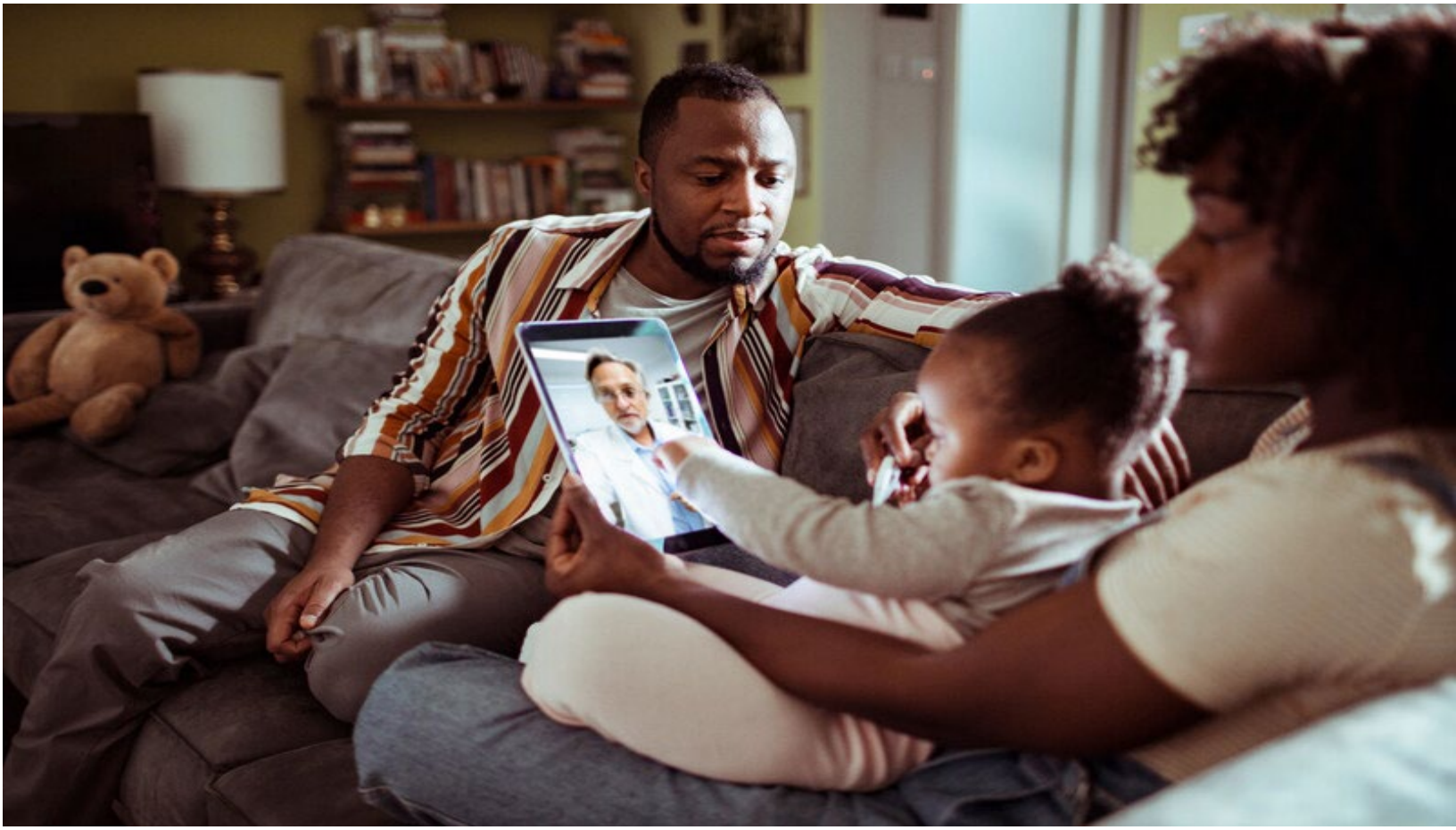
State Medicaid & CHIP Telehealth Toolkit

Policy Considerations for States Expanding Use of Telehealth

COVID-19 Version: Supplement #1



December 6, 2021

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Introduction

This document serves as supplement to the State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version released by the Centers for Medicare and Medicaid Services (CMS) on April 23, 2020. The purpose of the original toolkit was to assist states in general considerations for telehealth expansion in response to the COVID-19 Public Health Emergency (PHE) on behalf of the nation's nearly 73 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. States seeking to facilitate adoption of telehealth services are encouraged to review this toolkit.

The focus of this supplement is to provide additional support to state Medicaid and CHIP agencies in their adoption and implementation of telehealth. This supplement explores terminology, communication strategies, telehealth operations and implementation tools, and shared experiences and examples from states and territories across the nation. It includes updates to Frequently Asked Questions (FAQs) and Resources for states to consider as they expand telehealth and begin to plan beyond temporary flexibilities. While this supplement frequently references Medicaid programs, the tools and resources contained throughout this Supplement are generally also applicable to CHIP programs, though it should be noted that there is some guidance specific to CHIP in the Updated Appendix A: Frequently Asked Questions.

While telehealth has become a resourceful way to provide select services while maintaining social distance and reducing the risk of in-person COVID-19 transmission, it also has potential as an additional access pathway for services when social distancing is no longer required. Based on their own documented successes, many states are considering implementing policies for continued telehealth flexibilities following the PHE and on a more permanent basis. Implementing policy and service changes with managed care plans (MCPs), providers and beneficiaries continues to require a careful and well-thought-out process. Additionally, providing timely information in a consumable format is critical to enabling stakeholders to effectively utilize telehealth. States may use this supplemental toolkit to help think through how they will explain and clarify which policies are temporary or permanent, when flexibilities will expire, which services can be accessed through telehealth, which providers may deliver those services, the modality they may use to deliver telehealth services, and the circumstances under which telehealth can be reimbursed.

Updated Appendix A: Frequently Asked Questions

* Indicates newly added FAQ at end of question

Benefit Flexibilities

1. **What flexibilities are available to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?**

   States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic or video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A state plan amendment (SPA) would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

   With regard to 1915(i) face-to-face assessments, the use of telemedicine or other information technology medium is authorized under federal regulations at 42 C.F.R. § 441.720(a) under certain conditions. With regard to 1915(c) waivers, the state can complete an Appendix K to allow case management to be done via telephone or other information technology medium and, where personal care services only require verbal cueing and/or instruction, the personal care service can be expanded to permit information technology medium as a resource.

2. **Are there any available flexibilities in implementing the requirement for face-to-face encounters under Medicaid home health? Can telehealth be utilized?**

   Yes. For initiation of home health services, face-to-face encounters may occur using telehealth as described at 42 C.F.R. §440.70(f)(6). A physician, nurse practitioner or clinical nurse specialist, a certified nurse midwife, a physician assistant, or attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay may perform the face-to-face encounter. The allowed non-physician practitioner must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into the beneficiary's written or electronic medical record. Additionally, the ordering physician must document that the face-to-face encounter occurred within the required timeframes prior to the start of home health services and indicate the practitioner who conducted the encounter and the date of the encounter. A SPA would only be necessary to revise existing state plan language that imposes telehealth parameters that would restrict this practice. As is discussed above and at https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html, states are not required to submit separate SPAs for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. A SPA would be necessary to accommodate any revisions

to payment methodologies to account for telehealth costs.

3. **Can Pre-Admission Screening and Resident Review (PASRR) Level 1 and Level 2 evaluations be conducted remotely as opposed to through a face-to-face visit?**

   Yes. The PASRR statutory provisions require all applicants to and residents of Medicaid-certified nursing facilities (NFs) be screened for mental illness and intellectual disability, and, if necessary, be provided specialized services while in the NF.

   Federal regulations do not prohibit PASRR Level 1 and Level 2 evaluations from being conducted by telephone or through another electronic medium. Unless the state has a specific requirement that PASRR Level 2 evaluations be conducted in a face-to-face interview, there is no need to amend language in the state plan.

   States can also request an 1135 waiver to temporarily suspend pre-admission screening and resident review Level 1 and Level 2 for 30 days.

4. **How do the Medicaid flexibilities around use of telehealth as a service delivery mode interact with Medicare and commercial third party liability (TPL) requirements, which may be less flexible around telehealth? For example, a Medicare or commercial payer may require a face-to-face physician visit to order care or supplies.**

   Please note that Medicare has recently increased flexibilities related to telehealth due to the public health emergency, as summarized in the fact sheet available at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. While Medicare and commercial payers have increased flexibilities for telehealth, there may still be instances where coordination of benefits is necessary.

   Medicaid payment allows for state plan flexibilities in the event Medicare or a commercial insurer denies payment. If the third party denied the claim for a substantive reason (e.g., service not covered) and the service is covered under the Medicaid state plan, Medicaid would review for payment accordingly. If at a later time, the state is made aware of a third party's coverage for these specific services, the state, as it currently does, would chase recovery of payment accordingly. Therefore, in the example above, once Medicare or a commercial payer reviews a claim and denies for a substantive reason, such as face-to-face physician visit requirement, Medicaid would review and pay according to the state plan. If telehealth is permitted under the Medicaid state plan, Medicaid would pay accordingly.

5. **How can states ensure continuity of coverage for Medicaid services ordinarily delivered to children in schools while schools are closed due to COVID-19? ***

   The use of telehealth can assist states in continuing to deliver Medicaid-covered services to eligible children. As a reminder, the Early and Periodic Screening, Diagnostic, and

Treatment (EPSDT) benefit requires states to make available to eligible children under age 21 all medically necessary services included under section 1905(a) of the Act in order to correct or ameliorate defects and physical and mental illnesses or conditions. If the state establishes that a Medicaid service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020, to temporarily remove such restrictions during the period of the public health emergency. If the state needs flexibilities beyond the period of the public health emergency, CMS is available for technical assistance to determine if a SPA is needed. If telehealth is used, covered entities must provide effective communication to individuals with disabilities as per Section 1557 of the Affordable Care Act, Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act. For further information on Medicaid coverage and reimbursement of services delivered via telehealth, please refer to the Medicaid.gov web page: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. This page includes the State Medicaid & CHIP Telehealth Toolkit *Policy Considerations for States Expanding Use of Telehealth* COVID-19 Version and a link to **Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth.**

The Office for Civil Rights in the Department of Health and Human Services is exercising enforcement discretion to waive potential penalties for Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules violations against health care providers that in good faith provide patient care through remote communications technologies during the COVID-19 public health emergency. Additional guidance is available explaining how covered health care providers can use remote video communication products and offer telehealth to patients responsibly. See: https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html.

States may also refer to the guidance issued by the Office of Special Education Programs (OSEP) in the Department of Education for further information on the IDEA and other federal civil rights laws: https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf. For other updates on the Department of Education website, see: https://www.ed.gov/coronavirus.

Additionally, see "Section 1557: Ensuring Effective Communication with and Accessibility for Individuals with Disabilities," https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs- disability/index.html; "Disability Resources for Effective Communication," https://www.hhs.gov/civil-rights/for-individuals/special-topics/hospitals-effective- communication/disability-resources-effective-communication/index.html; and "ADA Requirements," https://www.ada.gov/effective-

comm.htm.

6. **Would an Individualized Education Program (IEP), an Individualized Family Service Plan (IFSP), Section 504 plan, or other plan that identifies Medicaid-covered services for a Medicaid-enrolled child need to expressly indicate that services can be delivered via telehealth as a pre-condition for receipt of Medicaid reimbursement for the services? ***

   No. Medicaid considers telehealth to be a service delivery method, not a service. Services included in an IEP, IFSP, Section 504 plan, or other plan, can be covered by Medicaid only if they are Medicaid services provided to a Medicaid-enrolled child by a Medicaid qualified practitioner. If these requirements are met, and there is an approved payment methodology for the services in the state Medicaid plan, then Medicaid can reimburse for the services, including when they are delivered via telehealth.

   Generally, states need to have current Medicaid state plan 4.19-B pages that set forth the reimbursement methodology for any covered Medicaid services that would be included in the child's IEP, IFSP, section 504 plan, or other plan of services for a child. States do not need to refer to telehealth reimbursement methodologies in their state plans unless the reimbursement rate or methodology for a service provided via telehealth is different from the rate or methodology that applies when the same service is provided face to face.

   Please also refer to the Medicaid.gov and the OSEP and Department of Education links noted above.

7. **Can early intervention services (EIS) under the Individuals with Disabilities Education Act (IDEA) be reimbursed by Medicaid when the services are delivered via telehealth? ***

   If the state establishes that a Medicaid-covered service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020 to temporarily remove such restrictions during the period of the public health emergency. States can cover and reimburse for EIS that are Medicaid-covered services provided to a Medicaid-enrolled child by a qualified Medicaid provider. As explained previously in the CMS telehealth FAQs (Section III. Benefits, Item B. Telehealth, Question 1) updated May 5, 2020, states have broad flexibility to cover services provided via telehealth under Medicaid, and also have flexibility regarding the methods of communication used to provide services via telehealth (such as telephonic, video technology commonly available on smart phones and other devices). Telehealth is important not just for people

who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for Medicaid services provided via telehealth in the same manner or at the same rate that states pay for those same Medicaid services when provided face-to-face. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs. The updated FAQs can be found here: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf. Providers of EIS who are not being reimbursed for delivery of services via telehealth should contact their state Medicaid agency. Additional information may be found at the OSEP guidance noted above and on the Department of Education website at https://www.ed.gov/coronavirus.

