



## States Reported Multiple Challenges With Using Telehealth To Provide Behavioral Health Services to Medicaid Enrollees

### Key Takeaways

- States reported multiple challenges with using telehealth to provide behavioral health services to Medicaid enrollees, including:
  - ✓ provider and enrollee training,
  - ✓ internet connectivity,
  - ✓ privacy of personal information, and
  - ✓ technology costs.
- Sharing information that addresses these challenges can help States meet the behavioral health needs of Medicaid enrollees.

### Why OIG Did This Review

States are increasingly relying on telehealth to provide behavioral health services to Medicaid enrollees. Before the COVID-19 pandemic, telehealth was an important tool for States to increase access to behavioral health services for enrollees in rural or underserved areas with provider shortages. During the COVID-19 pandemic, States expanded their use of telehealth to help meet the needs of enrollees while also reducing the risks from community spread of the virus. As the Nation confronts the psychological and emotional impact of COVID-19, the use of telehealth will be important in addressing behavioral health needs for Medicaid enrollees.

This data brief provides insight into States' challenges as reported in January and February 2020, before the expansion of telehealth due to the COVID-19 pandemic. It provides a useful foundation for the Centers for Medicare & Medicaid Services (CMS) and States by highlighting longstanding challenges with the use of telehealth that existed prior to the additional challenges caused by the pandemic. Understanding States' challenges with using telehealth to provide behavioral health services can help States improve their Medicaid program and assist enrollees with accessing needed care. Further,

States' expansion of telehealth during the COVID-19 pandemic has been largely on a temporary basis. As States consider making telehealth expansions permanent, they can use information in this data brief to develop effective programs and troubleshoot challenges in implementation. This data brief is a companion report to a data brief that describes the extent to which States evaluate the effects of telehealth on access, cost, and quality of behavioral health services and the extent to which States oversee telehealth for fraud, waste, and abuse.<sup>1</sup>

### How OIG Did This Review

States commonly provide behavioral health services to Medicaid enrollees through managed care organizations. We conducted a survey of State Medicaid Directors from 37 States that provide behavioral health services via telehealth through managed care organizations. We also conducted structured interviews with relevant stakeholders. While we asked about challenges specific to managed care, the respondents focused on States' challenges with using telehealth more generally.

## **What OIG Found**

Most States reported multiple challenges with using telehealth, including a lack of training for providers and enrollees, limited internet connectivity for providers and enrollees, difficulties with providers' protecting the privacy and security of enrollees' personal information, and the cost of telehealth infrastructure and interoperability issues for providers. Some States also reported other challenges, including a lack of licensing reciprocity and difficulties with providers obtaining informed consent from enrollees. These challenges limit States' ability to use telehealth to meet the behavioral health needs of Medicaid enrollees.

## **What OIG Recommends**

CMS plays an important role in facilitating the exchange of information among States to improve the use of telehealth for behavioral health services. Sharing information among States will help ensure that States realize the benefits of telehealth and make informed decisions about how to address challenges with using telehealth. We recommend that CMS share information to help States address the challenges they face with using telehealth. This information could include examples from States that describe how they have responded to these challenges. It could also include best practices from States as well as information about working with other State and Federal partners. Further, CMS could collect information from States detailing their experiences and lessons learned in response to the COVID-19 pandemic that address these challenges. CMS concurred with our one recommendation.

## Primer on: Telehealth for Behavioral Health in Medicaid

- ▶ Telehealth can be used to provide behavioral health services, including **mental health assessments, individual therapy, and medication management**.
- ▶ Telehealth for behavioral health is most commonly provided through **live, two-way video** between a provider and an enrollee.
- ▶ Telehealth can also be provided through **“store-and-forward”** transmission of recorded videos and digital images and through **remote patient monitoring** that collects personal health data and transmits it to the provider. States may also allow use of audio-only, text-only, or email communications to deliver behavioral health services via telehealth.
- ▶ Medicaid enrollees experience higher rates of behavioral health disorders—which include both mental health disorders and substance use disorders—than the general population. About **one-fifth of all Medicaid enrollees have a behavioral health diagnosis**, and many more enrollees may go undiagnosed.<sup>2</sup>
- ▶ States commonly provide behavioral health services to Medicaid enrollees **through Medicaid managed care organizations**. Managed care is the **primary delivery system** for Medicaid services, covering over 82 percent of the Medicaid population.<sup>3</sup>
- ▶ In most States, an enrollee can receive telehealth services **from the enrollees’ home**, particularly for behavioral health services.<sup>4</sup>
- ▶ In response to the COVID-19 pandemic, States have increasingly relied on telehealth to provide behavioral health services to Medicaid enrollees, including **temporarily** expanding the types of services, providers, and technologies, as well as the locations where enrollees can access telehealth services.<sup>5</sup>

# RESULTS

This data brief provides insight into States' challenges with using telehealth to provide behavioral health services to Medicaid enrollees as reported in January and February 2020, before the expansion of telehealth due to the COVID-19 pandemic. States have broad flexibility to use telehealth to provide these services. In addition, CMS has taken several steps to support the implementation and expansion of telehealth in Medicaid, particularly during the COVID-19 pandemic.

