

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

March 30, 2021

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 listen only mode. Afterwards, we will conduct a question and answer session. If you'd like to register a question, please press the one followed by the four on your telephone at any time. You will hear a three tone prompt to acknowledge your request, and your line will then be accessed from the conference to obtain your first and last name. If at any time during the conference you need to reach an operator, please press star zero. As a reminder, this conference is being recorded Tuesday, March 30th, 2021. I would now like to turn the call over to Jackie Glaze. Please go ahead.
- Jackie Glaze: Thank you, and good afternoon and welcome everyone to today's All-State call and webinar. I will now turn to Karen Shields, our Deputy Center Director, and she will provide highlights for today's discussion. Karen.
- Karen Shields: Yep. Thank you, Jackie. Hello, everyone again. And we appreciate you joining us today. As we have done in the past, we will use these All-State calls to share information on emerging issues as well as recent guidance and legislation. With that in mind, our first speaker today is Rory Howe from our Financial Management Group, who will provide an overview of Section 9814 of the American Rescue Plan Act. This section provides a five percentage point FMAP increase for eight quarters for states that newly cover the adult expansion group beginning on or after March 11th, 2021. Rory will share estimates of the magnitude of the funding increases that states could potentially see if they choose to newly adopt this eligibility group.
- Karen Shields: And after that, we will be joined by a special guest, Marissa Gordon-Nguyen from the Department of Health and Human Services Office of Civil Rights, who will join us to discuss their policies related to the intersection of audio telehealth technology and HIPAA protections, which we know has been an area of interest for states, especially as you consider what flexibilities will be retained after the end of the public health emergency.
- Karen Shields: Then Kirsten Jensen from our Disabled & Elderly Health Programs Group will present an overview of CMS' telehealth requirements for Medicaid and CHIP. After Marissa and Kirsten's presentations, we will open the lines for your questions. I'll note that for Rory's presentation today, we will use a webinar and you will be able to submit questions through the webinar chat throughout today's presentation. So if you're not logged into the webinar platform, which is

included in the invitation, it would probably be good to go ahead and do so now.

Karen Shields: But before we jump in, I wanted to make sure that everyone is aware that last week, President Biden announced that the Federally-Facilitated Marketplaces Special Enrollment Period will be extended for an additional three months until August 15. And with that announcement, I would like to turn things over to Rory to start his presentation.

Rory Howe: Thanks, Karen. And good afternoon everyone. So as Karen mentioned, the American Rescue Plan Act of 2021 provides a temporary five percentage point Federal Medical Assistance Percentage or FMAP increase for states that newly cover the adult expansion group, beginning on or after March 11th, 2021. Although the temporary FMAP is only available for up to eight quarters per state, the provision does not have an expiration date. It's also worth noting that if during these eight quarters a state stops covering the entire adult expansion group, the FMAP is no longer available. Next slide please.

Rory Howe: Generally, the five percentage point FMAP increase would apply to the same match rates as the 6.2 percentage point FMAP increase that was made available under the Families First Coronavirus Response Act (FFCRA). However, there are a few exceptions. For example, the five percentage point FMAP increase would not apply to Medicaid disproportionate share hospital (DSH) expenditures. In some instances, the FMAP increase would add on to existing FMAP increases, including the 6.2 percentage point increase under the FFCRA. Of note, the five percentage point FMAP increase would not apply to expenditures that would already receive increased match under sections 1905(y) and 1905(z) when those match rates are specific to adult group expenditures. So, we do intend to provide additional guidance regarding how exactly the five percentage point FMAP increase applies, and we'll have that available as soon as possible. Next slide please.

Rory Howe: To assist states and stakeholders, we have developed rough conservative state specific estimates of the possible fiscal impact of this provision only as it relates to the five percentage point FMAP increase, and only for an eight quarter period. And again, these estimates are intended to provide a general sense of magnitude of the possible impact of the provisions, and aren't precise projections. As I mentioned before, the five percentage point FMAP increase would generally apply to the same expenditure categories eligible for the 6.2 percentage point FMAP increase under the FFCRA. So we're able to use recent state expenditures reported on the Form CMS-64 for the first three calendar quarters of 2020 as the baseline for our estimate. We adjusted these expenditures by excluding those that relate to Medicaid DSH, and created an eight quarter projection from those three quarters of state expenditures, and did not trend any of those expenditures for 2020 at base period.