8. **Is Medicaid coverage available for evaluations to determine the need for EIS under the IDEA if providers conduct the evaluation via telehealth? ***

   Yes. If a state establishes that evaluations for EIS that Medicaid would otherwise cover can be delivered via telehealth, Medicaid qualified practitioners can bill for their time spent in conducting evaluations via telehealth as an applicable practitioner service.

9. **Can pediatric clinicians receive Medicaid reimbursement for well-child visits delivered via telehealth? ***

   Yes. Well-child visits are coverable under EPSDT, and states may elect to cover visits conducted via telehealth. Generally speaking, states can establish the same rate for Medicaid services delivered via telehealth that is paid when the same services are delivered face-to-face, but states may establish different rates. Each state has the discretion to set payment rates that are consistent with section 1902(a)(30)(A) of the Act. Accordingly, states may pay a different rate for services delivered via telehealth to account for differences between the cost of delivering the services face-to-face and the costs of delivering them via telehealth. If states choose to pay different rates for services when they are delivered via telehealth, a SPA submission would be necessary to describe and receive CMS approval for the new payment methodology.

10. **During the PHE, may states cover clinic services under 42 C.F.R. § 440.90 if the services are provided via telehealth and neither the patient nor clinic practitioner is physically onsite at the clinic? ***

    Yes, but only if CMS provides the state with time-limited waiver authority pursuant to section 1135(b)(1)(B) of the Act. Under that provision, CMS can modify the requirement in 42 C.F.R. §440.90 that clinic services be provided "by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients," to permit services under 42 C.F.R. § 440.90 to be provided via telehealth when patients and clinic practitioners are in their respective homes or in another location. 42 C.F.R. § 440.90(a) requires that services covered under that benefit be provided "at the clinic" — that is,

within the four walls of the clinic facility, with an exception at 42 C.F.R. § 440.90(b) for services furnished outside the clinic to people who are homeless. While states generally have broad flexibility to cover and pay for services provided via telehealth in their Medicaid program, unless states have a waiver of federal requirements applicable to specific Medicaid benefits, they must adhere to those federal requirements, including when benefits are provided via telehealth. Historically, states have covered clinic services under 42C.F.R. § 440.90 that were provided via telehealth only if either the patient or the clinic practitioner was physically onsite at the clinic facility. However, under section 1135 of the Act, CMS could modify the "facility" requirement in 42 C.F.R. § 440.90 to permit the state and clinic to temporarily designate a clinic practitioner's location as part of the clinic facility. This, in turn, would permit clinic services to be provided via telehealth when neither the patient nor practitioner is physically onsite at the clinic, because it would permit services provided via telehealth in clinic practitioners' homes (or another location) to be considered to be provided at the clinic for purposes of 42 C.F.R. § 440.90(a). Such a waiver would help to ensure continued Medicaid coverage for clinic services during the PHE, and would also facilitate the urgent need for states to employ all measures to prevent the spread of COVID-19 during the PHE. To submit a section 1135 waiver request, a state should send the request via email to its State Lead and to Jackie Glaze at Jackie.Glaze@cms.hhs.gov.

11. Can Money Follows the Person (MFP) programs use alternative communication methods such as telephone calls or video chat for transition activities that would normally be conducted on an in-person basis during the COVID-19 public health emergency? *

MFP programs may leverage MFP demonstration flexibility and resources to make temporary programmatic changes that are consistent with their states' and local communities' responses to COVID-19. States may choose to implement strategies using alternative communication methods such as video chat or telephone calls for transition activities that would normally be conducted on an in-person basis. CMS encourages states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care. Further guidance on telehealth/telemedicine may be found on Medicaid.gov: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf and https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html.

MFP grantees should notify their MFP Project Officer as soon as possible if they need to make programmatic changes, but states do not need to receive CMS approval before implementing programmatic changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19 and are otherwise allowable.

Please note that this pre-approval to implement MFP programmatic changes does not supersede any requirements that apply to section 1915(c) waivers or other Medicaid

HCBS authorities. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. States should reach out to their CMS HCBS lead and request the Appendix K for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver program or have any questions about how to request approval under another Medicaid authority.

12. In what ways might states use the Medicaid disaster relief SPA template to increase payments to providers during the PHE? *

States can use the Medicaid disaster relief SPA template to increase payments to providers during the emergency period. This includes, but is not limited to: increasing payments to providers that are seeing an influx in Medicaid patients as a result of the PHE; recognizing additional costs incurred through the provision of Medicaid services to COVID-19 patients; increasing payments to recognize additional cost incurred in delivering Medicaid services, including additional staff costs and/or personal protective equipment; adjusting payments to providers to account for decreases in service utilization but an increase in cost per unit due to allocation of fixed costs or an increase in patient acuity as a result of the PHE; or increasing payments for Medicaid services delivered via telehealth to ensure that Medicaid services are delivered in a safe and economical manner. The payment increases can take the form of dollar or percentage increases to base payment rates or fee schedule amounts, rate add-ons, or supplemental payments, depending on the applicability to the state's payment methodology for the provider and service categories. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act. SPA approvals and other COVID-19 related waiver documents may be found here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html.

13. Does federal Medicaid law and policy allow states to cover and reimburse for Medicaid services delivered using audio-only telehealth technologies?

Yes. States have broad flexibility to cover and pay for Medicaid services delivered via telehealth, including to determine which telehealth modalities may be used to deliver Medicaid-covered services. Nothing in federal Medicaid law or policy prevents states from covering and paying for Medicaid services that are delivered via audio-only technologies. This broad flexibility to cover and pay for Medicaid services delivered via telehealth, including via audio-only technologies, was in place prior to the COVID-19 PHE, has not changed during the COVID-19 PHE, and will continue to be available to states after the end of the COVID-19 PHE.

14. Are SPAs necessary to specify when states will cover and pay for Medicaid services that are delivered using telehealth?

Generally, a SPA is not necessary to describe when the state will cover and pay for already-covered Medicaid services when they are delivered via telehealth, if there are no changes to the benefit descriptions, limitations, or payment methodologies that are already in the state plan. However, a SPA would generally be necessary if states want to cover or pay for services delivered via telehealth differently than they do for services delivered face-to-face, such as when states reimburse differently for covered services delivered via telehealth than they do for covered services delivered face-to-face. States may elect to submit SPAs to more comprehensively document coverage and payment for services delivered via telehealth, but are not required to do so unless the state is covering and paying for services differently if they are provided via telehealth. Additional information about Medicaid telehealth policy can be found at https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. .

Financing Flexibilities

15. Are "telephonic services" provided by federally qualified health centers (FQHCs) or rural health clinics (RHCs) eligible for Federal Financial Participation (FFP) during and immediately following a declared state of emergency?

Yes, FFP is available for telephonic services. If a state's approved state plan excludes FQHC/RHC services from being provided telephonically, CMS can work with the state to expedite processing of a SPA to lift this restriction.

16. Do states need to a submit a SPA if they pay the same PPS rate for telephonic services provided by FQHCs or RHCs as they pay for services delivered in-person?

No SPA is needed if the state plan does not specifically define a visit for the purpose of reimbursing FQHC services as a "face to face encounter" with an eligible provider type. If it does, and states would like to reimburse telephonically delivered services at the PPS rate, they would need to submit a SPA amending the definition of a visit.

17. Can states pay FQHCs and RHCs an amount less than the PPS rate on a FFS basis with an approved SPA or waiver? Additionally, if a service is provided telephonically, can the state pay the provider an amount lower than Prospective Payment System (PPS) rate for the telephonic service delivered via telehealth?

If a service is covered within the scope of the FQHC/RHC benefit, section 1902(bb) of the Act requires a state to pay a provider using the state plan prospective payment system (PPS) rate or an alternative payment methodology (APM) that pays at least the PPS rate. For services that are not covered as part of the FQHC/RHC benefit, a state may pay providers using the state plan fee- for-service payment methodology established for that service. Rates for those services may be lower than the PPS or an APM paid for FQHC/RHC services, provided the rate is consistent with all other applicable requirements, including section 1902(a)(30)(A) of the Act. This policy applies whether a service is delivered face-to-face or telephonically.

18. **Healthcare Common Procedure Coding System (HCPCS) code G0071 is reimbursable to FQHC and RHCs for virtual communication activities, including telephone calls. Do states need to submit a SPA to activate that code?**

    States do not need to submit a SPA to activate HCPCS code G0071 unless the state decides to pay a rate for that code that is different from the face-to-face encounter rate approved in the Medicaid state plan.

Workforce Flexibilities

19. **What options are available if a state experiences a shortage of health care workers because of COVID-19?**

    To address provider shortages for individuals receiving 1915(c) waiver services, states can use Appendix K to expand provider qualifications (e.g., where a provider must be 21 years old, states could modify the age requirement to 18); add additional providers (including allowance of payment to family members and legally responsible relatives); add services, such as a live-in care giver; and temporarily adjust rates to entice more individuals into the workforce.

    For state plan services, a SPA can increase the types of providers a state authorizes to deliver services. As always, states should be mindful of state-level requirements that might impact provider flexibility in delegation of authority.

    Additionally, states have broad ability to cover telehealth through Medicaid, and no federal approval is needed for state Medicaid programs to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services, visits, or consultations. A SPA is necessary to accommodate any revisions to payment methodology to account for telehealth costs.

    To address state staff shortages, the Appendix K process can also be utilized for case managers under 1915(c) to permit the use of telehealth or telephonic consultations in place of typical face- to-face requirements. Under 1915(i), existing regulatory flexibility at 42 C.F.R. § 441.720(a) permits use of telehealth in place of face-to-face assessments when certain conditions are met.

Managed Care Flexibilities

20. **How can states implement or update Medicaid or CHIP managed care telehealth policies, including allowing remote monitoring and reimbursement of telehealth services at the in-person clinical services rate?**

    The available telehealth flexibilities allow Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that they can limit risk of exposure and spread of the virus. In fee-for-service, states are not required to submit separate SPAs for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner

or at the same rate paid for face-to-face services. Medicaid guidelines require all providers to practice within the scope of their State Practice Act, and states may have laws and regulations that govern the scope of telemedicine coverage. In fee-for-service, a SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

If a benefit is covered under the state plan or Medicaid waiver (e.g., section 1915(b) or 1915(c)) or a state demonstration (e.g., section 1115), CMS encourages states to amend managed care contracts (if the services are not already included in the contract) to extend the same telehealth flexibilities authorized under their state plan, waiver, or demonstration to services covered under the managed care contract. Absent coverage under the state plan or otherwise authorized through a Medicaid waiver or demonstration, services furnished under telehealth through managed care could also be provided as:

1. In-lieu of services (42 C.F.R. §438.3(e)(2) and 42 C.F.R. §457.1201(e)). Under these regulations, alternate services or services furnished in an alternative setting that the managed care plan or entity voluntarily agrees to cover in lieu of state plan-covered services must be: (i) authorized by the state as being a medically appropriate and cost-effective substitute for the covered service or setting under the state plan; (ii) authorized and identified in the managed care contract; and (iii) not required to be used by the enrollee in lieu of the state plan-covered service. In addition, there are specific rate development rules used when a managed care contract authorizes use of in-lieu of services.
2. Additional services, beyond those in the contract, voluntarily provided by managed care plans (commonly referred to as value-added services). No contract amendment is needed; however, the cost of value-added services cannot be included when determining the capitation rates (per 42 C.F.R. §438.3(e)(1)(i) and 42 C.F.R. §457.1201(e)).

   Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. If a state determines a retroactive adjustment to capitation rates under one or more of its managed care contracts is necessary for costs eligible for reimbursement, such as telehealth-related infrastructure costs, retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 C.F.R. §438.7(c)(2). The rate certification must describe the rationale for the adjustment, and the data, assumptions and methodologies used to develop the magnitude of the adjustment. For additional information about telemedicine, visit: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. For CHIP,

rates must be based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as described in 42 C.F.R. §457.1203(a). States that update their CHIP capitation payments due to telehealth related costs would not need to submit a rate certification.

Health Information Exchange Flexibilities

21. How can states establish, implement, and enhance telehealth technologies through the process described in 45 C.F.R. § 95.624 (emergency funding requests) as part of the COVID-19 response effort and in support of their Medicaid provider and beneficiary populations?

CMS is available to provide technical assistance regarding approaches to rapidly scale telehealth technologies. If states are granted waivers under section 1135 for federal requirements related to provider location or provider enrollment (https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf), complementary technology investments may be appropriate. CMS advises states to leverage existing infrastructure and technology. States should discuss any patient-facing telehealth proposals with their Medicaid Enterprise Systems (MES) State Officer. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

T-MSIS Coding Guidance

22. How should telehealth-related services be reported in the Transformed Medicaid Statistical Information System (T-MSIS)?

States should ensure that providers are educated on the correct submission of telehealth claims. States should report COVID-19 telehealth services to T-MSIS as they are billed on the claim form, identified through the procedure code and procedure code modifier fields. Please contact your CMS State Systems Officer with further questions. For general information on Medicaid telehealth, see Medicaid for Services Delivered via Telehealth.

Quality Reporting

23. In what ways will the COVID-19 pandemic affect FFY 2020 reporting for the Medicaid and CHIP Child Core Set and Adult Core Set? *

While all Core Set reporting continues to be voluntary on the part of states, CMS encourages states that can collect and submit this information safely to continue doing so. To this end, however, CMS recommends temporarily suspending the types of measurement activities that could present a health risk to state employees or contractors, such as conducting on-site medical chart reviews. In addition, CMS expects that the COVID-19 pandemic could affect the accuracy of Core Set reporting in a number of ways. For example, state performance on preventive care Core Set measures may decline, since individuals have generally been advised not to seek in- person routine or preventive care unless medically necessary at this time. Moreover, these services offered through telehealth may not be captured in the measure unless the measure specifications allow for

telehealth. All of these factors can affect not only the ability of states to collect and submit Core Set data to CMS on time but can also limit the accuracy of that information and the ability for CMS to trend state performance rates over time. To the extent those Core Set measures are also included in the Medicaid and CHIP Scorecard, state Scorecard performance and the ability to trend that information will also be affected.

