



CMCS Informational Bulletin

DATE: April 2, 2020

FROM: Calder Lynch, Deputy Administrator and Director

SUBJECT: Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth

This Center for Medicaid & CHIP Services Informational Bulletin (CIB) identifies opportunities for the utilization of telehealth delivery methods to increase access to Medicaid services and to comply with the requirement to publish guidance to states regarding federal reimbursement for furnishing services and treatment for substance use disorders under Medicaid using services delivered via telehealth, including in School-Based Health Centers. This requirement is set forth in section 1009(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. 115-271). This CIB provides state Medicaid agencies and other interested stakeholders information about options to facilitate access to services through the use of telehealth delivery methods as specifically outlined in 1009(b) of the SUPPORT Act, but these telehealth delivery methods could also be used in other circumstances, for example, to help respond to the COVID-19 public health emergency, as applicable. With this CIB, the Centers for Medicare & Medicaid Services (CMS) hopes to enhance our work with states to improve care for Medicaid beneficiaries through the use of telehealth delivery methods. This CIB is composed of the following two parts:

- I. Rural Health Care and Medicaid Telehealth Flexibilities; and**
- II. Medicaid Substance Use Disorder Treatment Services Furnished via Telehealth**

In addition, pursuant to section 1009(d) of the SUPPORT Act, CMS will submit a report to Congress identifying best practices and potential solutions for reducing barriers to using services delivered via telehealth to furnish services and treatment for substance use disorder (SUD) among pediatric populations under Medicaid, and the report will be made available online at www.medicare.gov once it has been published. Section 1009(d)(1) of the SUPPORT Act specifies that the report must identify and analyze differences in the provision of care for SUD among pediatric populations under Medicaid using services delivered via telehealth, and for children with SUD using services delivered in-person regarding utilization rates; costs; avoidable inpatient admissions and readmissions; quality of care; and patient, family, and provider satisfaction.

Telehealth

Telehealth is the use of information technology by providers to deliver covered services. Historically, the term “telemedicine” meant the use of interactive telecommunication equipment that included, at a minimum, audio and video equipment between beneficiary and practitioner at a distant site.¹ Similarly, the term “telehealth” refers to the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, monitoring, supervision, and information across distance.² However, given the advances and varying uses of technology in healthcare, the term telehealth has generally emerged as the umbrella term that encompasses the full range of services furnished remotely.² Telehealth could include services such as those furnished with medical information exchanged from one site to another, through audio and video equipment permitting two-way, real time, interactive communication between the beneficiary and a clinician at different locations. Such services could also include, but are not limited to, beneficiary consultations, remotely controlled or directed surgery, remote observation or monitoring, services furnished by clinicians or other health professionals such as screening for health conditions, mental health or SUD assessment, smoking cessation counseling, individual psychotherapy, and family psychotherapy.

Telehealth can be utilized to deliver services in many forms such as live video-conferencing, store and forward, remote patient monitoring, and mobile health.³ Live video-conferencing consists of two way, real time, video conferences between the patient and a healthcare provider; “store and forward” is when a patient’s healthcare documents are stored and shared electronically for use and analysis by a healthcare provider; remote patient monitoring is the collection of a patient’s healthcare data from one site that is electronically sent to healthcare providers at another site for monitoring and review; and mobile health is the utilization of smartphones and mobile applications to support the continued monitoring of a patient’s health. While other telehealth delivery methods may exist, these four methods are generally the most frequently utilized.³ Telehealth delivery methods, particularly the four primary telehealth methods of live video-conferencing, store and forward, remote patient monitoring, and mobile health, can address healthcare access barriers for beneficiaries in isolated geographic areas, such as rural areas.

The benefits of telehealth delivery methods are not limited to only rural areas, and telehealth delivery methods can be implemented more broadly in many communities. As part of an overall strategy, telehealth could increase access to services in underserved areas by increasing the availability of providers within a state. As a result, the use telehealth may help mitigate barriers to treatment through expanding access to a limited workforce.

¹ Telemedicine. CMS. Retrieved from: <https://www.medicaid.gov/medicaid/benefits/telemed/index.html>. Note that the federal Medicaid statute does not recognize telemedicine as a distinct service.

² Telehealth. Substance Abuse and Mental Health Services Administration. Retrieved from https://www.integration.samhsa.gov/hit/telehealthguide_final_0.pdf

³ Telehealth. (2017). Mayo Clinic. Retrieved from <https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/telehealth/art-20044878>

I. Rural Health Care and Medicaid Telehealth Flexibilities

Background

Approximately 60 million people live in rural areas across the United States. Rural communities often face multiple unique barriers to accessing care.⁴ These barriers can include distance and transportation, access to services, lower health literacy, social stigma, privacy issues, and workforce shortages.⁵ As a result, rural communities need to find creative solutions to assist individuals who live in rural areas in mitigating barriers to accessing care. Traditionally, these solutions involved the physical (i.e., face-to-face) connection of beneficiaries to providers, which usually meant an additional transportation expense. Now, however, rural communities are increasingly expanding their strategies to include telehealth to deliver care and services.

Telehealth in Medicaid

In Medicaid specifically, telehealth can be a cost-effective service delivery method to furnish care and services to beneficiaries. Unlike in the Medicare program, federal Medicaid law and regulations do not specifically address telehealth delivery methods or the criteria for implementation of telehealth delivery methods. As a result, states have broad flexibility in designing the parameters of telehealth delivery methods to furnish services so long as the underlying services are consistent with the overarching provisions in section 1905(a) of the Social Security Act (the Act) and the state's plan and policy framework as a Medicaid benefit. For example, in geographic areas where specialty care is limited, states may fill gaps in coverage by incentivizing specialty care practitioners in one area of the state to visit remotely with beneficiaries in another area of the state. In this example, the specialty care practitioner must meet the existing provider qualifications to perform this service, as well as any other state-established criteria for furnishing services through telehealth delivery methods. States that use Medicaid managed care plans to deliver services also can include telehealth delivery methods within their managed care contracts to ensure the Medicaid managed care plans adhere to the improved access states are working to achieve. States may encourage managed care plans to explore telehealth delivery options during the contracting process and make use of the flexibilities that states already have in this area.

As is common with emerging technologies, accessibility of telehealth interventions may be problematic for some populations of beneficiaries with disabilities – particularly those with visual and hearing disabilities and those with limited or no use of their hands.⁶ CMS recommends that states discuss accessibility needs and adaptations with their telehealth vendors. Please note that the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 apply to state's Medicaid programs and services.

⁴ CMS Rural Health Strategy. (2018). Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>

⁵ Healthcare Access in Rural Communities. (2019). Retrieved from <https://www.ruralhealthinfo.org/topics/healthcare-access#population-health>

⁶ Frieden, L., Nguyen, V. & Powers, G., Southwest ADA Center, TELEMEDICINE: ACCESS TO HEALTH CARE FOR PEOPLE WITH DISABILITIES, 17 Hous J. Health L. & Policy (2017), available online at http://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20Frieden-FinalPDF.pdf. This paper was funded in part by the National Institute on Disability, Independent Living, and Rehabilitation Research within the Administration for Community Living.