Rory Howe: Just another caveat with the expenditures. For those of you that may be familiar, expenditures from the CMS-64 are reported based on date of payment and are subject to prior period adjustments by states, which can generally occur within a two year reporting window. Again, it just speaks to the fact that these are sort of rough ballpark estimates that we're discussing here. Next slide, please.

Rory Howe: So the next two slides show our state specific estimates. And the estimates indicate a total of approximately \$15 billion that could be available in federal funding associated with a five percentage point FMAP increase that would be available to 16 states and territories should they qualify under this provision of the American Rescue Plan Act. The state specific estimates range from approximately \$4 million for the Commonwealth of the Northern Mariana Islands, to approximately \$4 billion for the state of Texas.

Rory Howe: So the first slide shows the first eight states and territories. And I can just run through them quickly for those of you that may not have the slides up. For Alabama, it would be approximately \$560 million. American Samoa approximately 5 million. Florida, approximately 2.5 billion. Georgia at approximately just over a billion. Kansas, about 380 million. Mississippi, about 540 million. Missouri, about 970 million. The Commonwealth of Northern Mariana Islands, about 5 million. And next slide please. And North Carolina, almost 1.4 billion. Oklahoma about 500 million. South Carolina, about 630 million. South Dakota, about 87 million. Tennessee, almost 1.2 billion. Texas, almost 4 billion. Wisconsin, about 1.1 billion. Wyoming about \$54 million. Next slide please.

Rory Howe: For additional information, we are providing also two slides that include a count of uninsured people by state that comes from a recent publication from the HHS Office of the Assistant Secretary for Planning and Evaluation. And this, the state specific count, identifies uninsured people under 65 and with income less than 138% of the federal poverty level and excludes undocumented immigrants. It's not exactly aligned with the possible Medicaid adult expansion population but we thought it might be helpful for states and stakeholders as a potential proxy and for your consideration.

Rory Howe: I'm not going to read through all the amounts here, but we have included a link to the ASPE publication in our slides for your information. Next slide please.

Rory Howe: And that's the second half of the uninsured count, and again at the bottom there, that includes a link to the ASPE publication. We hope you found this information helpful. I will say that we again do intend to provide more information regarding the applicability of the match rate and now I will turn it back to Jackie Glaze. Thank you.

Jackie Glaze: Thank you, Rory. And now we'll transition to Marissa Gordon-Nguyen from the Office of Civil Rights (OCR) and she will provide information on OCR's policies on telehealth. So Marissa, I'll turn it to you.

Marissa Gordon-Nguyen: Great. Thank you. Hi, everybody. I'm the Senior Advisor for Health Information Privacy Policy in HHS Office for Civil Rights. We administer and enforce the HIPAA privacy security breach notification and enforcement rules which we refer to collectively as the HIPAA rules. My office does not administer the HIPAA transactions standards. My goal today is to provide you with clarity and reassurance. So you can let me know afterward if I've succeeded or I need to start over and try again.

Marissa Gordon-Nguyen: I'll start with the requirements of HIPAA that generally apply to audio-only telehealth, so I can set a baseline before I move on to talk about the notification of enforcement discretion, and then on to talk about what we expect when the public health emergency ends. The first point to make I think is that, when it comes to audio-only telehealth, there are no specific HIPAA barriers to its use or to the ability of states or other jurisdictions to expand coverage or reimbursement for it, which is another question that we have received.

Marissa Gordon-Nguyen: One way I think that you can think about audio-only telehealth under the HIPAA rules is that conducting a telephone healthcare appointment with a patient is treated the same way as calling a patient to tell them a test result. There is a communication of PHI over the phone line and that is the relevant point. It doesn't really make a difference for HIPAA purposes, whether it's a two-minute conversation or it's a half-an-hour encounter. So keep that in mind as I talk through how the HIPAA rules apply to those communications.