24. How can states minimize the impact of the COVID-19 pandemic on quality measurement activities? *

CMS encourages states to rely as much as possible on quality data that can be submitted and validated electronically to enable quality measurement and reporting activities to continue while minimizing the public health impacts of COVID-19.

Where preventive and elective services can be provided through telehealth, CMS encourages states to do so and to include those visits in their Core Sets data submissions where technical specifications allow for them (please refer to the COVID-19 State Medicaid & CHIP Telehealth Toolkit and FAQ # III.B.1, regarding the delivery of telehealth services).

25. Can well-child screenings provided through telehealth be included in the Form CMS- 416, which provides a count of EPSDT services? *

The American Academy of Pediatrics (AAP) issued guidance to address the delivery of well- child screenings during the public health emergency, including the use of telehealth. To the extent it is clinically appropriate to conduct well-child screenings through telehealth and they can be provided according to the state's periodicity schedule, these screenings can be included in the count of EPSDT services on the Form CMS-416.

No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services provided in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to implement any revisions to payment methodologies to account for telehealth costs (please refer to the COVID-19 State Medicaid & CHIP Telehealth Toolkit and for example, please refer to FAQ Section III.B.1. regarding the delivery of telehealth services).

Updated Appendix B: Resources

* Indicates newly added resources

Focus Area	Resources
Medicaid COVID-19	• Policy Options for Paying Medicaid Providers https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf • COVID-19 FAQs (See pp.7, 8,10, 11, 14, 19, 23, 32, and 33) https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf
Medicaid	• Medicaid Telemedicine Landing Page https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html • Disaster Toolkit https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html • Managed Care Adequacy and Access Toolkit (See page 53) https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf
Medicare	• Medicare Telemedicine Toolkit https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf • Medicare Learning Network definition of telehealth services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
Recent Related Federal Regulation and Legislation	• CMS Interim Final Rule containing various telehealth-related coverage flexibilities, released March 31, 2020 (CMS-1744-IFC https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf • CARES Act of 2020 (“Stimulus bill”) containing several telehealth coverage flexibilities, signed into law March 27, 2020 https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf • CMS’s expansion of access for Medicare telehealth under the Secretary’s 1135 waiver authority, dated March 17, 2020 https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Focus Area	Resources
Office for Civil Rights	• Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html • Guidance: FAQs on HIPAA and Telehealth https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (English), https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (Spanish) • Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19), dated March 28, 2020 https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf
Office of Inspector General	• COVID-19 Policy Statement re Reducing or Waiving Cost Sharing Obligation - Physicians and Other Practitioners will not be subject to Administrative Sanction https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf
MACPAC	• MACPAC Chapter on Telehealth in Medicaid https://www.macpac.gov/wp-content/uploads/2018/03/Telehealth-in-Medicaid.pdf
Technical Assistance for Providers	• Office of the National Coordinator for Information Technology https://healthit.gov • National Consortium of Telehealth Resource Centers – Resources https://www.telehealthresourcecenter.org/resources/ – Toolkit https://www.telehealthresourcecenter.org/resource-documents/ – Contacts https://www.telehealthresourcecenter.org/wpcontent/uploads/2019/08/08.23.19-2019-contact-sheet.pdf
Guidance on treating substance use disorder via telehealth	• Substance Abuse and Mental Health Services Administration guidance on telehealth for medication assisted treatment https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf

Focus Area	Resources
	• Drug Enforcement Authority guidance on telemedicine https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telemedicine.pdf
Health Resources and Services Administration*	• Telehealth Resources Centers https://www.hrsa.gov/rural-health/telehealth/resource-centers • Telehealth Programs https://www.hrsa.gov/rural-health/telehealth • Training and Technical Assistance Hub https://www.hrsa.gov/library/telehealth
Center for Connected Health Policy*	• Telehealth Coverage Policies in the time of COVID-19 https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies • COVID-19 Related State Actions https://www.cchpca.org/covid-19-related-state-actions • Current State Laws & Reimbursement Policies https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies# • Telehealth Resources https://www.cchpca.org/resources/search-telehealth-resources

Appendix C: Common Telehealth Modalities

Achieving clarity on telehealth and telehealth policies can be a challenge for state Medicaid programs in part because of confusion about what services can be delivered using which technologies. Ultimately for Medicaid programs, however, the goal of the policy should be to clarify for stakeholders, such as providers, consumers, and payors, whether and how a range of communication technologies can be used to support care delivery in instances when a person's visit would already be covered. As a result of the COVID-19 PHE, there is new urgency for states to clarify what technologies can be used, and how, to maintain continuity of care for vulnerable individuals without exposing patients and providers to unnecessary risks.

This document is intended to describe each of the major communication technology types and how they are currently being used to support care delivery. Examples are drawn primarily from Medicaid, but are also germane to state CHIP programs, too. Because much of the language around telehealth is imprecise, this Appendix will describe a technology's capabilities and will place under this framework common terms that are used to describe similar capabilities. It should be kept in mind that not all services are billable by all providers under all circumstances in all states. State Medicaid agencies have broad flexibility to determine which types of telehealth are covered under their programs. States seeking to facilitate adoption of telehealth services should review the State Medicaid & CHIP Telehealth Toolkit: COVID-19 Version, which can be used to help identify policy obstacles, and to make telehealth definitions more consistent within their state.

In addition, the act of sending information—regardless of the modality—is not itself a billable visit. The billable component is the clinical decision making which should then be documented in line with the standard of care for an in-person visit. The service is NOT using technology itself; the service is the evaluation, management, diagnosis, etc. that is enabled by the technology.

In the context of COVID-19, all forms of telehealth are directly involved in reducing risk of transmission by maintaining distancing between patients, and between patients and providers. Telehealth can be an important tool to speed access to scarce provider resources.

Modality	Description	Uses	Limitations
2-Way Audio-Video	A real-time, interactive technology, 2-way audio-video is likely what most people think about when they consider telehealth. It requires a working camera, microphone, and speakers/headphones for individuals on both sides of the conversation to function at full capability. Most consumers can already support this through a smartphone, or a tablet, laptop, or desktop computer with the necessary components. It also requires enough internet bandwidth to support the upload/download of data for audio and moving video images. Of all telehealth modalities, 2-way audio-video is most widely available for providers of different types. If a provider cannot perform or bill for a visit using 2-way audio-video, they likely cannot receive reimbursement or perform other forms of telehealth.	Most commonly, 2-way interactive audio video is used to connect patients and providers. Sometimes the 2-way audio-video is supplemented with information from sensors or other peripheral devices at the patient site. This could include, for example, a scale, blood pressure cuff, or a glucometer, which can help inform a diagnosis or a treatment approach. Additional information could also include pictures or other still images; however, in most cases this would only enhance an existing 2-way audio-video visit without making it materially different. Depending on the state, the provider, and device/sensor in question, it may enable billing additional evaluation and management (E&M) codes. In addition to patient-to-provider visits, a less common use of 2-way audio-video telehealth is to support provider-to-provider consults. In these instances, a provider reaches out to another provider to get counsel on how to treat a patient. Note: Medicaid reimbursement for consultations between professionals	Providers generally cannot bill for every service that is delivered via 2-way audio-video telehealth, but states handle these limitations differently. Some states explicitly list those services or Current Procedural Terminology (CPT) codes that are eligible for reimbursement when delivered via 2-way audio-video; others rely on the provider scope of practice (and documentation requirements) to ensure that only those services that, in the professional estimation of the health care provider, can be delivered in a clinically appropriate way are delivered via this form of telehealth. Although smartphone adoption and use in the adult Medicaid population is roughly equivalent to the general adult population[1], there may be challenges within specific communities that include broadband availability, and/or fully-funded data plans for mobile technologies. In addition, the Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS)—the office that enforces the HIPAA Privacy and Security Rules—issued guidance effective for the period of the PHE allowing enforcement discretion for providers using non-public facing "audio or video communication"[2] in a good faith manner.

[1] https://www2.deloitte.com/us/en/insights/industry/public-sector/mobile-health-care-app-features-for-patients.html Accessed 8/3/2020
[2] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html Accessed 8/7/2020)

Modality	Description	Uses	Limitations
		regarding treatment for a patient may be available when these costs are incorporated into the rate a state pays a provider for a covered service for a beneficiary	
Audio-Only	Audio-only is a real-time interactive voice-only discussion, usually between a patient and a provider, and generally only requires a working phone. This includes older-style "flip" phones, or a traditional "land-line" phone that only supports an audio-based communication. Care delivered via audio-only technology is explicitly excluded from the definition of "telehealth" in several states. Even so, the American Medical Association has defined several codes related to audio-only communication that are included in the CPT code set. These audio-only CPT codes are used for specific time increments (5 minutes to 30 minutes) of reimbursable "phone-based consultations" between a provider and a patient.	Although states have broad flexibility under federal Medicaid law and policy to cover and pay for Medicaid services when those services are delivered via telehealth, including via audio-only technologies, many states explicitly excluded audio-only technologies from the definition of telehealth prior to the COVID-19 PHE. This means that even though they could choose to do so, not all states decided to cover or pay for Medicaid services when delivered via audio-only technologies, or at least did not opt to do so for all providers in all situations. For example, several states do not cover or pay for Medicaid services delivered via audio-only technologies when provided by certain provider types (e.g. physical therapists, among others). Audio-only technologies may be more appropriate for individuals who do not have access to sufficient bandwidth or technology to support 2-way audio-video. Thus, states report that defining telehealth to include "audio-only"	At the start of the COVID-19 PHE, many states expanded Medicaid coverage of and payment for services delivered via telehealth to include services delivered via "audio-only" technologies. After the COVID-19 PHE ends, states can still opt to cover and pay for Medicaid telehealth services provided via audio-only technologies. As noted above under the "2-Way Audio-Video" section, OCR has issued enforcement discretion with regard to provider use of an audio or video communication platform during the COVID-19 PHE. As a result of OCR's enforcement discretion, a covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 PHE can use any available non-public facing audio or video communication technology in connection with the good faith provision of telehealth to patients without risk of OCR imposing a penalty on the provider for violating applicable HIPAA Privacy, Security, and Breach Notification Rules (the HIPAA Rules). The OCR Notification of Enforcement Discretion will remain in effect until the HHS Secretary declares that the PHE no longer exists, or upon the expiration date of the declared PHE, whichever occurs first. OCR will issue a notice to the public when it is no longer exercising its enforcement

Modality	Description	Uses	Limitations
		technologies has expanded health care access for lower-income individuals. Medicare pays for services delivered via audio-only communications with restrictions on how close the audio-only communication is relative to an in-person visit.	discretion based upon the triggering of one of these events. When the PHE ends, covered entities may continue to provide services via telehealth in compliance with the applicable HIPAA Rules, as they could before the Notification went into effect.
Asynchronous Communications	Also called, "Store and Forward", of all forms of "telehealth" technology, asynchronous communications are the most heterogeneous and reflect the most complex range of capabilities, coverage, and applicability to different providers. These communications involve contact between two parties (patient-to-provider or provider-to-provider) in a way that does not require real-time interaction. For example, a patient sends a message to a provider, who reads the message several hours later and replies to the message. However, these communications could be a narrative (text-based) description, an image, a video recording, an audio recording, or responses to a	Like other forms of telehealth, asynchronous communications can support billable communication between a patient and a provider (sometimes call eVisits), or between a provider and another provider (sometimes called an	States' Medicaid programs differ in both how asynchronous or "store and forward" technology can be used, and in how to use it as part of a billable service. Different forms of asynchronous communication—narrative only, narrative with image, etc.—can support diagnoses or evaluation of a condition—but the degree to which this is the case is highly dependent on state regulations and policies. To a greater degree than 2-way audio-video, asynchronous communications are often limited to certain providers either by explicit regulation, or on the basis of a provider's scope of practice.

Modality	Description	Uses	Limitations
	survey, among other items. In most cases, the electronic system functioning as the conduit of the information should be a HIPAA-compliant technology that supports encrypted communication from one party to another. Finally—and critically—not all forms of asynchronous communication are billable. States that explicitly allow for asynchronous communication often require a narrative description with an image, so a simple text message would not suffice. Other states do not have an operational definition of asynchronous communication even though it is not explicitly prohibited; as a result, it is rarely used.	eConsult). [3] States should provide more detailed information on which providers may use this modality, using which form(s) of asynchronous communication, for which kind(s) of service. For example, some state Medicaid programs—such as Texas--allow a physician to bill for an office visit only when a narrative-based message from a patient is accompanied by an synchronous audio conversation, an image (including a moving image), or a medical record.[4] In Medicare, an asynchronous communication is called an "E-Visit" when a Medicare patient initiates a communication with a provider via a patient portal,[5] but it is called a "Virtual Check in" when using other communication methods like a secure email. Other examples of asynchronous communication include:	

[3] Medicaid reimbursement for consultations between professionals regarding treatment for a patient may be available when these costs are incorporated into the rate a state pays a provider for a covered service for a beneficiary.
[4] See §3.2.2 of the Texas Medicaid Provider Procedures Manual: Telecommunications Services Handbook (http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Telecommunication_Srvs.pdf) Accessed 7/31/2020
[5] Other conditions apply. See https://www.medicare.gov/coverage/e-visits Accessed 8/13/20

Modality	Description	Uses	Limitations

		• A detailed questionnaire response sent from a patient to a provider
		  ○ The provider evaluates the questionnaire response and provides a diagnosis and treatment.
		• Images of a skin infection that are sent from a patient to a provider with a narrative of when it began and how it has progressed;
		  ○ The provider evaluates the images, provides a diagnosis, and prescribes a medication; or
		• A primary care provider submits a clinical question as a recorded voice memo along with the patient information through a secure platform to an endocrinologist for an evaluation and recommendations.
		  ○ The endocrinologist provides an asynchronous consultation to aid diagnosis and treatment by the primary care provider.	

