



Opportunities Exist To Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid

Key Takeaways

- A few States reported being unable to identify which services are provided via telehealth, limiting their ability to evaluate and oversee telehealth.
- Only a few States have evaluated the effects of telehealth on behavioral health services.
- Despite concerns about fraud, waste, and abuse, many States do not conduct monitoring and oversight specific to telehealth.

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 State evaluations and oversight of telehealth for behavioral health services as of January and February 2020, before the expansion of telehealth due to the COVID-19 pandemic. It provides a useful foundation to inform the Centers for Medicare & Medicaid Services (CMS) and State decisions about how to evaluate the impacts of telehealth on access, cost, and quality of behavioral health services and to strengthen oversight of program

integrity. Evaluating the effects of telehealth on access, cost, and quality is particularly important in helping States make decisions about how best to use telehealth and about which populations benefit most from these services. Understanding States' efforts to oversee telehealth can help States protect their Medicaid programs. Further, States' expansion of telehealth during the COVID-19 pandemic has been largely on a temporary basis. As States consider making telehealth expansions permanent, States can use information in this data brief to help determine which services best support enrollees. This data brief is a companion report to a data brief that describes the challenges States reported with using telehealth to provide behavioral health services to Medicaid enrollees.¹

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 efforts specific to managed care, the respondents focused on States' efforts to evaluate and oversee the use of telehealth more generally.

What OIG Found

While most States can identify which services are provided via telehealth, a few reported being unable to, limiting their ability to evaluate and oversee telehealth. In addition, only a few States have evaluated the effects of telehealth in their State; these States found increased access and reduced costs. Based on their own experiences, other States believe that telehealth increases access, has uncertain impacts on costs, and raises concerns about quality. Further, despite concerns about fraud, waste, and abuse, many States do not conduct monitoring and oversight specific to telehealth.

What OIG Recommends

CMS and State efforts to evaluate and oversee telehealth are critical to meeting Medicaid enrollees' behavioral health needs and to safeguarding the Medicaid program from potential fraud, waste, and abuse. These efforts are particularly important as the telehealth landscape continues to evolve. Accordingly, we recommend that CMS: (1) ensure that the three States that are unable to distinguish telehealth from in-person services implement indicators to identify which services are provided via telehealth, (2) conduct evaluations, and support State efforts to evaluate the effects of telehealth on access, cost, and quality of behavioral health services, and (3) conduct monitoring for fraud, waste, and abuse, and support State efforts to oversee telehealth for behavioral health services. CMS concurred with the first recommendation but did not explicitly indicate whether it concurred with the other two recommendations.

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.²
- ▶ 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.³
- ▶ In most States, an enrollee can receive telehealth services **from the enrollees’ home**, particularly for behavioral health services.⁴
- ▶ 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.⁵

RESULTS

This data brief provides insight into State evaluations and oversight of telehealth for behavioral health services for Medicaid enrollees as of 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.⁶ These organizations contract with providers to deliver services to Medicaid enrollees.

This data brief describes the results of States' efforts to evaluate the effects of telehealth on access, cost, and quality, as well as the experiences of States with using telehealth. It also describes States' oversight of telehealth to detect fraud, waste, and abuse of behavioral health services. 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.⁷ While we asked about efforts specific to managed care, the respondents focused on States' efforts to evaluate and oversee the use of telehealth more generally.

Understanding States' efforts to evaluate and oversee telehealth to provide behavioral health services can help States improve and protect their Medicaid programs and better serve enrollees. States play an important role in conducting such evaluation and oversight of telehealth for behavioral health services. It is essential that States oversee—and coordinate with managed care organizations to oversee—telehealth services to ensure that their Medicaid programs deliver quality services, and that funds are not misused for fraud, waste, or abuse. CMS also plays an important role by working with States to evaluate and oversee telehealth for behavioral health services.

While most States can identify which services are provided via telehealth, a few are unable to, limiting their ability to evaluate and oversee telehealth

The ability to identify which specific services are provided via telehealth is critical to understanding the effects of telehealth on access, cost, and quality and to monitoring and providing oversight of these services. Despite this, a few States (3 of 37) are unable to distinguish which services are provided via telehealth from those delivered in-person.⁸ These States cannot do any analysis on the effects of telehealth, nor do they have the ability to perform basic monitoring and oversight specific to telehealth services, which are essential to ensuring the fiscal integrity of the Medicaid program and to protecting Medicaid enrollees.

