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MACPAC Offers Reserved But Positive Outlook on Telehealth's Integration Into Medicaid Program

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In March 2018, the Medicaid and CHIP Payment and Access Commission (MACPAC) made its 2018 report to Congress, which included the Commission's evaluation of telehealth services provided through the Medicaid program. Chapter 2 of MACPAC's report had a positive outlook on telehealth's contribution toward better accessibility of health care services to underserved individuals as well as individuals with disabilities.

Unlike its larger counterpart, Medicare, federal policy has not placed many restrictions on state Medicaid programs in terms of adopting or designing telehealth coverage policies. For example, there is limited reimbursement coverage of telehealth services provided through the Medicare Fee-For-Service (FFS) program (*e.g.*, geographical restrictions). However, there is little federal guidance or information regarding the implementation of telehealth services in state Medicaid programs or coverage for these services. As a result, state Medicaid coverage of telehealth services is highly variable across state lines, in terms of telehealth modalities, specialties and services, provider types, and even permissible site locations where telehealth services may be rendered. This high degree of variability stems, at least in part, from the unique federal-state partnership that provides the foundation for all state Medicaid programs.

Federal Medicaid Program Requirements*.* Although the federal requirements for coverage of telehealth services provided through the Medicaid program are few, in comparison to comparable requirements under the Medicare FFS program, some broad CMS guidelines do require Medicaid providers to practice within the scope of their state practice laws and to comply with all applicable state professional licensing laws and regulations. Additionally, any payments made by state Medicaid programs for telehealth services must satisfy the federal Medicaid program requirements for efficiency, economy, and quality of care. Furthermore, although Medicaid program requirements for comparability, state-wideness, and freedom of choice do not apply to telehealth services, states choosing to limit access to telehealth services (e.g., limited to particular providers or regions) must ensure access to and cover face-to-face visits in areas where such services are not available. Moreover, states are not required to submit a Medicaid state plan amendment to cover and pay for telehealth services as long as the program is in a state where telehealth parity laws are in effect, which are intended to ensure same coverage and payment of telehealth services as those provided in-person.

***State-to-State Variations in Medicaid Coverage of Telehealth Services*.** A big focus of the MACPAC report was the impact that state-by-state variations may have on providing access to telehealth services through state Medicaid programs. As previously noted, because of the lack of any unified federal telehealth policy, state Medicaid program coverage of telehealth services is inconsistent. Some states, like West Virginia, mirror their Medicaid policies and regulations after the Medicare program, meaning that telehealth services are covered only if the originating site is in a rural location that either meets the definition of a non-metropolitan statistical area or a rural health professional shortage area, or originating site must be at hospitals, critical access hospitals, physician offices, federally qualified health centers, etc. In other words, in these states, Medicaid recipients would be required to travel to particular qualified locations for their telehealth service to be covered under Medicaid. Interestingly, MACPAC reported that some states that initially adopted these Medicare-like standards have changed their policies over time, as the state Medicaid programs have gained experience and understanding of the implications for access, cost, and quality. Other states are increasingly allowing homes, workplaces, and schools to serve as originating sites for telehealth services, while some states do not explicitly require patients to be at any specific sites in order to receive telehealth services. For example, while West Virginia's Medicaid program specifies that originating sites must be a physician's or other health care practitioner's office, hospitals, rural health centers, skilled nursing facilities, etc., Medicaid recipients in Washington state may choose the location they would like to receive telehealth services, without these types of restrictions.

Similarly, the types of telehealth services that are covered vary greatly from state-to-state. For example, Idaho's Medicaid program covers live video telehealth for mental health services, developmental disabilities services, primary care services, physical therapy services, occupational therapy services, and speech therapy services. In contrast, Arizona's Medicaid program covers live video telehealth for a variety of specialty services including cardiology, dermatology, endocrinology, pediatric subspecialties, hematology-oncology, home health, infectious diseases, neurology, obstetrics and gynecology, oncology and radiation, ophthalmology, orthopedics, pain clinic, pathology, pediatrics, radiology, rheumatology, and surgery follow-up and consultation.

Across state Medicaid programs there also is wide variation regarding the types of health care practitioners who may provide telehealth services to Medicaid program recipients. Nineteen states (*e.g.*, Connecticut, Florida, Hawaii, Iowa, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Utah, and Vermont) do not specify the type of providers that may provide health care services via telehealth and therefore are presumed to have the most inclusive provider policies. There also is variation with respect to professional licensure requirements for these providers, with some state policies allowing out-of-state practitioners to provide telehealth services as long as they are licensed in the state from which they are providing the service and are registered with the state's Medicaid program (*e.g.*, Arizona) while other state policies require practitioners to be licensed or certified to practice in the state unless only providing episodic consultation services (*e.g.*, Arkansas).

States set their own payment levels for telehealth services provided to Medicaid recipients. Some payment rates for telehealth services may be lower than payment rates for the same services provided in-person. State Medicaid programs also vary in terms of payments for facility fees and transmission fees, which assist providers with covering associated telecommunications costs. Additionally, state Medicaid policies for telehealth services may differ between managed care and FFS plans. Some states do not require Medicaid managed care plans to provide services via telehealth at all. For example, Florida's live video telehealth is covered under Medicaid FFS but is optional for Medicaid managed care plans, while in Massachusetts telehealth services are not covered under Medicaid FFS but there is some coverage under at least one of the state's Medicaid

managed care plans.

