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November 13, 2020

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The Honorable Alex Azar II
Secretary
U.S. Department of Health and Human Services
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Washington, DC, 20201

Re: Report to Congress on Reducing Barriers to Furnishing Substance Use Disorder (SUD) Services Using Telehealth and Remote Patient Monitoring for Pediatric Populations Under Medicaid Final Report

The Medicaid and CHIP Payment and Access Commission (MACPAC) is pleased to comment on the U.S. Department of Health and Human Services (HHS) report, *Reducing Barriers to Furnishing Substance Use Disorder (SUD) Services Using Telehealth and Remote Patient Monitoring for Pediatric Populations Under Medicaid: Final Report*. MACPAC is required by statute to review HHS reports to Congress and provide written comments to the Secretary and appropriate committees of Congress.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (SUPPORT Act, P.L. 115-271) directed the Secretary to report on best practices and potential solutions for reducing barriers to using services delivered via telehealth for treatment of SUD among pediatric populations with Medicaid coverage. This

legislation also called for an analysis of any differences in utilization; cost; avoidable inpatient admissions; quality of care; and patient, family, and provider satisfaction with services delivered in-person and via telehealth.

Report Summary

The primary findings of the Secretary's report to Congress are that telehealth programs for providing pediatric SUD services are emerging and that there is limited evidence on their use and effects. The report characterizes evidence as scant or emerging on a range of topics including best practices; barriers and solutions; differences in utilization, costs, avoidable inpatient admissions and readmissions; quality; and satisfaction with pediatric SUD services delivered by telehealth. The report also notes that most of the evidence for providing SUD services via telehealth is based on adult populations. These findings are based on an environmental scan, key informant interviews, and case studies of two university medical center-based telehealth programs that provide pediatric behavioral health services.

Because there is little information that specifically addresses the issues described in the SUPPORT Act, the HHS report describes findings on use of telehealth for general health services or broader behavioral health services, not SUD services specifically. We note that the report is not always clear as to whether findings from the environmental scan or expert interviews are specific to Medicaid populations.

The report notes the importance of understanding barriers to the use of telehealth for pediatric SUD services and practices for overcoming them. Based on available information, the report identifies use of videoconferencing, support staff (e.g., telehealth coordinators and nurses), and school-based programs as best practices for tele-behavioral health for pediatric populations. The report also describes barriers and solutions related to quality, patient safety, acceptance of telehealth, financing, consent, and studying the cost of telehealth.

The report concludes that there is great potential for telehealth to increase access to behavioral health services for children, although there are many questions requiring further study.

MACPAC Comments

The rapid growth in telehealth use in state Medicaid programs since the onset of the COVID-19 pandemic and the interest in its continued use make the issuance of this report particularly timely. States have already begun to look beyond the public health emergency (PHE) to consider which telehealth flexibilities implemented in response to the pandemic to retain. In addition, telehealth can help mitigate barriers to behavioral health services that are due to provider shortages. Prior MACPAC analysis found that just 35.7 percent of psychiatrists accept new Medicaid patients, compared to 62.1 percent accepting new Medicare patients and 62.2 percent accepting new patients with private coverage (MACPAC 2019). Moreover, according to the Health Resources and Services Administration (HRSA), as of September 30, 2020, there

are 5,733 mental health professional shortage areas nationwide, of which 66.6 percent are in rural or partially rural areas (HRSA 2020).

The findings of this HHS report may be useful in thinking about approaches for effectively using telehealth to provide behavioral health services to children covered by Medicaid and factors that should be considered in the development of new policies. The report also raises several other points, which we comment on below.

Need for additional research

MACPAC agrees with the report's conclusion that additional research is needed on the effects of telehealth in Medicaid; these include effects on utilization, cost, outcomes, quality, and beneficiary and provider satisfaction. While the body of research on telehealth in Medicaid has grown since MACPAC commented on the paucity of research in its March 2018 report to Congress, information and data gaps remain. The HHS report points out that existing evidence on providing SUD services via telehealth is primarily based on adult populations, and even that evidence is still emerging. Additional research focused on the unique needs of pediatric populations is needed. Such studies could also inform what policies and processes would best ensure access to the services and address any quality, safety, or program integrity concerns related to the broader use of telehealth.

While the HHS report responds to a focused congressional request, the multiple modalities of telehealth, potential uses across populations and covered services, and the relative lack of research focused on telehealth in Medicaid suggest further research is needed. In response to the COVID-19 pandemic, state Medicaid programs rapidly increased their use of telehealth for primary, acute, and specialty care. States considering the parameters for post-pandemic telehealth policies would benefit from understanding the effects of telehealth on utilization, cost, and outcomes for Medicaid beneficiaries and services. In addition, the October 2020 *Preliminary Medicaid & CHIP Data Snapshot* on telehealth, issued by the Centers for Medicare & Medicaid Services (CMS), is an important development because it uses data from the Transformed Medicaid Statistical Information System (T-MSIS) to understand telehealth in Medicaid. We urge CMS to continue publishing analyses using T-MSIS data, and to explore and document whether there are any data quality and completeness concerns beyond typical claims lag that would affect studies on telehealth.

Additional research is also needed to examine the extent to which disparities exist in Medicaid beneficiaries' ability to use telehealth, the causes, and solutions. Such research should examine whether there are disparities across racial and ethnic groups, eligibility pathways, and geographic areas.

Need for sharing information on state telehealth approaches

States pursuing telehealth to provide pediatric SUD or other services would benefit from technical assistance from CMS and structured opportunities to share information with other states on policy design and overcoming barriers. As the HHS report describes, most of the published information on best practices

is not specific to SUD or pediatric populations. While such information may be useful, there are likely considerations and solutions that are particularly pertinent to Medicaid programs and beneficiaries.