In contrast, the other 34 States are able to distinguish between specific services provided via telehealth and in-person. To indicate when services are delivered via telehealth, these States typically require the use of a modifier, a place of service code, or telehealth-specific procedure codes on the claim. These States are able to conduct analysis on the effects of telehealth, as well as monitoring and oversight specific to telehealth. For example, such analysis could include identifying providers that are outliers in billing for telehealth services.

Although the ability to identify services delivered via telehealth is a critical first step, there are concerns about incomplete data that may hinder States' ability to evaluate and oversee telehealth. Providers may not use the appropriate modifiers or other indicators consistently, especially when payment for services is not contingent on inclusion of a modifier. This may be the case when telehealth services are paid at the same rate as those provided in-person.⁹ As one stakeholder notes, modifiers may be left off the claim due to errors on the part of providers or a lack of clarity in State policies.

Only a few States have evaluated the effects of telehealth in their State; these States found increased access and reduced costs

States are responsible for ensuring access to care, controlling costs, and addressing the quality of care when providing behavioral health care services to Medicaid enrollees.¹⁰ As States increasingly shift toward the use of telehealth to provide these services, it is critical to evaluate the effects of telehealth on each of these measures. To evaluate the effects of telehealth on access, cost, or quality, States report conducting evaluations or collecting data from analyses conducted by managed care organizations in their State.

In total, two States have evaluated the effects of telehealth specifically on access to behavioral health services for Medicaid enrollees. One State found that, prior to the

pandemic, the percentage of enrollees who used telehealth for behavioral health services was 70 percent in rural counties, versus just 24 percent in urban counties in one of its managed care plans. This State notes that, absent telehealth, enrollees in rural areas would likely have had to travel or be transported a significant distance to urban centers in order to receive behavioral health care. Additionally, a second State found that telehealth increased access to certain types of providers, such as psychiatrists, psychologists, and nurse practitioners specializing in mental health.

Further, only one State evaluated the effects of telehealth specifically on cost. This State—one of the States that also analyzed its data on access—found that, prior to the pandemic, telehealth produced savings of \$8,600 in emergency room avoidance for one managed care plan, as well as \$484,000 in reduced transportation costs for another managed care plan.

No State has evaluated the effects of telehealth specifically on the quality of behavioral health services. For example, no State reported looking at the effects of telehealth on continuity of care or patient safety.

Given the increased use of telehealth during the COVID-19 pandemic, it is important that States evaluate the effects of telehealth specifically. Such analyses could help States ensure the effective use of telehealth and improve health outcomes for different populations. For example, one State plans to present future analyses on the cost of telehealth services to its State legislature to determine the types of telehealth services that the State would like to continue, or begin, reimbursing to best serve its Medicaid population.



Analysis can help States make decisions about which behavioral health services should be allowed via telehealth on a permanent basis.

Based on their experiences, other States believe that telehealth increases access, has uncertain impacts on cost, and raises concerns about quality

States have experience with using telehealth, including firsthand knowledge of the impacts of telehealth on access, cost, and quality of behavioral health services. Although it is important that States move beyond program observations and more rigorously evaluate the effects of telehealth, it is also valuable to highlight States' experiences so that stakeholders can understand the context for State decisions as many take steps to change their telehealth policies in the wake of the COVID-19 pandemic.

Some States report telehealth increases access to care

Although they have not evaluated the effects, some States (17 of 37) report that telehealth increases access to care based on program observations. Several States report that telehealth facilitates access to an increased number of providers. For example, one State observes that the number of behavioral health providers seeking approval to provide services via telehealth is increasing, adding that there are now behavioral health providers approved for telehealth in every county of the State. Access to an increased number of providers is particularly important for States with areas experiencing provider shortages. Another State notes that its enrollees are able to access services from a broader range of behavioral health providers, including physicians, psychiatrists, psychologists, and social workers, as these types of providers are now available in all areas of the State, including those with provider shortages. Additionally, one State reports that telehealth has expanded access to specialists for enrollees living in rural and frontier areas of the State, while another State notes that telehealth has increased access to prescribing for enrollees living in rural areas.

“Patients are getting care quicker, especially for behavioral health, where wait time [for in-person services] can exceed 4 to 6 months.”

