver services via telehealth. Next slide, please.

The next part of Section 4 offers best practices for using telehealth to deliver services to specific populations. The first subsection on medically underserved urban and rural communities describes how medically underserved communities can exist in both rural and urban areas, and both experience similar barriers related to access to care. States can use telehealth to overcome provider shortages by encouraging existing Medicaid providers to use telehealth and by contracting with additional providers, including those located remotely and in other states, to deliver services via telehealth. Next slide, please.

In the subsection on racial and ethnic groups, we discuss disparities in telehealth utilization among these groups, such as video telehealth rates being

significantly lower among individuals who are Latino, Asian, and Black than among individuals who are White, and we described steps that states can take to develop policies that expand access to telehealth equitably across these groups. The toolkit include examples of best practices in this area, including for example, allowing services to be delivered via audio only telehealth and clinically appropriate. Next slide, please.

In the subsection of American Indian and Alaskan Native or AIAN individuals, we discussed the disproportionate chronic and behavioral health disease burden, and the fact that AIAN individuals' access to telehealth, which could help to reduce these disparities, is hindered by various barriers, such as lack of internet access, geographic isolation, and resource challenges.

When developing telehealth policies, they should consider the unique needs of and barriers faced by AIAN individuals. For example, given the internet access issues common among AIAN individuals, particularly in rural areas, states should consider allowing services to be delivered via audio-only telehealth.

HHS has a website on preparing patients for telehealth in American Indian and Alaskan Native communities that includes information on how providers can prepare to deliver services via telehealth to AIAN individuals. One tip on the website is to keep AIAN cultural values in mind.

For example, a sense of traditional spirituality, respect for elders, and historic distrust of institutions. States can also work with tribes and tribal organizations to better understand how telehealth is already being used for tribal services and programs. Next slide, please.

The next subsection describes the particular difficulties individuals with

limited English proficiency or LEP could have an accessing services via telehealth. For example, even if patients with English as a second language have an interpreter available for a telehealth appointment, these individuals could face challenges in navigating the telehealth platform to start the appointment in the first place.

Multiple federal laws and regulations require covered entities like state Medicaid agencies to take reasonable steps to provide meaningful access to people with LEP. For example, state Medicaid and CHIP agencies are required to provide language services. HHS' telehealth.hhs.gov website provides some helpful resources and tips for promoting the delivery of accessible care through telehealth. For example, states could develop multilingual patient resources on telehealth. Next slide, please.

Individuals with disabilities may also experience accessibility issues when using telehealth. This is particularly relevant for individuals with visual and hearing disabilities and those with limited or no use of their hands. Research indicates that individuals with a disability are less likely than those without a disability to own digital devices, which further challenges equitable access to telehealth.

To help mitigate access issues, states should consider tailored training and outreach to individuals with disabilities and conduct community engagement to inform the design of telehealth policies, for example. Next slide, please.

Older adults may experience barriers using telehealth as well due to lack of familiarity with using a computer or smartphone, and some older adults might have physical or cognitive barriers that reduce their ability to use telehealth. To mitigate these issues, states have encouraged providers to consider strategies when providing services via telehealth to older adults.

For example, providers could contact an older adult prior to a telehealth appointment to make sure their device is working properly for the appointment. Next slide, please. Using telehealth can be common among all Medicaid and CHIP beneficiaries, but sometimes these challenges are unique.

For example, children and youth may not be able to find a private space to have a behavioral health telehealth visit. States can consider a number of strategies to ensure that children and youth benefit from telehealth, including, for example, allowing components of well-child visits to be delivered via telehealth. Next slide, please.

Additionally, any student enrolled in Medicaid or CHIP can receive covered services at the school, and using telehealth to deliver these services can enhance access. This can play a significant role in bridging equity gaps among students in low-income and rural communities. It can also support earlier detection of mental health and SUD symptoms. Next slide, please.