Along these lines, a State can determine whether to use telehealth to provide behavioral health services. A State can also determine the types of services that are allowed, where telehealth may be used, which technology can be used, and which types of providers may deliver services via telehealth. States commonly provide behavioral health services through managed care organizations.<sup>6</sup> These organizations contract with providers to deliver services to Medicaid enrollees.

This data brief describes the challenges reported by States that affect providers and enrollees in the Medicaid program. It is based on a survey of State Medicaid Directors from States that provide behavioral health services via telehealth through managed care organizations and interviews with key stakeholders. (Hereinafter, we refer to these State Medicaid Directors as "States.") These stakeholders include representatives from organizations that have direct experience with using telehealth to provide these services, such as health care coordination organizations, managed care organizations, and Telehealth Resource Centers.<sup>7</sup> While we asked about challenges specific to managed care, the respondents focused on States' challenges with using telehealth more generally.

Gaining an understanding of the challenges with using telehealth to provide behavioral health services can help States meet the needs of enrollees. Further, insights into the challenges that were present prior to the COVID-19 pandemic provide an important foundation for understanding longstanding issues that may have been exacerbated by the pandemic. As States consider how they will use telehealth once the pandemic subsides, CMS can play an important role in helping States to learn from other States' experiences and to make informed decisions about how to address these challenges.

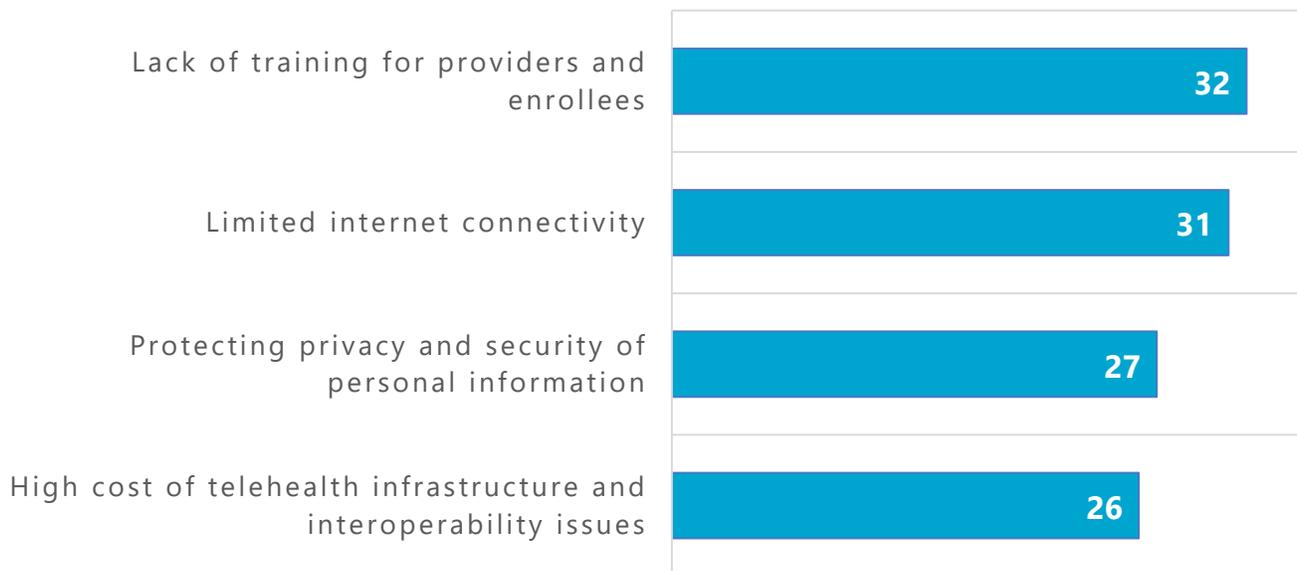
## **Most States reported multiple challenges with using telehealth, including training, internet connectivity, privacy of personal information, and technology costs**

Most States (34 of 37) report multiple challenges with using telehealth to provide behavioral health to Medicaid enrollees.<sup>8</sup> In fact, many States (27 of 37) report five or

more challenges that affect providers and enrollees in the Medicaid program. States most commonly cite: a lack of training for providers and enrollees, limited internet connectivity for providers and enrollees, difficulties with providers' protecting the privacy and security of enrollees' personal information, and the cost of telehealth infrastructure and interoperability issues for providers.

Information about the challenges States face with using telehealth is crucial, especially as States turn to telehealth to provide behavioral health services during the COVID-19 pandemic. It is also helpful for States as they consider which services to deliver via telehealth on a more permanent basis once the pandemic has subsided, as well as which populations could most benefit from telehealth services in the future.

### Exhibit: Number of States Reporting Challenges With Using Telehealth To Provide Behavioral Health Services.



Source: OIG analysis of survey data, 2020.



**Lack of provider and enrollee training.** Most States (32 of 37) find that a lack of provider or enrollee training about telehealth is a challenge. Educating providers and enrollees is important, as it can help with successfully managing telehealth programs while also addressing enrollees' resistance to receiving services remotely.