- Health Care Coordination Organization

In addition, a few States report that telehealth increases access by potentially reducing barriers to care. For example, one State notes that allowing enrollees to receive care at various sites, including the enrollee's home, school, community-based settings, or traditional telehealth sites helps increase access to behavioral health services. In addition, another State reports that telehealth may increase access by reducing barriers related to a lack of transportation, while another State notes that access may be increased with telehealth through shorter wait times for behavioral health services. Further, a few stakeholders note that telehealth helps circumvent the stigma related to receiving behavioral health services. For example, enrollees living in small, tightly knit communities, where someone may notice their car in the parking lot of a therapist or other mental health professional, may avoid getting the care they need as they are concerned about being unfairly stigmatized or marginalized.

Several States report uncertain impacts of telehealth on cost

Several States (6 of 37) suggest that the impact of telehealth on cost is largely uncertain. A few States cite the fact that, in their State, telehealth is reimbursed at the same rate as in-person services, which makes the overall impact on cost unclear. One State notes that services rendered through telehealth may help offset costs of non-emergency medical transportation and provider travel reimbursement. Additionally, one stakeholder notes that if telehealth increases access it may increase costs, although there are a few instances where the reduction in transportation costs outweighs the increase in costs from increased access.

Some States highlight concerns about the effects of telehealth on quality of care

Some States (10 of 37) note concerns about the quality of services that are delivered via telehealth, particularly for certain types of behavioral health services, such as prescribing, and for services that are delivered audio-only versus audio-video. For example, one State raises concerns about quality, but notes that these concerns can be minimized through appropriate clinical practice as well as provider training on best telehealth practices. Similarly, another State reports that the effects of telehealth on quality of services appear to be largely dependent on the training of providers to effectively deliver these services via telehealth. According to the State, “providers without such training more frequently have patients that request other options or providers.”

“It can be challenging for providers to pick up on an enrollee’s social, non-verbal cues...which could lead to misdiagnosis.”

- Health Care Coordination Organization

Despite concerns about fraud, waste, and abuse, many States do not conduct monitoring and oversight specific to telehealth

Many States (23 of 37) report that fraud, waste, and abuse is a concern with using telehealth to provide behavioral health services. States report uncovering fraud schemes that are unique to telehealth, as well as those that expand on schemes that have occurred with the use of in-person services. These schemes include: providers inappropriately billing for both delivering the telehealth service remotely and facilitating the telehealth service at the enrollee’s location, providers billing for services that were not rendered, and providers located outside of the United States delivering services. Further, the schemes identified by States are similar to complaints received by the Office of Inspector General (OIG). (See text box.)

Examples of fraud and abuse complaints
OIG has received specific to telehealth
include:

- providers instructing staff to “cold call” beneficiaries via telephone and bill for a telehealth visit;
- “upcoding” telehealth visits by billing for visits longer than they lasted, or providing basic services and billing for more complex visits;
- billing for services not rendered to the patient;
- billing for an impossible number of telehealth visits over a day or shorter period of time; and
- using overseas providers to provide telehealth services.

Despite concerns about telehealth, only 11 States conduct monitoring and oversight to detect fraud, waste, and abuse that is specific to telehealth. States are responsible for monitoring their Medicaid program and are the first line of defense against fraud,

waste, and abuse.¹¹ However, several States explain that their program integrity efforts include little or no additional efforts that specifically target telehealth. According to one State, telehealth is monitored like any other service, but specific monitoring is currently being developed. A few States further note the difficulty of overseeing and verifying that telehealth services are provided appropriately.

The States that conduct monitoring specific to telehealth employ strategies similar to their other program integrity efforts. These strategies include reviewing medical records, analyzing claims data, conducting outlier reports, and investigating complaints.

Several States (6 of 37) also note that managed care organizations in their State conduct program integrity functions, such as monitoring and oversight, specific to telehealth.¹² It is important for the State to be aware of these program integrity efforts and their results. If not, the State cannot effectively understand the program integrity risks across managed care organizations, take appropriate actions, and improve their Medicaid programs.

“We do not see a large amount of proactive activity to monitor and oversee their [telehealth] programs for fraud.”

-Telehealth Resource Center

RECOMMENDATIONS

Given the importance of telehealth in Medicaid during the pandemic, States need to identify the services provided via telehealth so that they can better understand the effects of telehealth on access, cost, and quality of behavioral health services for Medicaid enrollees. It is increasingly important that States evaluate the effects of telehealth to inform their decisions about how they will use telehealth in the future. Further, States also need to monitor and provide oversight of telehealth, as expanding the use of telehealth may present additional risk for fraud, waste, and abuse.