The next part of Section 4 talks about how telehealth can be used to deliver specific services. In this first subsection, we talk about how services can be delivered via telehealth to address maternal morbidity and mortality in the U.S. Research shows that maternal mortality rates have been on the rise since 2000. Additionally, non-Hispanic black and non-Hispanic AIAN women experienced higher pregnancy related mortality ratios in 2019 than all other racial or ethnic populations.

Research that looked at telematernity visits during the PHE indicates that these visits spiked nationally. And using telehealth for postpartum care was associated with decreased racial disparities and postpartum care attendance.

Given the potentially positive impact of telehealth and maternal health, states could consider expanding access to telehealth for these services.

For example, in North Carolina, during the COVID-19 PHE, Medicaid providers were temporarily permitted to provide perinatal care, maternal support services, and postpartum depression screening via telehealth. And in 2023, they were permanently permitted to use telehealth for prenatal and postpartum visits. Next slide, please.

Next, we discussed using telehealth to deliver behavioral Health Services. Majority of Americans view the country as being in a mental health crisis, particularly with regards to young adults. Telehealth has a demonstrated ability to maintain or enhance access to behavioral health treatment without negatively impacting patient outcomes or satisfaction. As a result, most states have taken steps to maintain or expand coverage for behavioral health services delivered via telehealth. Next slide, please.

For children and youth specifically all-state Medicaid programs include some form of coverage and payment for mental health services delivered via telehealth, though this hasn't completely resolved the well-documented pediatric behavioral health workforce shortage. If a state is implementing new or expanding existing telehealth coverage services for children and youth, they should make sure to consider consent requirements for pediatric populations, and review provider licensure and credential requirements to evaluate whether there will be a barrier to telehealth delivery.

Next slide, please. Telehealth has played an increasing role in delivering services related to opioid use disorder, or OUD. Research on telehealth use for OUD services during the PHE was associated with a reduced overdose risk and increased length of staying treatment. States should keep in mind that

OUD treatment delivered via telehealth and Medicaid beneficiaries may include the delivery of medication-assisted treatment.

Additionally, permitting the whole practitioners to deliver services via telehealth is an important strategy for improving access to buprenorphine, since nurse practitioners and physician's assistants have been central to the increase in buprenorphine prescription growth among Medicaid beneficiaries. Next slide, please.

Telehealth can also be used to address behavioral health provider shortages. For example, states can cover qualifying community-based mobile crisis intervention services and may incorporate telehealth into the delivery of these services. Next slide, please.

Section 5 goes into operational considerations for states in implementing telehealth. This includes approaches for evaluating telehealth and considerations for integrating telehealth into value-based care models, as well as strategies for conveying information about telehealth to providers and beneficiaries. Next slide, please.

Given the rapid increase in telehealth utilization, it's important to research the impact this has had on healthcare quality, costs, and outcomes, as well as whether it's made a positive impact on access, equity, and beneficiary experience. Accordingly, states have indicated that they are intending to assess telehealth quality, or that assessment initiatives were already in place.

When conducting these assessments, they should consider a number of promising practices, such as adopting a standard billing and coding approach to help easily identify telehealth on claims to enable data analysis on telehealth quality. Next slide, please. To support provider capacity and reduce

healthcare costs, states can also consider including telehealth as a component of a value-based care, or VBC model, which rewards providers based on quality measures that demonstrate the delivery of high-quality care.

For example, states can reduce the inappropriate use of emergency departments by designing VBCs that provide financial incentives to utilize care in more appropriate settings with some service delivery to teleheath. Next slide, please.

States can help support awareness of services that may be delivered via telehealth as well as any telehealth changes by communicating with interested parties including providers and beneficiaries. When conveying information to providers about telehealth they have indicated that it's easier to find and comprehend policies when the information is organized by clinical area or provider specialty. Next slide, please.

Mature and person provider trainings are also critical in educating providers on telehealth policies, and it's especially helpful when trainings and resources are comprehensive and easily accessible. States can also consider establishing coordinated support process and systems for providers under fee for service and managed care. Next slide, please.