Modality	Description	Uses	Limitations
Remote Patient Monitoring	Although Remote Patient Monitoring (RPM) could take many forms, it typically involves the deployment and use of technology to capture biometric information about the patient that is automatically shared with a remote provider. The provider can then review the data and determine the appropriate course of action. RPM typically involves the use of "peripheral devices" that are designed to capture patient biometric information such as weight, blood pressure, blood oxygen levels, etc.	In an outpatient setting, a patient with hypertension uses a web-enabled blood pressure cuff to take readings several times a day. This information is shared securely with a provider who regularly reviews readings and, as needed, follows up with the patient to support diet and other behavior changes to reduce blood pressure. Providers can oversee many patients simultaneously using remote patient monitoring technologies that help identify individuals who have readings that fall outside established parameters and therefore warrant follow-up.	Medicare and several states do not consider RPM a type of telehealth. As with asynchronous communications, RPM is not widely reimbursed across different Medicaid programs, or there may be billing rules that specify which providers are permitted to bill. In 2018, the American Medical Association added several CPT codes to facilitate billing for RPM, but these have not been widely adopted in Medicaid programs. Several states only allow remote patient monitoring under specific circumstances for: patients in home health settings; specific clinical conditions; certain provider types. Billing for RPM can be complex and may not cover the cost of RPM hardware. In State Medicaid programs that are more advanced in the use of value-based contracting with providers, there may be more leeway and/or incentive to cover remote monitoring technologies that help patients maintain a healthy lifestyle. Generally, RPM is only for established patients who are under the active care of a provider.

Appendix D: State Medicaid Telehealth Assessment/Action Plan

Introduction

Although telehealth services have been available in many states for decades, the recent PHE resulting from COVID-19 has accelerated the interest in this model of service delivery. CMS has actively supported states in expanding their use of telehealth in Medicaid for physical health services, behavioral health services, and long-term services and supports as well as in CHIP during this unprecedented PHE. Early in the PHE, CMS issued guidance to state policy makers related to state efforts to expand the use of telehealth services. See State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth. This new Assessment/Action Plan is intended as a supplement to the previous toolkit.

Background

States continue to have a great deal of flexibility with respect to covering Medicaid and CHIP services provided via telehealth. States have the option to determine whether (or not) to utilize telehealth; what types of services to cover; where in the state it can be utilized; how it is implemented; what types of practitioners or providers may deliver services via telehealth, as long as such practitioners or providers are enrolled in the Medicaid program and qualified according to federal and state statute and regulation; and how services delivered via telehealth are reimbursed. States have full discretion to select from a variety of Healthcare Common Procedure Coding System (HCPCS) / CPT codes and modifiers in order to identify, track and reimburse for these services.

States are not required to submit a SPA to pay for services delivered via telehealth if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting. States may submit a coverage SPA to describe services delivered via telehealth. A state would need an approved state plan payment methodology (and thus, might need to submit a SPA) to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face setting.

Medicare Telehealth Policy Implications

There is no requirement that State Medicaid and CHIP telehealth policies follow Medicare guidance. State Medicaid programs have the flexibility to decide their own telehealth policies keeping in mind the best interests of their Medicaid and CHIP beneficiaries. Concurrent with state Medicaid telehealth initiatives, Medicare has expanded access to telehealth services. Clinicians providing services to Medicare beneficiaries can now provide more services via telehealth, enabling more Medicare beneficiaries to readily access necessary care while maintaining physical distancing where appropriate. As states adjust their telehealth policies, it makes sense to take into consideration the telehealth policy changes Medicare and other payers have made during this PHE. There are advantages to states, their providers and beneficiaries in considering potential alignments across payers. It makes adherence easier for providers and beneficiaries when there can be some consistency across payers.

Use of Assessment/Action Plan

The following Assessment/Action Plan Template supplement outlines a list of potential policy areas to consider in addressing the appropriate use of telehealth for Medicaid and CHIP populations after the PHE expires. The list can be used to capture telehealth policies related to your Medicaid and/or CHIP program which were in place prior to the COVID-19 PHE and which policy changes were adopted during the COVID-19 PHE. As the PHE eases, the Assessment/Action Plan will also help focus and capture discussions of which telehealth policies can/should be continued in your state; which could be modified, better defined, or eliminated; and which should be given further consideration. These decisions will be affected by your experience with telehealth during the PHE and the feedback you have received from your stakeholders.

As it will be critical to update policies and communicate with MCPs, providers and beneficiaries in a timely manner to encourage adoption and reduce confusion moving forward, the Assessment/Action Plan provided below will also support Medicaid policy makers in facilitating discussions within the state Medicaid agency, with decision makers and with other stakeholders. It will also prompt states to consider what, if any, SPAs, legislative authorities or other external approvals may be needed to implement and promote adoption.

On the next page are two versions of the State Medicaid Telehealth Assessment/Action Plan template. (Please note that additional rows can be added to reflect state policies not specifically noted in the prepopulated list; likewise, items on the list can be removed if not considered relevant to state policy considerations):

1. **Blank Version:** The first template is a blank version configured for state telehealth policy and operations teams to use in summarizing your current and proposed plans related to telehealth. Note that this blank version not only provides space to capture descriptive information (See columns D through F), but also allows for the opportunity to capture specific decision points, dates and action items (see columns G through I). The Potential State Coverage Policies cited in the template on Column A are not exhaustive and states are encouraged to include any additional, relevant, and state-specific policies they consider to be appropriate to capture in the document or remove any policies that do not apply.

2. **Sample Version:** The second table includes policy-specific samples of how a state might complete each of the fields in the template depending on the telehealth policies in place in your state prior to COVID-19, during the PHE period, as well as how you plan to use telehealth in your Medicaid and CHIP programs going forward.

State Medicaid Telehealth Assessment/Action Plan

Blank Version

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states' own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed[6]	H. Affected Stakeholders[7]	I. Proposed Effective Date of Change
1.0	**General policies**	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	---	---	---	---	---	---	---	---
1.2	Established patient-provider relationship required prior to telehealth	---	---	---	---	---	---	---	---
1.3	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---
2.0	**State-level Originating/Distant Site Policies[8]**	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	---	---	---	---	---	---	---	---
2.2	Originating site permitted to be in an urban area	---	---	---	---	---	---	---	---
2.3	Originating site: any limitations	---	---	---	---	---	---	---	---

[6] Such as legislation, regulation, state Medicaid policy change, state plan amendment (SPA), system change, managed care organization (MCO) contract amendment
[7] Such as providers, beneficiaries, state licensing agencies, MCOs
[8] State-level policies will be listed here because originating and distant sites are not defined by federal policy or regulations.

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states' own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed[6]	H. Affected Stakeholders[7]	I. Proposed Effective Date of Change
2.4	Distant site: Clinicians permitted to provide care via telehealth while outside of the clinical setting	---	---	---	---	---	---	---	---
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	---	---	---	---	---	---	---	---
2.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---
3.0	**Payment, cost-sharing, & billing**	---	---	---	---	---	---	---	---
3.1	Payment parity for telehealth services	---	---	---	---	---	---	---	---
3.2	Originating site payments made to providers suspended	---	---	---	---	---	---	---	---
3.3	Beneficiary cost-sharing for all telehealth services suspended	---	---	---	---	---	---	---	---
3.4	Providers required to use a telehealth-specific 'place of service' code on all telehealth claims	---	---	---	---	---	---	---	---

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states' own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed[6]	H. Affected Stakeholders[7]	I. Proposed Effective Date of Change
3.5	Providers billing for telehealth services must use a telehealth-specific 'modifier' code on all telehealth claims	---	---	---	---	---	---	---	---
3.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---
4.1	Coverage parity for telehealth services relative to in-person services	---	---	---	---	---	---	---	---
4.2	Telehealth for Evaluation & Management services (standard office visits)	---	---	---	---	---	---	---	---
4.3	Emergency medical services	---	---	---	---	---	---	---	---
4.4	Telehealth for Gynecological Services	---	---	---	---	---	---	---	---
4.5	Telehealth for Pediatric services	---	---	---	---	---	---	---	---
4.6	Telehealth for Behavioral Health Services	---	---	---	---	---	---	---	---
4.7	Telehealth for Physical Therapy	---	---	---	---	---	---	---	---
4.8	Telehealth for Occupational Therapy	---	---	---	---	---	---	---	---

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states' own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed[6]	H. Affected Stakeholders[7]	I. Proposed Effective Date of Change
4.9	Telehealth for Speech Pathology	---	---	---	---	---	---	---	---
4.10	Telehealth for Home Health services	---	---	---	---	---	---	---	---
4.11	Telehealth for Hospice services	---	---	---	---	---	---	---	---
4.12	Telehealth for Personal Care and Home and Community-based Services[9]	---	---	---	---	---	---	---	---
4.13	Telehealth Visits for Medication Assisted Treatment (MAT)	---	---	---	---	---	---	---	---
4.14	Telehealth Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	---	---	---	---	---	---	---	---
4.15	*Add additional services to be evaluated*	---	---	---	---	---	---	---	---
5.0	**Eligible providers**	---	---	---	---	---	---	---	---
5.1	Primary care physicians	---	---	---	---	---	---	---	---

[9] States may add lines to this section if they wish to delineate specific home and community-based services in addition to personal care.

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states' own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed[6]	H. Affected Stakeholders[7]	I. Proposed Effective Date of Change
5.2	Behavioral Health service providers	---	---	---	---	---	---	---	---
5.3	Occupational therapists	---	---	---	---	---	---	---	---
5.4	Physical therapists	---	---	---	---	---	---	---	---
5.5	OBGYN	---	---	---	---	---	---	---	---
5.6	*Add additional providers to be evaluated*	---	---	---	---	---	---	---	---
6.0	**Modalities**	---	---	---	---	---	---	---	---
6.1	Audio-only visits	---	---	---	---	---	---	---	---
6.2	Audio-video visits	---	---	---	---	---	---	---	---
6.3	Virtual Check-ins (brief patient-provider two-way audio-video correspondence)	---	---	---	---	---	---	---	---
6.4	E-visits (online portal)	---	---	---	---	---	---	---	---
6.5	Store and Forward (emails of text)	---	---	---	---	---	---	---	---
6.6	E-consults (inter-professional consultations)	---	---	---	---	---	---	---	---
6.7	Remote Patient Monitoring	---	---	---	---	---	---	---	---
6.8	Direct-to-consumer telehealth provider contracted	---	---	---	---	---	---	---	---

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states' own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed[6]	H. Affected Stakeholders[7]	I. Proposed Effective Date of Change
6.9	*Add additional modalities to be evaluated*	---	---	---	---	---	---	---	---
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---
7.1	Licensure of clinicians: Permits out-of-state clinicians to practice in-state (physicians, nurses, social workers) via telehealth	---	---	---	---	---	---	---	---
7.2	Licensed professionals permitted to bill for telehealth visits	---	---	---	---	---	---	---	---
7.3	MCPs must incorporate all Medicaid FFS telehealth requirements	---	---	---	---	---	---	---	---
7.4	State Medicaid Telehealth Provider Training Provided	---	---	---	---	---	---	---	---
7.5	Telehealth Specific Fraud and Abuse Policies	---	---	---	---	---	---	---	---
7.5	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---

State Medicaid Telehealth Assessment/Action Plan

Sample Version

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed	H. Affected Stakeholders	I. Proposed Effective Date of Change
1.0	**General policies**	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	Yes	Yes	Regardless of category, services that allow for a temporary telehealth option require documented consent from the beneficiary agreeing to this as a service delivery option	10/23/20	Yes	Regulation, policy, SPA, Waiver Amendment, MCP agreement, provider agreements	All providers and beneficiaries; MCPs	Already Implemented
2.0	**Originating/Distant Site Policies**	---	---	---	---	---	---	---	---
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	No	Yes	Allow any site within the US or territories to be a distant site, including FQHCs & provider residences	10/23/20	Yes with modifications: Allow FQHCs & provider residences as distant sites; post-PHE, any distant site must be within the state	Legislation change, regulation, policy, SPA, systems, MCP agreement, provider agreements	Providers, beneficiaries, MCPs, legislature	Upon passage of legislation
3.0	**Payment, cost-sharing, & billing**	---	---	---	---	---	---	---	---
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---
4.2	Telehealth for Evaluation & Management services (standard office visits)	No	Yes	Allow telehealth for any clinically appropriate, medically necessary covered service	10/23/20	Yes	Regulation, policy, SPA, systems, MCP agreement, provider agreements	Providers, beneficiaries, MCPs, licensing board/ agency	10/23/20
5.0	**Eligible providers**	---	---	---	---	---	---	---	---

Ref #	A. Potential State Coverage Policies (List to be used as reference in documenting state policies; states own policies may vary)	B. Pre-COVID-19 Policy Yes/No	C. COVID-19 Temp Policy Yes/No	D. Description of Temporary Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable)	E. Date Temp Policy Expires	F. Continue COVID-19 Policy or Consider Modifying Policy (Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable) Yes, Yes with modifications - explain, No	G. Follow Up Action Needed	H. Affected Stakeholders	I. Proposed Effective Date of Change
5.5	OBGYN	No	Yes	OBGYNs may bill for telehealth in place of in-office visits. Specific to state plan physical health services	10/23/20	Yes	Regulation, policy, SPA, systems, MCP agreement, provider agreements	Providers, beneficiaries, MCPs, licensing board/ agency	Already implemented
6.0	**Modality**	---	---	---	---	---	---	---	---
6.2	Audio-video visits	Yes	Yes	Temporarily allow two-way audio only telehealth visits for all telehealth services	10/23/20	Yes: After PHE, allow audio-only telehealth for limited services	Regulation, policy, SPA, systems, MCP agreement, provider agreements	Providers, beneficiaries, MCPs, licensing board/ agency	10/23/20
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---

Appendix E: Comparison Tool – Fee-for-Service /Managed Care Telehealth Policies

State Medicaid and CHIP agencies seeking to track the variation in telehealth coverage across the Fee-For-Service (FFS) and managed care programs in their state may benefit from using a standardized evaluation tool which enables a clear simplified view of the coverage across these Medicaid/CHIP service delivery options. In the current environment, telehealth coverage is likely to include a complex array of permanent and temporary telehealth coverage policies that may differ across FFS and managed care. The matrix below offers a method for consolidating and evaluating this information.