Many States report a lack of provider training, which can hinder the ability of providers to use telehealth as a regular part of their clinical practice. One State notes that providers generally have a limited understanding about how to use telehealth technology. In addition, stakeholders

**“States that take the time to educate their providers have been more successful.”**

- Telehealth Resource Center

explain that a lack of education about which services are covered and confusion among providers about billing for telehealth services are problems. One stakeholder notes that States face challenges with getting providers to correctly use modifiers that indicate the service was delivered via telehealth when submitting their claims.

Similarly, States report a lack of training for enrollees, which can inhibit enrollees from receiving services remotely. As one State notes, enrollees who are unfamiliar with technology need to be educated to increase uptake of telehealth for behavioral health services. In addition, one stakeholder explains that managed care plans often rely on providers to train enrollees on how to use the technology, which is something providers do not prioritize over many other responsibilities.

**“[Education] is a neglected area that could be used to make [enrollees] more comfortable using telehealth.”**

- Telehealth Resource Center

To help address a lack of training for providers and enrollees, a few States report issuing guidance to managed care plans about educating providers and enrollees. To educate providers on the use of telehealth, these States issue informational letters, bulletins, and newsletters highlighting best practices. States also discuss collaborating with other stakeholders, including the Department of Health and Human Services’ (HHS’s) Health Resources and Services Administration (HRSA), regional Telehealth Resource Centers, and public universities, to provide educational webinars on telehealth.



**Limited internet connectivity.** Most States (31 of 37) report that internet connectivity is a challenge with using telehealth to provide behavioral health services for both providers and enrollees. For telehealth, internet connectivity is defined as high-speed internet

access with sufficient bandwidth to remotely access services whether the enrollee is at home, at a provider’s office, at a clinic, or at another facility. This is also referred to as broadband access.<sup>9</sup>

**“Many areas have problems with broadband coverage. [There’s] no cell service—cannot access the internet. Some people are still using dial-up for DSL or landlines.”**

- Health Care Coordination Organization

Several States explain that a lack of internet access in rural areas is a challenge with using telehealth. As one stakeholder notes, some clinics do not have broadband access at all, and many enrollees do not have sufficient bandwidth in their homes, which further impedes their ability to access care using telehealth.

Although a lack of internet connectivity has not traditionally been considered a health care issue, the relationship between internet connectivity and health outcomes has recently been recognized as a health care issue, also known as a social determinant of health.<sup>10</sup> Further, increased reliance on telehealth by enrollees emphasizes the importance of considering internet connectivity a health care issue. As one

stakeholder notes, broadband access has recently been included as a social determinant of health in their State.



**Protecting privacy and security of personal information.** Many States (27 of 37) note challenges with providers' protecting the privacy and security of enrollees' personal information when using telehealth. To maintain privacy and security of personal information, providers must use software and devices that include controls on the collection, use, and disclosure of sensitive personal information.

States note challenges with providers' protecting enrollee health information. These challenges may stem from the types of technology and methods of transmission used by providers and enrollees. For example, certain methods of telehealth, such as store-and-forward or text-only, can be transmitted via unencrypted devices or as unencrypted messages and thus could potentially be accessed by third parties.<sup>11</sup> In addition, one State points out that protecting patient confidentiality is a particular concern for behavioral health services, especially when it comes to sharing sensitive health information, such as substance use.

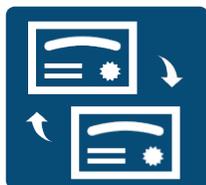


**High cost of telehealth infrastructure and interoperability issues.** Many States (26 of 37) cite the high cost of telehealth infrastructure or interoperability issues as a challenge for providers. Telehealth infrastructure, including electronic equipment and software, can often be costly for providers. As one State notes, providers may lack capital funds to develop the infrastructure and implement successful programs. A few stakeholders further explain that the initial investment is often high, and connectivity costs for rural providers can be expensive. As one stakeholder notes, part of the high cost of telehealth infrastructure is the initial cost of equipment. Further, there are additional costs associated with the maintenance and repair of telehealth equipment.<sup>12</sup>

A few States also report challenges with interoperability. Providers are better able to communicate and coordinate enrollee care when the telehealth equipment and systems that providers and enrollees use are interoperable with enrollees' electronic health records.<sup>13</sup> According to one State, providers experience difficulties in navigating different telehealth systems due to incompatibility between the systems used by the provider and enrollee. Similarly, another State reports problems with interoperability between telehealth systems and the electronic health record systems that providers use. This State notes that health systems and provider offices would benefit from using health IT applications that allow for the creation of a health record generated from the telehealth visit that is accessible to the enrollee's other providers.

## Some States reported other challenges, including a lack of licensing reciprocity and difficulties with obtaining informed consent

In addition to the above challenges with using telehealth to provide behavioral health services to Medicaid enrollees, some States note other challenges, including a lack of licensing reciprocity between States and difficulty with providers obtaining informed consent from enrollees. These challenges further inhibit States' ability to use telehealth to meet the behavioral health needs of their enrollees.