Payment for Services Furnished Through Telehealth

Federal requirements for efficiency, economy, and quality of care must be satisfied in order to receive federal financial participation (FFP) for Medicaid covered services. Using telehealth delivery methods as part of a comprehensive strategy to increase the availability of Medicaid covered services can be taken into account as the state determines appropriate payment methodologies. In Medicaid, states are allowed to set different rates for services provided through telehealth delivery methods. As an example, states may reimburse providers at the distant site and reimburse a facility fee to the originating site. Additional costs such as technical support, transmission charges, and equipment can also be incorporated into the payment methodology. A state may also reimburse providers for medically necessary Medicaid services, and recognize the varied costs of providing care based on the setting(s) in which the services are provided or the severity of need. States may also pay for individually covered services or, if determined as a more efficient payment method, may develop bundled rates to reimburse for services. In addition, states may develop payment methodologies that offer incentives for improved outcomes and quality care.

Generally, a State Plan Amendment (SPA) is not necessary to incorporate telehealth delivery methods if there are no changes to the 1905(a) benefit descriptions, limitations, or payment methodologies. However, a SPA would generally be necessary when states add specific distinctions for coverage or different reimbursement methodologies for services furnished through telehealth delivery methods.

When using a managed care delivery system, Medicaid managed care plans are not limited by the payment arrangements outlined in the state plan and could pay alternate fees for additional provider types or for other telehealth modalities in order to improve access and increase provider capacity. In addition, States may implement delivery system and provider payment initiatives under Medicaid managed care contracts, including for providers furnishing services through telehealth delivery methods, consistent with 42 CFR section 438.6(c).

Nationwide Telehealth Trends

The use of telehealth delivery methods is growing nationwide as providers and payers seek to improve access to services and better manage patient care, while reducing health care spending.⁷ State laws and policies related to reimbursement, licensure, and practice standards are changing in response to the development of new technology and the growing evidence base demonstrating the impact of telehealth on access, quality, and cost of care.⁷

A Fall 2019 examination of laws and Medicaid policies in all 50 states and the District of Columbia found that all Medicaid agencies in the states and the District have some form of reimbursement for services delivered by telehealth.⁷ The predominant form of telehealth that is being reimbursed in all 50 states is live video, while 14 states reimburse for store-and-forward.⁷ Additionally, 22 states have some form of reimbursement for remote patient monitoring in their Medicaid programs.⁷ Finally, 19 state Medicaid programs explicitly allow the home and schools to serve as originating sites, although there are often additional restrictions on these sites such as geographic or specialty restrictions.⁷

⁷ State Telehealth Laws and Medicaid Policies: 50-State Survey Findings. (2019). *Manatt*. Retrieved from <https://www.echpca.org/sites/default/files/2019-10/50%20State%20Telehealth%20Laws%20and%20Reimbursement%20Policies%20Report%20Fall%202019%20FINAL.pdf>

II. Medicaid Substance Use Disorder Treatment via Telehealth

Section 1009(b)(1) of the SUPPORT Act requires CMS to issue guidance on state options for Federal reimbursement for services and treatment for SUD under Medicaid delivered via telehealth, including assessment, medication-assisted treatment, counseling, medication management, and medication adherence with prescribed medication regimes. Section 1009(b)(1) also requires that such guidance include information on furnishing services and treatments that address the needs of high-risk individuals, including at least the following groups: American Indians and Alaska Natives (AI/AN), adults under the age of 40, individuals with a history of non-fatal overdose, individuals with a co-occurring mental illness and a SUD, and pregnant women with a SUD.

Section 1009(b)(2) of the SUPPORT Act further requires CMS to address in guidance state options for federal reimbursement of expenditures under Medicaid for education directed to providers serving Medicaid beneficiaries with substance use disorders using the hub and spoke model, through contracts with managed care entities, through administrative claiming for disease management activities, and under Delivery System Reform Incentive Payment (“DSRIP”) programs. Historically, DSRIP programs provided states with resources to catalyze significant reforms through the development of infrastructure, workforce enhancements, redesign of systems and processes, and provider incentives to promote positive health outcomes. CMS has not approved a state to use a DSRIP program to support provider education. CMS anticipates that approving such a request to support provider education under DSRIP programs in the future is unlikely. DSRIP awards were time limited investments in system transformation.

Section 1009(b)(3) of the SUPPORT Act requires CMS to address in guidance state options for federal reimbursement of expenditures under Medicaid for furnishing services and treatment for SUD for individuals enrolled in Medicaid in a school-based health center using services delivered via telehealth.

This section of this CIB addresses the requirements listed above.

Substance Use Disorder Treatments and Application of Telehealth

The services described below are generally coverable under 1905(a) Medicaid benefits. In response to the national growing opioid epidemic, many states have implemented telehealth delivery methods to reach communities that have previously encountered barriers to accessing SUD treatment services.⁷ States are uniquely positioned to identify SUD services that would be most beneficial to their populations. Beyond the federal Medicaid requirements of free choice of providers, statewide operation, and comparability of services for medically needy and categorically needy groups, states generally have flexibility in determining which services are most appropriate for their beneficiaries’ needs. Appendix A sets forth some examples of how states are currently utilizing telehealth delivery methods to furnish services to Medicaid beneficiaries. Additionally, Appendix B identifies other existing Federal funding streams that may compliment Medicaid’s federal financial participation.

Assessment

An assessment is the evaluation of the health status of an individual along the health continuum, which is a concept that guides and tracks patients over time through a comprehensive array of

health services spanning all levels and intensity of care.⁸ The purpose of an assessment is to establish an individual's health needs, diagnosis, and treatment approaches in relationship to the health continuum.⁸ Historically, assessment services required an individual to visit a practitioner's office, which may entail having to leave work during business hours and overcoming transportation barriers, but with the increase of telehealth delivery methods many of the challenges individuals faced in obtaining face to face assessment services may be alleviated. Several states are utilizing telehealth delivery methods to furnish assessments.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) is the use of certain drugs that are often generally prescribed as an adjunctive therapy to support treatment for SUD, along with counseling and behavioral health therapies. Whether or not telemedicine is used, when the medications prescribed for MAT are controlled substances, the prescriber must comply with the federal Controlled Substances Act (CSA). Among other requirements, a practitioner seeking to prescribe controlled substances must be registered with the U.S. Drug Enforcement Administration (DEA). If a narcotic controlled substance is being prescribed for MAT, the practitioner must also obtain a waiver pursuant to the Drug Abuse Treatment Act, comply with 21 U.S.C. § 823(g)(2), and the substance used must be in schedules III, IV, or V and approved by FDA for use in maintenance or detoxification treatment.