Despite these variations, MACPAC found that Medicaid plays a significant role as a payor with respect to the following types of telehealth services:

Behavioral Health. MACPAC reported that non-institutionalized adult, children, and adolescents covered by Medicaid have a higher rate of behavioral health disorders compared to their privately insured counterparts. Barriers to care include fragmented delivery systems, lack of accessibility to provider and resources, and patients' concerns regarding confidentiality and fear of stigma attached to seeking mental treatment. MACPAC reported that there is increasing evidence that telehealth has the potential to improve access to evidence-based care for mental health and substance use disorders for individuals located in underserved areas. As of now, all state Medicaid programs that cover telehealth services include as part of that coverage access to behavioral health services via videoconferencing, although the scope of coverage varies state-to-state. Generally, most commonly covered services include mental health assessments, individual therapy, psychiatric diagnostic interview exams, and medication management. Although most state Medicaid programs will cover behavioral health services via telehealth if provided by licensed or certified psychiatrists, advanced practice nurses, and psychologists, some states also will cover those services if treatment is delivered by social workers and/or counselors. MACPAC reported that there is a growing number of studies showing that behavioral health care services provided via telehealth is effective, particularly for assessment and treatment of conditions such as depression, post-traumatic stress disorder, substance use disorder, and developmental disabilities. MACPAC reported high patient satisfaction with behavioral health care services via telehealth was on par with non-Medicaid payor populations, although MACPAC indicated that more research is needed.

Oral Health. Oral health services among Medicaid participants are relatively low. Barriers to oral health care include cost, difficulty of finding dentists who accept Medicaid, and inconvenience of location and time. MACPAC reported that the use of telehealth in dentistry has been recognized for its potential in improving access to primary and specialty oral health care services in communities that either lack or have limited provider capacity. Typically a patient is joined by an oral health professional at the originating site during a real-time video consultation with a dentists or specialty dentists for diagnosis and development of a treatment plan. Store-and-forward modality allows the provider at the originating site to send images (*i.e.*, x-rays, photographs, lab results) to the dentist for review. As of 2017, 11 states were identified for including some Medicaid coverage for teledentistry (*e.g.*, Arizona, California, Colorado, Florida, Hawaii, Minnesota, Missouri, Montana, New Mexico, New York, and Washington). Studies have shown that certain teledentistry services such as screening of childhood dental caries and orthodontic referrals appear to be as effective as in-person visits. MACPAC reported that patients expressed satisfaction of these dental health care services provided via telehealth because of greater convenience and improved access to care.

Maternity Care. In 2010, although state Medicaid programs covered nearly half of all births in the U.S., nearly 50 percent of U.S. counties had no obstetrician-gynecologists providing direct patient care. Telehealth can be used to manage pregnancies in several ways including the use of videoconferencing between a patient and her regular maternity care provider or between two providers during labor and delivery. Live videoconferencing could also be utilized during genetic counseling or even neonatal resuscitation. MACPAC reported that pilot studies have tried videoconferencing for prenatal care visits, group prenatal care, and breastfeeding support, which include women with both high-risk and low-risk pregnancies. MACPAC also reported that an emerging practice is the use of telehealth to diagnose congenital heart defects via live videoconferencing between the radiographer and fetal cardiologists, or the use of store-and-forward

technology to allow a specialist to review echocardiograms post hoc.

***MACPAC Recommendations*.** Before integrating or expanding telehealth services in their respective Medicaid programs, MACPAC recommended that states weigh the costs and the resource requirements associated with using or implementing telehealth against their goals of improving access for Medicaid recipients to needed health care services. One of the primary concerns voiced against greater use of telehealth services is the inappropriate use or overuse of those services. For example, MACPAC asked the states to consider whether inclusion of facility or transmission fees would increase the overall costs to their Medicaid programs if telehealth services replaced in-person services. MACPAC also asked states to consider whether telehealth services had the potential to increase fragmentation of care if services were provided by different telehealth providers or providers were unable to obtain updated patient medical records. MACPAC emphasized that while there appeared to be growing number of studies showing the effectiveness of telehealth services, there are still very few published studies addressing the effect of telehealth in Medicaid populations.

MACPAC also noted several factors that contributed to limited adoption of telehealth in Medicaid. The combination of lower payment rates for Medicaid and yet potential high costs for licensing across different state lines may deter providers from using telehealth for Medicaid services. Telehealth technology is dependent on reliable and affordable broadband connectivity. Unfortunately many rural areas and Native American reservations still lack such connectivity. An estimated 53 percent of individuals living in rural areas lack access to broadband speeds needed to support telehealth. Furthermore, costs of broadband can be almost three times that in urban areas. Costs associated with the acquisition, installation, and maintenance can be quite cost-prohibitive to providers and affect their ability or willingness to adopt telehealth. Additionally, telehealth-focused remote prescribing laws vary from state-to-state while prescribing of controlled substances are limited by the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. The law generally prohibits prescribing of controlled substances through the internet without a valid prescription, which requires the prescriber to have conducted at least one in-person medical examination of the patient. Although the law includes a telehealth exemption, the exemption requires the originating site to be located at Drug Enforcement Administration (DEA)-registered clinic or hospital. In addition, state medical licensing boards may also limit the circumstances in which providers can prescribe controlled substances via telehealth. As illustrated above, the varying length and degree of Federal and state laws and regulations governing telehealth services is complex and may deter providers from entering into the telehealth service market.

Overall, the MACPAC report illustrates a positive outlook on telehealth’s integration into state Medicaid programs. However, in its recommendation to Congress, MACPAC did not outright push states to adopt telehealth into their Medicaid programs. Rather, the Commission continues to seek more research and collaborative studies among states to gain better insight and understanding of the effects of telehealth on access to care, quality, and cost of care of the Medicaid program.

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