Marissa Gordon-Nguyen: As far as the actual requirements of the HIPAA rules, the security rule doesn't apply to standard telephone communications. The security rule applies only to electronic protected health information, and information being transmitted via a telephone generally is not electronic PHI because it's not in electronic form before it's transmitted. So this is one important way in which audio-only telehealth differs from the sorts of video telehealth electronic applications that have become much more widely used during the pandemic than they had done before, but the video platforms, generally, they package and they transmit the data in packets in electronic form between parties and so the security rule applies there.

Marissa Gordon-Nguyen: Another point of difference is that the video telehealth app developers are providing a data transmission service to healthcare providers in a way that makes them a HIPAA business associate when they have access to PHI on a routine rather than an infrequent basis. Or they maintain the PHI for a period of time, so their access to it is persistent and not just transient. Those terms

that I just used, routine versus infrequent, persistent versus transient, they're part of a Privacy Rule concept of a conduit of PHI. And we've stated before in our rules that a telephone line is an example of what would be a mere conduit of PHI. And as a result, a phone company is not a business associate, which means that a healthcare provider doesn't need to put in place a business associate agreement with the phone company to be able to use their phone line to contact their patients.

Marissa Gordon-Nguyen: Now, on to the Privacy Rule, the Privacy Rule does apply when using audio-only telehealth like it does for any sort of oral communication or written communication. So for example, the prohibitions against impermissible uses and disclosures of PHI apply, and provisions that require reasonable safeguards to protect privacy and that limit some permitted uses and disclosures of PHI to the minimum necessary to the purpose, and requirements about limiting incidental disclosures, sort of some of the basics of Privacy Rule protections.

Marissa Gordon-Nguyen: So as an example, a doctor can use a telephone for telehealth, and reasonable safeguards will include doing it in a manner that the PHI that is discussed isn't disclosed to a third party except for minimum necessary disclosures that are incident to the communication. If you think about a provider who is conducting telehealth visits from their own home because of social distancing, think of their responsibility to take reasonable precautions to minimize the PHI that they disclose to their family members who are also in the home. Like closing the door to the room where they are working, not speaking in a loud voice unless that is needed for the patient to be able to hear them. They're reasonable safeguards; they're situational.

Marissa Gordon-Nguyen: So if you can speak at a low voice and have a productive appointment, then that is probably a reasonable safeguard. If your patient needs a loud speaking voice, then that gets taken into consideration and what is reasonable as far as what your family who's in your workspace can hear. What would be reasonable for protections. So it's sort of a silly example, but I think it's illustrative that if a doctor was doing telehealth on the metro or the subway using a speakerphone on their telephone, that pretty clearly would be an example of failing to implement reasonable safeguards. So I think that give us a sense of the common sense nature of safeguards under the Privacy Rule.

Marissa Gordon-Nguyen: Now to look at the notification of enforcement discretion for telehealth. At the beginning of the pandemic, OCR started receiving a lot of questions about whether covered health care providers could use video chat apps and whether they needed a business associate agreement with the app developer, and whether they would be violating the Security Rule in using these apps. You'll notice that I didn't say we started receiving questions about audio-only

telehealth, but we did decide to specifically include it just in case there was any nervousness about the ability to use audio-only telehealth.

Marissa Gordon-Nguyen: So we recognize, in this case, there was an urgent need to facilitate a rapid ramping up of course of telehealth to provide care. And so we announced that OCR would not impose penalties for violations of the HIPAA rules in connection with the good faith provision of telehealth during the COVID-19 public health emergency. And we were especially concerned about reaching patients and beneficiaries who may be most at risk, including older persons and people with disabilities. And the notification of enforcement discretion applies to telehealth provided for any reason, such as a dental consultation or a psychological evaluation. So it doesn't matter whether the telehealth service is related to diagnosis or treatment of health conditions that are related to COVID-19.

Marissa Gordon-Nguyen: And under the notification, the way that we framed this in our own minds was that, in addition to or instead of using audio-only communication methods, like landline and wireless telephones, which we thought of as sort of easy and something that people were already doing, we wanted to make sure that covered health care providers could now use popular non-public facing remote video communication apps like FaceTime, Zoom, or Skype, to provide telehealth. So in the notification, we expressly stated that a covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the public health emergency can use any non-public facing remote communication product that's available to communicate with patients.