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.¹³ 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.

States' experiences with telehealth expansion during the COVID-19 pandemic offer a valuable opportunity for evaluating what worked well and what could be improved with using telehealth for behavioral health, while safeguarding against poor quality of care or inappropriate billing for these services. To leverage this opportunity, CMS should continue to build on its efforts and work with States to gain a better understanding of the effects of telehealth on access, cost, and quality and to monitor and oversee telehealth for behavioral health services for Medicaid enrollees. The need for additional research is further supported by the *Medicaid and CHIP Payment and Access Commission (MACPAC)*, which observes that there is currently limited information about the effects of telehealth on outcomes, cost, and program integrity within the Medicaid program.¹⁴ MACPAC concludes that CMS could do more to facilitate research to help States, providers, and other stakeholders gain a more robust understanding of the effects of telehealth on access to care, quality of care, and cost of care for Medicaid enrollees.

CMS and States play important roles in evaluating and overseeing Medicaid telehealth services. Evaluating the effects of telehealth on access, cost, and quality of behavioral health services is particularly important in helping States make decisions about how best to use telehealth and about which populations benefit most from these services. In addition, this information can help States decide which policies should be made permanent after the pandemic subsides, such as those regarding services and where enrollees can receive telehealth.

We recommend that CMS:

Ensure that the three States that are unable to distinguish telehealth from in-person services implement indicators to identify which services are provided via telehealth

The ability to identify the services that are provided via telehealth is essential to evaluating the effects of telehealth on access, cost, and quality. It is also critical to performing basic monitoring and oversight specific to telehealth services to protect Medicaid enrollees and ensure the fiscal integrity of the Medicaid program. To meet these needs, CMS should work with the three States that are unable to identify which services are provided via telehealth to ensure that they use indicators allowing them to distinguish services provided via telehealth from those delivered in-person.

Conduct evaluations, and support State efforts to evaluate the effects of telehealth on access, cost, and quality of behavioral health services

To ensure telehealth is able to meet the needs of enrollees, CMS should conduct evaluations of the impact of telehealth on access, cost, and quality of behavioral health services for Medicaid enrollees. Building off of the Medicaid telehealth analysis included in CMS's COVID-19 data snapshot, CMS could conduct national evaluations that include specific detail on the effects of telehealth on access, cost, and quality of behavioral health services.¹⁵

CMS should also work with States to encourage them to initiate evaluations of telehealth that assess its effects on access, cost, and quality for Medicaid enrollees. CMS should look for ways to support States in developing such evaluations, including partnering with other agencies, researchers, or other entities. One way to do this is to incorporate telehealth-focused reviews related to access, cost, and quality for the organizations that are responsible for monitoring each State's Medicaid managed care program.¹⁶

In addition, CMS should share information and best practices with States about how to evaluate the effects of telehealth on access, cost, and quality. CMS should also share information with States about the results of CMS's and States' evaluations of telehealth so that States can learn from these efforts and use them to develop their telehealth programs. States could benefit from State-to-State learning, data collection, and analyses.¹⁷

Conduct monitoring for fraud, waste, and abuse, and support State efforts to oversee telehealth for behavioral health services

Expanding the use of telehealth may present additional risk for fraud, waste, and abuse. States report uncovering schemes specific to telehealth, such as providers inappropriately billing for both delivering the telehealth service remotely and facilitating the telehealth service at the enrollee's location. Additionally, these schemes are similar to complaints received by OIG. CMS should take into account these schemes and build on its own efforts to conduct monitoring and oversight specific to telehealth for behavioral health services to identify potential fraud, waste, and abuse in Medicaid. CMS should focus analyses on identifying providers that are using telehealth in a suspicious manner, as well as identifying specific behavioral health services that may be particularly subject to fraudulent or wasteful billing. For example, CMS should apply additional scrutiny to providers that are outliers in terms of billing for telehealth services compared with other providers. CMS's role in conducting monitoring and oversight specific to telehealth is particularly important as CMS is able to take a national view and identify schemes that may be common across State Medicaid programs.