CMS could build upon its existing infrastructure to facilitate this information sharing. For example, CMS could add to its Medicaid telehealth toolkit, which the agency created and has updated in response to the COVID-19 pandemic. The toolkit, which currently highlights policy considerations for states in implementing broad telehealth expansions including statutory and regulatory changes that may be needed, could be adapted to address SUD-related factors. CMS also could facilitate state-to-state learning through its existing Medicaid and CHIP Learning Collaborative structure. States may be able to draw upon their several months of experience providing expanded coverage for tele-behavioral health services during the COVID-19 pandemic to identify approaches that have worked, as well as challenges they experienced.

Technical assistance and state learning opportunities should address an array of Medicaid policy and operational topics that may affect use of telehealth for pediatric SUD and other health services. For example, CMS could share approaches for payment (e.g., parity of provider payment for telehealth and in-person services, use of alternative payment methodologies) and the implications of such payment policies on provider acceptance of telehealth in Medicaid. In addition, states may benefit from technical assistance or learning from other states about approaches for providing telehealth to beneficiaries who also have other sources of coverage. We note that in 2012, an estimated 6.4 percent of children with Medicaid also had private coverage (GAO 2015). Another area ripe for state exchange is using telehealth in school-based programs which, as noted in the report, have the potential to increase access to and compliance with treatment for behavioral health needs, including SUD. The report provides detailed information on the approaches of two school-based telehealth programs including the services provided, eligible providers, and how students and families can access services. States may also find it useful to have information on practices and policies (e.g., credentialing, payment rates) related to peer support services.

Need to address technology barriers

Ensuring equitable access to pediatric SUD and other health services for Medicaid beneficiaries via telehealth will require addressing barriers to technology for both beneficiaries and providers as well as improving the reach of reliable broadband. As the HHS report describes, lack of access to and challenges with technology can reduce beneficiary and provider acceptance of telehealth. Technology barriers described in the HHS report have also been previously documented. For example, in 2019 only about 63 percent of adults in rural areas had access to broadband services at home, 71 percent had a smartphone, 49 percent had a tablet, and 60 percent had a computer (Perrin 2019). In rural areas where broadband is available, the cost of broadband services can be three times that in urban areas (ASPE 2016). Low-income populations may also experience challenges in accessing telehealth given limits on available technology (DeMars 2020, Kisla 2020). In 2019, 29 percent of low-income individuals reported not having a smartphone, 44 percent did not have home broadband, and 46 percent did not have a computer (Anderson and Kumar, 2020). Providers in rural areas may also struggle with obtaining technology and broadband services and their costs.

Solutions to these concerns reach beyond the Medicaid program. State Medicaid programs could help to inform providers and beneficiaries about the availability of resources to address certain technological barriers. For example, the Federal Communications Commission administers the Lifeline Program, which provides eligible, low-income individuals with discounted telecommunications and broadband services, and the Rural Health Care Program, which provides funding assistance to eligible rural providers (FCC 2020a, 2020b).

MACPAC will continue to monitor state Medicaid program use and expansion of telehealth services. The unprecedented growth of Medicaid telehealth during the COVID-19 pandemic has shown the potential of telehealth to maintain or increase access to many health services, in addition to pediatric SUD services. As the HHS report makes clear, ongoing research and analysis will be important to understanding how telehealth can best be used to serve Medicaid beneficiaries.

Sincerely,

Melanie Bella, MBA
Chair

Cc: Seema Verma, Administrator, Centers for Medicare & Medicaid Services
Anne Marie Costello, Acting Deputy Administrator and Director for the Center for Medicaid & CHIP Services

References

Anderson, M., M. Kumar. Pew Research Center. 2019. *Digital divide persists even as lower-income Americans make gains in tech adoption.* Washington, DC: Pew. https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2016. *Report to Congress: E-health and telemedicine*. Washington, DC: ASPE. https://aspe.hhs.gov/pdf-report/report-congress-e-health-and-telemedicine.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Services delivered via telehealth among Medicaid & CHIP beneficiaries during COVID-19*. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf.

De Mars, C., Oregon Health Authority. 2020. Primary care and prevention: The limits and potential for telehealth. Presentation at the National Academy for State Health Policy 2020 Conference. August 19, Washington, DC. https://infogram.com/1pql507qzrd1eyaq7g2m6p9ywlh6ymv322?live.

Federal Communications Commission (FCC). 2020a. Rural health care program. Washington, DC: FCC. https://www.fcc.gov/general/rural-health-care-program.

Federal Communications Commission (FCC). 2020b. Lifeline support for affordable communications. Washington, DC: FCC. https://www.fcc.gov/lifeline-consumers#:~:text=Lifeline%20is%20the%20FCC's%20program,participating%20wireline%20or%20wireless%20providers.

Health Resources and Services Administration (HRSA). U.S. Department of Health and Human Services. 2020. *Designated health professional shortage areas statistics. Fourth quarter of fiscal year 2020, designated HPSA quarterly summary, as of September 30, 2020*. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

Kiszla, J., District of Columbia Department of Health Care Finance. 2020. Telemedicine in DC Medicaid. Presentation at the National Academy for State Health Policy 2020 Conference. August 19, Washington, DC. https://infogram.com/1pql507qzrd1eyaq7g2m6p9ywlh6ymv322?live.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. Physician acceptance of new Medicaid patients. January 24, 2019, Washington, DC. https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

Perrin, A., Pew Research Center. 2019. *Digital gap between rural and nonrural America persists.* Washington, DC: Pew. https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/.

U.S. Government Accountability Office (GAO). 2015. *Additional federal action needed to further improve third-party liability efforts*. Report no. GAO-15-208. Washington, DC: GAO. https://www.gao.gov/assets/670/668134.pdf.