Marissa Gordon-Nguyen: And we explain what we meant by non-public facing, that it's technologies that limit the participants to the call, to those who are intended to be in the call, which generally would be doctor and patient. And we said that public facing apps like Facebook Live and Twitch and TikTok should not be used, and were not covered. And we explained that for providers seeking additional privacy protections for telehealth while they're using video communication products, we identified some vendors that represent that they provide HIPAA compliant video communication products and that they'll enter into HIPAA business associate agreements.

Marissa Gordon-Nguyen: Then, a couple of days after we issued a notification, we issued some FAQs that explain how OCR is applying the notification to support the good faith provision of telehealth. And they include, who's covered by the notification? Any covered health care provider? What parts of the HIPAA rules are included? All of the HIPAA rules. And as I said, speaks more about what is a non-public facing remote communication product.

Marissa Gordon-Nguyen: Now, in the guidance, we also expressly stated, telehealth services may be provided, for example, through audio text messaging or video communications technology, including video conferencing software. We said that for purposes of reimbursement, certain payers, like through CMS might impose restrictions on the types of technologies that can be used, but any restrictions there do not limit the scope of OCR's notification of enforcement discretion. And of course, it was really the same week that there began a series of issuances from CMS about expanding reimbursability.

Marissa Gordon-Nguyen: So, we also provide in the notification and in the guidance that OCR expects that health care providers will ordinarily conduct telehealth in private settings, like a doctor in their clinic or their home office, connecting to a patient who may be at home or may be in another clinic even. And that we said that providers should always use private locations and patients should avoid receiving telehealth services in public or semi-public settings. Because we don't regulate individuals, but it is the individual's choice. But that is a way that the individual can maintain their own privacy, and that a provider should not provide services when the provider is in a public or semi-public setting unless the patient has agreed to it or there are exigent circumstances.

Marissa Gordon-Nguyen: And we said if telehealth can't be provided in a private setting, then a covered healthcare provider should continue to implement reasonable safeguards to limit incidental uses or disclosures of protected health information. And again, we noted that reasonable precautions could include using lowered voices, not using a speakerphone, recommending that a patient move to a distance from others when they're discussing PHI.

Marissa Gordon-Nguyen: And then finally, we state in the notification and in the guidance that the enforcement discretion will remain in effect until the Secretary of HHS declares that the public health emergency no longer exists, or upon the expiration date of the declared public health emergency, including any extensions, whichever happens first. And we also said in the FAQs that, we have this sort of built-in end, but we'll also provide notification so people know when the notification of enforcement discretion is going to be coming to an end.

Marissa Gordon-Nguyen: So you might get the sense, and I hope you're getting the sense from my discussion of the notification of enforcement discretion, that from OCR's perspective, there was not a concern or barrier to audio-only telephone communications. That the main thrust of doing the notification was to address these video apps. But we included audio so that we could be comprehensive, and make sure that people didn't look at the notification and say, "Wait a minute, you're not saying that we can do audio here. You're only saying we can do video." So we wanted to be sure that there was no uncertainty, nobody perceived barriers.

Marissa Gordon-Nguyen: So what do we expect after it's a public health emergency? And you can provide me with, I would be very happy to hear, input about that that would change my assumptions about this. But honestly, we don't expect the end of the period for the notification of enforcement discretion to create any real disruption to audio-only telehealth from a HIPAA perspective at least, for the same reasons that I talked about at the outset. Because at baseline, even without the notification of enforcement discretion, the Security Rule doesn't apply, a business associate agreement isn't needed with the phone service providers, and it's really just common sense safeguards. The same sorts of safeguards that apply when you're talking to someone in-person in the hallway of your clinic or hospital, like talking in a private location, if you can. And so those sorts of protections, we don't expect them to create a new burden at the end of the public health emergency.

Marissa Gordon-Nguyen: So that's my little spiel. And I'm happy to hear input or questions from folks based on how the organizers are conducting the meeting. I will defer.

