Moving Beyond COVID-19: Considerations for Using PHE Flexibilities to Improve Person-Centered Care

FRIDAY, MARCH 3, 2023

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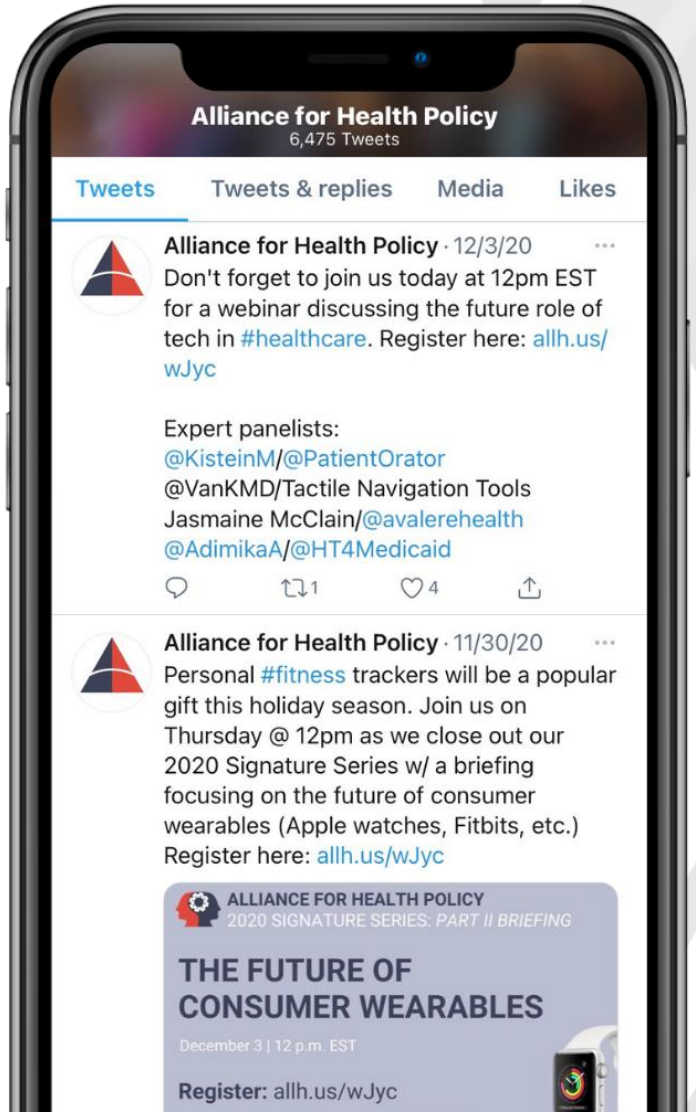

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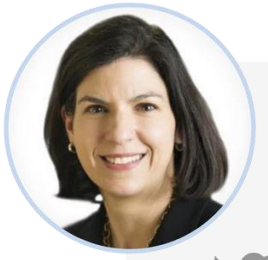

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March 3, 2023

Kristal Vardaman, PhD, MSPH

Aurrera HealthGroup™

Mission driven. Forward thinking.

Key Dates

Date	Milestone
January 21, 2020	First confirmed case of COVID-19 in the United States
January 31, 2020	COVID-19 declared a public health emergency
March 6, 2020	Enactment of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020
March 13, 2020	COVID-19 declared a national emergency; HHS Secretary invoked Section 1135 authority
March 18, 2020	Enactment of the Families First Coronavirus Response Act
March 22, 2020	CMS issued Medicaid waiver templates to assist states
March 27, 2020	Enactment of the Coronavirus Aid, Relief, and Economic Security (CARES) Act
March 11, 2021	Enactment of the American Rescue Plan Act of 2021 (ARP)
December 29, 2022	Enactment of the Consolidated Appropriations Act, 2023

Key Accomplishments

- Medicare
  - As of January 2021, CMS had issued over 130 blanket Medicare waivers and over 100 additional Medicare waivers
  - Waivers included expanding hospital and workforce capacities as well as telehealth waivers
- Medicaid
  - As of December 2020, CMS had approved over 600 Medicaid waivers, state plan amendments, and other flexibilities
  - Included tools to help serve beneficiaries in home and community-based settings

Source: Government Accountability Office, 2021, GAO-21-575T

Looking Ahead

- Which flexibilities should federal and state policymakers make permanent?
- What can we learn about the outcomes of these flexibilities?
- Will a future evidence base support additional policy changes?

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Leveraging COVID-19 PHE Flexibilities to Advance Person-Centered Care for Older Adults and People With Complex Care Needs

A Roadmap for Policymakers

March 3, 2023

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Background and Context

Background and Context

January 2020
Public Health Emergency (PHE) Declared

In response to the COVID-19 pandemic public health emergency (PHE), the federal government and states approved hundreds of temporary Medicare and Medicaid regulatory flexibilities to minimize administrative, clinical and financial barriers to care.

March 2022
Publication of issue brief and policymaker playbook: *Learning From COVID-19-Related Flexibilities: Moving Toward More Person-Centered Medicare and Medicaid Programs*

In anticipation of the PHE ending, with support from The SCAN Foundation, HMA and Manatt identify PHE flexibilities with the greatest promise to foster flexible, person-centered care delivery.

Summer 2022
Stakeholder and Expert Engagement

The SCAN Foundation supported several organizations to engage diverse stakeholders and subject matter experts to advise policymakers on future role of those flexibilities.

January 2023
Publication of *Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers*

The Roadmap provides guidance for federal and state leaders in their decision-making on which Medicare and Medicaid COVID-19 PHE flexibilities may be worth continuing on a permanent basis and can be used to prepare for future emergencies.

May 11, 2023
End of PHE

Biden Administration announced decision to end the PHE declarations that pertain to COVID-19 in May.