The matrix below allows for a comparison of Medicaid/CHIP FFS telehealth policy with the telehealth policies of up to three MCPs[10] but can be modified or expanded depending on the number of MCPs to be considered. The matrix also provides space to capture descriptive information about FFS and MCPs' telehealth policies. It includes some completely blank rows in each of the policy sections to enable states to add telehealth policies to the matrix that are unique to their state; states can also remove policies that do not apply.

Following the matrix is also a brief example of how the matrix can be completed.

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
1.0	**General Policies**	---	---	---	---	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	---	---	---	---	---	---	---	---	---	---	---	---
1.2	Established patient-provider relationship required prior to telehealth	---	---	---	---	---	---	---	---	---	---	---	---
1.3	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---
2.0	**Originating/Distance Site Policies**[11]	---	---	---	---	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	---	---	---	---	---	---	---	---	---	---	---	---

[10] A managed care plan can be a Managed Care Organization (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plan (PAHP), as defined in 42 CFR 438.2.

[11] State-level policies will be listed here because originating and distant sites are not defied by federal policy or regulations.

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
2.2	Originating site permitted to be in an urban area	---	---	---	---	---	---	---	---	---	---	---	---
2.3	Originating site: any limitations	---	---	---	---	---	---	---	---	---	---	---	---
2.4	Distant site: Clinicians permitted to provide care via telehealth while outside of the clinical setting	---	---	---	---	---	---	---	---	---	---	---	---
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	---	---	---	---	---	---	---	---	---	---	---	---
2.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---
3.0	**Payment, Cost Sharing and Billing**	---	---	---	---	---	---	---	---	---	---	---	---
3.1	Payment parity for telehealth services	---	---	---	---	---	---	---	---	---	---	---	---
3.2	Originating site payments made to providers waived	---	---	---	---	---	---	---	---	---	---	---	---
3.3	Beneficiary cost-sharing for all telehealth services suspended	---	---	---	---	---	---	---	---	---	---	---	---
3.4	Providers required to use a telehealth-specific 'place of service' code on all telehealth claims	---	---	---	---	---	---	---	---	---	---	---	---
3.5	Providers billing for telehealth services must use a telehealth-specific 'modifier' code on all telehealth claims	---	---	---	---	---	---	---	---	---	---	---	---
3.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---	---	---	---	---
4.1	Coverage parity for telehealth services relative to in-person services	---	---	---	---	---	---	---	---	---	---	---	---
4.1	Telehealth for Evaluation & Management services (standard office visits)	---	---	---	---	---	---	---	---	---	---	---	---
4.3	Emergency medical services	---	---	---	---	---	---	---	---	---	---	---	---
4.4	Telehealth for Gynecological Services	---	---	---	---	---	---	---	---	---	---	---	---
4.5	Telehealth for Pediatric services	---	---	---	---	---	---	---	---	---	---	---	---
4.6	Telehealth for Behavioral Health Services	---	---	---	---	---	---	---	---	---	---	---	---
4.7	Telehealth for Physical Therapy	---	---	---	---	---	---	---	---	---	---	---	---
4.8	Telehealth for Occupational Therapy	---	---	---	---	---	---	---	---	---	---	---	---
4.9	Telehealth for Speech Pathology	---	---	---	---	---	---	---	---	---	---	---	---
4.10	Telehealth for Home Health services	---	---	---	---	---	---	---	---	---	---	---	---
4.11	Telehealth for Hospice services	---	---	---	---	---	---	---	---	---	---	---	---
4.12	Telehealth for Personal Care and Home and Community-based Services[12]	---	---	---	---	---	---	---	---	---	---	---	---

[12] States may add lines to this section if they wish to delineate specific home and community-based services in addition to personal care.

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
4.13	Telehealth Visits for Medication Assisted Treatment (MAT)	---	---	---	---	---	---	---	---	---	---	---	---
4.14	Telehealth Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	---	---	---	---	---	---	---	---	---	---	---	---
4.15	*Add additional services to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---
5.0	Eligible Providers	---	---	---	---	---	---	---	---	---	---	---	---
5.1	Primary care physicians	---	---	---	---	---	---	---	---	---	---	---	---
5.2	Behavioral Health service providers	---	---	---	---	---	---	---	---	---	---	---	---
5.3	Occupational therapists	---	---	---	---	---	---	---	---	---	---	---	---
5.4	Physical therapists	---	---	---	---	---	---	---	---	---	---	---	---
5.5	OBGYN	---	---	---	---	---	---	---	---	---	---	---	---
5.6	*Add additional providers to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---
6.0	**Modality of telehealth**	---	---	---	---	---	---	---	---	---	---	---	---
6.1	Audio-only visits	---	---	---	---	---	---	---	---	---	---	---	---
6.2	Audio-video visits	---	---	---	---	---	---	---	---	---	---	---	---
6.3	Virtual Check-ins (brief patient-provider two-way audio-video correspondence)	---	---	---	---	---	---	---	---	---	---	---	---
6.4	E-visits (online portal)	---	---	---	---	---	---	---	---	---	---	---	---
6.5	Store and Forward (emails of text)	---	---	---	---	---	---	---	---	---	---	---	---
6.6	E-consults (inter-professional consultations)	---	---	---	---	---	---	---	---	---	---	---	---

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
6.7	Remote Patient Monitoring	---	---	---	---	---	---	---	---	---	---	---	---
6.8	Direct-to-consumer telehealth provider contracted	---	---	---	---	---	---	---	---	---	---	---	---
6.9	*Add additional modalities to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---	---	---	---	---
7.1	Licensure of clinicians: Permits out-of-state clinicians to practice in-state (physicians, nurses, social workers) via telehealth	---	---	---	---	---	---	---	---	---	---	---	---
7.2	Licensed professionals permitted to bill for telehealth visits	---	---	---	---	---	---	---	---	---	---	---	---
7.3.	MCPs must incorporate all Medicaid FFS telehealth requirements	---	---	---	---	---	---	---	---	---	---	---	---
7.4	State Medicaid Telehealth Provider Training Provided	---	---	---	---	---	---	---	---	---	---	---	---
7.5	Telehealth Specific Fraud and Abuse Policies	---	---	---	---	---	---	---	---	---	---	---	---
7.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---	---	---

Sample: Some examples of how the matrix can be used

Cells within the matrix marked with a dash (-) indicate there is no applicable telehealth policy in place, while cells marked with an asterisk (*) indicate the applicable telehealth policy associated with the MCP is consistent with FFS.

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
1.0	**General Policies**	---	---	---	---	---	---	---	---	---	---	---	---
1.2	Established patient-provider relationship required prior to telehealth	---	Yes	Only behavioral health services	---	Yes	Applies to all types covered services	---	Yes	*	---	Yes	*
2.0	**Originating/Distance Site Policies**	---	---	---	---	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	---	Yes	Any Medicaid covered service	---	Yes	*	---	Yes	*	---	Yes	*
3.0	**Payment, Cost Sharing and Billing**	---	---	---	---	---	---	---	---	---	---	---	---
3.5	Providers billing for telehealth services must use a telehealth-specific 'modifier' code on all telehealth claims	Yes	Yes	Use claim modifier code = '95'	Yes	Yes	*	Yes	Yes	*	Yes	Yes	Use claim modifier code = 'GT'
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---	---	---	---	---
4.7	Telehealth for Physical Therapy	---	---	---	---	---	---	---	Yes	Any PT service	---	---	---
5.0	**Eligible Providers**	---	---	---	---	---	---	---	---	---	---	---	---
5.2	Behavioral Health service providers	---	Yes	Psychiatrists and psychologists	---	Yes	Adds LCSWs	---	Yes	*	---	Yes	Adds LCSWs, and LCADAC
6.0	**Modality of telehealth**	---	---	---	---	---	---	---	---	---	---	---	---
6.1	Audio-only visits	---	Yes	Behavioral health services only	---	Yes	Permitted for all services	---	Yes	Permitted for all services	---	Yes	*
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---	---	---	---	---

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	MCP 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
7.1	Licensure of clinicians: Permits out-of-state clinicians to practice in-state (physicians, nurses, social workers) via telehealth	---	Yes	Physicians and nurses	---	Yes	*	---	Yes	*	---	Yes	*

Complete Example

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	P 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
1.0	**General Policies**	---	---	---	---	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
1.2	Established patient-provider relationship required prior to telehealth	-	Yes	Applies only to behavioral health providers	-	Yes	Applies to all types covered services	-	Yes	*	-	Yes	*
2.0	**Originating/Distance Site Policies**	---	---	---	---	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	-	Yes	Any Medicaid covered service	-	Yes	*	-	Yes	*	-	Yes	*
2.2	Originating site permitted to be in an urban area	-	Yes	Any Medicaid covered service	-	Yes	*	-	Yes	*	-	Yes	*
2.3	Originating site: any limitations	-	Yes	Any Medicaid covered service	-	Yes	*	-	Yes	*	-	Yes	*
2.4	Distant site: Clinicians permitted to provide care via telehealth while outside of the clinical setting	-	Yes	Any Medicaid covered service	-	Yes	*	-	Yes	*	-	Yes	*
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	-	Yes	Any Medicaid covered service	-	Yes	*	-	Yes	*	-	Yes	*
3.0	**Payment, Cost Sharing and Billing**	---	---	---	---	---	---	---	---	---	---	---	---
3.1	Payment parity for telehealth services	-	Yes	-	-	Yes	*	-	-	Telehealth services reimbursed at 80% of in-person services	-	Yes	*
3.2	Originating site payments made to providers waived	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	P 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
3.3	Beneficiary cost-sharing for all telehealth services suspended	-	-	-	-	Yes	No cost sharing for telehealth behavioral health services	-	-	-	-	Yes	No cost-sharing for any telehealth services
3.4	Providers required to use a telehealth-specific 'place of service' code on all telehealth claims	Yes	Yes	Use place of service code = '02'	Yes	Yes	*	Yes	Yes	*	Yes	Yes	*
3.5	Providers billing for telehealth services must use a telehealth-specific 'modifier' code on all telehealth claims	Yes	Yes	Use claim modifier code = '95'	Yes	Yes	*	Yes	Yes	*	Yes	Yes	Use claim modifier code = 'GT'
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---	---	---	---	---
4.1	Coverage parity for telehealth services relative to in-person services	-	-	-	-	-	-	-	Yes	Any Medicaid covered service	-	-	-
4.2	Telehealth for Evaluation & Management services (standard office visits)	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
4.3	Emergency medical services	-	-	-	-	-	-	-	Yes	Any ED service	-	-	-
4.4	Telehealth for Gynecological Services	-	Yes	-	-	Yes	*	-	Yes	-	-	Yes	*
4.5	Telehealth for Pediatric services	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
4.6	Telehealth for Behavioral Health Services	-	-	-	-	-	-	-	Yes	*	-	-	-
4.7	Telehealth for Physical Therapy	-	-	-	-	-	-	-	Yes	Any PT service	-	-	-
4.8	Telehealth for Occupational Therapy	-	-	-	-	-	-	-	Yes	Any OT service	-	-	-
4.9	Telehealth for Speech Pathology	-	-	-	-	Yes	-	-	-	Any SP service	-	-	-

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	P 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
4.10	Telehealth for Home Health services	-	-	-	-	Yes	Any HH service	-	-	-	-	-	-
4.11	Telehealth for Hospice services	-	-	-	-	Yes	Any Hospice service	-	-	-	-	-	-
4.12	Telehealth for Personal Care and Home and Community-based Services[13]	-	Yes	-	-	Yes	Any Personal Care Services	-	Yes	-	-	Yes	-
4.13	Telehealth Visits for Medication Assisted Treatment (MAT)	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
4.14	Telehealth Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
4.15	Coverage parity for telehealth services relative to in-person services	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
5.0	**Eligible Providers**	---	---	---	---	---	---	---	---	---	---	---	---
5.1	Primary care physicians	-	Yes		-	Yes	*	-	Yes	*	-	Yes	*
5.2	Behavioral Health service providers	-	Yes	Psychiatrists and psychologists	-	Yes	Psychiatrists, psychologists, and LCSWs	-	Yes	*	-	Yes	Psychiatrists, psychologists, LCSWs, and LCADAC
5.3	Occupational therapists	-	-	-	-	-	-	-	-	-	-	-	-
5.4	Physical therapists	-	-	-	-	-	-	-	-	-	-	-	-
5.5	OBGYN	-	Yes	-	-	Yes	-	-	Yes	-	-	Yes	-

[13] States may add lines to this section if they wish to delineate specific home and community-based services in addition to personal care.