Jackie Glaze: Thank you. Thank you, Marissa. We will take questions. We have one additional presentation and then we will open it up for questions, but really appreciate your presentation. Next, Kirsten Jensen will provide an overview of CMCS' telehealth requirements. Kirsten.

Kirsten Jensen: Thank you, Jackie. Hi, this is Kirsten Jensen. I'm the Director of the Division of Benefits and Coverage. And for those of you that attend this call pretty regularly, you may have heard me talk about Medicaid and telehealth flexibilities inherent in the program.

Kirsten Jensen: I'd just like to first point out the significant flexibility that states have in establishing the delivery of services using telehealth in your state. As you've seen during the course of the pandemic, you've been able to expand the use of telehealth pretty extensively within the program. You have the flexibility to determine the services to cover, the practitioners to cover, what types of technology to use, where in the state it will be covered, and how the services will be reimbursed.

Kirsten Jensen: So as you're looking forward to what does telehealth look like in our state post-PHE, you still have the flexibility to expand or contract the use of telehealth in your state really as long as the services are delivered using telehealth and you communicate to your providers what services or codes to use, those sorts of things.

Kirsten Jensen: And the other reminder here is the Medicaid telehealth policy is not dependent upon Medicare rules. So we have heard through the course of the last year, many states seem to link their Medicaid telehealth policy to Medicare rules. But

that is not a federal Medicaid requirement. So as you're reviewing your plans in your state, just please do keep that in mind.

Kirsten Jensen: In terms of state plan amendments (SPAs), some states have been submitting an expansion of telehealth in the disaster relief SPAs; other states have not. We do not require a state plan amendment, either disaster relief or regular state plan amendment, on the coverage side, for states to delineate what they're doing in terms of telehealth. Some states do choose to submit a coverage page indicating that. Some states will indicate within each benefit which services can be provided using telehealth. Some will use a general statement at the front of the 3.1-A pages to kind of apply to the whole plan. That is also a flexibility that states have in terms of if and how they want the telehealth policies to be reflected in the plan.

Kirsten Jensen: States also do not need to submit a payment SPA unless the state is paying a different rate for the service fee being delivered via telehealth versus being delivered face-to-face. So again, we can work with you individually on that point if you're planning to pay differently for a service delivered via telehealth.

Kirsten Jensen: We also issued two telehealth toolkits. I think the last update was maybe in the September, October timeframe. And those have very good tools in them, particularly the second one that states can really use to assess what's happening in the state now and some considerations for determining where to go in the future.

Kirsten Jensen: So as always, CMS is available for technical assistance. We are interested in learning about telehealth and what has worked for the states during this time and what has not. We invite conversation on that point. But just please do remember that you have the flexibility from a federal perspective in terms of putting your programs together and making sure that beneficiaries continue to have good access to services.

Kirsten Jensen: So with that, Jackie, I'm thinking a little shorter than I intended. Though we can turn it over to the questions if you'd like.

Jackie Glaze: Yes. Thank you very much, Kirsten. So yes, we're ready to take questions now. So we'll begin by taking questions through the chat function followed by questions through the phone. So we have time to take those questions. So you can begin submitting your questions and then we will walk through those. And then again, we'll be prepared to take questions over the phone line. So I'll turn it to you, Ashley.

Ashley Setala: Okay, great. Thanks, Jackie. We have a number of questions that have come in so far. And I'll actually start. So we've gotten a couple of questions asking about

whether the slides will be posted, or whether CMS is planning to publish the estimates that Rory walked through on the call.

Ashley Setala: And we'll just say that the slide deck will be posted to the COVID-19 page that is accessible from the Medicaid.gov homepage. And they should be up by the end of the day. So states can look for them there.

Ashley Setala: And then, we have a number of questions that have come in around telehealth. And the first question is for Marissa, and it says, "Will the use of non-public facing video platforms that aren't under a business agreement no longer be permissible after the end of the PHE?"

Marissa Gordon-Nguyen: Generally, there will be a need for a business associate agreement with those vendors after the public health emergency, because they fall within the scope of providing data transmission services for a covered entity or another business associate. So yes, business associate agreement will be needed for the video app.

Ashley Setala: Okay, thank you. Then we have a question for Kirsten on her telehealth presentation. And it says, "I would like to ensure that when Kirsten uses the term telehealth, this term is including audio-only telephone."