COVID-19 PHE Flexibilities Working Group Members

Name	Organization
LaRae Cantley	Camden Coalition's National Center for Complex Health and Social Needs
Josephina Carbonell	Independent Living Systems, LLC, and Florida Community Care
Lindsey Copeland, J.D.	Medicare Rights Center
Scott Cormier, CHEP, and Kelly Randall, Ph.D.	Ascension
Karen M. Dale, MSN, R.N.*	AmeriHealth Caritas
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Brian Hasselfeld, M.D.*	Johns Hopkins Medicine
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Michael Monson, MPP*	Altarum
Jennifer E. Moore, Ph.D., R.N., FAAN*	Institute for Medicaid Innovation
Sarah Hudson Scholle	National Committee for Quality Assurance
Hemi Tewarson, J.D., MPH*	National Academy for State Health Policy
Josh Trent, M.A. *	Leavitt Partners, an HMA Company
Sophia Tripoli, MPH*	Families USA
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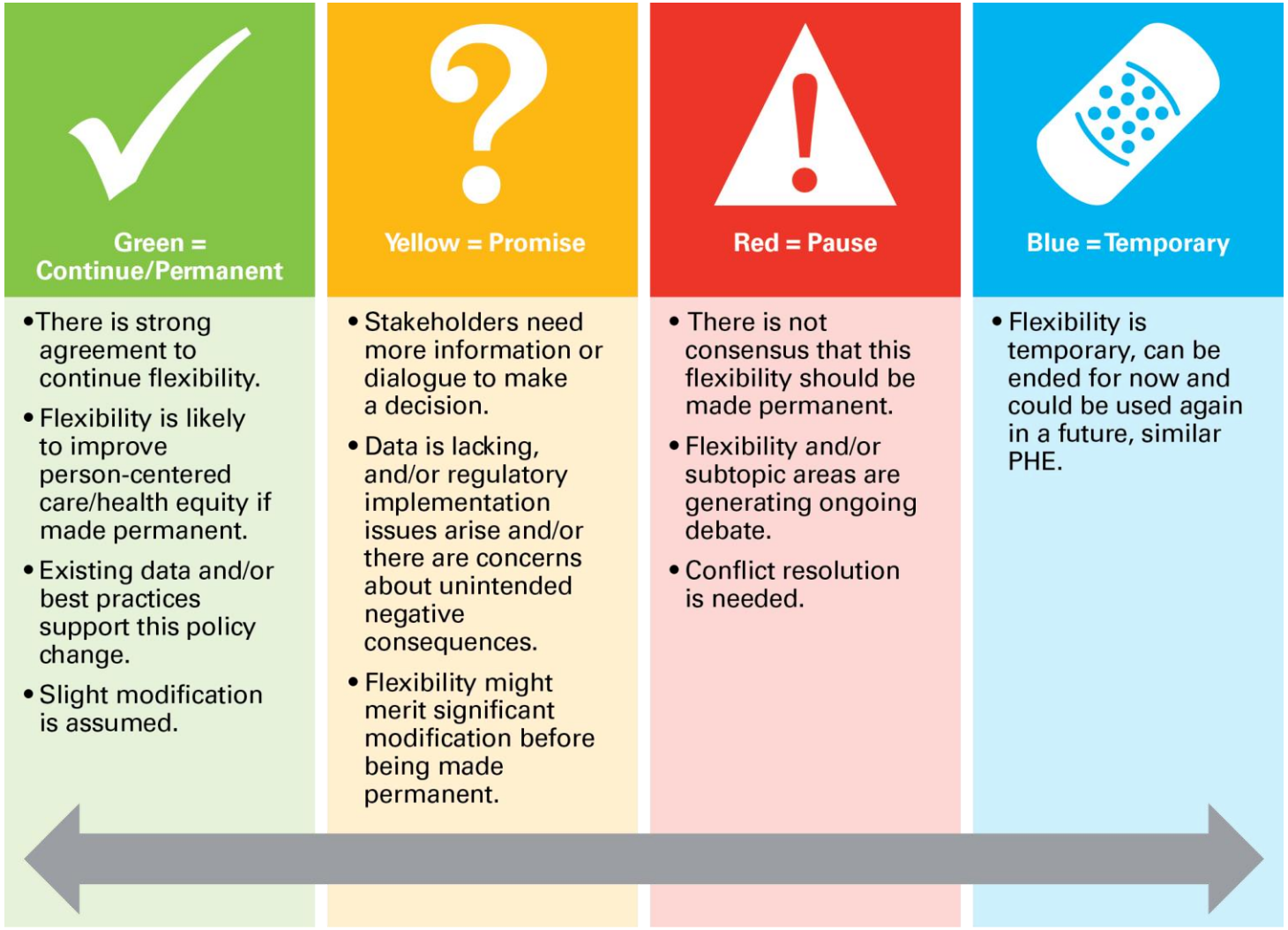
* Denotes participation in this Working Group as an individual only. Their affiliation is listed here only as identification and does not reflect that their organization endorses, agrees with or supports this Roadmap.

PHE Flexibilities Decision-Making Framework



Six Guiding Principles

1	Prioritize maintaining Medicare and Medicaid flexibilities that enable person-centered care: health care that is guided by an individual's personal values and preferences and is designed to help people achieve what matters to them most.
2	Prioritize health equity in programs and policies for the attainment of the highest level of health for all people.
3	Recognize that federal and state data collection, monitoring, oversight and transparent reporting are essential to support policymakers in monitoring access, quality of care and costs, and that the perspectives of people who are impacted by the policies must inform these processes.
4	Prioritize equitable access to health care regardless of the type of coverage or insurance status.
5	Recognize that state governments differ in the contexts guiding their considerations of certain flexibilities and that these differences also influence the effect of federal flexibilities across states.
6	Recognize that as policymakers advance person-centered and equitable care, they will need to consider multiple goals, such as beneficiary protections, program integrity and budget constraints.

Priority Flexibilities Fall into Three Overarching Categories

The Working Group prioritized certain flexibilities based on their ability to advance person- and community-centered care in the least intensive or least restrictive setting and better align Medicare and Medicaid program rules.