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	P 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
6.0	**Modality of telehealth**	---	---	---	---	---	---	---	---	---	---	---	---
6.1	Audio-only visits	-	Yes	Permitted for behavioral health services	-	Yes	Permitted for behavioral health services and evaluation and management services	-	Yes	Permitted for behavioral health services	-	Yes	Permitted for behavioral health services
6.2	Audio-video visits	Yes	Yes	Permitted for all Medicaid covered services	Yes	Yes	*	Yes	Yes	*	Yes	Yes	*
6.3	Virtual Check-ins (brief patient-provider two-way audio-video correspondence)	-	-	-	-	Yes	Evaluation and management services	-	-	-	-	-	-
6.4	E-visits (online portal)	-	-	-	-	Yes	Evaluation and management services	-	-	-	-	-	-
6.5	Store and Forward (emails of text)	-	-	-	Yes	Yes	Dermatology services	-	-	-	Yes	Yes	Dental services
6.6	E-consults (inter-professional consultations)	-	-	-	-	-	-	-	-	-	-	-	-
6.7	Remote Patient Monitoring	-	-	-	-	-	-	-	Yes	COVID-19 patients discharged from the hospital	-	Yes	Post-surgical cardiac rehab patients and patients with multiple chronic conditions
6.8	Direct-to-consumer telehealth provider contracted	-	-	-	Yes	-	Contracts with Telehealth firm to provide urgent care services	-	-	-	-	Yes	Contracts with Telehealth firm to provide

Ref #	Potential State Coverage Policies	FFS: Pre-COVID-19 Policy (Yes/No)	FFS: Temporary policy for COVID-19 (Yes/No)	FFS: Detail	MCP 1: Pre-COVID-19 Policy (Yes/No)	P 1: Temporary policy for COVID-19 (Yes/No)	MCP 1: Detail	MCP 2: Pre-COVID-19 Policy (Yes/No)	MCP 2: Temporary policy for COVID-19 (Yes/No)	MCP 2: Detail	MCP 3: Pre-COVID-19 Policy (Yes/No)	MCP 3: Temporary policy for COVID-19 (Yes/No)	MCP 3: Detail
													behavioral health services
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---	---	---	---	---
7.1	Licensure of clinicians: Permits out-of-state clinicians to practice in-state (physicians, nurses, social workers) via telehealth	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
7.2	Licensed professionals permitted to bill for telehealth visits	-	Yes	Physicians and nurses	-	Yes	*	-	Yes	*	-	Yes	*
7.3	MCPs must incorporate all Medicaid FFS telehealth requirements	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
7.4	State Medicaid Telehealth Provider Training Provided	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*
7.5	Telehealth Specific Fraud and Abuse Policies	-	Yes	-	-	Yes	*	-	Yes	*	-	Yes	*

Appendix F: State Medicaid Telehealth Communication Strategies

When making new changes to telehealth policy, processes, or procedures, states rely on communications, training, feedback and support as useful elements of a successful implementation. Each of these elements create a balanced bi-directional dialogue and a pathway to close information gaps to make providers and beneficiaries aware of state Medicaid and/or CHIP requirements. They allow collection of input from stakeholders to implement informed policy and program improvements on an ongoing basis. They also ensure MCPs, providers and beneficiaries may pose questions and find answers about services available via telehealth, how they can be rendered and reimbursed, and how they are accessed under individual state Medicaid/CHIP programs.

Amidst the COVID-19 PHE, these implementation tools have become critical in broadcasting the message that telehealth is a viable option for MCPs, providers and beneficiaries in place of in-office or in-person services. Providers who are able to deliver virtual services receive a clear message that this is a supported method of service delivery and beneficiaries are able to receive routine and non-routine care without interruption when these services are not available in person.

The next few pages will outline some successful strategies states may use to implement new or existing telehealth services. Communications, training, feedback and support will be the focus of these strategies illustrated through examples from state Medicaid programs that expanded use of telehealth services before or during the COVID-19 PHE. While these examples demonstrate how state Medicaid programs used expanded flexibility to quickly implement telehealth during the PHE, states may also want to consider how these strategies may be used to support more permanent telehealth policies and services.

Following these strategies, this Appendix recommends the type of information states may consider in communications and training to providers about the telehealth rules that apply to their specific clinical area or unique circumstances. This is critical to providers as they assess the needs of their patient population and make decisions about the extent to which to invest in telehealth infrastructure. The strategies and recommended information described are not all inclusive, nor is it suggested that states must utilize all of these options. States are encouraged to consider using the most appropriate approach based on their individualized implementation requirements.

Communications

As states develop or update requirements related to telehealth, it is helpful to consider the functions communications may serve. Communications efforts support:

- alerting MCPs, providers and beneficiaries of telehealth changes or updates,
- educating on the operational and billing requirements being implemented,
- garnering support for providers who are willing to adopt new methods of delivering care but also may need additional assistance, and
- providing a call to action when there are gaps telehealth may help to fill.

Communication is key to the successful implementation of programs and program changes, including those related to telehealth initiatives. During the PHE, many best practices related to

communication strategies are emerging to potentially support state efforts with the implementation of these program changes.

For instance, tailoring information to a subset of stakeholders such as those involved in a home and community-based services (HCBS) waiver program will allow states to create detailed training materials, billing guidance, and implementation instructions. These kinds of communications have allowed states to promote telehealth when providers of a certain type seem to have low telehealth adoption rates or have more questions due to the nature of their specialty. Targeted communications have also been used to provide specific information to beneficiaries who are more likely to have a gap in utilizing certain services, such as during a PHE. To reach all audiences, it is essential for the state to make materials available in alternative and Americans with Disabilities Act (ADA)-compliant formats and the materials must be translated in multiple languages. In extenuating circumstances, such as the onset of the PHE, additional consideration is needed for distributing information to those audiences when crisis-based timeframes may not allow for rapid development of alternative formats.

Timing, frequency of updates, level of detail, and communication vehicles all impact the implementation of telehealth policies. For instance, when making announcements, alerts, or reminders, states may choose to broadcast frequent messages to a wide audience of MCPs, providers and/or beneficiaries through multiple vehicles to ensure that information is reaching the intended audience. During a PHE, this is not always feasible. However, as states move beyond the PHE, there may be opportunities to utilize multiple vehicles to explain what components of telehealth may be implemented on a more permanent basis. States often alternate between summary level documents and more comprehensive multi-page guides and manuals. This varied method allows providers, for example, to consider how they will operationalize changes quickly, but also to understand more granular billing and services requirements as they make internal process changes.

Some states regularly leverage partnerships with other stakeholders, such as provider associations or advocacy organizations, to help promote new initiatives. This approach is particularly helpful when pushing information out quickly to many providers or broader populations. For instance, MCPs and associations (hospital and provider) may incorporate messages into their own newsletters, meetings, e-mail blasts/listservs, etc. These types of organizations will know how best to convey information to their providers and members. Engaging with these partners early on is a strategy states have used not only to extend the reach of communication but also to garner support from these organizations as all parties work toward a common goal, especially in the wake of a PHE. It also ensures that these organizations are using the same tone with the same clear and consistent messages. Additionally, while telehealth coverage may vary between MCPs, communications may be linked on the state website or in a resource document to direct providers to the appropriate policy reference material.

Deciding Which Information to Share

Amidst the PHE, providers have had to juggle day-to-day changes to direct service provision amidst a plethora of policy and procedural changes. It can be challenging to stay informed about the rules and guidance involving Medicaid telehealth for fee-for-service and waiver programs, and across Medicaid MCPs. Specifically, providers may grapple with locating and identifying

telehealth rules that apply to their specific clinical area or unique circumstances. The clarity of this information is critical for providers as they assess the needs of their patient population and make decisions about the extent to which to invest in telehealth infrastructure.

In recent months, providers have shared feedback with CMS and states about their experience with new or changing telehealth requirements. Most notably, providers have expressed that they have found it easier to search for and comprehend complex and rapidly changing telehealth policy when the information is organized by clinical area or provider specialty. Additionally, these communications are useful when they include information on:

- how telehealth policy has changed from the pre-COVID-19 period to the period of the PHE,
- the expiration date of temporary telehealth policies,
- the specific services providers are permitted to supply via telehealth (by description and billing code),
- the types of providers permitted to bill for specific services (e.g., physicians, nurse practitioners, physician assistants, psychologists),
- the rules for billing for telehealth services (e.g., CPT billing codes, modified codes, and place of service codes),
- the modality of telehealth that is permitted (e.g., audio-video, audio-only, store-and-forward, remote patient monitoring),
- any originating or distant site limitations that may apply,
- any geographic limitations that may apply (e.g., urban or rural or health professional shortage area), or
- plans to permanently incorporate telehealth flexibilities added during the PHE

Since the beginning of the PHE, state governments have made clear efforts to generate guidance and rules as quickly as possible to better serve their patients. During this time, guidance or rules on various topics have been packaged together to facilitate a faster release of the information. The packaging of this information has successfully streamlined the rulemaking process and disseminated information rapidly but may also slow the ability of providers to gather and digest new guidance and rules. In more recent months, state governments have enhanced their efforts to convey and communicate information to providers about telehealth coverage and may refine this process in considering telehealth applications beyond the PHE.

As states collect the information needed, or already shared with providers, beneficiaries and stakeholders, it can be helpful to create an inventory to ascertain where there are opportunities for enhancement in both developing and communicating changes. The table below provides a potential template that states may use to collect and record this information. This table is not all-inclusive; rather, it is provided as a reference document. States may adapt this list by adding, changing, or removing items as appropriate for their state-specific implementation and communications plans. Following the blank version of the template table are a few completed illustrative example rows (see sample version) to provide insight into how a state may use this table.

Blank Version

Clinical Service	Description of new rule	Source (regulation or guidance)	Expiration date of policy	Provider Type/Specialty	Billing Codes/Ranges	Geographic Limits	Billing Changes	Other
Evaluation and management services	---	---	---	---	---	---	---	---
Emergency medical services	---	---	---	---	---	---	---	---
Gynecological services	---	---	---	---	---	---	---	---
Pediatric	---	---	---	---	---	---	---	---
Behavioral health	---	---	---	---	---	---	---	---
Physical therapy	---	---	---	---	---	---	---	---
Occupational therapy	---	---	---	---	---	---	---	---
Speech pathology	---	---	---	---	---	---	---	---
Home health	---	---	---	---	---	---	---	---
Hospice services	---	---	---	---	---	---	---	---
Personal Care and Home and Community-based Services	---	---	---	---	---	---	---	---
Medication Assisted Treatment	---	---	---	---	---	---	---	---
Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	---	---	---	---	---	---	---	---
Add additional rows as needed	---	---	---	---	---	---	---	---

Sample Version

Clinical Service	Description of new rule	Source (regulation or guidance)	Expiration date of policy	Provider Type/Specialty	Billing Codes/Ranges	Geographic Limits	Billing Changes	Other
Behavioral health	Licensed Clinical Social Worker (LCSW) added to the list of eligible providers	www.state.gov/telehealth	10/23/2020	Psychiatrics, LCSWs, psychiatrists	List all billing codes	Urban and rural	Place of service = 02 Modifier = 95	Audio-only and audio-video permitted
Home and Community-based services	Permits certain aspects of services to be conducted via telehealth	www.state.gov/telehealth	10/23/2020	Any type of home and community-based provider	List all billing codes	Urban and rural	Place of service = 02 Modifier = 95	Audio-video only
Emergency medical services	Nurse practitioners added to the list of eligible providers	www.state.gov/telehealth	10/23/2020	Physicians and nurse practitioners	List all billing codes	Urban and rural	Place of service = 02 Modifier = 95	Audio-video permitted

Additionally, the list below also describes the vehicles some state Medicaid programs may utilize to communicate to MCPs, providers and beneficiaries. This list includes the potential utility these vehicles have in disseminating information about telehealth through implemented state Medicaid examples in practice from an array of states. This list is not all-inclusive. Many states employ a combination of these vehicles to disseminate information tailored to the purpose of the message they want to convey, their audience, and the urgency of the broadcast.

- **Websites**: Many states have developed highly organized websites that summarize information about telehealth rule changes by clinical specialty or provider type. Organizing website information in this way reduces the amount of time providers spend searching for information and sorting through policy details that may or may not apply to them. For example,
  - The Missouri Department of Social Services has developed a web page which lists all COVID-19 and non-COVID-19 policy updates by subject: https://dss.mo.gov/mhd/providers/pages/provtips.htm, Accessed August 13, 2020
  - MassHealth in Massachusetts has developed a web page which lists COVID-19 related policy updates by provider type: https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers, Accessed August 13, 2020

- Georgia's dedicated COVID-19 website for providers includes up to date information about telehealth, such as guidance that the agency has issued, announcements for training webinars specific to telehealth, and a Feedback Form to collect provider and member telehealth experiences and satisfaction: Georgia Medicaid/COVID-19, Accessed September 22, 2020. Beginning April 9th, Georgia held webinars for providers that covered policy changes in the areas of originating site, distance site, provider types allowed to deliver services through telehealth, and billing requirements. A recorded webinar is available on Georgia's Medicaid Management Information System in *COVID-19 Reference Materials:* COVID-19 Reference Materials, Accessed September 22, 2020.