Kirsten Jensen: Thanks. This is Kirsten. To be very clear, Medicaid allows for the use of audio-only. And it is up to the state to determine what types of technology you would like to use in the state. But audio-only is certainly permissible.

Ashley Setala: Okay, thanks, Kirsten. And then we have a question that says, "Are there any additional telehealth considerations relevant to FQHCs?"

Kirsten Jensen: Sure. This is Kirsten. Not that I'm aware of. But I will take that one back, to make sure that I'm not missing anything and that is that, maybe it would help... Are you referring to paying the PPS rate for a telehealth visit? Or is it really about them being able to use telehealth as an FQHC? Let's get some clarification there, that would be helpful.

Ashley Setala: It looks like they said yes, related to PPS.

Kirsten Jensen: Related to PPS. Okay, let me take that one back and we'll get an answer back out to you.

Ashley Setala: Okay, great. Then there is a question that says, "Is there discussion of expansion of telehealth on the Medicare side? This is important for states with a large number of dual-eligibles."

Kirsten Jensen: This is Kirsten. I'll also need to reach out to Medicare to find out where they are in terms of telehealth, I don't have that answer at the ready.

Ashley Setala: Okay, then we have a question that says, "would a state plan amendment be needed if the audio-only is to be reimbursed at a different rate than the video apps that require a BAA?"

Kirsten Jensen: This is Kirsten. Yeah, if the audio-only rate is different than what you would pay otherwise for a face-to-face visit, you would need a state plan amendment. And similarly for the other technology you mentioned, if that rate is different than a face-to-face service, you would need a state plan amendment or if it's the same, you do not need a state plan amendment for that particular technology.

Ashley Setala: Okay, then we have a question that says, "Will CMS continue to allow audio-only for telemedicine after the PHE?"

Kirsten Jensen: Yes. This is Kirsten. And I want to be really clear on this point. The use of audio-only in Medicaid telehealth policy has always been available. That was not something new that we implemented as part of the PHE. So you can continue to use it going forward. It will remain in place for states to use.

Ashley Setala: Okay, then we have a question that says, "What about any flexibilities with Tribal Health Clinics and use of the all-inclusive rates. This is along the lines of the FQHCs and their PPS payments as well."

Kirsten Jensen: Sure, I'll take that one back, too. I don't know that we have the right colleagues on the phone to answer these today. So we'll circle back.

Jeremy Silanskis: Hey, this is Jeremy. I am one, but I agree. I think we need to take that back and think about it a little bit more.

Kirsten Jensen: Yes. Okay. Great. Thank you.

Ashley Setala: Okay. And then we have a question that says, "Just to clarify, if states wish to continue audio-only coverage, a SPA isn't needed if reimbursement is the same as in-person. Is there still FMAP for this? If CMS doesn't cover audio-only services, states would be responsible for full cost of duals?"

Kirsten Jensen: Yes, that's correct. And just to say it again, audio-only provision of services is allowable in Medicaid telehealth. So a state plan amendment is not required if you are reimbursing for the service delivered using audio-only technology if it's the same as the reimbursement rate that you pay for an in-person service.