**Lack of licensing reciprocity.** Some States (17 of 37) cite a lack of licensing reciprocity between States as a challenge with using telehealth for behavioral health services. Telehealth increases opportunities for States to leverage providers from other States to offer services to enrollees. Yet, many States require providers to be licensed in the same State where the enrollee is located.<sup>14</sup> During the COVID-19 pandemic, however, most States have allowed out-of-State providers to deliver telehealth services to enrollees in their State on a temporary basis.<sup>15</sup>

Licensing requirements can be burdensome for providers, as they often must pay a fee for each State license, in addition to the time spent and the administrative effort to acquire separate licenses and periodically renew them.<sup>16</sup> States can potentially ease these burdens through licensing reciprocity, which allows practitioners who are licensed in one State to practice in another State without obtaining another license.

Another option States use to allow providers to offer services to enrollees in other States is a licensure compact. Several States report that they are a member of at least one

licensure compact.<sup>17</sup> Such compacts allow licensed providers in member States to provide services in other member States without acquiring a separate license for each State. The Nurse Licensure Compact, for example, allows State nursing boards to recognize individuals licensed as nurses from other participating States.<sup>18</sup>

Another strategy States use is an arrangement among States that allows providers to go through an expedited licensure process.<sup>19</sup> Some States report that they are a part of at least one expedited licensure arrangement. Expedited licensing involves a streamlined application process that allows providers to acquire licenses in multiple States. Although an expedited licensure process is not the same as licensing reciprocity, it can potentially help with making the licensing of out-of-State providers easier and less burdensome.



**Licensure compacts are designed to ease the administrative burden of obtaining multiple licenses.**

However, concerns exist about allowing licensing compacts, expedited licensing, and other arrangements. As one stakeholder notes, participation in licensure compacts can be contentious, as certain States may be hesitant to cede control of their role in licensing practitioners. This reluctance may be because States do not want to forgo the revenue they receive from licensure fees or do not want to increase competition for health care services in their State.<sup>20</sup>



**Difficulties with obtaining informed consent.** A few stakeholders and one State report that difficulties with obtaining informed consent are particularly challenging when delivering services via telehealth. Informed consent ensures that enrollees know about the services they may receive so that they are able to make an informed decision about whether they would like to authorize the

provider to deliver these services. Many States require providers to obtain consent from enrollees prior to the delivery of medical services. In addition, some States require providers to obtain specific consent for telehealth services.<sup>21</sup> For example, consent for telehealth can include providers informing enrollees about what telehealth is, what to expect as a part of the telehealth visit, and what security measures are taken to ensure privacy.

These difficulties may be exacerbated by varying policies for obtaining informed consent across States and the fact that States may not always clearly communicate these policies to their providers. For

example, some States allow providers to obtain verbal consent from enrollees whereas others require written consent prior to a telehealth visit.<sup>22</sup> When written consent is required, providers must either have the enrollee mail in a signed form

prior to the telehealth visit, have the enrollee email a signed form, or have the enrollee sign a virtual consent form through an online patient portal. This can potentially cause delays in care and be a barrier to enrollees' receiving behavioral health services via telehealth. This patchwork of requirements across States and the difficulties with providers' obtaining informed consent may impede the uptake of telehealth more broadly and contribute to improper billing as it makes provider compliance more difficult.

**“One of the biggest challenges is that no one is telling providers how to get consent...so providers then just make up their own policies.”**

- Telehealth Resource Center

# RECOMMENDATIONS

States reported multiple challenges with using telehealth to provide behavioral health services to Medicaid enrollees. They most commonly cite: a lack of training for providers and enrollees, limited internet connectivity for providers and enrollees, difficulties with providers' protecting the privacy and security of enrollees' personal information, and the cost of telehealth infrastructure and interoperability issues for providers. States also reported other challenges, including a lack of licensing reciprocity and difficulties with providers obtaining informed consent from enrollees.

States have broad flexibility to determine how they use telehealth in their Medicaid programs. In addition, CMS has taken several steps to support the implementation and expansion of telehealth, particularly during the COVID-19 pandemic. It maintains a webpage on telehealth in Medicaid and has issued a toolkit with a supplement to help States respond to the COVID-19 pandemic and expand their use of telehealth in Medicaid.<sup>23</sup> This toolkit includes Frequently Asked Questions, resources for States, and examples from States about their telehealth programs. It also includes a template that outlines potential policy areas for States to consider addressing as they make decisions about which telehealth policies to continue on a more permanent basis once the pandemic subsides.

With the expanded use of telehealth during the pandemic and potential changes to telehealth being considered by States, CMS has an opportunity to build on its prior initiatives and work with States to address the specific challenges with using telehealth to provide behavioral health services to Medicaid enrollees. CMS plays an important role in facilitating the exchange of information about approaches to addressing these challenges among States. Sharing this information among States will help ensure that States realize the potential benefits of telehealth and make informed decisions about how to address these challenges.