The CSA permits the prescribing of controlled substances via telemedicine in certain circumstances. In general, it is a per se violation of the CSA for a practitioner to issue a prescription for a controlled substance by means of telemedicine without having conducted at least one in-person medical evaluation. Nevertheless, a qualified practitioner who has previously conducted at least one in-person medical evaluation of the patient may thereafter prescribe controlled substances to the patient via telemedicine, including controlled substances for the purpose of MAT. In addition, a qualified practitioner may prescribe controlled substances to a patient, including for the purpose of MAT, without conducting an in-person medical evaluation when the practitioner is engaged in the practice of telemedicine as defined at 21 U.S.C. § 802(54).⁹ The practice of telemedicine under the CSA is limited to communication using audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site practitioner. The practice of telemedicine under the CSA includes a practitioner communicating with a patient or healthcare professional while the patient is being treated by, and is physically located in, a DEA-registered hospital or clinic, or while the patient is being treated by, and is in the physical presence of, a DEA-registered practitioner. The practice of telemedicine under the CSA also includes telemedicine prescribing by a practitioner who is an employee or contractor of the Indian Health Service, or is working for an Indian tribe or tribal organization under its contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, acting within the scope of the employment, contract, or compact, and who is designated as an Internet Eligible Controlled Substances Provider by the Department of Health and Human Services (HHS). The CSA definition also permits telemedicine prescribing by a practitioner who has obtained a special registration for telemedicine from DEA and is operating within the scope of that registration. DEA intends to propose regulations in the near future outlining the circumstances under which a practitioner may obtain and use a special registration for telemedicine.

⁸ Si, S., Moss, J., Sullivan, T., Newton, S., & Stocks, N. (2014). Effectiveness of general practice-based health checks: a systematic review and meta-analysis. *The British Journal of General Practice*. 64(618): 47–53.

⁹ For more information about some of the ways to prescribe controlled substances for MAT via telemedicine, see DEA's Use of Telemedicine While Providing Medication Assisted Treatment guidance document, https://www.deadiversion.usdoj.gov/mtgs/pract_awareness/resources/Telemedicine_MAT.pdf.

Congress enacted these limitations on the prescribing of controlled substances via telemedicine in the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (RHA), to address the grave threat to public health and safety caused by physicians who prescribed controlled substances via the internet without establishing a valid doctor-patient relationship. The limitations in the RHA and in DEA's implementing regulations are designed to balance the need to address the use of the internet to divert prescription controlled substances with the need to preserve access to the valid practice of medicine via telemedicine.

State rules governing the prescribing of medications via telehealth vary, ranging from more to less specific to silent. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends have emerged. Several states have begun incorporating specific documentation and/or confidentiality, privacy, and security guidelines within their manuals for telehealth. Laws and regulations allowing practitioners to prescribe medications through live video interactions have also increased, as well as a few states even allowing for the prescription of controlled substances over telehealth, within Federal limits.¹⁰

Barriers to states implementing medication-assisted treatment (MAT) that impact the delivery of MAT via telehealth include the limited number of providers that can prescribe certain MAT medications, funding barriers to implementing MAT, and lack of access to medical personnel with expertise in delivering MAT via telehealth. Some states have laws prohibiting prescribing via telehealth due to concerns that without meeting in person, providers may not have sufficient medical history or information to safely prescribe medication, and some states require at least one in-person visit before allowing a doctor to prescribe MAT via telehealth. In other states, clinicians are able to prescribe via telehealth just as they would prescribe during a face-to-face visit, provided that the provider-patient relationship has been established.¹¹

Some states are actively changing their laws and rules in order to identify strategies to address the opioid epidemic. Six states have enacted laws that allow controlled substance prescribing through telehealth without a prior in-person examination (Delaware, Florida, Indiana, Michigan, Ohio, and West Virginia), provided that specific state requirements are met. For example, Indiana allows prescribing of buprenorphine via telehealth, while also attempting to address the opioid epidemic by limiting remote access to most prescription opioids.¹²

Counseling

Counseling is a professional relationship between patient and licensed or certified healthcare provider that empowers diverse individuals, families, and groups to attain mental health and wellness, and it can be used for individuals with SUD.¹³ Telehealth delivery methods now often offer access to mental health specialists, including, but not limited to psychiatrists, psychologists, clinical social workers, substance use disorder counselors, and mental health counselors, as an

¹⁰ Patient-centered interventions to improve medication management and adherence: a qualitative review of research findings. *Patient Education Counsel.* 2014 Dec; 97(3): 310–326.

¹¹ Telehealth in Medicaid, MAPAC. (2018). Retrieved from <https://www.macpac.gov/wp-content/uploads/2018/03/Telehealth-in-Medicaid.pdf>

¹² National Council for Behavioral Health Financing Reform and Innovation (2018). The Use of Telehealth to Treat Opioid Use Disorder: An Environmental Scan.

¹³ Counseling. (2019). *American Counseling Association*. Retrieved from <https://www.counseling.org/about-us/about-aca/20-20-a-vision-for-the-future-of-counseling/consensus-definition-of-counseling>

avenue for extending counseling beyond the office and into communities where access to healthcare and substance use disorder services is limited.¹⁴ Beyond using telehealth for individual treatment, specialists can use the platform for group counseling, family counseling, as well as various other counseling services that meet the requirements of 1905(a), which can give providers the opportunity to treat more people in several locations without the need for the provider to travel. Several states are utilizing telehealth delivery methods to furnish counseling services, such as Arizona, Delaware, Kentucky, Maryland, Michigan, Minnesota, New York, and Utah.⁷

Medication Management and Medication Adherence with Prescribed Medication Regimen

The term medication management encompasses services that focus on medication education, appropriateness, effectiveness, safety, monitoring, and adherence with the goal of improving health outcomes.¹⁵ People fail to take their prescribed medications for many reasons, including, but not limited to, burdensome and complex adherence regimens, concerns about cost and side effects, doubts about the benefit of medications, and poor health literacy. Medication management aims to increase adherence through shared decision-making, use of methods that enhance effective prescribing, systems for eliciting and acting on patient feedback about medication use and treatment goals, and reinforcing medication-taking behavior.¹⁶

Medication management via telehealth can be as successful as face-to-face treatment.¹⁷ Studies to date generally show high patient and provider satisfaction with care delivered via videoconferencing, although some providers express concern that telehealth may affect the therapeutic relationship between patient and provider. Telehealth and remote technologies may also be used to monitor clinical aspects of a patient, such as blood sugar levels for an individual with diabetes being reported to a clinician, despite distance, which could help ensure that monitoring is optimally convenient for the patient.¹⁸

Although medication management may be possible through texting or e-mail, live video conferencing is used most commonly to allow for a thorough collection of patient information, including medication-taking behaviors, adherence, and identification of medication-related problems. In addition, some states require real-time encounters in order for providers to receive compensation for services furnished via telehealth.¹⁹

High-Risk Populations

Section 1009(b)(1) of the SUPPORT Act requires CMS to issue guidance on furnishing services and treatments that address the needs of high-risk individuals, including at least the following groups: American Indians and Alaska Natives (AI/AN), adults under the age of 40, individuals with

¹⁴ Using Telehealth to Coordinate Care for Substance Abuse Disorders. (2018). *mHealth Intelligence*. Retrieved from <https://mhealthintelligence.com/features/using-telehealth-to-coordinate-care-for-substance-abuse-disorders>

¹⁵ Joint Commission of Pharmacy Practitioners. (2018). <https://jcpp.net/wp-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf>

¹⁶ Patient-centered interventions to improve medication management and adherence: a qualitative review of research findings. (2014). *Patient Education Counsel*. 97(3): 310–326.