- Ashley Setala: Okay. And then we have another SPA question that says, "If a state's reimbursement rate is the same for an in-person visit, but the state wants to have a lower audio-only rate, does this require a SPA?"
- Kirsten Jensen: Yes, that circumstance would require a SPA.
- Ashley Setala: Okay. Then we have a question around the American Rescue Plan Act legislation and it says, "When can we expect to receive guidance on the 100% FMAP for vaccine administration?"
- Jeremy Silanskis: So this Jeremy. I think Anne Marie touched on... Oh, go ahead, Rory.
- Rory Howe: Yeah, I was just going to say, we're aware, I think, that there's certainly interest related to guidance. We do intend to provide guidance and are working to provide it as as soon as possible.
- Ashley Setala: Okay. Then we have a couple more telehealth questions. The first says, "We have a question about face-to-face and in-person. Previously face-to-face was a stand in for in-person, but with telecommunications (video) can be face-to-face. Do we need a SPA to clarify?"
- Kirsten Jensen: This is Kirsten. I understand the language as it's described. So we can reframe that if it's the same as an in-person visit, if the payment rate... The standard is, is the payment rate the same as the in-person visit? And if it's the same for the service being delivered using whatever technology, then you do not need a state plan amendment. If it is different, then you would need a state plan amendment of 4.19-B page.
- Kirsten Jensen: So it's for that. I think the standard is, I go to the doctor and I'm at the clinic and I see the doctor in an office. If you're paying the same rate for that visit as you would pay for a service delivered via telehealth, then we do not need a state plan amendment. If you are paying something different, then we need a state plan amendment.
- Ashley Setala: Okay. Then we have one more telehealth question and it says, "Does CMS consider telemedicine and telehealth to be the same thing?"
- Kirsten Jensen: Yes. We've kind of merged that over the years as the use of telehealth, telemedicine has become more acceptable and there's more ways of it, more technologies that can be used. So we are generally using the terms interchangeably at this point.
- Ashley Setala: Okay-

Kirsten Jensen: [crosstalk 00:45:07] we often use telehealth more often these days, though. Yeah.

Ashley Setala: Great, thank you. And then we have a question asking for an update on COFA, and says, "Can we get an update on the Asian Pacific Islands or COFA webinar that was to occur, mentioned a few calls ago?"

Sarah Lichtman Spector: Hi, this is Sarah Lichtman Spector. We are working on setting that up, and there will be information forthcoming soon. We are definitely providing technical assistance. For any states that are interested or have particular questions, feel free please to contact your state lead. And we are doing ongoing technical assistance, and please do stay tuned for more details about the webinar. That's forthcoming.

Ashley Setala: Thanks, Sarah. Then we have a question that says, "States needed an 1135 Waiver to allow telehealth at clinics when neither the patient or the clinician was physically located at the clinic, due to the federal clinic regulation. After the PHE, will this telehealth flexibility no longer be available due to the federal regulation?"

Kirsten Jensen: We'll have to take that one back as well. We've not examined that question for what it will look like post-PHE.

Ashley Setala: Okay. Thanks, Kirsten. It looks like we've addressed all of the questions that have come in through the chat.

Jackie Glaze: Thanks, Ashley. So operator, will you please provide instructions to the audience for asking their questions over the phone?

Operator: Thank you. If you would like to register a question over the phone, press the one followed by the four. You'll hear a three-tone prompt to acknowledge your request. Your line will then be accessed from the conference to obtain your first and last name. And one moment for the first question.

Operator: And as a reminder, to register for a question, press the one followed by the four on your telephone keypad right now. First question comes from the line of Arvind Goyal. Please proceed with your question.

Arvind Goyal: Thank you very kindly. This is Arvind Goyal from Illinois Medicaid and CHIP program. My question has to do with telehealth by telephone only. Number one, do you have any data that you can share with the states as far as the quality and other factors, other utilization data, etc., that might guide our post-pandemic emergency accommodations?

Arvind Goyal: And number two, in the CPT guidance or CMS guidance, we've had the prescribed components of each level of evaluation and management service. Do those guidelines still hold when services are being provided by telephone and the physical examination or point of service interventions are not available by phone?

Kirsten Jensen: Okay, this is Kirsten. And on your first question about data, I can certainly check with our colleagues to see what kind of telehealth data that we have regarding audio-only. I am fairly certain that we have not looked at data in terms of quality of services. We could certainly look at data in terms of services provided, audio-only perhaps. But we have not done any analysis of the quality piece. I think we've deferred to states on that side of things as you're putting your programs together.

Kirsten Jensen: And the second question about the coding, we do not typically give out coding advice. If you would like us to try to take a look at that question, I would need it written up and sent in. But typically, we don't provide coding advice about how the codes are used, or what code states should use. But I'm open to getting a write-up and seeing if we can find any information for you about those codes or how they're to be used. If there are additional issues, perhaps, and that's really what the crux of the question is, and we might be able to help find out some information about the definitions of the codes and what they're for.

Arvind Goyal: Thank you.