Additionally, CMS should work with States to expand their efforts to oversee and monitor telehealth for behavioral health services specifically. This should include supporting States' efforts to work with their program integrity units and Offices of Medicaid Inspectors General, as appropriate. CMS should share information and provide assistance to States, including providing information to States on program integrity concerns specific to telehealth services, as well as sharing best practices of States with robust oversight of telehealth. In addition, this should include supporting States' efforts to communicate and coordinate with managed care organizations to conduct oversight of telehealth services and ensure that these organizations have processes in place to identify fraud, waste, and abuse specific to telehealth.¹⁸

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with one recommendation but did not indicate whether it concurred with the other two recommendations.

CMS concurred with our recommendation to ensure that the three States that are unable to distinguish telehealth from in-person services implement indicators to identify which services are provided via telehealth. CMS stated that it will reach out to the three States to ensure that they are informed about the ways to distinguish telehealth services from in-person services in the claims and encounter systems. OIG appreciates these efforts and looks forward to additional detail in CMS's Final Management Decision.

CMS did not explicitly indicate whether it concurred with our recommendation to conduct evaluations and support State efforts to evaluate the effects of telehealth on access, cost, and quality of behavioral health services. CMS noted that it provided the States with a toolkit and supplement and has provided technical assistance. It further stated that it will consider the results from this study to determine how it can further support State and managed care organization efforts to evaluate the effects of telehealth. We ask that CMS—in its Final Management Decision—provide details on any plans and progress toward implementing our recommendation.¹⁹

CMS also did not explicitly indicate whether it concurred with our recommendation to conduct monitoring for fraud, waste, and abuse, and support State efforts to oversee telehealth for behavioral health services. CMS noted that it is currently monitoring the impact of the COVID-19 pandemic on behavioral health services delivered via telehealth by managed care organizations and has provided States with a Risk Assessment Template to assist State efforts in identifying and addressing program risks. CMS stated it will consider the results from OIG's study to develop ways to support State efforts to oversee behavioral health services delivered via telehealth by managed care organizations. We ask that CMS—in its Final Management Decision—provide details on any plans and progress toward implementing our recommendation.

In its response, CMS noted that there is more work to be done to determine how to effectively conduct monitoring for fraud, waste, and abuse, and support State efforts to oversee behavioral health services delivered via telehealth by managed care organizations. OIG agrees, and we stress to CMS the importance of its role and the need to be active in evaluating and overseeing the use of telehealth. OIG's findings show that, prior to the pandemic, there were opportunities for States to do more to evaluate and oversee the use of telehealth for behavioral health services. Given the growth of, and increased dependence on, telehealth during the pandemic, these opportunities have become even more critical to address, warranting additional steps

by CMS to support and supplement State efforts to evaluate and oversee telehealth. Building on its current efforts in these ways will help CMS to ensure that telehealth meets the behavioral health needs of Medicaid enrollees while protecting the integrity of the Medicaid program.

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.²⁰ We administered the survey electronically in January and February 2020.

Our survey focused on the use of telehealth to provide behavioral health services for Medicaid enrollees. As part of this survey, we asked about whether States are able to distinguish between services provided via telehealth and in-person, and what methods they use (e.g., a modifier or a place of service code on the claim, or telehealth-specific procedure codes). We also asked about States' efforts to evaluate the effects of telehealth on access, cost, and quality of services provided to Medicaid enrollees. While we asked about efforts specific to managed care, the respondents focused on States' efforts to evaluate and oversee the use of telehealth more generally.

Finally, we asked about States' activities to monitor and oversee telehealth for behavioral health services. This included information about State analyses and any audits or other activities that the State conducts. In addition, we asked States to describe any specific fraud or abuse schemes related to telehealth that they have identified.

Structured Interviews With Stakeholders

We conducted structured interviews with key stakeholders from a variety of organizations. These include representatives from national and regional Telehealth Resource Centers, health care coordination organizations, the Health Resources and Services Administration, 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 effects of telehealth on access, cost, and quality for behavioral health services. We also asked about any concerns, as well as successful strategies, for using telehealth to improve access, cost, and quality of behavioral health services for Medicaid enrollees. Finally, we asked stakeholders about monitoring and oversight of telehealth and any fraud

and abuse schemes related to telehealth. 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 24, 2021

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

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

SUBJECT: Office of Inspector General (OIG) Draft Data Brief: Opportunities Exist to Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid (OEI-02-19-00401)

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 appreciates OIG's effort in surveying State Medicaid Directors and various stakeholders to determine how states are overseeing behavioral health services delivered via telehealth for Medicaid beneficiaries. However, as these surveys were conducted in January and 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 reflect states' current efforts in monitoring and evaluating telehealth for behavioral health services; specifically, such services provided through managed care organizations (MCOs), which provided the basis of the OIG's findings and recommendations.