¹⁷ Mostafa et al., (2017). *Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723163/>

¹⁸ Telehealth Application Domains. Rural Health Information Hub. Retrieved from <https://www.ruralhealthinfo.org/toolkits/telehealth/1/application-domains>

¹⁹ State Telehealth Laws and Reimbursement Policies. (2018). Center for Connected Health Policy. Retrieved from https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf

a history of non-fatal overdose, and individuals with a co-occurring mental illness and a SUD. CMS addresses each of these groups below, as well as pregnant women with a SUD, given that SUD during pregnancy has increased dramatically in the last two decades.²⁰ The telehealth delivery methods referenced above can assist high-risk populations in overcoming barriers to healthcare access and increasing access to needed providers.

American Indians and Alaska Natives

According to 2010 U.S. Census data, there are approximately 5.2 million AI/AN living in the United States.²¹ Out of this number, approximately 2.6 million AI/AN receive services from health programs operated by the Indian Health Service (IHS), Tribes or tribal organizations, and Urban Indian Health Organizations.²² Individuals living on reservations are often more severely affected than the rest of the AI/AN population due to rural isolation, poverty, and challenges accessing healthcare services. The combined effects of poverty, limited educational opportunities, and substance use disorders have led to a disproportionate risk of chronic disease and a lower life expectancy among AI/AN populations.²³ In many rural tribal communities, access to specialty providers continues to be a challenge in providing care for complex medical conditions.

One way IHS and Tribes address the need for access to specialty providers is through more robust services that can be delivered via telehealth. For example, the IHS Telebehavioral Health Center of Excellence (TBHCE) consists of a small team of IHS personnel who provide telebehavioral health services at 25 delivery sites located at IHS, tribal, or urban health programs in the contiguous 48 states and Alaska. In 2019, the Center provided over 4,627 hours of telebehavioral health services encounters covering culturally sensitive counselling, behavioral health therapy and medication assisted treatment to AI/ANs.

SAMHSA's 2018 National Survey on Drug Use and Health (NSDUH) noted that the prevalence of past-year illicit drug use among all AI/AN youth aged 12-17 was 18.1 percent as compared to 16.7 percent among all youth.^{24, 25} In addition, the 2018 NSDUH indicated that the prevalence of past-year opioid misuse (either heroin use or prescription pain reliever misuse) was 0.9 percent as compared to 2.8 percent for all youth; the prevalence of past-year prescription tranquilizer or sedative misuse was 3.0 percent as compared to 1.8 percent for all youth; the prevalence of past-year substance use disorder was 3.9 percent as compared to 3.7 percent of all youth; and the

²⁰ "Opioid Crisis in Medicaid: Saving Mothers and Babies." Health Affairs Blog. May 1, 2018.

²¹ The American Indian and Alaska Native Population: 2010. (2012). *U.S. Census*. Retrieved from <https://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>

²² In 1976, Congress amended titles XVIII and XIX of the Social Security Act to authorize IHS facilities (whether operated by the IHS or by an Indian Tribe or Tribal organization as defined in section 4 of the Indian Health Care Improvement Act (IHCIA)) to receive Medicare and Medicaid reimbursement for services covered under those programs and provided by these facilities, so long as the facilities meet generally applicable Medicare and Medicaid program conditions and requirements. Congress also amended section 1905(b) of the Act to establish a 100% Federal Medical Assistance Percentage (FMAP) for state expenditures on Medicaid-covered services provided to AI/AN Medicaid beneficiaries when those services are "received through" an IHS facility (whether operated by the IHS or by an Indian Tribe or Tribal organization as defined in section 4 of the IHCIA). In 2016, CMS updated its interpretation of when 100% FMAP under section 1905(b) of the Act is available for Medicaid services received through an IHS/Tribal facility. See State Health Official (SHO) Letter#16-002.

²³ Adakai, M., Sandoval-Rosario, M., Xu, F., Aseret-Manygoats, T., Allison, M., Greenlund, K., & Barbour, K. (2017). Health Disparities Among American Indians/Alaska Natives — Arizona, 2017. *Morbidity and Mortal Weekly Report*. (67):1314–1318.

²⁴ Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Retrieved from <https://www.samhsa.gov/data/sites/default/files/cbhsqreports/NSDUHDetailedTabs2018R2/NSDUHDetTabsAppB2018.htm>

²⁵ Information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children under the age of 21 can be found at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf and <https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf>

prevalence of past-year illicit drug use disorder was 3.7 percent as compared to 2.9 percent of all youth; and the prevalence of past-year illicit drug use was 18.1 percent as compared to 16.7 percent of all youth.²⁴ The prevalence rates are not statistically significant between AI/AN youth and all U.S. youth.²⁴

SAMHSA's NSDUH also reports that 5.2 percent (72,000) of AI/AN aged 18 and older reported misusing a prescription drug in 2018 and 4.0 percent (56,000) of AI/ANs aged 18 and older reported misusing a prescription pain reliever in 2018.²⁶ In addition, the Centers for Disease Control and Prevention (CDC) reported that AI/ANs had the highest drug overdose death rates among adults in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015, compared to other racial and ethnic groups.²⁷ During that time, deaths rose more than 500 percent among the AI/AN adult population.²⁸

Given the high rates of substance use disorders and behavioral health conditions in AI/AN populations, opioid treatment to AI/ANs could include MAT, which may be delivered via telehealth delivery methods.²⁹ Additionally, while not required by CMS, treatment that acknowledges the importance of AI/AN cultures in recovery can allow healthcare providers to take meaningful steps in attempting to curb the rates of AI/AN opioid use disorder.³⁰

Telehealth can bridge the gap in service delivery created by the geographic isolation of the remote Indian communities and associated transportation limitations. While treatment centers in rural areas are less likely than their urban counterparts to provide buprenorphine and other evidence-based services, such as case management, furnishing counseling services via telehealth has helped to overcome these geographic limitations and yielded encouraging outcomes.³¹ Additionally, specific attributes, such as having high rates of co-occurring conditions, high rates of co-occurring mental health diagnosis, and high rates of co-occurring SUD diagnosis, could be addressed further through the increased utilization of SUD services delivered via telehealth.

Adults under the Age of 40

Individuals under the age of 40 make up the majority of Americans with SUD in the United States.³² Using 2016 Medicaid claims data, there is evidence of telehealth usage in service delivery to individuals in this age group: of those individuals who had an SUD diagnosis and a telehealth claim filed, 34.5 percent were age 18 to 24, 17.5 percent were age 25 to 34, and 29.8 percent were age 35 to 49.³³ Of these individuals, 18 to 24 year olds represent the highest percentage of telehealth use (34.5 percent), followed by those 35 to 49 years old (29.8 percent).³³

²⁶ Jones, C. (2018). Testimony from Christopher M. Jones, PharmD., M.P.H. on Opioids in Indian Country: Beyond the Crisis to Healing the Community before Committee on Indian Affairs. *Substance Abuse and Mental Health Services Administration*. Retrieved from <https://www.hhs.gov/about/agencies/asl/testimony/2018-03/opioids-indian-country-beyond-crisis.html>

²⁷ Centers for Disease Control and Prevention. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *Morbidity and Mortality Weekly Report*. 66(19): 5-11.