## We recommend that CMS:

### **Share information to help States address challenges with using telehealth to provide behavioral health services to Medicaid enrollees**

CMS should share information to help States address the challenges they face with using telehealth. This information could include examples from States that describe how they have responded to these challenges. It could also include best practices from States as well as information about working with other State and Federal partners. Further, CMS could collect information from States detailing their experiences and lessons learned in response to the COVID-19 pandemic that address

these challenges. This information could address the following challenges, as well as any additional challenges that may have emerged during the pandemic and that CMS has identified in its ongoing work with States:

- ▶ **Lack of provider and enrollee training.** To successfully implement telehealth, it is important for providers to be trained to use telehealth and understand their role in addressing potential barriers to enrollees receiving services remotely. CMS could share examples with States about ways to: engage providers, offer training that is accessible, work with managed care organizations to educate providers, and keep providers up-to-date on an ongoing basis. Building off of the examples of provider training in the supplement to the Medicaid Telehealth Toolkit, these examples could include actions States have taken to educate providers in their State about the use of telehealth, as well as billing for services provided via telehealth. CMS could also identify opportunities to work with other Federal and State partners and share this information with States. For example, HRSA supports Telehealth Resource Centers, which provide educational materials to providers and administrators. Additionally, the Assistant Secretary for Preparedness and Response's TRACIE program provides resources to train providers on the use of telehealth.<sup>24</sup>

Similarly, a lack of training for enrollees can inhibit enrollees from receiving services remotely. CMS could share examples with States about training enrollees on the use of telehealth. These examples could include a checklist of topics to educate enrollees about, such as what services they can receive via telehealth, what technology they need to use telehealth, and how to use the technology necessary for a telehealth visit. Similar to the examples of provider training in the supplement to the Medicaid Telehealth Toolkit, these examples could highlight strategies that States have used to educate enrollees in their State.

- ▶ **Limited internet connectivity.** High-speed, reliable internet connectivity is needed for health care providers and enrollees to benefit from telehealth. CMS could share information with States about additional funding opportunities for internet connectivity and broadband-related projects, including options under the American Rescue Plan and other Federal programs that can fund projects in the areas of planning, public access, and deployment.<sup>25</sup> To disseminate information about funding and improving internet connectivity, CMS could assist States with sharing their experiences. For example, CMS could create a forum for States to share this information with other States. CMS could also share this information during technical assistance calls, as well as post this information on its Medicaid telehealth webpage.
- ▶ **Protecting privacy and security of personal information.** Telehealth systems must ensure enrollees' health information is private and secure. CMS could coordinate with the HHS Office for Civil Rights (OCR), which is responsible for Health Insurance Portability and Accountability Act (HIPAA) enforcement, to ensure that as providers expand their use of telehealth they are aware of how

HIPAA standards for privacy and security apply to the delivery of behavioral health services via telehealth.<sup>26</sup> This could include jointly hosting trainings for States about protecting privacy and security of protected health information when using telehealth, as well as responding to questions States may have about HIPAA standards for telehealth technology.

- ▶ **High cost of telehealth infrastructure and interoperability issues.** As they consider expanding the use of telehealth on a more permanent basis, there may be additional need for States to invest in the development and maintenance of technology and infrastructure that allows providers to connect to enrollees remotely and promotes interoperability between systems. CMS could work with States to make sure that they are aware of the funding mechanisms available for these types of investments, as well as how to pursue them.<sup>27</sup> As CMS notes in its Medicaid Telehealth Toolkit, States may pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for the delivery of telehealth services.<sup>28</sup> To claim Medicaid reimbursement, a State needs an approved State Plan Amendment that specifies the ancillary costs and circumstances under which those costs are payable. To make this process easier for States, CMS could create a State Plan Amendment template, similar to its State Plan Amendment template for disaster relief.<sup>29</sup> CMS could also gather information from States that have invested in telehealth infrastructure, including those that have done so during the COVID-19 pandemic, and share their experiences so that other States can learn from them. CMS could also share information with States about interoperability, including examples of States that have taken action to ensure the interoperability of telehealth systems with existing health IT applications, such as electronic health records. Ensuring the interoperability of telehealth systems should be a focus for States as they seek to expand their investments in new telehealth infrastructure, as well as invest in updating their current telehealth infrastructure.
- ▶ **Lack of licensing reciprocity.** Telehealth increases opportunities for States to leverage providers from other States to offer services to enrollees. Yet, many States require providers to be licensed in the same State where the enrollee is located. CMS could work with States to disseminate information about States' perspectives and experiences with licensing reciprocity. This effort could include identifying and disseminating information about lessons learned from States that have entered licensing compacts or expedited licensure arrangements. CMS could gather information from States that have allowed out-of-State providers to deliver services to enrollees in their State during the COVID-19 pandemic and share their experiences so that other States can learn from them as they make decisions about their telehealth policies once the pandemic subsides.
- ▶ **Difficulties with obtaining informed consent.** The informed consent process helps ensure that providers explain what telehealth is and describes the expected benefits and risks, so enrollees are fully informed before receiving services. CMS could work with States to share best practices about informed consent for

telehealth among States. For example, best practices could include informing enrollees of their rights when receiving telehealth, including their right to refuse treatment; describing the responsibilities of enrollees when receiving telehealth services; and informing enrollees about what to do if technology or equipment fails during the telehealth session.<sup>30</sup> In addition, these best practices could highlight ways to make the consent process faster and more efficient, such as allowing enrollees to consent virtually rather than having to mail in a signed consent form prior to the telehealth visit.

# AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with our recommendation to share information to help States address challenges with using telehealth to provide behavioral health services to Medicaid enrollees. CMS noted that it will take into account the broader concerns OIG identified with using telehealth in determining how it can further support States with using telehealth to ensure the provision of high-quality behavioral health services to Medicaid enrollees.