Beneficiaries may also need help understanding the telehealth options available to them, as well as education on how to access and use the technology for a telehealth visit. States could consider offering educational opportunities to beneficiaries on a regular basis. States can also rely on established partnerships with managed care plans, providers, or other third parties to engage beneficiaries on telehealth. Next slide, please.

Finally, I wanted to mention that the toolkit has a number of tools listed here

that may be useful for states when implementing telehealth in Medicaid and CHIP programs. Thank you very much, and with that, I'll turn it over to Annie for her presentation.

Annie Hollis: Thanks so much. Next slide, please. Okay. As you may know, we published the lawfully present final rule on May 8th. I'm going to start with providing a brief high-level overview of the final rule's provisions. This rule makes changes to eligibility for DACA recipients and Marketplaces in BHP, making these individuals newly eligible for coverage on these programs.

The rule also makes small technical changes to the lawfully present definitions used for the Marketplace in BHP. These technical changes are for very targeted groups of noncitizens. While we are not going to dive into the details in this presentation, our colleagues at SOCIO are providing more details to state-based exchanges on these small changes in eligibility for Marketplaces and BHP. The rule also makes technical changes to the definition of qualified noncitizen used for Medicaid and CHIP. We're going to discuss that in more detail today.

Finally, I do want to mention there will be a special enrollment period, or SEP, form Marketplace coverage. I'll touch on this later in the presentation. And both we and our SOCIO colleagues are providing additional operational information to Medicaid agencies at our eTAG meetings and SOCIO with the APTC. Next slide, please.

Diving in the final rule, effective November 1, 2024, the rule changes the definition of lawfully present used for Marketplace and BHP eligibility to include DACA recipients, including to determine eligibility for APTC and cost-sharing reductions.

This means that starting November 1, 2024, DACA recipients can enroll in a qualified health plan through an exchange with financial assistance and a BHP if they meet all other eligibility criteria for those programs. The rule also makes other technical changes to eligibility for certain and other noncitizens for Marketplace and BHP coverage. Next slide, please.

We are not finalizing the definition of lawfully present used for Medicaid and CHIP at this time. To be clear, the definition of lawfully present is only used in Medicaid and CHIP in states that elect the so-called CHIP or 214 option, which is the option to cover lawfully residing children or pregnant individuals.

We are taking more time to evaluate and carefully consider the comments on our proposal with respect to Medicaid and CHIP, and 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.

Given that, we do want to remind you that these individuals will likely be eligible for coverage in the Marketplace if they meet all other eligibility requirements. Due to the special rule for noncitizens with income below 100% of the federal poverty level. States that have elected to cover lawfully present children or pregnant individuals in Medicaid or CHIP should continue to reference and implement the lawfully present definition set forth in the state health official letters 1006 and 12002. We have finalized an updated definition of qualified noncitizen, and I'm going to talk more about that next. Next slide, please.

Our modified Qualified noncitizen definition finalizes and adds detail to the existing definition of Qualified noncitizen used for Medicaid and CHIP based on the federal statutes that govern these definitions. The definition newly

includes noncitizens treated as refugees, such as victims of trafficking, certain Afghan evacuees, and certain Ukrainian parolees.

A definition also includes the recent updates to the statute for COPA migrants that allow immediate eligibility for COPA migrants for coverage in a separate CHIP if they meet all other eligibility requirements in the state. The revised definition of qualified noncitizen does not change or expand eligibility to any new category of noncitizens, but is intended to promote clarity and consistency. Next slide, please.

Now I'll go into some operational considerations for Medicaid and CHIP. We want to note that state Medicaid and CHIP agencies can comply with the final rule without making any new eligibility system changes. Since the revised definition of lawfully present does not apply to Medicaid or CHIP, COPA recipients and other noncitizens impacted by the final rule continue to not be 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 or change eligibility. We recommend that states confirm that their policy and operational guidance align with the final rule. Medicaid and CHIP agencies that rely on HUB indicators to verify immigration status can continue to accurately verify status for noncitizens with no updates to their system.