Category	Description
Expand Telehealth Benefits	Targeted and equitable expansion of remote care delivery opportunities, particularly telehealth, for all beneficiaries.
Modify Provider Scope of Practice and Related Requirements	Modifications to provider licensure, scope of practice, qualifications and payment rates to strengthen and expand the workforce (clinical providers, direct care workers and paid family caregivers).
Other Temporary Flexibilities	Adjustments to other Medicare and Medicaid program requirements such as three-day prior hospitalization requirement for skilled nursing facility (SNF) stays, self-directed home- and community-based services (HCBS) and financial eligibility rules.

Assessing the Medicare Flexibilities

Medicare Flexibilities Examined Are a Snapshot of the Full Set of Medicare Waivers

The consensus recommendations considered operational feasibility as well as the 6 guiding principles:

- Medicare flexibilities were designed to waive or modify the way Medicare providers and suppliers can deliver care and services.
- The Working Group noted as part of their deliberations
  1. The existing regulatory and programmatic infrastructure is not equipped to deliver the care provided through these flexibilities sustainably or at scale.
     - Need to identify and adopt well-designed guardrails to ensure that these new permanent policies can operate seamlessly within the broader Medicare program.
     - The Working Group members would like to see CMS make conforming changes to its operational structure, including provider enrollment, payment and beneficiary protection requirements for any flexibilities made permanent.
  2. Broader policy debate occurring around Medicare - financing issues, value-based care, workforce issues and initiatives to improve health equity
  3. Role of Medicare Advantage—plan financing, risk adjustment, beneficiary access and other programmatic requirements
  4. Despite complexity, important to focus on approaches to achieve person-centered care across Medicare and Medicaid.

Summary of Medicare Flexibilities

Medicare Flexibility	Working Group Consensus recommendation
Allow Medicare to reimburse for telehealth in urban areas	
Allow Medicare to reimburse for telehealth from any location the patient prefers, including patients' homes	
Allow Medicare to reimburse for audio-only telehealth services when these are needed or preferred by patients	
Allow Medicare to reimburse for nonphysician practitioners to provide telehealth services	
Set payment rates for evaluation and management visits equal for telehealth and in-person	
Allow Medicare to reimburse if the practitioner is allowed to practice across state lines, subject to state licensure flexibilities, etc. (enrollment, Medicare-based policies and payment)	
Include diagnoses that Medicare Advantage (MA) organizations collect by two-way, audio-video, and by audio-only telehealth for risk adjustment	
Continue federal flexibilities to permit physicians to delegate tasks to nonphysician practitioners in skilled nursing facilities (SNF) to the extent allowed by state licensure	
Continue federal flexibilities to waive physician supervision of certified registered nurse anesthetists at the discretion of the hospital, critical access hospital, or ambulatory surgical center to the extent state licensure or scope of practice allows	
Continue federal flexibilities to reduce the requirement for physician supervision of nurse practitioners (NP) in federally qualified health centers (FQHC) and rural health clinics (RHC) to the extent licensure allows	
Continue federal flexibilities to allow physicians to delegate skilled nursing facility (SNF) visits to a nurse practitioner, physician assistant, or clinical nurse specialist to the extent state licensure allows	
Allow Medicare Advantage (MA) to enhance benefits midyear that were not included in the original bid	
Waive three-day prior hospitalization requirement for skilled nursing facility (SNF) stays	

The Roadmap Recommendations and the Consolidated Appropriations Act and End of the PHE

Medicare policies changing in the coming months

- The CAA decoupled many of the Medicare telehealth flexibilities from the PHE. The Working Group supported the continuation of these flexibilities. They are represented by green votes.
- However, certain other flexibilities that also were supported such as practicing across state lines and other provider enrollment requirements will sunset at the end of the PHE in May.
- The Working Group noted potential operational issues surrounding some of these flexibilities. They also encouraged further study to determine whether the flexibilities would be appropriate to continue and if modifications are needed.

Medicare Example: Expand Telehealth Benefits

Medicare Flexibility: Set Payment Rates for E/M Visits Equal for Telehealth and In-Person

Policy Context	Areas for Modification or Further Study, Monitoring or Evaluation
Under current law, Medicare pays the facility rate to providers for telehealth services regardless of whether they were provided in a facility or non-facility setting.	Congress and CMS should monitor the utilization of telehealth services but implement policies to maintain beneficiary access to evaluation and management visits delivered via telehealth. Flexibility can be made permanent as long as it is monitored for the principles and evaluated over time to ensure each type of service is paid at a rate to reflect the appropriate resources needed to deliver the care.

Medicare Example: Ease Program Requirements

Medicare Flexibility: Waive 3 Day Stay for SNF Admissions	
Policy Context	**Areas for Modification or Further Study, Monitoring or Evaluation**
Law requires a beneficiary have been a hospital inpatient for three days before Medicare will pay for a stay in a skilled nursing facility	Changes to this provision will improve person-centered care and can help address health equity and disparity issues.

Assessing the Medicaid Flexibilities

Medicaid Flexibilities Focus on Enhancing Access to Long-Term Services and Supports (LTSS) for Older Adults and People With Disabilities

The consensus recommendations relate to how states should consider the flexibilities as part of their Medicaid policy toolkit if their goal is to advance person-centered, equitable health care:

1. States can implement these policies under existing Medicaid authorities outside of a PHE. Going forward, individual state circumstances will guide policy decisions and modifications related to the PHE flexibilities.
2. The Working Group assessed the Medicaid flexibilities based on their ability to:
    a. Address persistent challenges in accessing person-centered care and equitable care, such as chronic workforce shortages and disparate access to telehealth
    b. Minimize misaligned Medicare and Medicaid policies; for the over 12 million dual-eligible individuals and their providers, a return to pre-COVID Medicare policies in some cases could perpetuate administrative/regulatory burden for providers
3. To the extent states avail themselves of these flexibilities on a permanent basis, they should:
    a. Consider the broader applicability of these LTSS-specific flexibilities across many Medicaid services, such as primary care, hospital and behavioral health services.
    b. Evaluate and share impacts on beneficiary health care access, quality and outcomes, an on providers and payers.
4. As Medicaid is a joint federal-state program, the federal government has a responsibility to provide Medicaid oversight, FFP, quality monitoring, best practice sharing and additional research related to these flexibilities.