²⁸ The IHS Launches New Opioids Website. (2018). *Indian Health Service*. Retrieved from <https://www.ihs.gov/newsroom/ihs-blog/july2018/the-ihs-launches-new-opioids-website/>

²⁹ Crisis Response. (2019). *Indian Health Service*. Retrieved on February from <https://www.ihs.gov/opioids/recovery/telemat/>

³⁰ Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). SAMHSA American Indian/Alaska Native Data. Retrieved from https://www.samhsa.gov/sites/default/files/topics/tribal_affairs/ai-an-data-handout.pdf

³¹ Opioid Use Disorder: Challenges and Opportunities in Rural Communities. (2019). *The Pew Charitable Trusts*. Retrieved from https://www.pewtrusts.org/-/media/assets/2019/02/opioiduseruralcommunities_final.pdf

³² Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. (2019). *Substance Abuse and Mental Health Services Administration*. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm>

³³ Utilization of Telehealth Services in the Treatment of People with Opioid Use Disorder. (2018). *IMB Watson Health*. Cambridge, MA.

Among those with an SUD diagnosis in 2016, adults under the age of 40 accessed telehealth services most frequently. The 2016 Medicaid claims data results also indicated that 68.4 percent of these individuals with an SUD diagnosis and telehealth claims were women, 64.4 percent lived in urban geographic locations, 83 percent identified as non-Hispanic whites, and many had co-occurring diagnostic conditions. Specifically, 56.1 percent of the individuals under the age of 40 had a co-occurring SUD diagnosis, 87 percent had a co-occurring mental illness diagnosis, and 39 percent had a co-occurring medical/non-SUD diagnosis.³³

When developing treatments for adults under 40 with SUD, it is important to recognize the high rates of co-occurring conditions and to address these co-occurring conditions when possible during the course of SUD treatment. While there is a current gap in the literature as to what method of telehealth is most effective in providing SUD treatments, a study by the University of Michigan found that the most common type of telehealth in use, is direct video conferencing (40 percent of respondents), the most common type of behavioral health providers using telehealth are psychiatrists (78 percent of respondents), and the most common type of service telehealth is used for is medication management (54 percent of respondents).³⁴ As a result, telehealth can be further utilized in the Medicaid program to facilitate the delivery of medication management services to treat SUD, as well as address the co-occurring SUD and mental illness diagnosis specific to adults under 40 who are Medicaid beneficiaries.

Individuals with a history of non-fatal overdose

In general, there are approximately 30 non-fatal overdoses for every fatal overdose.³⁵ Those who survive an overdose remain at elevated risk for all-cause mortality in the year after the overdose. One study of adult Medicaid enrollees found that the one-year all-cause mortality rate after an overdose was more than 24 times higher than what would be expected for age, sex, and race/ethnicity-matched community controls. The one-year mortality was higher for a range of causes, including fatal overdose, suicide, chronic respiratory diseases, viral hepatitis, and HIV.³⁶ Because of this pronounced risk of all-cause mortality, it is especially important that people who survive an opioid overdose be linked to treatment for substance abuse, mental health disorders, and other health conditions. Research shows that medication treatments should be initiated before an individual leaves the emergency department (ED)³⁷ as there are demonstrated decreases in mortality in opioid overdose survivors who receive medication treatments in the ED. Despite this, one study found that only 30 percent of patients receive appropriate medications for opioid use disorder in the 12 months following a non-fatal overdose.^{37, 38, 39}

³⁴ Mace, S., Boccanelli, A. & Dormond, M. (2018). The Use of Telehealth Within Behavioral Health Settings: Utilization, Opportunities, and Challenges. *University of Michigan Behavioral Health Workforce Research Center*. Retrieved from http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf

³⁵ Frazier, W., Cochran, G., Wi-Hsuan, L.C. et al. (2017). Medication Assisted Treatment and Opioid Use Before and After Overdose in Pennsylvania Medicaid. *Journal of the American Medical Association*. 318(8): 750-752. Retrieved from <https://jamanetwork.com/journals/jama/fullarticle/2649173>

³⁶ Olfson M et al. (2018). Causes of death after nonfatal opioid overdose. *JAMA Psychiatry*. 1;75(8):820-7. Retrieved from <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2685326>

³⁷ Larochell, M.R., Benson, D., Land, T. et. al. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study. *Annals of Internal Medicine*. 169(3): 137-145 Retrieved from <https://annals.org/aim/fullarticle/2684924/medication-opioid-use-disorder-after-nonfatal-opioid-overdose-association-mortality>

³⁸ Utilization of Telehealth Services in the Treatment of People with Opioid Use Disorder. (2018). *IMB Watson Health*. Cambridge, MA.

ED-based interventions alone are insufficient to improve longer-term outcomes for people who have overdosed.³⁹ To promote sustained treatment engagement and long-term recovery, SAMHSA recommends a “warm handoff” after a non-fatal overdose. These handoffs “comprise a range of interventions aimed at helping individuals...connect with the people, resources, and/or services they need to prevent future overdoses and other negative health outcomes.” A warm handoff can include ED-based screening and referral, ED-based naloxone provision, and post-overdose outreach and follow-up.⁴⁰ In settings where face-to-face interactions with professional substance use disorder specialists are not possible, telehealth may be a viable alternative.⁴¹

Individuals with co-occurring mental illness and substance use disorder

Research indicates that individuals with a mental illness are more likely to have a co-occurring SUD when compared to individuals without a mental illness.⁴² In 2018, among the 47.6 million adults who had any mental illness in the past year, 9.2 million (19.3 percent) also had a SUD.⁴³ In contrast, only 5.1 percent of adults who did not have a mental illness (10.2 million adults) in 2017 met the criteria for a SUD. Among the 11.2 million adults who had a mental illness⁴⁴ in the past year, 3.1 million (27.6 percent) had a SUD.⁴⁵ Conservative estimates in the adult population based on self-reports, excluding homeless and incarcerated individuals, suggest that among people with SUD, 64 percent have any mental illness and nearly 27 percent have a serious mental illness.⁴⁶ Data from the 2008 – 2014 NSDUH revealed that 47 percent of individuals with OUD and co-occurring mild/moderate mental illness did not receive any behavioral health treatment, and 21 percent of those with co-occurring serious mental illnesses did not receive any behavioral health treatment. Among those with OUD and co-occurring mild/moderate mental illness, 16 percent reported receiving both substance use disorder and mental health treatment; among those with co-occurring serious mental illness the rate was 32 percent.⁴⁷ Additionally, among 358,000 adolescents with co-occurring substance use disorders and a major depressive episode, only 5.4 percent received both mental health care and substance use treatment.⁴³ Despite the strong association between SUD and mental illness, most people with co-occurring SUD and mental illness do not receive treatment for more than one disorder.

³⁹ D’Onofria, G., Chawarski, M.C., O’Connor, P.G., et al. (2017). Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. *Journal of General Internal Medicine*. 32(6)660-666. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/28194688>

⁴⁰ Substance Abuse and Mental Health Services Administration. (2019). Retrieved from <https://www.integration.samhsa.gov/clinicalpractice/sbirt/referral-to-treatment>

⁴¹ Boudreaux, E.D., Haskins, B. Harralson, T., et al. (2015). The Remote Brief Intervention and Referral to Treatment Model: Development, Functionality, Acceptability, and Feasibility *Drug and Alcohol Dependence*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4624210/>

⁴² Why is there comorbidity between substance use disorder and mental illness. National Institute of Drug Abuse. Retrieved from <https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/why-there-comorbidity-between-substance-use-disorders-mental-illnesses>

⁴³ Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>

⁴⁴ Defined as having at any time during the past year, a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment and that substantially interferes with or limits one or more major life activities.