We recommend that doctor-recipients and noncitizens impacted by the final rule should apply for Marketplace or BHP coverage directly with the Marketplace or BHP, rather than as a state Medicaid or CHIP agency. Next slide, please.

CMS is not making any changes to the HUB in conjunction with this rule, and I want to emphasize that, as shown here, these values are accurate for purposes of Medicaid and eligibility, but they are not accurate for Marketplace and BHP eligibility.

The most important thing to note is that for those of you with SBEs in your state, you will need to make changes to your systems in order to correctly determine eligibility for Marketplace and BHP coverage. Next slide, please.

So, some key takeaways to five for you all include, starting November 1, 2024, DACA recipients and other impacted noncitizens are considered eligible to enroll in Marketplace and BHP coverage and for financial assistance if otherwise eligible. BHP coverage can begin as early as November 1, 2024.

This final rule does not change or expand eligibility for DACA recipients and other noncitizens impacted by the final rule in Medicaid or CHIP. But they do remain eligible for limited coverage of treatment of an emergency medical condition under Medicaid if they meet all of the eligibility requirements in the state plan.

DACA recipients and other noncitizens impacted by the final rule should apply at healthcare.gov to enroll in Marketplace Coverage. Soccer recipients and other noncitizens can work with an agent, broker, or assistant when applying through these channels. DACA recipients and other noncitizens who apply for Marketplace coverage between November 1, 2024, and November 30, 2024, can enroll in Marketplace coverage as soon as December 1, 2024, through an SEP, yes.

As we discussed earlier, 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. Next slide, please.

And on this slide, we just have some resources and links related to the final goal. And with that, I'm going to hand things back to Jackie Glaze. Thanks so much.

Jackie Glaze: Thank you, Annie. So, we are ready now to take state questions. So, we will begin with the chat function, so you can begin submitting your questions at this time, and then we'll transition to the phone lines. So, with that, I will turn to you, (Krista).

(Krista): Thank you so much, Jackie. At this time, I'm not seeing any questions in the chat, so if folks who are listening and have questions, they should feel free to drop them in the chat. Jackie, I'm still not seeing any questions in the chat. We want to try to open the phone lines and see if anybody might want to come off mute and ask a question.

Jackie Glaze: Sure. So, yes, so thank you, (Krista), so we'll circle back. So, (Michelle), if you could please open the phone lines and then provide instructions for how to register the questions, please.

Coordinator: Thank you. At this time, if you would like to ask a question, you may press Star 1. Please unmute your phones and state your first and last name when prompted. Again, that is Star 1 if you would like to ask a question or if you do have any comments. And Star 2 will withdraw your question. One moment, please. Once again, if you do have any questions, you may press Star 1. At this time, I am showing no questions.

Jackie Glaze: Okay. Thank you, (Michelle). So, we will circle back once again.

And (Krista), I'm not seeing any questions in the chat. Are you?

(Krista): I am not. Not at this time.

Jackie Glaze: Okay. So, we'll give folks another minute or so and see if they do have questions, and then we just may wrap up early today. So, I'll ask both (Michelle) and (Krista) if you could just alert me if you do see a question come through.

Coordinator: Thank you. And once again, if you do have any questions, please press Star 1.

Jackie Glaze: We'll give it another minute and then I think we'll go ahead and wrap up. Okay. So, I think we will end early today. So, I do want to thank our presenters, Betsy Conklin and Annie Hollis for their presentations today. If you do have questions that would come up before our next call, please feel free to reach out to us, your state leads, or bring your questions to our next call. So, we do thank you all for joining us today, and we hope everyone has a great afternoon. Thank you.

Coordinator: And thank you. This concludes today's conference call. You may go ahead and disconnect at this time.

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