- **Written guidance, memorandums, or fact sheets**: Many states have posted written guidance or memorandums to their Medicaid websites summarizing new telehealth policies by clinical area or provider specialty. This method is a helpful supplement when posting a regulation or executive order enacting new telehealth policies, because the regulations and orders are written in a legal or regulatory style that can be difficult to interpret. In addition, by organizing the information by clinical area or specialty, providers can more rapidly access the information that pertains to their practice. For example,
  - The Louisiana Department of Health releases provider-specific memorandums detailing policy changes as they occur, such as the following for mental health providers: http://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-4.pdf, Accessed August 13, 2020.
  - The Colorado Department of Health Care Policy and Finance releases provider-specific guidance clarifying current telehealth policy and current billing rules, such as the following for dental providers: https://www.colorado.gov/pacific/sites/default/files/COVID-19%20Guidance%20for%20Dental%20Providers%203-23-2020.pdf, Accessed August 13, 2020.
  - While not targeted to providers, in response to the COVID-19 pandemic, the Washington Health Care Authority published telehealth guidance for Apple Health (Medicaid) beneficiaries: https://www.hca.wa.gov/assets/free-or-low-cost/telehealth-guidance-apple-health-clients.pdf, Accessed August 13, 2020. This one-page document includes information about how to request telehealth services, PHI privacy concerns, coverage, and interpreter availability. The document is also available in 36 languages.

- **Frequently Asked Questions**: Many states have posted lists of Frequently Asked Questions (FAQs) to their websites describing the common questions providers ask about the new telehealth policies and their implementation. These FAQs are most effective when they are tailored to specific clinical areas (e.g., behavioral health services or home health) or provider specialties (e.g., family medicine or speech pathologists). The FAQs often provide insight into providers' common concerns, implementation problems, and billing issues. For example,

- The Iowa Department of Human Services includes on its web page an FAQ which details COVID-19-related telehealth policy changes, their expiration date, permitted modality, and key rules for provider types such as physical therapists: https://dhs.iowa.gov/ime/providers/faqs/covid19/telehealth, Accessed August 13, 2020.
- The Washington State Health Care Authority includes on its web site an FAQ document that details the COVID-19-related telehealth policy changes for behavioral health providers: https://www.hca.wa.gov/assets/billers-and-providers/behavioral-health-policy-and-billing-COVID-19.pdf, Accessed August 13, 2020.
- Medi-Cal's Telehealth FAQs (https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx, Accessed August 13, 2020) includes a link that directs providers to the California Telehealth Resource Center (CTRC), a robust website dedicated to providing support to providers who implement and sustain telehealth programs. The website includes information across payers in one place, including Medicaid. Supports include: program needs assessment for implementation or expansion, equipment selection, telehealth presenter training, contracting with specialists, and billing, and credentialing information. In addition, the CTRC also produces a Telehealth Program Developer Kit, a step-by-step guide to help providers develop a telehealth program. The CTRC also provides toolkits, trainings and policy updates specific to using telehealth to address the COVID-19 PHE: https://www.caltrc.org/, Accessed August 13, 2020.
- New York's Medicaid Agency compiled information detailing COVID-19 telehealth changes in an FAQ document: https://www.health.ny.gov/health_care/medicaid/covid19/docs/faqs.pdf, Accessed August 13, 2020. It lists services, applicable provider types, modifiers, POS codes, notes, and more. The table of contents allows providers to easily click on topics to be directed to information applicable to specific provider types or services. The Medicaid guidance also includes links to guidance by the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), the Office of Children and Family Services (OCFS), and the Office of Addiction Services and Supports (OASAS) on Medicaid payment policy for Medicaid members being served under their authorities, so providers can click on the link rather than researching separately.

- **Webinars:** Some states have conducted live webinars or stakeholder telephone calls to educate providers about the various telehealth policy changes. While many of these events are live and enable providers to ask questions of state officials in real time, states conducting these events also often maintain recorded versions of these events on their websites for providers to download and digest as they have time. In addition, some states also choose to maintain the slide-decks of these events on their websites and edit them as policy changes. For example,
  - The New York Department of Health includes on its website both a webinar and a slide deck intended to communicate new COVID-19 telehealth policies to providers in New York State. The webinar is saved through www.YouTube.com: https://health.ny.gov/health_care/medicaid/covid19/index.htm, Accessed August 13, 2020.

- The Washington State Health Care Authority includes on its website an announcement to a webinar aimed at communicating to behavioral health providers changes to telehealth policy resulting from the COVID-19 pandemic: https://www.hca.wa.gov/webinar-use-telehealth-behavioral-health-and-recovery-services-response-covid-19, Accessed August 13, 2020.
- The Oregon Health Authority includes on its website a link to a webinar they conducted early in the COVID-19 pandemic to communicate telehealth policy changes to providers: https://www.youtube.com/watch?v=h3A7IeTidso&feature=youtu.be, Accessed August 13, 2020.
- Florida's Medicaid Agency for Health Care Administration (AHCA) leveraged email blasts (Florida Medicaid Health Care Alerts) to alert ambulatory providers of a free 10-week telemedicine training through a partnership between the U.S. Department of Health and Human Services, the ECHO Institute at the University of New Mexico, and the Public Health Foundation's TRAIN Learning Network. The "Telemedicine Hack", a virtual, peer-to-peer learning community is offering five teleECHO sessions; five virtual "office hour" discussion panels; and inter-session peer-to-peer learning facilitated via virtual discussion boards to support wide adoption of telemedicine, from July 22–September 23, 2020. https://echo.zoom.us/webinar/register/WN_c3mWhTm8Q5K3XHDv0zyHuQ, Accessed August 13, 2020.

- **Stakeholder telephone calls, email announcements, or direct mail:** For provider audiences without robust access to online services (e.g., broadband services), state Medicaid agencies may consider conducting telephone-based stakeholder conference calls to disseminate information. In addition, to reach these provider audiences, states may consider conducting targeted communications by emailing new telehealth policy guidance to them directly. For example,
  - The Wisconsin Department of Health Services conducts periodic stakeholder conference calls for providers to discuss policy changes related to COVID-19 pandemic: https://www.dhs.wisconsin.gov/dms/policycalls/covid-19.htm, Accessed August 13, 2020.
  - The California Department of Health Care Services implemented a system for electronically notifying providers of ongoing changes to telehealth policy changes. Providers must sign up for these announcements: https://www.dhcs.ca.gov/Pages/DHCSListServ.aspx, Accessed August 13, 2020.

- **Matrixes:** Some states post simplistic matrixes to their websites that clearly summarize new telehealth policies by clinical area or provider specialty. For example,
  - The Wisconsin's Medicaid program incorporates a matrix on their website for providers: https://www.forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_resources.html.spage, Accessed August 13, 2020.

In essence, providers need to know what they are expected and able to do, when they may do so, as well as the parameters under which they are able to deliver and receive compensation for

services appropriately. Resources such as those above, may help to provide that information. Providers will also have questions they want to ask, and feedback to contribute as states move from telehealth implementations during the PHE to more permanent changes. As states are aware, these exchanges add value and help to inform future messaging, as well as keep the dialogue open and continuous.

Provider Training

Virtual provider training is especially helpful when it is comprehensive and easily accessible. Many states ensure providers have adequate training opportunities by offering variable date and time options and allowing for multiple presentations of the same training to eliminate any impediments to service delivery. During the PHE, training for providers may be limited or general. Longer term, states may have more latitude to provide general training for all providers, as well as targeted training for individual provider types on an ongoing basis so providers have up-to-date information. This includes training for providers who have not been exposed to telehealth before, as well as experienced providers who need to be made aware of policy or reimbursement changes. States may consider multiple vehicles to advertise training, as well as engaging provider association and MCP partners in sharing information about the training or hosting training. States may also consider recording webinars and publishing them on websites with other training materials as a reference for providers.

Training is also an opportunity for providers to ask questions or seek clarification and allows them to provide feedback about telehealth services, implementation considerations, or even the training itself. It also is an opportunity to outline the ongoing support and resources available for providers and their patients.

Beneficiary Training

Many beneficiaries may not have participated in or initiated a telehealth provider visit prior to the COVID-19 PHE. In order for telehealth to be an effective tool in reducing gaps in services and maintaining social distancing, beneficiaries may need help understanding the telehealth options available to them, and using the technology required to conduct a telehealth visit. States may consider offering training opportunities to beneficiaries on a regular basis in order to keep beneficiaries apprised of evolving coverage policies. Training can be offered informally, such as through an update during public meetings (e.g., stakeholder telephone conference calls or virtual meetings), or more formally through virtual webinars or training videos posted on a website. These training offerings provide a platform to explain what types of visits or interactions are covered and may be accessed through telehealth. The trainings may also provide information about what technologies beneficiaries must possess in order to participate in a telehealth visit. Similar to trainings aimed at providers, beneficiary trainings may include information about the ongoing resources available to beneficiaries to support their use of telehealth, as well as information explaining the process for submitting questions.

Feedback

Feedback is an important part of evaluating the successful delivery of a service through telehealth and offers information that will ultimately improve the effectiveness of telehealth in supporting the service-related needs of beneficiaries. Under normal circumstances, vehicles such as a Request for Information (RFI), formal inquiry, or public comment in response to a posted

bulletin or paper are often used when states seek feedback on a specific topic. However, during a PHE where rapid deployment of flexible service options is essential, the normal channels of feedback collection may not work. Under these circumstances, states may collect feedback on telehealth changes or flexibilities through the documentation of day-to-day interactions and public discussions that may be valuable in making observations about telehealth implementations. The feedback loop often reveals opportunities for enhancements in providing support to providers and beneficiaries using or considering telehealth and may help facilitate a smoother and well-supported implementation.

When feedback needs to be disseminated or operationalized quickly, this can be accomplished in something as simple as publishing an FAQ document, forming a focus group or committee, or incorporating topics into a meeting agenda. While not all feedback will result in immediate changes to the delivery of the service or to support improvement, it is still extremely valuable to understand how telehealth as a service delivery option is being perceived by stakeholders as a tool for continuous improvement.

Provider Support

Technical support to providers may take many forms. Some states provide support internally, but in situations like the current PHE, other states have relied on contracted vendors to help train providers and troubleshoot billing and technical questions related to delivering telehealth services. Some states may designate a help desk; others might train or utilize existing provider services staff who support multiple provider service needs. Solutions may cover on-call responses or utilize a dedicated or existing email address for troubleshooting and addressing issues and concerns. Documentation itself may serve as support in supplying links to helpful resources such as the Health Resources and Services Administration (HRSA), where FQHCs may access information about grant opportunities and resource centers, or state licensing boards who may have additional requirements for specific provider types, as well as technical help desks for technology vendors whose platforms are being used by providers to deliver services. It is imperative that whatever the mode of support, the pathway is apparent and known to providers. States may want to consider their provider environment and whether most providers are familiar with telehealth modalities. Timeliness of the response could present a barrier to telehealth adoption and service delivery.

States may want to consider establishing a coordinated support process and system for providers under both Fee-for-Service and managed care. This may include engaging provider associations and MCPs in unified messaging. Regardless, states may collect and summarize information about the implementation of telehealth and ensure MCPs and provider associations are broadcasting messages and providing support to providers to help defray confusion and barriers in rendering or receiving services. States may also want to consider how they will also support inquiries from beneficiaries through the vehicles they have available to them, such as hotlines, e-mail boxes, or FAQs.

Summary of Strategies for Communications, Training, Feedback and Support

State Medicaid programs have implemented several different strategies for communicating information about new telehealth policies. Programs have developed websites, disseminated written guidance and memorandums, developed FAQ documents, conducted webinars, training and stakeholder calls, published matrixes, and for providers without robust access to online

services, have conducted outreach to providers via telephone and direct mail. States may consider some of these examples, seek feedback from providers, beneficiaries and other stakeholders and further enhance these communications and training materials. States are encouraged to draw on their experience, and the experience of other states, as they move beyond the PHE and utilize telehealth to deliver services in the future.

Appendix G: COVID-19 State Telehealth Experience Profiles

Introduction

The COVID-19 PHE has accelerated adoption of telehealth throughout the healthcare system, including behavioral health (BH) and long-term services and supports (LTSS). Through increased flexibilities, CMS has actively supported states in expanding their use of telehealth in Medicaid and CHIP. Early in the PHE, CMS issued guidance to state policy makers related to state efforts to expand the use of telehealth services. CMS is now examining the rapid changes and flexibilities that were implemented due to the PHE and how this experience may impact telehealth in Medicaid in the future. As a part of this work, five states with notable telehealth developments were interviewed. Cross-state trends in responses and unique state highlights are described below.

Cross-State Response Trends

Telehealth Policy Changes

While there was variability among the five states in telehealth policy prior to the PHE, state Medicaid agencies, providers, and beneficiaries all embraced telehealth in the face of COVID-19. In all cases, implementation was swift and expansive, using flexibilities to ensure that barriers to care were removed and beneficiary and provider safety was prioritized.

Even in states with progressive coverage policies, pre-COVID-19 telehealth utilization was not high. States reported a sharp increase in utilization in response to the PHE with all states reporting high satisfaction with the resulting services. Some remarked that skepticism surrounding certain telehealth modalities (such as audio-only) or use with certain provider types were assuaged as they saw them in practice. Suspension of HIPAA enforcement by the Office of Civil Rights (OCR) and the Office of the National Coordinator for Health Information Technology (ONC) was cited as a key factor by many in the success of telehealth.

