State Medicaid Waivers and Telehealth

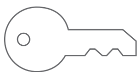
Background

"States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services."[1]

Like the Medicare waiver, the available telehealth flexibility allows Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that risk of exposure and spread of the virus can be limited.

According to an outline of telehealth benefits "States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services."[2]

CMS also released a bulletin to assist states in understanding policy options for telehealth services. The overview and sample state plan language apply to Medicaid fee-for-service payments and additional considerations may be warranted for states interested in offering telehealth within other delivery systems. CMS encourages states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care.[3]



Some of the key take-aways from this bulletin include:

- ✓ States are not required to submit a State Plan Amendment (SPA) to pay for telehealth services if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting.
- ✓ States may pay a qualified physician or other licensed practitioner at the distant site (the billing provider) and the state's payment methodology may include costs associated with the time and resources spent facilitating care at the originating site. The billing provider may distribute the payment to the distant and originating sites.
- ✓ States may also pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for the delivery of telehealth services. A state would need an approved state plan payment methodology that specifies the ancillary costs and circumstances when those costs are payable.
- ✓ Ancillary costs associated with the originating site for telehealth may be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state when a Medicaid service is delivered. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth and properly allocated to the Medicaid program.
- ✓ States are encouraged to reach out to their state lead as soon as possible, if they are interested in submitting a state plan amendment.

Despite this general guidance, states often have varied and unique services and benefit requirements. Therefore, in lieu of attempting to list the varied details of each plan and their corresponding waivers, nThrive has located two resources that enables our clients to link to plan details based on each state:[4]

https://www.cchpca.org/resources/covid-19-related-state-actions

https://mtelehealth.com/home/reimbursement-policies/TX-state-telehealth-laws-and-reimbursement-policies/

The links address several Medicaid issues and waivers for each state in addition to those that address telehealth services. Many of the waivers address flexibility in the plans themselves versus the benefits.

Appendix K Waivers may be found at:

https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html

Waivers to state governed insurance rules and guidelines are granted on a state-by-state basis Unlike Medicare, where the federal government issued blanket waivers, the Medicaid programs must apply individually for waivers. nThrive has endeavored to compile a list of the 1135 waivers, current as of March 26, 2020, in the table below. This table may be updated as additional plan waivers are approved.[5]

STATE	Prior Auth	Prior Auth Extension	PASRR Waiver	Hearing & Appeals	Provider Enrollment	Alternate Settings	SPA Flexibilities	Tribal Consults
Alabama			✓					
Arizona		✓			✓			
California		✓		✓	✓	✓		
Florida		✓	✓	✓	✓	✓		
Illinois		✓	✓	✓	✓	✓		
Indiana		✓	✓	✓	✓	✓		
Iowa			✓					
Kentucky			✓	✓	✓	✓		
Kansas		✓	✓	✓				
Louisiana			✓	✓	✓	✓		
Mississippi		✓	✓	✓	✓	✓		
Missouri		✓	✓	✓	✓	✓	✓	
New Hampshire		✓	✓	✓	✓	✓		
New Mexico		✓	✓	✓	✓			
New Jersey		✓	✓	✓	✓	✓		
N Carolina			✓	✓	✓	✓		
N Dakota		✓	✓	✓	✓			✓
Oklahoma			✓	✓	✓	✓		
Puerto Rico					✓			
Rhode Island		✓		✓	✓			
S Dakota			✓	✓	✓	✓		
Virginia		✓		✓				
Washington	✓		✓	✓	✓	✓	✓	✓

Definitions

Prior Authorization: CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services provided on or after March 1, 2020 through the termination of the emergency declaration for at least 90 days and up to 180 days (up to the last day of the emergency period under section 1135(e) of the Act). This pertains to beneficiaries with a permanent residence in the geographic area of the public health emergency declared by the Secretary.

Prior Authorization Extension: CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services approved to be provided on or after March 1, 2020, to continue to be provided without a requirement for a new or renewed prior authorization, through the termination of the public health emergency, including any extensions (up to the last day of the emergency period under section 1135(e) of the Act).

PASRR: Section 1919I (7) of the Act allows Level I and Level II assessments to be waived for 30 days. All new admissions can be treated like exempted hospital discharges. After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available.

Fair Hearing and Appeals: CMS approves a waiver under section 1135 that allows enrollees to have more than 90 days, up to an additional 120 days for an eligibility or fee for service appeal to request a fair hearing. Modification of the timeframe for managed care entities to resolve

appeals under 42 C.F.R. §438.408(f)(1) before an enrollee may request a State Fair Hearing to no less than one day in accordance with the requirements specified below; this allows managed care enrollees to proceed almost immediately to a state fair hearing without having a managed care plan resolve the appeal first; it permits the state to modify the timeline for managed care plans to resolve appeals to one day so the impacted appeals satisfy the exhaustion requirements.

Modification of the timeframe under 42 C.F.R. §438.408(f)(2) for enrollees to exercise their appeal rights to allow an additional 120 days to request a fair hearing when the initial 120th day deadline for an enrollee occurred during the period of this section 1135 waiver.

CMS approves a modification of the timeframe, under 42 C.F.R. §438.408(f)(2), for managed care enrollees to exercise their appeal rights. Specifically, any managed care enrollees for whom the 120-day deadline described in 42 C.F.R. §438.408(f)(2) would have occurred between March 1, 2020 through the end of the public health emergency, are allowed up to an additional 120 days to request a State Fair Hearing.

Provider Enrollment: Relaxation of some criteria, but not all criteria related to:

- ✓ Payable claims from out-of-state providers.
- ✓ Provisionally, temporarily enroll the out-of-state provider for the duration of the public health emergency to accommodate participants who were displaced by the emergency.
- ✓ Provisionally, temporarily enroll the providers for the duration of the public health emergency.
- ✓ Temporarily cease revalidation of providers who are otherwise directly impacted by the emergency.

Alternate Setting: CMS approves a waiver under section 1135(b)(1) of the Act to allow facilities, including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs), and hospital NFs, to be fully reimbursed for services rendered to an unlicensed facility (during an emergency evacuation or due to other need to relocate residents where the placing facility continues to render services) provided that the State makes a reasonable assessment that the facility meets minimum standards, consistent with reasonable expectations in the context of the current public health emergency, to ensure the health, safety and comfort of beneficiaries and staff. The placing facility would be responsible for determining how to reimburse the unlicensed facility.

State Plan Amendment Flexibility: SPAs related to the COVID-19 emergency by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. §430.20. CMS is approving this request pursuant to section 1135(b)(5) of the Act. This approval applies only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to alternative benefit plans (ABPs) to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof).

Public notice for SPAs is required under 42 C.F.R §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to ABPs. These requirements help to ensure that the affected public has reasonable opportunity to comment on these SPAs. CMS is approving the state's request to waive these notice requirements applicable to SPA submissions. Even though CMS is approving this waiver, we encourage the state to make all relevant information available to the public, so they are aware of the changes.

- ✓ **Tribal Consults**: The state has flexibility in modifying their tribal consultation timeframe, including shortening the number of days before submission or conducting consultation after submission of the SPA.

Guidance

- ✓ Review Medicaid plan waivers applicable to your State.
- ✓ Implement strategies as appropriate.
- ✓ Utilize the link provided to review telehealth and other program benefit changes resulting from the COVID-19 health emergency.

Sources

1. https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
2. https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html
3. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf
4. © Public Health Institute/ Center for Connected Health Policy 2019: http://cchpca.org
5. https://www.cms.gov/newsroom/press-releases/cms-approves-medicaid-section-1135-waivers-11-additional-states-response-covid-19 ■