⁴⁵ Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Retrieved from <https://www.samhsa.gov/data/>

⁴⁶ Jones, C.M., McCance-Katz, E.F. (2019). Co-Occurring Substance Use and Mental Disorders Among Adults with Opioid Use Disorder, *Drug and Alcohol Dependence*, 197, 78-82. Retrieved from <https://reader.elsevier.com/reader/sd/pii/S0376871618305209?token=8EE2E410C307B89E8B81EB2B5C210B1D265D6FCDB80AF87C14A94603AFF367AC4B131B5F752A140D517DA91C8B9CC8E4>.

⁴⁷ Novak, P., Feder, K.A., Ali, M.M., et al. (2019). Behavioral health treatment utilization among individuals with co-occurring opioid use disorder and mental illness: Evidence from a national survey. *Journal of Substance Abuse Treatment*. 98:47-52. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0740547218304781?via%3Dihub>

In addition to counseling and MAT to treat SUDs, people with mental illnesses are likely to need medication management for drugs to treat mental illness, and compared to those without a mental illness, may need more intensive services such as case management and psychotherapy or behavioral treatment. Telehealth can be a means to connect people with co-occurring mental illness and SUD with mental health services. Multiple studies have examined the outcomes of using telehealth to treat mental illness.

Pregnant Women with Substance Use Disorders

Access to comprehensive approaches to care are a critical barrier for pregnant and postpartum women with substance use disorder, who often have difficulty accessing care coordination services. Increasing access to care coordination services through telehealth delivery methods may lead to a reduction in the number of babies born with neonatal abstinence syndrome and may result in beneficial health outcomes for both mother and child. The surge in substance use-related illness and death in recent years particularly affects pregnant women, and is now a leading cause of maternal death. SUD has been associated with increased risk of preterm labor, early onset delivery, poor fetal growth, and stillbirth. Additionally, women who used opioids during pregnancy were four times as likely to have a prolonged hospital stay, had babies with increased rates of neonatal abstinence syndrome, and were almost four times more likely to die before discharge.⁴⁸ Several barriers to SUD treatment exist for women who are pregnant, including but not limited to lack of access to SUD treatment, lack of available SUD treatment for pregnant women specifically, fear of the stigma associated with the use of opioids or other substances during pregnancy, as well as legal consequences in some states with statutes that sanction pregnant women with SUD.⁴⁹ In some instances, healthcare treatment for pregnant women with SUD may be delayed by fears that seeking prenatal care or addiction treatment will trigger child welfare involvement and possible loss of parental rights for their children.

Women diagnosed with SUDs, who are pregnant or in the 60 day postpartum period, require access not only to effective SUD treatment but also to the full array of mandatory and optional pregnancy and pregnancy-related services available through Medicaid, including treatment of conditions that may complicate pregnancy. Increasing the utilization of services delivered via telehealth could be effective in addressing the needs of pregnant women with SUD.

Medicaid Payment for Education to Providers Regarding Telehealth

The below options have been included pursuant to section 1009(b)(2) of the SUPPORT Act.

Medicaid Payment to Providers Serving Medicaid Beneficiaries with Substance Use Disorders

States have significant flexibility in how they elect to cover and reimburse for services rendered to Medicaid-eligible individuals who have been diagnosed with SUDs. A state may reimburse providers for medically necessary Medicaid services, and recognize the varied costs of providing care based on the setting(s) in which the services are provided or the severity of need. States may

⁴⁸ Whiteman, VE, Salemi, JL, Mogos, M F, et al. (2014). Maternal Opioid Drug Use during Pregnancy and Its Impact on Perinatal Morbidity, Mortality, and the Costs of Medical Care in the United States. *Journal of Pregnancy*, 906723. Retrieved from <http://doi.org/10.1155/2014/906723>.

⁴⁹ Substance Abuse and Mental Health Services Administration. (2018). Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054: Rockville, MD.

reimburse for individually covered services or, if determined as a more efficient payment method, may develop bundled rates⁵⁰ to pay for services. In addition, states may develop payment methodologies that offer incentives for improved outcomes and quality care. By utilizing service delivery mechanisms such as the Medicaid Health Home benefit or other benefits, states may create integrated care models (ICMs), which support value-driven strategies that emphasize person-centered, continuous, comprehensive care.⁵¹ ICMs are characterized by organized and accountable care delivery and payment methodologies that are aligned across payers and providers to ensure effective, seamless, and coordinated care. ICMs include integration of various types of health care services such as primary, acute, specialty, dental, behavioral, long-term support services, and SUD-related services. States may use a variety of Medicaid authorities to implement ICMs, including section 1905(t) and 1932(a) primary care case management (and including coordinating, locating and monitoring activities under section 1905(t)(1), section 1945 health homes, and section 1115(a) demonstration authorities, and to create incentive payments for providers who demonstrate improved performance on quality and cost measures.⁵²

Hub and Spoke Model

When utilizing telehealth delivery methods the predominant model of service delivery is the “hub and spoke” design. With regard to telehealth services, the hub site means the location of the telehealth consulting provider, which is considered the place of service, and spoke site means the location where the patient is receiving the telehealth service. The hub and spoke model is widely used throughout the United States for healthcare service delivery, and is the model many telehealth delivery methods are currently utilizing when delivering services through live video conferencing.⁵³ Education directed to providers serving Medicaid beneficiaries with SUDs on how to most effectively utilize the hub and spoke model could be built into the overhead component of a fee-for-service rate paid for the provision of a direct service, and can serve to increase provider knowledge on how to furnish services through telehealth delivery methods.

Medicaid Payment through Managed Care Contracts

States can use varying delivery systems when providing services to its Medicaid beneficiaries. Some states use a managed care plan to deliver a set of services to its enrollees in a risk-based arrangement where the managed care plan gets paid a set amount per enrollee, generally called a capitation payment, to provide all of the covered services under the contract. The capitation payment must be developed only on state plan services, but must also be an amount that is adequate to allow the managed care plan to efficiently deliver those covered services to its enrollees in a manner that is compliant with contractual requirements, including the requirements of the Mental Health Parity and Addiction Equity Act detailed at 42 CFR 438, Subpart K.⁵⁴

⁵⁰ CMS issued guidance for developing bundled payment rates, which can be found at <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf>

⁵¹ The Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects states’ health home providers to operate under a “whole-person” philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the whole person.

⁵² CMS has several programs that encourage states to provide integrated care models, a concept that provides the full array of Medicaid and Medicare benefits through a single delivery system in order to provide quality care for dual eligible enrollees, improve care coordination, and reduce administrative burdens.

⁵³ Telehealth: The Big Picture. (2016). *National Organization of State Offices of Rural Health*. Retrieved from

<http://dhhs.ne.gov/publichealth/RuralHealth/Documents/NOSORH%20Telehealth%20Big%20Picture%20Fact%20Sheet%20FINAL.pdf>

⁵⁴ See 42 CFR 438.3(c)(1)(ii) and 438.5(e).