State-reported benefits of telehealth included:

- Reduced no-show rates;
- Decrease in non-emergency transportation costs;
- Ability to engage populations that were historically difficult to bring into care; and
- Greater access for beneficiaries with limitations on time off from work or childcare concerns to attend appointments.

States and providers were aligned in their desire to quickly implement. For states, the push was ensuring that beneficiaries retained access to services. For providers, transitioning to telehealth was no longer optional to sustain a revenue stream during the PHE. This was particularly true for providers whose primary source of funding is Medicaid, such as Home and Community-Based Services (HCBS) providers. This led to creativity in implementation strategies as well as a partnership with the state in determining which services could be effectively delivered via telehealth and how.

In many instances, states looked to providers to define what services could be effectively delivered. For example, one state reported variability in implementation of telehealth with Obstetrics providers. Some issued blood pressure cuffs and scales to patients and conducted

prenatal visits by telehealth. Others continued office-based visits with enhanced infection control processes.

Communication Strategies

All states interviewed communicated PHE telehealth policy changes using their typical communication channels, which often included provider notifications and email/fax blasts. These methods were enhanced by dedicated webpages with PHE-specific content and Frequently Asked Questions (FAQ) documents. Most states conducted a series of webinars to present the policy changes, and some held a series of regular provider calls to answer questions and hear of concerns and successes. Clarifying policy and reassuring providers who were apprehensive that the relaxed regulations (e.g. verbal consent, audio-only calls permitted, etc.) would not be honored were primary reasons for strategies that allowed for dialog between providers and the state.

A close partnership with provider associations and beneficiary advocates was highlighted as an important component of both communicating policy changes and learning about and quickly finding solutions to concerns. Although several states had beneficiary focused strategies, all emphasized the primary role of beneficiary communication through providers.

Several states noted that the volume and detail of changes were difficult for providers to manage early on. The use of plain language, and clear communications that were succinct and dated was identified as an important lesson learned.

Innovations

Audio-only visits were repeatedly identified as one of the most important factors of telehealth success during the PHE. Telephone visits work for beneficiaries in rural and frontier areas with limited broadband access necessary for audio-visual communication. Moreover, telephone visits are accessible to a greater number of low-income beneficiaries who cannot afford a data plan or device such as a smartphone or tablet. One state in particular shared the excitement expressed by behavioral health providers who have been able to readily engage some consumers who did not previously come into offices for care.

Implementation of telehealth with HCBS providers was important to states to promote service continuity while maximizing safety. They examined specific service components to determine which would effectively be provided via telehealth. Remote coaching for Activities of Daily Living and virtual assessments and care plan development were common provisions implemented. Many states are considering retaining some of the changes, most notably the ability to virtually conduct assessments.

Considerations for Overcoming Barriers

All states identified use in rural areas as a consideration necessary to address for telehealth success. While rural areas have the greatest potential benefit from maximizing telehealth use, both in the PHE and in normal operations, they also have the most challenges to implementation. Many states indicated that they are actively working to increase broadband access in rural communities.

Alignment across Medicaid payers was identified as an important success factor. States with significant managed care operations discussed the need to maximize consistency between FFS and managed care policies and procedures, as well as between managed care plans. Beyond Medicaid, several states noted that differences in coverage as well as billing processes with Medicare and commercial insurers was a deterrent for adoption, particularly among smaller rural providers. These concerns were further compounded when providers believed the changes to be temporary, furthering their belief that it was not worth the effort to implement.

States were asked about the impact of telehealth on their value-based purchasing (VBP) strategies. Three states expressed optimism that telehealth would eventually positively contribute, either through increased utilization or by encouraging providers to transition to a higher Alternative Payment Methodology that better allows for creative approaches to service delivery. In the near term, however, impacts to quality reporting due to service utilization decreases or measures that require in-person visits, are impacting current VBP programs.

Use of telehealth in certain populations was raised in several interviews. One state noted challenges with providing services to individuals with Intellectual/Developmental Disabilities. Others identified the older adult population as notable, although with differing reports. One experienced low uptake with older adults in rural communities who were technology adverse, while another state was surprised to learn of the enthusiasm with which older adults embraced telehealth, particularly the availability of the telephone only option.

Plans Post-Public Health Emergency

Although in various levels of commitment, all states viewed telehealth positively and were considering extending some or all of the flexibilities adopted during the PHE. The audio-only modality was the most cited flexibility under consideration, with discussion of the use of telehealth with previously unused providers and services, such as HCBS, also under consideration.

States are recognizing the need to more closely examine the effectiveness of these services delivered via telehealth. While any service was preferable to no service during the PHE, that approach does not hold true for normal operations going forward. Consideration of quality, adherence to community standards, and fraud, waste, and abuse potential were all mentioned as aspects to consider. How to address services that require hands on components, such as immunizations and recording of height and weight as part of well-child visits were noted as important considerations to address. Also identified were concerns about confidentiality, particularly with behavioral health services delivered in the home with other family members nearby, and written consent that was typically obtained during an initial in-person visit.

With the speed upon which changes were implemented, several states are now taking care to more carefully address policies and gaps. For example, one state noted that they did not have coding modifiers in place to indicate a service was rendered via telehealth, limiting their ability to track telehealth in their own data systems and T-MSIS. Others recognized the need to coordinate with licensing agencies when considering long-term changes.

Several states noted that changing the policy that prohibits use of Medicaid funding for purchase of devices would facilitate telehealth access as a desired change at the Federal level. One state also noted a desire for consideration of telehealth as an integral part of a broader move to Hospital at Home approaches to care.

State Profiles
Colorado

Telehealth Feature	Pre-PHE	PHE	Notable Findings
Payment Parity	✓	✓	

Beneficiary Home Permitted	✓	✓	• Colorado offered a robust telehealth coverage policy prior to the PHE, including parity, allowance of service in the beneficiary's home, and delivery by a wide variety of providers. • Colorado approached changes in three streams: o Changes to the FFS benefit o HCBS for persons with disabilities o Behavioral health services provided by capitated entities. • A wide array of HCBS services were identified as appropriate for telehealth in the PHE and included services such as: Home Modification and Adaptations, Peer Mentorship, Substance Use Counseling, Supported Employment, and Vehicle Modification. • Use of telehealth with BH services such as Day Treatment and Assertive Community Treatment for behavioral health, have been successful. • Multi-site FQHCs were advantaged in transitioning to telehealth due to their administrative infrastructure. • Telehealth use among Indian Health Services providers was low, as was the case with Rural Health Clinics. The IHS benefits manager is providing proactive outreach to IHS providers to determine why telehealth adoption has been low. • Live chat is available as a telehealth modality.
All Providers within Scope of License	-	-	
All Services that can be Effectively Delivered	-	✓	
FQHC/RHC Encounter Billing	-	✓	
Out-of-State Providers Allowed	-	-	
Audio-Only Permitted	-	✓	
Remote Patient Monitoring	✓	✓	
Store and Forward	-	-	
Committed to Extending Post-PHE	✓	✓	

Idaho

Telehealth Feature	Pre-PHE	PHE	Notable Findings
Payment Parity	✓	✓	• Idaho Medicaid has been a leader in payment parity for telehealth and had enacted comprehensive coverage policy prior to the PHE, working closely with the behavioral health and dental carve-out vendors to align approaches. • The state, not specific to Medicaid, has established a Telehealth Task Force. It is a 12-member body that meets monthly. Twenty-six subject
Beneficiary Home Permitted	✓	✓	
All Providers within Scope of License	-	✓	

All Services that can be Effectively Delivered	✓	✓	matter experts are preparing recommendations for the Healthcare Innovations Council. • The Medicaid agency worked closely with the Medical Care Advisory Committee and provider associations to communicate changes. A sister agency had dedicated focus on supporting telehealth with critical access hospitals and rural health clinics. • Providers are often the primary source to communicate telehealth availability to beneficiaries. • St. Luke's Health System reported a 58% reduction in emergency department utilization, an 80% reduction in acute hospitalizations, and reduced readmissions with implementation of Remote Patient Monitoring pre-PHE. • The Governor created an office in the Department of Commerce to address broadband connectivity statewide. • The state of Idaho is conducting an evaluation of telehealth needs through an independent consultant. The project includes an environmental scan, stakeholder focus groups, and key informant interviews.
FQHC/RHC Encounter Billing	✓	✓	
Out-of-State Providers Allowed	✓	✓	
Audio-Only Permitted	-	✓	
Remote Patient Monitoring	-	-	
Store and Forward	-	-	
Committed to Extending Post-PHE	✓	✓	

Maine

Telehealth Feature	Pre-PHE	PHE	Notable Findings
Payment Parity	✓	✓	• Maine had a comprehensive telehealth coverage policy prior to the PHE, but utilization was not high. That changed significantly with the PHE, almost overnight.
Beneficiary Home Permitted	-	✓	

All Providers within Scope of License	✓	✓	• There were initial concerns about the use of certain platforms due to security concerns, but those have since resolved. • Maine added a specific code for FQHCs to bill (G0071), which is a five minute checkin visit. • MaineCare added codes to enable dental practices to bill for traige and screening services conducted via telehealth, and is looking to address, at the service code level, which other dental services are billable through telehealth in accordance to the Board of Dental Practice. MaineCare is working with other state partners to update related statutes to allow these and other changes. • Maine made heavy use of its Medicaid Advisory Committee and provider associations as effective communication strategies, as well as its relationship with the Northeast Telehealth Resource Center. • To address beneficiary engagement, Maine contracted with an advertising agency for a comprehenisve campaign that included a dedicated webpage, television and social media/digital advertisements, and direct mailings, emphasizing the availability of the telephone only option. • The Medicaid agency participated in weekly Town Hall meetings hosted by the Office of Behavioral Health and Office of Child and Family Services to support behavioral health providers with telehealth implementation. • MaineCare is considering seeking the necessary authorites to extend the allowance for take-home doses of Medication Assisted Treatment (MAT).
All Services that can be Effectively Delivered	✓	✓	
FQHC/RHC Encounter Billing	-	✓	
Out-of-State Providers Allowed	-	✓	
Audio-Only Permitted	-	✓	
Remote Patient Monitoring	✓	✓	
Store and Forward	-	✓	
Committed to Extending Post-PHE	-	✓	

Massachusetts

Telehealth Feature	Pre-PHE	PHE	Notable Findings
Payment Parity	-	✓	• Prior to the PHE, Medicaid coverage of telehealth was limited to BH and Substance Use Disorder treatment, which began in March 2019. However, the Medicaid agency was in the process of finalizing a comprehensive telehealth strategy when the PHE was declared, that was founded on principles of equity in access and high-quality care. The PHE was a vehicle to implement many of the planned policies, which will continue after the PHE ends.
Beneficiary Home Permitted	-	✓	
All Providers within Scope of License	-	✓	

All Services that can be Effectively Delivered	-	✓	• Massachusetts created an innovative approach to connecting residents to services, an approach that goes beyond, but is inclusive of, Medicaid. Called Buoy, this online symptom tracker allows users to check symptoms for possible COVID-19 infection. To support safe care, Buoy connects the user to telehealth providers, which may include a contracted telehealth vendor, if care is indicated. Called Telehealth Network Providers, three vendors are available to care for users who do not have a regular source of care. • Telehealth availability was communicated to residents, which include Medicaid beneficiaries, through an opt-in statewide texting system. Medicaid also sent information as mailer inserts to beneficiaries. • Massachusetts created a Remote Patient Monitoring (RPM) program specific to COVID-19. For those being discharged from an inpatient unit and those who have tested positive with a high risk of hospitalization, 7 days of RPM is authorized, which may be reauthorized. Tools include, minimally, a pulse oximeter and thermometer but may include other tools as indicator. Providers assess data and symptoms daily. Expansion to beneficiaries with chronic conditions is under consideration.
FQHC/RHC Encounter Billing	-	✓	
Out-of-State Providers Allowed	-	✓	
Audio-Only Permitted	-	✓	
Remote Patient Monitoring	-	✓	
Store and Forward	-	-	
Committed to Extending Post-PHE	✓	✓	

Wisconsin

Telehealth Feature	Pre-PHE	PHE	Notable Findings
Payment Parity	✓	✓	• Wisconsin passed comprehensive telehealth legislation just prior to the PHE, which included asynchronous modalities and Remote Patient Monitoring. The PHE became the vehicle to implement provisions quickly. • Focused implementation assistance was provided to behavioral health and long-term care providers.
Beneficiary Home Permitted	✓	✓	
All Providers within Scope of License	-	✓	

All Services that can be Effectively Delivered	-	✓	• Markedly positive results are noted with behavioral health use of telehealth, including reduced no-shows and better therapy outcomes, particularly among young people. • Continued allowance of out-of-state providers could be a key strategy to addressing critical provider shortages long-term. • Created telephonic check ins for beneficiaries receiving MAT with multi-day dosing. • The Medicaid agency is working closely with the State Mental Health Authority to identify and address regulatory barriers that would allow telehealth using SAMHSA funding. • Some HCBS providers struggled with revenue loss, even with the opportunity to provide telehealth services. Several managed care organizations supported them with retainer payments out of their margin.
FQHC/RHC Encounter Billing	-	✓	
Out-of-State Providers Allowed	✓	✓	
Audio-Only Permitted	-	✓	
Remote Patient Monitoring	✓	✓	
Store and Forward	✓	✓	
Committed to Extending Post-PHE	✓	✓	