The telehealth landscape has vastly changed and is continuing to rapidly evolve during the PHE. As such, in response to the PHE, CMS has taken a number of actions to support states in their efforts to continue providing care to Medicaid beneficiaries during this tumultuous time, including in those states that use MCOs to administer Medicaid and Children's Health Insurance Program (CHIP) benefits. For example, in 2020, CMS created a dedicated website for Medicaid-related COVID-19 information, which includes links to relevant information regarding COVID-19.¹ As OIG noted, in April 2020, CMS released the Telehealth Toolkit that provides states with statutory and regulatory infrastructure 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.² The Toolkit describes and discusses challenges regarding topics such as patient populations eligible for telehealth, 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 adoption and implementation of telehealth as they begin to plan beyond PHE flexibilities by discussing topics such as communication strategies, telehealth

¹ COVID-19 Medicaid and CHIP Resources, <https://www.medicare.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html>

² Telehealth Toolkit, <https://www.medicare.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>

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operations and implementation tools, and shared experiences and examples from states and territories across the nation.³

CMS continues to discuss telehealth with states on regularly scheduled all-state calls, and will continue to provide one-on-one technical assistance support to states, often through review of the states' submitted State Plan Amendments and discussion of specific state questions on telehealth requirements. CMS also provides technical assistance to states on an ongoing basis on all Medicaid topics including telehealth, and has assigned a State Lead for each state to serve as the central point of contact for any assistance states would need.

In an effort to address vulnerabilities that may arise from the new waivers and flexibilities granted during this time period, while also protecting Medicaid beneficiaries, CMS has built a suite of analyses to detect and address vulnerabilities in the rapidly-changing telehealth landscape. As part of this effort, CMS' Vulnerability Collaboration Council used the Government Accountability Office's Fraud Risk Framework to evaluate the various telehealth waivers and flexibilities issued to states during the PHE to assess associated program integrity risks (including likelihood, financial impacts, and beneficiary impacts) and determine appropriate mitigation activities. Using the results of these risk assessments, CMS also developed a Risk Assessment Template to support state Medicaid agencies' efforts to identify and address program risks associated with COVID-19 PHE waivers, flexibilities, and other requirements.⁴ Specifically, the Risk Assessment Template is a flexible document designed to serve as a starting point for states to implement a risk assessment process by providing a suggested step-by-step approach for identifying, assessing, prioritizing, and addressing program integrity risks that can be tailored as needed to fit each state's unique Medicaid program. The Risk Assessment Template is not limited just to COVID-19 PHE waivers, flexibilities, and other requirements, but can also be used to conduct a risk assessment on any aspect of a state's Medicaid program, including the continued expansion of telehealth services after the PHE, should the state choose to make certain flexibilities permanent.

While CMS maintains close communication with states regarding the administration of their Medicaid programs, states are responsible for overseeing MCOs in a managed care delivery system. As noted above, all 37 states surveyed by the OIG use MCOs to provide behavioral health services via telehealth. Because these services are provided by MCOs and not directly by the state, the MCOs bear the first-line responsibility for maintaining oversight of their services and providers. States' primary oversight responsibilities are to ensure effective oversight of the MCOs, who are in turn conducting such oversight of the services and providers described in the OIG's report. Given that the OIG's surveys are based solely on states' perspectives, it remains unclear to what extent MCOs are conducting oversight of behavioral health services delivered via telehealth. Including the critical MCO perspective in the OIG's report would have provided a more complete and effective analysis of oversight efforts of behavioral health services delivered via telehealth in these 37 states.

Given that many states provide behavioral health telehealth services through MCOs, states have broad flexibility to conduct oversight of such services. 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 setting specifically, and CMS will continue to work with states as issues arise and as the PHE continues to evolve.

³ Telehealth Toolkit Supplement, <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf>

⁴ COVID-19 Risk Assessment Template, <https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx>

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OIG's recommendations and CMS's responses are below.

OIG Recommendation

Ensure that the three States that are unable to distinguish telehealth from in-person services implement indicators to identify which services are provided via telehealth.

CMS Response

CMS concurs with this recommendation. CMS will reach out to the three states identified by the OIG to ensure that they are informed about the ways to distinguish telehealth services from in-person services in the claims and encounter systems, if the state has not already done so during the intervening 18 months since the interviews were conducted.