Summary of Consensus Approach on Medicaid Flexibilities

Medicaid Flexibility	Working Group Consensus Recommendation
Expand utilization of state plan LTSS and HCBS waiver remote service benefits	
Expand remote service delivery to include audio-only modalities	
Allow out-of-state providers to provide and receive payment for long-term services and supports (LTSS) through expedited licensing processes and modified requirements, or under special circumstances*	
Expand the number and types of providers eligible to order and provide LTSS/HCBS (e.g., authorizing nonphysician practitioners to order services without physician supervision)	
Temporarily increase payment rates for HCBS to maintain provider capacity despite service suspensions and volume reductions	
Provide retainer payments to LTSS providers to maintain provider networks despite reductions in service utilization	
Institute or expand opportunities for self-directed HCBS (e.g., personal support, transportation, personal care attendant, home-delivered meals), including expanding access to paid family caregiving	
Apply less restrictive income or asset rules or counting methodologies for individuals most likely to use LTSS (e.g., eliminating resource tests for people with disabilities, not counting unemployment compensation)	

*Note: Working Group members suggested that the Medicare and Medicaid out-of-state provider flexibilities should be captured as Medicaid flexibilities. The Medicaid flexibilities in this report are focused on LTSS/HCBS, which are not typically covered by Medicare. However, the Working Group recommended that if covered, CMS enable Medicare to reimburse these providers to the extent a state allows.

Medicaid Example: Expand Telehealth Benefits

Medicaid Flexibility: Expanded the use of state plan LTSS and HCBS waiver remote service benefits

Policy Context	State Examples	Areas for Modification or Further Study, Monitoring or Evaluation
• This flexibility enabled providers (and more types of providers) to provide care virtually to minimize exposure to COVID-19 for beneficiaries and providers and to support beneficiaries in their ability to use remote service benefits. • This flexibility was critical to ensure seamless and safe access to care and services as shutdowns and quarantines occurred.	• Idaho allowed 1915(c) waiver participants to receive most waiver services (e.g., respite, supported employment, financial management, adult day care) remotely; • Colorado allowed individuals to receive LTSS via telephone or live chat function and removed a requirement for an initial face-to-face visit prior to using telehealth; • California added assistive technology (computer monitors, cameras, speakers, electronic devices that stream video, installation, repairs and participant training on the technology) as a 1915(c) waiver service to facilitate use of remote service delivery.	• States should consider the impacts on workforce shortages and equitable access to broadband and telehealth-enabling equipment, such as computers, by race, ethnicity, age, disability, geography and other measures

Medicaid Example: Modify Provider Scope of Practice and Related Requirements

Medicaid Flexibility: Provided retainer payments to LTSS providers to maintain provider networks despite reductions in service utilization.

Policy Context	State Examples	Areas for Modification or Further Study, Monitoring or Evaluation
• This flexibility enabled states to ensure HCBS provider sustainability when there are interruptions in service delivery that could jeopardize the provider's financial viability and, thus, access to care. Because Medicaid payments are typically tied to service use (versus lack of service use), CMS permits these payments under limited circumstances (e.g., types of providers, amounts) and for limited time periods.	• Arizona extended retainer payments to habilitation and personal care service providers; • Delaware provided retainer payments across various state plan and HCBS waiver service providers when a participant is hospitalized or otherwise not using services, when the provider's overall attendance and use drop by 50%, or when the state deems it necessary to preserve its provider network; • Washington D.C. provided retainer payments equal to 25% of the standard per diem rate to adult day care providers when a participant was unable to attend and the service was not delivered remotely.	• States should develop PHE-related provider or health plan contract clauses or addendums or develop a "playbook" with lists of flexibilities they can deploy based on the type of PHE (e.g., natural disaster, infectious disease pandemic).

Medicaid Example: Ease Program Requirements

Medicaid Flexibility: Applied less restrictive income or asset rules or counting methodologies for individuals most likely to use LTSS (e.g., eliminating resource tests for people with disabilities, not counting unemployment compensation)

Policy Context	State Examples	Areas for Modification or Further Study, Monitoring or Evaluation
• This flexibility, which states can adopt outside of a PHE, as recently clarified in SMD# 21-004 re: Medicaid rule of construction, helped reduce the number of uninsured people and expand access to HCBS for people needing these services during the COVID-19 pandemic.	• Washington did not count unemployment compensation in the Medicaid financial eligibility test for people eligible based on age or disability	• States should balance potentially competing goals of expanding access to Medicaid-covered LTSS in a way that enables people to preserve more of their assets for other life expenses that allow them to remain in the community, delaying or avoiding more costly institutional services, and acknowledging resource constraints and the need to meet state balanced-budget requirements.

QUESTIONS?

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30 YEARS

March 3, 2023

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The Medicaid Policy Context

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Overview

- About MACPAC
- Medicaid policy context
- Telehealth in Medicaid: Pre-PHE
- Telehealth in Medicaid: During the PHE
- The evolving policy context

The Medicaid and CHIP Payment and Access Commission (MACPAC)

- Provides analysis and advice to Congress and HHS on Medicaid and CHIP policy issues
- 17 commissioners appointed by GAO
- Reports annually on March 15 and June 15
- Technical assistance to Congress
- Information resource to states and the broader health policy community

The Medicaid Policy Context

Definition

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth is not a benefit, but a way to deliver services.