We appreciate CMS's efforts to address these important issues. Our findings indicate that there are common challenges across States that could impede Medicaid enrollees' use of telehealth for behavioral health. Importantly, these challenges existed prior to the additional challenges caused by the COVID-19 pandemic. Sharing information among States will help ensure that States realize the benefits of telehealth and make informed decisions about how to address challenges with using telehealth, including lessons learned during the pandemic. We ask that CMS—in its Final Management Decision—provide details on its plans and any progress toward implementing our recommendation.<sup>31</sup>

For the full text of CMS's comments, see Appendix A.

# METHODOLOGY

## Survey of State Medicaid Directors

We based this data brief on a survey of State Medicaid Directors and a review of relevant documentation to support their responses. This is the same survey that is the basis of the companion data brief.

We conducted the survey with State Medicaid Directors from 37 States that provide behavioral health services through managed care organizations and use telehealth to provide these services. We identified these States by surveying State Medicaid Directors in all 50 States, Puerto Rico, and the District of Columbia.<sup>32</sup> We administered the survey electronically in January and February 2020.

Our survey focused on States' use of telehealth to provide behavioral health services to Medicaid enrollees. As part of this survey, we requested information about the challenges that States face with using telehealth to provide these services. In addition, in some cases States provided information about strategies they developed to address these challenges. While we asked about challenges specific to managed care, the respondents focused on States' challenges with using telehealth more generally.

## Structured Interviews With Stakeholders

We conducted structured interviews with key stakeholders from a variety of organizations. These stakeholders include representatives from national and regional Telehealth Resource Centers, health care coordination organizations, the HRSA, HHS's Office of the Assistant Secretary for Planning and Evaluation, a State health department, a Medicaid managed care organization, and a Medicaid provider. As part of these interviews, we asked about the challenges that States face with using telehealth to provide behavioral health services to Medicaid enrollees. We also discussed the strategies States have developed to address these challenges. We conducted these interviews throughout the course of the study.

## Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX A: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** August 20, 2021

**TO:** Christi A. Grimm  
Principal Deputy Inspector General  
Office of Inspector General

**FROM:** *Chiquita Brooks-LaSure*  
Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Data Brief: States Reported Multiple Challenges with Using Telehealth to Provide Behavioral Health Services to Medicaid Enrollees (OEI-02-19-00400)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of collaborating with states to increase the availability of behavioral health services delivered via telehealth for Medicaid beneficiaries and appreciates OIG's effort in surveying State Medicaid Directors and various stakeholders to determine how states are using telehealth to provide these services to Medicaid beneficiaries. However, as these surveys were conducted from January to February of 2020, before the widespread expansion of the use of telehealth in response to the COVID-19 Public Health Emergency (PHE), this information may not detail states' current perspectives on the use of telehealth for behavioral health services.

The telehealth landscape has changed vastly and is continuing to rapidly evolve during the PHE. Notably, CMS's latest public data on telehealth utilization in Medicaid and CHIP reveals a 2745 percent increase in services were delivered through telehealth from March 2020 to October 2020 compared to the same period in 2019.<sup>1</sup> As such, in response to the PHE, CMS has taken a number of actions to protect the health and safety of Medicaid beneficiaries. In 2020, CMS created a dedicated website for Medicaid-related COVID-19 information, which includes links to relevant information regarding COVID-19.<sup>2</sup> As OIG noted, in April 2020, CMS released the Telehealth Toolkit that provides states with information to consider as they evaluate the need to expand their telehealth capabilities and coverage policies, with a section dedicated to telehealth coverage for pediatric behavioral health services.<sup>3</sup> The Telehealth Toolkit describes and discusses topics such as coverage and reimbursement policies, providers and practitioners eligible to provide telehealth, technology requirements, and pediatric considerations. Furthermore, in October 2020, CMS released the Telehealth Toolkit Supplement in order to provide additional support to states in their

<sup>1</sup> Preliminary Medicaid & CHIP Data Snapshot, <https://www.medicare.gov/sites/default/files/2021-05/covid-19-medicare-data-snapshot.pdf>

<sup>2</sup> COVID-19 Medicaid and CHIP Resources, <https://www.medicare.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html>

<sup>3</sup> Telehealth Toolkit, <https://www.medicare.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>

adoption and implementation of telehealth as they begin to plan beyond PHE flexibilities by discussing topics such as communication strategies, telehealth operations and implementation tools, and shared experiences and examples from states and territories across the nation.<sup>4</sup>

CMS is committed to providing opportunities for states to improve access to behavioral health care and through the efforts described above, we are assisting states and other stakeholders in meeting this goal throughout the PHE and beyond. Although the recent PHE has accelerated the interest in service delivery through telehealth, telehealth services have been available in many states for decades and CMS has long assisted states in their efforts to expand the use of telehealth for behavioral health services. For example, in order to assist states in developing their network adequacy and service availability standards, CMS formed a working group of states to discuss common access challenges and goals and created a forum for states to present their successful techniques for establishing and monitoring network adequacy in their programs. In addition, in April 2017, CMS published the Network Adequacy Toolkit, which provides technical assistance to states in the development and oversight of Medicaid managed care plan networks including mental health providers.