OIG Recommendation

Conduct evaluations, and support State efforts to evaluate the effects of telehealth on access, cost, and quality of behavioral health services.

CMS Response

CMS has supported state telehealth efforts by providing states with a toolkit, including a supplement, of resources regarding implementing and delivering Medicaid services via telehealth. CMS will continue to provide technical assistance to states on an ongoing basis on all Medicaid topics, including behavioral health services delivered via telehealth by MCOs. The telehealth landscape is continuing to evolve in the ongoing PHE, and states' oversight efforts have changed drastically since the OIG conducted their state surveys in January and February of 2020. However, CMS will consider the results from the OIG's surveys to determine how CMS can further support state and MCO efforts to evaluate the effects of telehealth on access, cost, and quality of behavioral health services.

OIG Recommendation

Conduct monitoring for fraud, waste, and abuse, and support State efforts to oversee telehealth for behavioral health services.

CMS Response

CMS is currently monitoring the impact of the COVID-19 PHE on behavioral health services delivered via telehealth by MCOs and has provided states with a Risk Assessment Template to assist state efforts in identifying and addressing program risks associated with PHE waivers, flexibilities, and other requirements. CMS appreciates the OIG's work in this pre-PHE area, but believes there is more work to be done to conclusively determine how to effectively conduct monitoring for fraud, waste, and abuse, and support state efforts to oversee behavioral health services delivered via telehealth by MCOs. The telehealth landscape is continuing to evolve in the ongoing PHE, and states' oversight efforts have changed drastically since the OIG conducted their state surveys in January and February of 2020. However, CMS will consider the results from the OIG's surveys to determine their relevance in the current telehealth landscape and develop ways to support state efforts to oversee behavioral health services delivered via telehealth by MCOs.

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To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ENDNOTES

¹ See OIG, States Reported Multiple Challenges With Using Telehealth To Provide Behavioral Health Services to Medicaid Enrollees (OEI-02-19-00400).

² See 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.

³ This represents individuals enrolled in any Medicaid managed care program, including comprehensive managed care, limited benefit managed care, and Primary Care Case Management. See Centers for Medicare and Medicaid Services (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.

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

⁵ 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.

⁶ Managed care organizations include organizations that administer prepaid inpatient health plans, prepaid ambulatory health plans, comprehensive managed care plans, limited benefit managed care, and Primary Care Case Management.

⁷ 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.

⁸ 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.

⁹ For more information about concerns with the use of modifiers, 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.

¹⁰ Federal regulations require States to have a written strategy for assessing and improving the quality of health care services offered by all managed care organizations, including required standards for access to care (see 42 CFR § 438.202(a) and 42 CFR § 438.206(b)(1)). Further, CMS requires States to demonstrate that payment amounts are reasonable, appropriate, and attainable. Finally, States are responsible for ensuring that payments for Medicaid services are directly linked to quality improvement. See CMS, RE: Additional Guidance on State Directed Payments in Medicaid Managed Care, January 8, 2021. Accessed at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf> on March 18, 2021.

¹¹ See CMS, Comprehensive Medicaid Integrity Plan for Fiscal Years 2019 – 2023. Accessed at <https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf> on January 27, 2021.

¹² In addition to State responsibilities, managed care organizations also have responsibilities to conduct oversight and monitoring. Through its contract with a managed care organization, the State must require that the managed care organization implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. See 42 CFR § 438.608.

¹³ 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>.

¹⁴ 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.

¹⁵ See CMS, Medicaid and CHIP COVID-19 Summaries, Preliminary Medicaid & CHIP Data Snapshot. Accessed at <https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf> on June 23, 2021.

¹⁶ These organizations are known as External Quality Review Organizations, or EQROs. EQROs must conduct four mandatory activities each year. There are also six optional activities, including focus studies on quality of care. The State has discretion to determine which optional activities, if any, to conduct. For more information about these organizations see: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html>.

¹⁷ 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.

¹⁸ In a prior report, OIG recommended that CMS provide assistance to States to help facilitate improvement of communication and coordination between managed care organizations and State-level program integrity entities. These entities include Medicaid Program Integrity Units, State Offices of Inspectors General, State auditors, and others. See OIG, Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse (OEI-02-15-00260), July 2018, available at <https://oig.hhs.gov/oei/reports/oei-02-15-00260.pdf>.

¹⁹ 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.

²⁰ 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."