Federal Rules

- States have substantial flexibility to design telehealth coverage
- Where states limit telehealth to certain providers or regions, they must provide access to in-person visits
- SPAs are not needed except in some circumstances
- State scope of practice rules apply

Telehealth in Medicaid: Pre-PHE

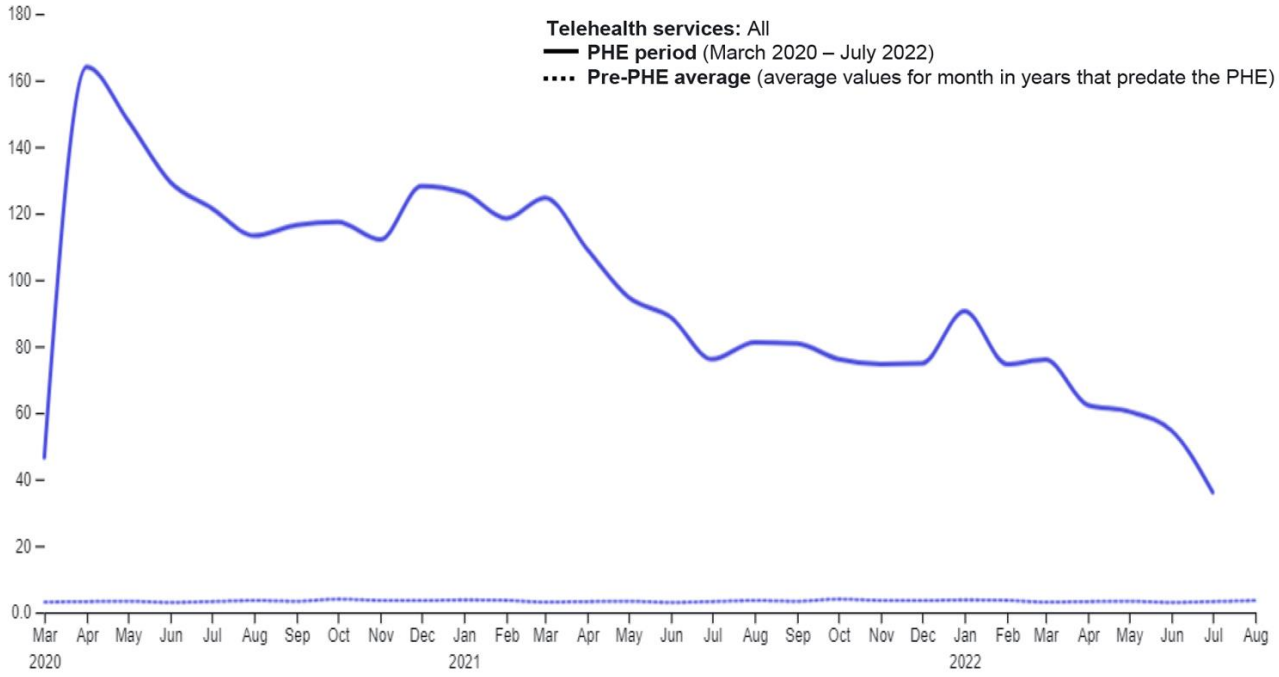
- Substantial state flexibility to cover telehealth
- Nearly all state Medicaid programs provided some coverage of telehealth
- Considerations for state telehealth decisions (e.g., connectivity and technology, licensure, privacy, provider workflow)
- Little published data or research on Medicaid use, spending, or outcomes of telehealth

Telehealth in Medicaid: During the PHE

- Federal rules remained flexible
- CMS issued telehealth guidance and toolkits
- Rapid expansion of state coverage of telehealth: services, providers, and modalities
- Unprecedented use of telehealth (e.g., behavioral health)

Telehealth use has declined since April 2020 but remains high compared to pre-PHE years

Number of services delivered via telehealth per 1,000 Medicaid and CHIP beneficiaries during the PHE, by month



Note: Data for recent months are likely to be adjusted upward due to claims lag.

Source: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2023. *Medicaid and CHIP and COVID-19 public health emergency. Preliminary Medicaid and CHIP data snapshot. Services through July 31, 2022.* Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-07312022.pdf.

The Evolving Policy Context

- States are considering post-PHE telehealth policies
  - Permanent changes to state telehealth policies
  - Some contraction of PHE-era policies (e.g., audio only?, payment parity?)
  - Pre-PHE considerations still relevant
- Emerging considerations
  - Equitable access
  - Network adequacy
  - Program integrity
  - Quality
- Additional research on access, cost, quality, outcomes, and beneficiary and provider experience

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Considerations for Telehealth Policy

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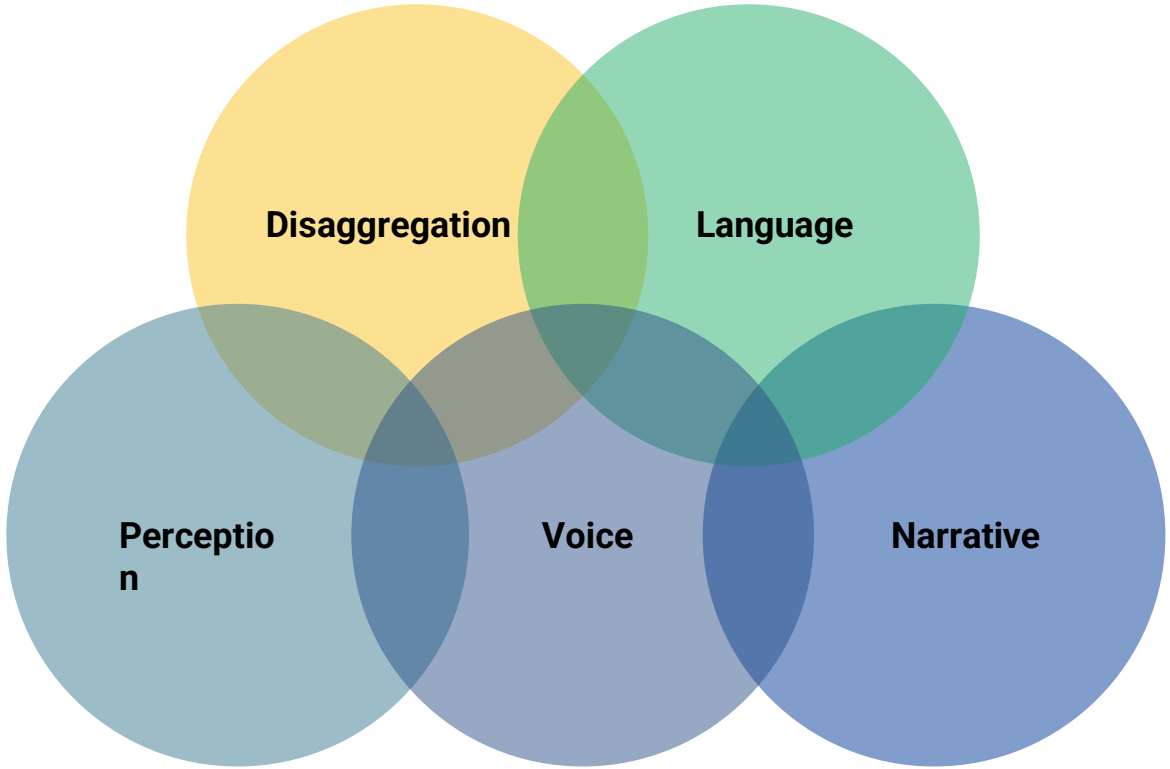
HealthTech 4 Medicaid's Purpose