Given the unique nature of each state's Medicaid program, states are key players to develop meaningful and appropriate network adequacy and service availability standards, in keeping with federal guidelines, that reflect the scope of their programs, the populations served, and the demographics and characteristics of each state. States have broad flexibility to determine what services to deliver using telehealth and what they will pay for them. However, as detailed above, CMS meets regularly with, and has provided a significant amount of guidance and assistance to states about telehealth in general and in the managed care delivery system specifically, and CMS will continue to work with states as issues arise.

OIG's recommendation and CMS's response is below.

**OIG Recommendation**

Share information to help States address challenges with using telehealth to provide behavioral health services to Medicaid enrollees.

**CMS Response**

CMS concurs with this recommendation. While the landscape of telehealth has drastically changed and grown since the OIG conducted its survey, CMS will take into account the broader concerns OIG identified with telehealth in determining how CMS can further support states with using telehealth to ensure the provision of high quality behavioral health services to Medicaid enrollees.

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<sup>4</sup> Telehealth Toolkit Supplement, <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf>

# ACKNOWLEDGMENTS AND CONTACT

## Acknowledgments

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This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

## Contact

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# ENDNOTES

<sup>1</sup> See OIG, Opportunities Exist To Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid (OEI-02-19-00401).

<sup>2</sup> See Medicaid and CHIP [Children’s Health Insurance Program] Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP, Chapter 4: Behavioral Health in the Medicaid Program—People, Use, and Expenditures, June 2015. Accessed at <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf> on December 11, 2020.

<sup>3</sup> This represents individuals enrolled in any Medicaid managed care program, including comprehensive managed care, limited benefit managed care, and Primary Care Case Management. See CMS, Medicaid Managed Care Enrollment and Program Characteristics, 2018. Accessed at <https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf> on December 11, 2020.

<sup>4</sup> In this report, we refer to medical services delivered via telehealth as “telehealth services.”

<sup>5</sup> See Center for Connected Health Policy (CCHP), COVID-19 Related State Actions. Accessed at <https://www.cchpca.org/covid-19-related-state-actions> on March 18, 2021.

<sup>6</sup> Managed care organizations include organizations that administer prepaid inpatient health plans, prepaid ambulatory health plans, comprehensive managed care plans, and Primary Care Case Management.

<sup>7</sup> As described in the methodology, among the stakeholders we interviewed were representatives from health care coordination organizations. These organizations assist providers with activities such as deploying telehealth programs and transitioning to alternative payment models. We also interviewed representatives from Telehealth Resource Centers, which assist providers and States with developing and implementing telehealth programs. Telehealth Resource Centers are funded by the HRSA and are a part of the National Consortium of Telehealth Resource Centers. Accessed at <https://www.telehealthresourcecenter.org/> on December 11, 2020.

<sup>8</sup> This analysis is based on 37 States that responded to our survey indicating that they provided behavioral health services through managed care organizations and used telehealth to provide these services prior to the COVID-19 pandemic. The number of States that provide these services via telehealth may have increased during the COVID-19 pandemic.

<sup>9</sup> Current industry standards recommend that health care providers have internet capability in line with U.S. Federal Communications Commission (FCC) broadband internet benchmarks. Broadband download speeds are generally 25 Mbps for streaming ultra HD 4k video. This is in line with the bandwidth needed to stream high-quality video generally. See CMS, Report to Congress Reducing Barriers to Furnishing Substance Use Disorder (SUD) Services Using Telehealth and Remote Patient Monitoring for Pediatric Populations Under Medicaid: Final Report, May 15, 2020. Accessed at <https://www.medicaid.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf> on March 18, 2021.

<sup>10</sup> The Centers for Disease Control and Prevention (CDC) notes that access to the internet is one of several factors that are related to health outcomes. These factors, which include economic and social conditions, influence the health of individuals and are often referred to as “social determinants of health.” See CDC, What Are Social Determinants of Health?. Accessed at <https://www.cdc.gov/nchhstp/socialdeterminants/faq.html> on April 21, 2021.

<sup>11</sup> See Substance Abuse and Mental Health Services Administration, TIP 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services, November 2015. Accessed at <https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924> on June 24, 2021.

<sup>12</sup> See MACPAC, Report to Congress on Medicaid and CHIP, Chapter 2: Telehealth in Medicaid, March 2018. Accessed at <https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/> on November 30, 2020.

<sup>13</sup> See National Academy of Medicine, Procuring Interoperability: Achieving High-Quality, Connected, and Person-Centered Care. Accessed at <https://nam.edu/procuring-interoperability-achieving-high-quality-connected-and-person-centered-care/> on July 1, 2021. See also FCC, Intergovernmental Advisory Committee to the Federal Communications Commission Advisory Recommendation No: 2019-2, In the Matter of State, Local Tribal, and Territorial Regulatory and Other Barriers and Incentives to Telemedicine. Accessed at <https://docs.fcc.gov/public/attachments/DOC-360696A5.pdf> on June 24, 2021.

<sup>14</sup> These State requirements are enforced through medical practice requirements, payment conditions, or other laws and regulations. See also MACPAC, Report to Congress on Medicaid and CHIP, Chapter 2: Telehealth in Medicaid, March 2018. Accessed at <https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/> on June 24, 2021.