Operator: And as a reminder, to register for a question, press the one followed by the four on your telephone keypad right now. There are no questions on the phone at this time. I'll now turn the presentation back to the speakers.

Jackie Glaze: Thank you. Ashley, I see a couple more questions. So I think we can take those before we wrap it up today?

Ashley Setala: Yep, we have a few more that have come in. So the first one says that, "This telehealth conversation seems to focus on state plan services. Does the information apply to waiver services as well, in services such as employment supports possibly?"

Kirsten Jensen: I'm sorry, can you repeat that question please?

Ashley Setala: Sure. It says, "The telehealth conversation seems to focus on state plan services. Does that information apply to waiver services as well? And waiver services such as employment support?"

Melissa Harris: Kirsten, this is Melissa Harris, and I'll jump in here. I know we've had this conversation a little bit, at least internally, and I'm happy to provide a readout more publicly.

Melissa Harris: So certainly, the telehealth policy does not differ between the types of services that are being provided, state plan versus waivers. When we look at some of the long term nature of the waiver services, and the fact that the waivers have an extra slant of community integration to them, we want to make sure that states are being mindful of the fact that a service that's provided in a long term way remotely might need to have some periodic check-ins to make sure that the individual's person centered service plan, for example, is still being adhered to, and the individual's community integration preferences are still being adhered to.

Melissa Harris: Now recognizing, we're in a pandemic now. And that's obviously going to have impact on how anyone is interacting with their community. And so what I'm talking about really is for ongoing policy conversations, not just use of telehealth during this public health emergency. So CMS continues to be very supportive of the use of telehealth right now, for COVID purposes, and much longer term as a traditional method of service delivery.

Melissa Harris: There does need to be, particularly when we're on the other side of the public health emergency, some care taken with regard to long term care services provided to make sure that our beneficiaries are still getting the right kind of facilitation into the community. That does not though mean that telehealth is not available for waiver services. States should just kind of expect the flavor of the CMS questions to include a bit more of a longer range goal of community integration, but it is still very much a green light for telehealth.

Ashley Setala: Okay, thanks, Melissa. Then we have a question that says, "May a Medicaid 1915(c) HCBS recipients receive both telehealth adult day training (ADT) and personal assistance services simultaneously if the personal assistance services are necessary for the recipient participation in telehealth ADT?"

Melissa Harris: Yeah, this is Melissa-

Ralph Lollar: Yeah. This is Ralph and it's-

Melissa Harris: Oh, thank you. Thanks, Ralph. Go ahead.

Ralph Lollar: I'm sorry, this is Ralph. And the question is, is this question relative to the pandemic and the PHE period? If it is, then the answer would be that this service, if it's a per diem rate for residential services, and the day program services are being delivered via telehealth, both can be billed at the same time.

- Ashley Setala: Okay. Thanks, Ralph. Then we have a question that says, "Is there guidance around hybrid visits? Meaning some services might be delivered via telehealth and then have a component that is in-person. For example EPSDT or other well-child or routine follow-up visits?"
- Kirsten Jensen: This is Kirsten. We don't have particular guidance around that issue. And again, if there's more to the question, is it because a bundled rate is paid and the services are delivered in-person and via telehealth? If this is the question? I'm trying to understand more fully what the issue is with this.
- Jackie Glaze: We might need to follow back up on that one, Kirsten.
- Kirsten Jensen: Yeah, a little bit more information would be helpful so that we could come back with a fulsome answer.
- Jackie Glaze: Thank you. So I know we're getting close to closing time, so I want to thank all of our participants for their excellent presentations and information shared with us today. Looking forward based on the feedback that we received from states, we will now be adjusting our schedule for these calls moving forward on a bi-weekly basis. So we will meet with you again on April the 13th in two weeks. The topics and invitations for the next call will be forthcoming.
- Jackie Glaze: We also receive really great feedback from the states on these calls, and we will be using your suggestions to develop our contents for future calls, including today, we included the telehealth topic. As you have questions that come up between calls, please reach out to us and reach out to your state leads or bring questions to the next call. So we thank you again for joining us today and we hope that everyone has a great afternoon. Thank you.
- Operator: And that does conclude today's call. We thank you for your participation. And I ask that you please disconnect your line.