HealthTech4Medicaid (HT4M) is dedicated to supporting innovation in Medicaid. Our purpose is to further improve quality, equity and access to care for Medicaid recipients, their families and communities.

We are a mission-based market enabler that facilitates cross-sectoral, collaborative partnerships in health technology nationwide. We radically change the pace of innovation in Medicaid through innovative program service delivery, infrastructure/ecosystem development and issue/policy advocacy to facilitate cutting-edge forums and partnerships for entrepreneurs, payers, providers, policymakers, advocates, investors and the Medicaid community.

Framework: Considerations for Telehealth Policies

The United State's public health emergency exposed deficiencies in the healthcare system, serving as a catalyst to advanced telehealth care policies, efforts, and practices. Since then, telehealth has become an tool to address health system barriers, increase access to care, and improve affordability for patients.



Tethered Untanglement of Medicaid

The Consolidated Appropriations Act 2023 (signed into law on Dec 29, 2022), decouples Medicaid continuous enrollment provision from the PHE and terminates the provision on March 31, 2023. States can begin disenrolling people from Medicaid as early as April 1, 2023.

Unpack:

1. Medicaid/CHIP enrollment grew to 91.3 Million (as of October 2022) from 20.2M in February 2020
    a. Let's ask ourselves "who are these new enrollees?"
    b. Economic conditions spurred by the pandemic
    c. The newly adopted Medicaid expansion, namely Nebraska, Missouri and Oklahoma
    d. Continuous enrollment provision (Families First Coronavirus Response Act)
        i. LIFE "PRESERVER" that allowed coverage to continue due to the prevention of States being able to disenroll

WHAT'S HAPPENING WITH MEDICAID REDETERMINATION IN 2023?

During the COVID-19 Public Health Emergency, Medicaid disenrollments were paused in every state. Through the Families First Coronavirus Response Act and additional federal Medicaid funding that states received during the pandemic, Medicaid enrollees did not have to face redetermination.

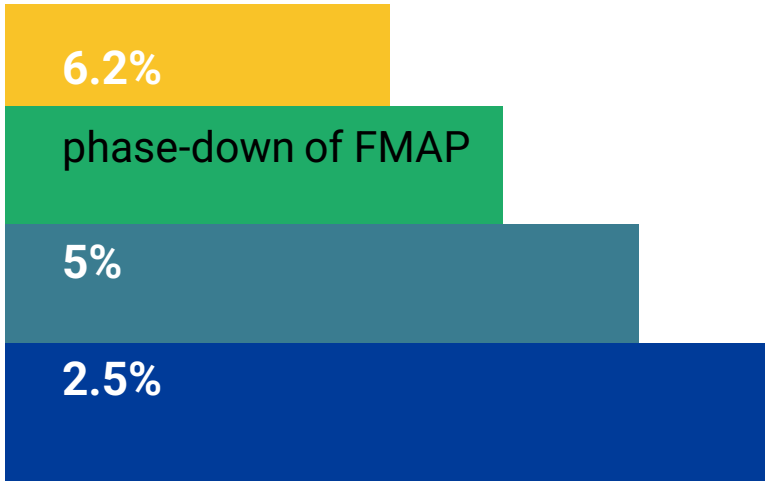
The Consolidated Appropriations Act, 2023 has called for continuous coverage to end on March 31, 2023. States will be able to resume Medicaid disenrollment starting April 1, 2023.

Consequently, **an estimated 18 million people could lose their Medicaid coverage this year.**

Follow the $$ (FMAP)

The continuous coverage provision increased State spend for Medicaid, although many estimate that the enhanced Federal funding from a 6.2% increase in FMAP may have balanced or exceeded State costs.

STAIRSTEPS:



Starting April 1, 2023, States can resume Medicaid disenrollments and

April 1 – June 30, 2023

July 1– September 30, 2023

October 1 – December 31, 2023

States are required to maintain up-to-date contact information and attempt to contact enrollees prior to disenrollment if or when mail is returned.

Telehealth Lessons Learned from the PHE

CHURN BURN – We learned that the temporary loss of coverage common in Medicaid was stopped or slowed.

a) Short-term changes in income
b) Circumstances that suddenly make you ineligible for Medicaid

CHURN CAUSES – Access problems, barriers to, additional and typically unnecessary administrative costs

RISK – We already had a population of about 22.5M who qualified for Medicaid and will not/have not/likely will not ever get on the program.

Barriers to coverage due to renewal processes, periodic eligibility checks, not understanding notices, not receiving notices, forms requesting additional information or do not respond in reasonable timeframes due to other life events

What Did We Already Know?: the Patient Perspective

Medicaid – Assuming you were a full benefit Medicaid beneficiary, it was common for there to be gaps in coverage

a) 10.3% gaps were less than a year
b) 9.1%, 4.25% were disenrolled and then re-enrolled within 3 months
c) 6.9% were dis-enrolled and re-enrolled within 6 months

CHIP – We have seen case studies and horror stories how pre-pandemic churn rates more than doubled following annual renewal

State Operational Plans

Where We Are Now: the Patient Perspective

Who is at risk?