States have the flexibility to define network adequacy standards for their managed care plans, including the delivery of SUD services, which could include such specificity as the SUD specialists that are required to be in the plan network as well as requiring the use of a hub and spoke telehealth delivery method. The managed care plan development of the network, education to providers on the use of the hub and spoke model, and additional technical assistance/training to providers, could be included under the non-benefit component of a capitation rate if the state were to contractually require such standards for the delivery of SUD services. Many managed care plans provide education and trainings to providers on a regular basis as part of network development and retention efforts, even if it is not explicitly identified in the capitation rate development process.

Medicaid Payment through Administrative Funds for Disease Management Services

Medicaid can cover disease management services, such as care coordination, counseling, behavior modification, collecting, recording, and reporting on health outcome measures, and analysis and determination of the effectiveness of current interventions and the individual's needs for future interventions.⁵⁵ Disease management programs that focus interventions on the beneficiary may qualify as medical services under Medicaid.

Disease management programs that are limited to administrative activities, furnished by the state and its designated contractors, would not constitute "medical assistance." Administrative activities, however, could be eligible for Federal matching funds for administration of the state plan at the standard administrative matching rate of 50 percent. For example, states or their contractors may work with providers within their state to promote adherence to evidence-based treatments and guidelines, improve provider-patient communication, and analyze the Medicaid-enrolled individual's utilization of services. Contact with Medicaid-enrolled individuals is indirect and the change in provider practice patterns should enhance beneficiary care. Additionally, targeted informational mailings to Medicaid-enrolled individuals may improve patient knowledge, but no face-to-face contact occurs. The examples described in this section are generally considered to be administrative functions, and may be eligible for Federal administrative match.⁵⁶ Medicaid state plan requirements, such as statewide operation and comparability of services for medically and categorically needy groups, are not applicable to services deemed to be administrative functions.

School Based Health Centers

The below information has been included pursuant to section 1009(b)(3) of the SUPPORT Act.

Background

Section 2110(c)(9) of the Act defines a school-based health center (SBHC) as a health clinic that: 1) is located in or near a school facility of a school district or board, or of an Indian tribe or tribal organization; 2) is organized through school, community, and health provider relationships; 3) is administered by a sponsoring authority; 4) provides through health professionals primary health services to children in accordance with state and local law, including laws relating to licensure and certification; and 5) satisfies such other requirements as a state may establish for the operation of such a clinic. Additionally, section 2110(c)(9) of the Act defines a sponsoring facility to include any

⁵⁵ CMS SMDL #04-002 <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd022504.pdf>

⁵⁶ CMS SMDL #04-002 <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd022504.pdf>

of the following: a hospital; a public health department; a community health center; a non-profit health care agency; a local educational agency; or a program administered by the IHS or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization.⁵⁷

Authorizing legislation at 42 U.S.C. § 280h-4 provided the requirements for SBHCs to receive construction-related grant funding from HRSA. From FY 2011-2013, HRSA administered the School Based Health Center Capital (SBHCC) awards to address significant and pressing capital needs, improve service delivery, and support the expansion of services at SBHCs. Organizations eligible to apply for SBHCC funding included SBHCs or a sponsoring facility of a SBHC. Nearly \$200 million was available in FY 2011-2013, and funds remained available until expended. In February 2019, HRSA awarded \$11 million in SBHCC funding to SBHCs to specifically increase access to mental health, substance use disorder, and childhood obesity-related services by funding minor alteration/renovation projects and/or the purchase of equipment, including telehealth equipment.

Frequently furnished services by SBHCs include immunizations, acute illness treatment, prescriptions, collection of blood or urine samples for lab analysis, substance use counseling, and health education on topics such as nutrition and reproductive health. Many health centers also manage students' chronic conditions, such as asthma or diabetes, and educate them on disease prevention and how to remain in good health. In addition, in 2012, mental health services such as baseline assessment and counseling were available in approximately 45 percent of SBHCs, and general dental care, such as fillings and basic cleanings, were available in about 10 percent of SBHCs.⁵⁷

Medicaid Coverage

SBHCs are not a recognized Medicaid facility benefit. However, SBHCs may qualify as a Medicaid facility if they meet the requirements of the clinic benefit or the Federally Qualified Health Center (FQHC) benefit. In addition, Medicaid could cover services under 1905(a) of the Act furnished by an SBHC. States may elect to cover SUD treatment services such as assessments, counseling, MAT, and medication management under several Medicaid benefits. These benefits may include the Physicians' Services, Other Licensed Practitioner Services, or Rehabilitative Services benefits. Services provided by SBHCs vary since they are tailored to meet the needs of the communities which SBHCs serve.⁵⁸

Medicaid Reimbursement and Telehealth Options

Some states have taken the step to enroll SBHCs as Medicaid providers that meet the state's Medicaid benefit provider qualification requirements. States may request technical assistance from CMS with regard to reimbursement of Medicaid covered services and treatment via telehealth for substance use disorders that are delivered by a SBHC.⁵⁸

⁵⁷ School-Based Health Center Capital Program (SBHCCP). (2012). *Health Resources and Services Administration*. Retrieved from <https://bphc.hrsa.gov/programopportunities/fundingopportunities/sbhcc/fy13sbhccappfaqs.pdf>

⁵⁸ School Based Health Centers. (2011). *National Conference of State Legislatures*. Retrieved from <http://www.ncsl.org/research/health/school-based-health-centers.aspx>

State Readiness Assessment for Implementing Telehealth Delivery Methods

The above guidance has detailed coverage and reimbursement opportunities available to states for Medicaid services delivered via telehealth delivery methods. States may choose to examine several areas if implementing or expanding telehealth delivery methods are right for their state. In addition, during the period of public health crisis related to COVID-19, states may also use the following questions to assess telehealth in their state. The following questions should help a state determine which paths to pursue to align with the above telehealth coverage and reimbursement options for expansion of telehealth in their state under typical operations or in an emergency:

1. Assess the state operational environment by reviewing state policies and regulations governing services being delivered through telehealth delivery methods.
 - a. Do state policies/regulations prohibit services from being delivered through telehealth delivery methods?
 - b. Do state policies/regulations prohibit professionals from providing services delivered through telehealth delivery methods?
 - c. Does the state need to establish new regulations or seek authority from its legislature to furnish services delivered through telehealth delivery methods?
 - d. Does the state's provider scope of practice laws allow for practitioners to furnish services being delivered through telehealth delivery methods?
 - e. Do the state's managed care contracts have requirements regarding services being delivered through telehealth delivery methods? Please refer to page 14 of this CIB for additional information regarding reimbursement under managed care contracts.
2. Assess the state's technological capabilities to implement or expand services being delivered through telehealth delivery methods.
 - a. Do providers within the state have the technological capabilities to furnish services using telehealth delivery methods?
 - b. Are there any barriers to implementing or expanding technology in the state to furnish services being delivered through telehealth delivery methods?
 - c. Are there enough providers familiar with the technology used to furnish services using telehealth delivery methods?
3. Assess whether a state plan amendment is necessary for coverage and reimbursement of the proposed services.
 - a. Does the state's existing Medicaid state plan indicate that specific services are being delivered through telehealth delivery methods? Please refer to page 3 of this CIB for additional information regarding Medicaid state plan coverage flexibilities.