<sup>15</sup> States are taking steps to modify licensure requirements in response to COVID-19. See Federation of State Medical Boards, U.S. States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19, updated February 26, 2021, and U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19, updated March 2, 2021. Accessed at <https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensure-requirements-covid-19.pdf> and <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf>, respectively, on March 12, 2021.

<sup>16</sup> See Rural Health Information Hub, Licensing and Credentialing of Telehealth Programs. Accessed at <https://www.ruralhealthinfo.org/toolkits/telehealth/4/licensing-and-credentialing> on February 24, 2021. See also Health Affairs Blog, Doctors Without State Borders: Practicing Across State Lines, 2014. Accessed at <https://www.healthaffairs.org/doi/10.1377/hblog20140218.036973/full/> on February 24, 2021.

<sup>17</sup> Examples include the Enhanced Nurse Licensure Compact, the Physical Therapy Interstate Compact, the Psychologist Interjurisdictional Compact, and the Recognition of EMS Personnel Licensure Interstate Compact.

<sup>18</sup> See Nurse Licensure Compact, Facts about the NLC. Accessed at [https://www.ncsbn.org/NLC\\_Facts-FINAL.pdf](https://www.ncsbn.org/NLC_Facts-FINAL.pdf) on February 24, 2021.

<sup>19</sup> In addition to licensure compacts and expedited licensure arrangements, States may also have other licensing agreements, including physician consultation exceptions and emergency provisions. These arrangements do not confer full licensure, but they allow providers to deliver services in limited ways or for a limited duration.

<sup>20</sup> See HRSA, Health Licensing Board Report to Congress. Accessed at <https://www.hrsa.gov/sites/default/files/ruralhealth2/about/telehealth/licenserpt10.pdf> on February 24, 2021. See also Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition, July 2004. Accessed at <https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf> on February 24, 2021. See also Health Affairs Blog, Doctors Without State Borders: Practicing Across State Lines, 2014. Accessed at <https://www.healthaffairs.org/doi/10.1377/hblog20140218.036973/full/> on February 24, 2021.

<sup>21</sup> Telehealth consent requirements may be located in the State's Medicaid program, or in statute or rules regulating health care professionals.

<sup>22</sup> See CCHP, State Telehealth Laws & Reimbursement Policies, Fall 2020. Accessed at <https://cchp.nyc3.digitaloceanspaces.com/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf> on June 23, 2021.

<sup>23</sup> See CMS, State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version. Accessed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> on October 21, 2020. CMS also issued a supplement titled State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1. Accessed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> on November 17, 2020. The CMS Medicaid telehealth webpage can be accessed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>.

<sup>24</sup> See HHS Office of the Assistant Secretary for Preparedness and Response, Topic Collection: COVID-19 Telemedicine/Virtual Medical Care Resources. Accessed at <https://asprtracie.hhs.gov/technical-resources/116/covid-19-telemedicine-virtual-medical-care-resources/99> on March 25, 2021.

<sup>25</sup> For examples of Federal funding sources, including grants funded by HHS, see FCC, Funding Broadband-Enabled Health Care. Accessed at <https://www.fcc.gov/general/funding-broadband-enabled-health-care> on March 18, 2021. Additionally, the 2021 American Rescue Plan Act allocated \$500 million to the U.S. Department of Agriculture to be used on grants for rural health care, including increasing telehealth capacity. Section 1002 of the American Rescue Plan Act of 2021. Accessed at <https://www.congress.gov/bill/117th-congress/house-bill/1319/text> on April 13, 2021.

<sup>26</sup> Although providers are not subject to penalties for HIPAA noncompliance in connection with the good faith provision of telehealth during the COVID-19 Public Health Emergency, once the Public Health Emergency ends the HHS Office for Civil Rights will be responsible for enforcing penalties related to HIPAA noncompliance.

<sup>27</sup> For example, the FCC provided \$200 million to health care providers for telehealth-related infrastructure and equipment as a part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act in June 2020. The FCC announced a second round of COVID-19 telehealth funding for providers in March 2021. See FCC, COVID-19 Telehealth Program (Invoices & Reimbursements). Accessed at <https://www.fcc.gov/covid-19-telehealth-program-invoices-reimbursements> on April 13, 2021.

<sup>28</sup> See CMS, State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version. Accessed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> on October 21, 2020.

<sup>29</sup> See CMS, Medicaid State Plan Disaster Relief State Plan Amendments. Accessed at <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html> on April 13, 2021.

<sup>30</sup> For more information, see the MACPAC, Report to Congress on Medicaid and CHIP, Chapter 2: Telehealth in Medicaid, March 2018. Accessed at <https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/> on November 30, 2020.

<sup>31</sup> The Final Management Decision is provided by CMS within 6 months of the release of the data brief and details what actions CMS plans to take to address each recommendation, including the timeline for taking these actions.

<sup>32</sup> Of these, 11 State Medicaid Directors reported that managed care organizations in their respective States did not use telehealth to provide behavioral health services to enrollees and 4 State Medicaid Directors did not respond to the survey. A total of 36 States and the District of Columbia responded to our survey; for the purposes of this report, we refer to these 37 entities as "States."