- People who have moved in State and across State lines during the pandemic
- People who do not have adequate or accurate data in system
- People with limited English proficiency
- People who rely on caregivers or family members to assist them with communicating with Medicaid
- People with disabilities
- People with traditional mistrust of the government
- People with poor loyalty relationships with MCO, caregiver or other government re

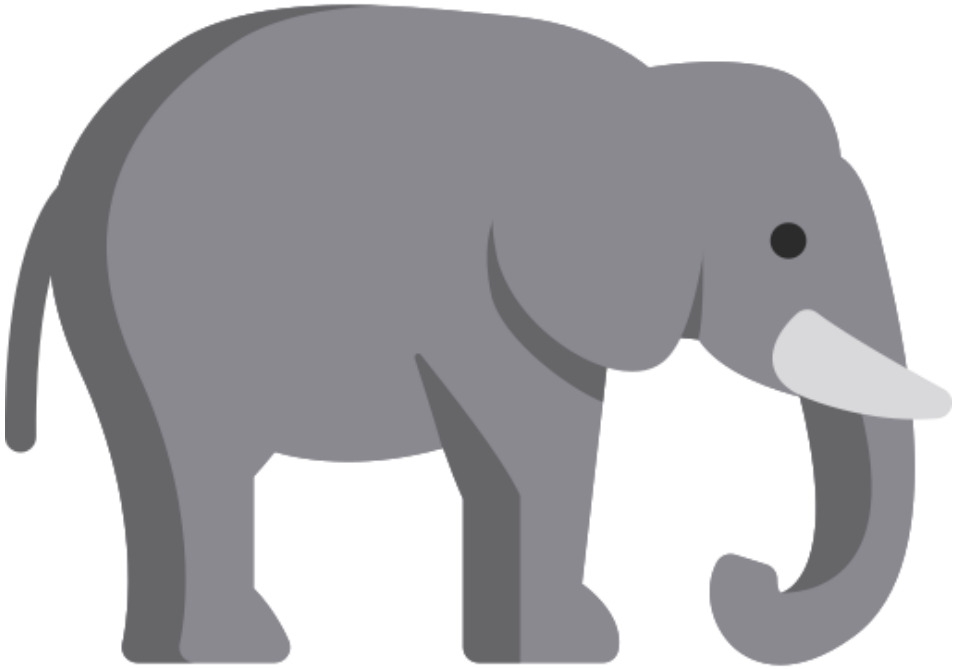
WHAT DO CURRENT MEDICAID ENROLLEES NEED TO DO?

An estimated **64% of Medicaid enrollees,** their caregivers, or family members said that they have not received any information about upcoming Medicaid redeterminations or had any knowledge of them.

Two steps Medicaid enrollees can take now to prepare for redetermination process:

- Become familiarize with your state's Medicaid eligibility rules and policies
- Update your contact information, including your mailing address and phone number

Where We Are Now: the Elephant in the Room



OUTREACH

- MCOs, including nonprofit and safety-net plans
- Community Health Centers
- Navigators and other marketplace “assisters”
- CBOs
- Other partners

WHAT DO MEDICAID STAKEHOLDERS NEED TO DO?

According to a Kaiser Family Foundation survey, most payer plans have fewer than **75% of their enrollees' correct contact information.**

The most important step payers in the Medicaid ecosystem can take now to prepare for the redetermination process is ensuring they have updated beneficiary contact information.

Patient Consumer Outcomes

Patient reported outcomes (both digitally reported and non-digitally reported)- Pros/Cons to these methodologies and variability in the methodology and timing of the data collection, using and harmonizing these data across different systems remains challenging

Patient data sharing concerns- Consent, transparency, consumer oversight, and the ability to delete data, plus agreeing with the intended use of patient data, help build trust in patient data sharing.

Novel models with HIE's- State-designated health information exchange (HIE) are expanding Medicaid Redetermination Notification projects to all interested providers and Managed Care Organizations (MCOs).

Telehealth Access Considerations

There have been success stories from both patients, caregivers and physicians who see the expansion of telehealth as a positive step for health care delivery. In terms of access, it can increase convenience and enable better provider/patient communication and trust.

Nonetheless, telehealth's expansion still inflicts disproportionately barriers to access and services. For older, rural, poorer, and minority populations, access to high-quality telehealth services, such as video calls.

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Thank You.

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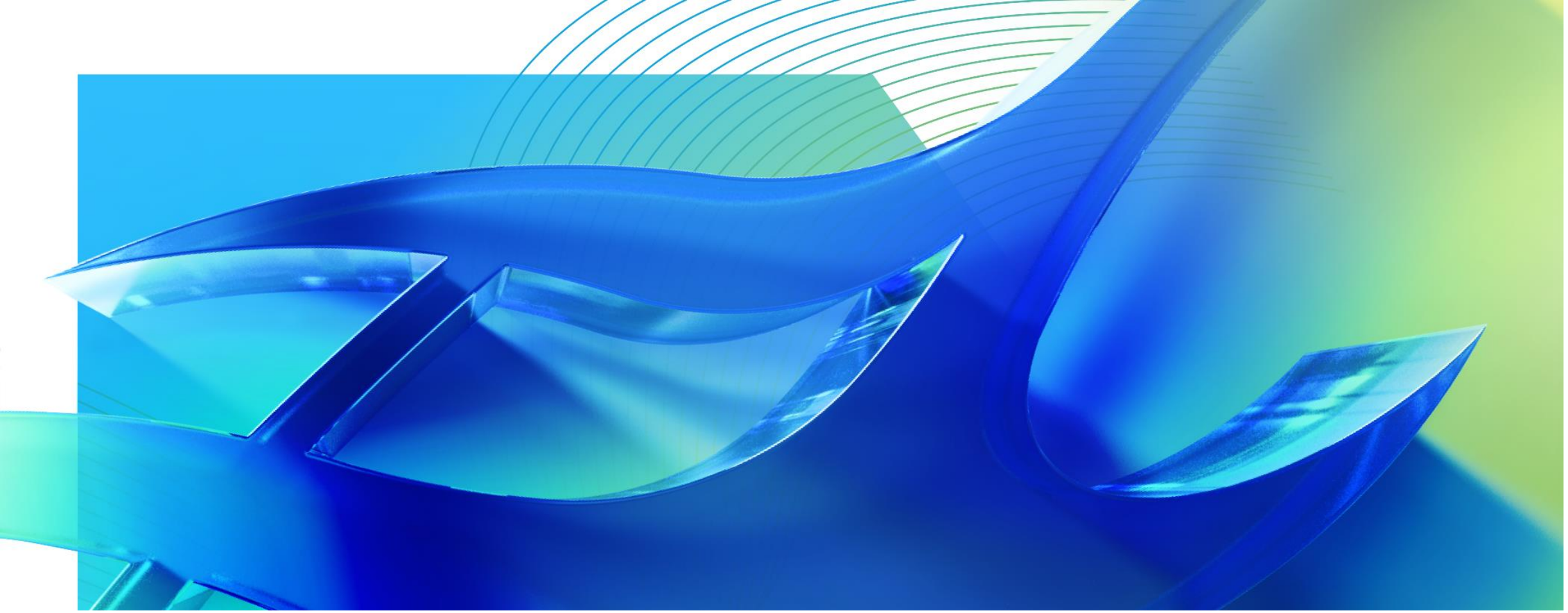

Future of Telehealth – Post PHE and Beyond

Avalere Health | Part of Fishawack Health
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The Post-PHE Policy Landscape Raises Substantial Policy Questions for Stakeholders

At the federal level, policymakers enacted multiple telehealth flexibilities, but state-based responses varied greatly, yielding 3 key areas of increased stakeholder impact as the PHE winds down.

Medicaid Coverage Policy

- All state Medicaid programs cover live video telehealth services, but some states limit eligible providers and audio-only telehealth
- These limitations create health equity concerns for Medicaid beneficiaries

Commercial Market Coverage Limitations

- Coverage and payment flexibilities encouraged providers to offer more telehealth services to patients with commercial coverage, but limitations may return post-PHE
- Many states do not require payment parity for telehealth services, and allow separate networks for telehealth providers

State Licensure Policies

- Every state has different health care licensure standards, and interstate compacts are necessary to ensure delivery of telehealth services across state lines
- Licensure standards can also limit the providers eligible to offer telehealth services in-state

Telehealth policies will likely be a focus of state legislatures as they return to session in early 2023.

PHE: Public Health Emergency

Omnibus Extends Medicare PHE Flexibilities Including Telehealth Through 2024

The Omnibus includes multiple key clarifications to Medicare coverage and payment post-PHE. Most significant among these is an additional 2 years of provider payment increases. Further action on provider payment and telehealth extensions are possible before the relevant provisions expire at the end of 2024.

Medicare Payment

- While the FY2021 and 2022 funding bills raised Medicare payments to physicians by 3.75% and 3% respectively, the FY2023 CAA prevents prospective cuts to physician payment and increases the base payment rate by 2.5% in 2023 and 1.25% in 2024.
- The CAA postpones the phasing in of private payer rates for clinical laboratory test payments until 2024.
- The CAA requires that Medicare cover intensive outpatient mental health services.

Telehealth

- The CAA extends PHE-related telehealth flexibilities through the end of 2024, including:
  - No facility fees for new telehealth sites.
  - Occupational, physical, and speech therapies can be conducted over telehealth.
  - FQHC and rural health clinics may provide telehealth services.
  - Mental health services over telehealth.
  - Coverage for audio-only telehealth.

COVID Extensions

- The CAA requires Part D coverage for COVID-19 prescription oral antiviral drug, under Emergency Use Authorization, (i.e., Paxlovid and molnupiravir) through the end of 2024.
- The bill also allows Part D plans to cover products meant to prevent, diagnose, or treat COVID-19 and have an EUA through 2024.

CAA: Consolidated Appropriations Act; PHE: Public Health Emergency; FY: Fiscal Year; FQHC: Federally Qualified Health Center; EUA: Emergency Use Authorization

End of PHE Policy Changes Yield Challenges and Key Considerations for Stakeholders

As the PHE winds down, it will be essential for stakeholders to monitor how the expiration of PHE flexibilities will impact the policy landscape across 3 key areas:

Reimbursement	Access	Operations
• As the PHE expires, providers may experience greater limitations in payment for telehealth services, potentially reducing the number of providers offering telehealth services	• Differences across state policies are likely to drive variance in levels of access to telehealth across the country • New federal requirements for in-person visits for certain medications will also impact access	• Payers, providers, and vendors will need to navigate differing environments across states based on licensure, SOP policy, and eligible provider policy • These variations will drive how providers, technology platforms, and payers develop and operate businesses across states

Recent federal guidelines limiting prescription of certain controlled substances via telehealth highlight increased scrutiny and potential future challenges.

PHE: Public Health Emergency; SOP: Scope of Practice

Payers and Policymakers Need Evidence for Telehealth's Optimal Position in the Care Continuum

The details of how and when telehealth is delivered can have a major impact on outcomes

Equity and Access

- Must deliver care in a patient-centric way, accounting for patient preferences for telehealth vs. in-person care
- Some studies show concerns for equity based on internet access, whereas others show that traditionally underserved populations have widespread access via smartphones[1,2]

Quality and Care Models

- Professional societies have begun to issue guidelines, best practices, and toolkits, but more is needed to identify optimal care pathways, clinical scenarios, and populations that benefit from telehealth
- Quality must be measured carefully, balanced with potential benefits of access and patient-centricity

Operational Models

- Organizations engaged in value-based care stand to gain the most from cost savings achieved through telehealth but need to determine the most efficient care pathways
- Must ensure workforce models optimize quality and efficiency while minimizing risk of burnout

1 Avalere Health. Limited Internet Access May Drive Disparities in Telehealth Use Dec. 8, 2022
2 JMIR Mhealth Uhealth. Sociotechnical Factors Affecting Patients' Adoption of Mobile Health Tools: Systematic Literature Review and Narrative Synthesis May 2022

QUESTIONS?

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TAKE OUR SURVEY

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