- b. Does the state's existing Medicaid state plan include language prohibiting services being delivered through telehealth delivery methods?
- c. Does the state's existing Medicaid state plan include a reimbursement methodology that differs for services being delivered through telehealth delivery methods? Please refer to page 3 of this CIB for additional information regarding Medicaid state plan reimbursement flexibilities.

Conclusion

Delivering SUD services via telehealth yields many positive impacts for Medicaid beneficiaries and for states. Telehealth delivery methods, including the four primary telehealth methods of live video-conferencing, store and forward, remote patient monitoring, and mobile health, can address healthcare access barriers for beneficiaries in rural and isolated geographic areas. Multiple states are currently delivering Medicaid covered services using telehealth delivery methods and designing services to meet the needs of their state. In addition to Medicaid reimbursement for services, several other Federal agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources & Services Administration (HRSA), the Administration for Children and Families (ACF), and IHS have grants and entitlement programs which can be utilized to cover SUD services delivered via telehealth. Many states are utilizing Federal funding authorities to deliver assessment, MAT, counseling, and medication management services via telehealth. Services are particularly needed for special populations such as AI/AN, adults under age 40, individuals with a history of non-fatal overdose, and individuals with co-occurring mental illness and SUD, who have been identified as having unique needs and challenges in obtaining SUD treatment services.

Under Medicaid, states have several options for receiving Federal financial participation to furnish SUD services delivered via telehealth. First, states may receive Federal financial participation for Medicaid services that meet the benefit requirements of the Act. Second, states may include SUD services delivered via telehealth in their managed care contracts and rates, creating some flexibility in determining adequacy standards for managed care plans. The state would then receive FFP for the whole capitation rate, including the services delivered via telehealth. Third, disease management services such as care coordination, collecting, recording, and reporting on health outcome measures, and analysis and determination of the effectiveness of current interventions and the individual's needs for future interventions, may be reimbursed by Medicaid as administrative activities at the 50 percent administrative rate. Fourth, states can receive Federal financial participation by utilizing service delivery mechanisms such as the Health Home benefit or other benefits to create ICMs, which support value-driven strategies that emphasize person-centered, continuous, comprehensive care, which can include SUD-related Medicaid services.⁵⁹ Fifth, some states have enrolled SBHCs as Medicaid providers to receive Federal financial participation for services delivered via telehealth that are coverable under Medicaid and included in a state's approved Medicaid state plan or waiver program. And, states may utilize the state readiness assessment questions to determine which paths to pursue in order to align with the telehealth coverage and reimbursement options previously referenced.

⁵⁹ CMS issued four State Medicaid Director Letters concerning ICMs, which can be located at the following URLs: <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf>, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>, <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf>, and <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf>

States seeking Medicaid Federal financial participation for SUD services delivered via telehealth may request technical assistance from CMS. If you have questions or would like to request CMS technical assistance related to this guidance, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

Appendix A

State Model Examples

In response to the national growing opioid epidemic, many states have implemented telehealth models to reach communities that have previously encountered barriers to accessing SUD treatment services. As of 2017, live video conferencing was covered under fee-for-service Medicaid by all 50 states and the District of Columbia.⁶⁰ As of the Fall 2019, remote patient monitoring, defined as the secure transmission of patient health and medical data collected at the originating site to a provider who will assess them at a distant site, was reimbursed under Medicaid by 22 states (Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New York, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, and Washington). Finally, store-and-forward services, which involve the secure transmission of data, images (e.g., X-rays, photos), sound, or video that are captured at the originating site and sent to specialists at a distant site for evaluation, were covered under Medicaid by 15 states (Alaska, Arizona, Connecticut, California, Georgia, Maryland, Minnesota, New Mexico, Nevada, New York, Tennessee, Texas, Virginia, and Washington). States structured their coverage and reimbursement of services furnished by telehealth delivery methods differently to account for the unique population needs within each state, but each program has integrated at least one telehealth service delivery mechanism.⁶⁰

The following are some examples of how some states are currently utilizing certain telehealth service delivery mechanisms:

Idaho

Idaho Medicaid covers specific services delivered via telehealth technology to help ensure Idaho Medicaid beneficiaries receive the best possible care regardless of geographic location. Since 2003, Idaho's Medicaid program covers live video telehealth for mental health services, specifically pharmacological management counseling, psychiatric diagnostic interviews, psychiatric crisis interventions, and psychotherapy services. In addition, Idaho allows for behavioral health services delivered via telehealth methods under a managed care contract. Effective as of 2008, Idaho allows for mental health services provided via telehealth to be provided by physicians in mental health clinics, as well as to sites beyond mental health clinics. Crisis intervention services were added as covered services in 2011.⁶¹

Arizona

Arizona Medicaid covers many medically necessary services delivered via two telehealth delivery methods. The first method is "real time" telehealth, meaning interactive, live video conferencing in order for the patient and healthcare provider to engage directly by utilizing technology. Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication. The second method is "store-and-forward", meaning transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image

⁶⁰ State Telehealth Laws and Medicaid Policies: 50-State Survey Findings. (2019). *Manatt*. Retrieved from <https://www.cchpca.org/sites/default/files/2020-01/Historical%20State%20Telehealth%20Medicaid%20Fee%20For%20Service%20Policy%20Report%20FINAL.pdf>

⁶¹ Idaho Medicaid Policy: Telehealth Services. (2018). *Idaho Department of Health and Welfare*. Retrieved from <http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthPolicy.pdf>

that is sent (forwarded) via telecommunication to another site for analysis. Arizona's Medicaid coverage of services via live video conferencing or "store-and-forward" is expansive and permits coverage of cardiology, dermatology, endocrinology, pediatric subspecialties, hematology-oncology, home health, infectious diseases, neurology, obstetrics and gynecology, oncology and radiation, ophthalmology, orthopedics, pain clinic, pathology, pediatrics, radiology, rheumatology, and surgery follow-up and consultation services.⁶²

Kentucky

Kentucky Medicaid covers several classes of services provided via telehealth using live video: mental health evaluation and management services; individual psychotherapy; pharmacological management counseling; psychiatric, psychological, and mental health diagnostic interview examinations; individual medical nutrition counseling; individual diabetes self-management counseling; occupational, physical, or speech therapy evaluation or non-hands on treatment; neurobehavioral status examination; and end stage renal disease monitoring, assessment, or counseling services. Kentucky requires that the Department of Health requirements for coverage and reimbursement of services are equivalent for in-person services and services delivered via telehealth, unless the telehealth provider and the Medicaid program agree to a lower reimbursement rate for telehealth services, or the Kentucky Department of Health establishes a different reimbursement rate.⁶⁰

Georgia

Georgia Medicaid covers office visits, pharmacological management, limited office psychiatric services, limited radiological services, and a limited number of other physician fee schedule services delivered via live video conference. Georgia Medicaid reimburses for mental health services for residents in nursing homes via telehealth for dually eligible Medicaid and Medicare beneficiaries.⁶³ In Georgia, store-and-forward is not reimbursable as interactive telecommunications; however, Georgia Medicaid reimburses for teleradiology and ultrasound services in which results are electronically sent to other practices for qualified providers to analyze and interpret the results, and which are then sent back to the originating hospital or directly to the patient depending on the method used. Georgia was one of the first states to reimburse store-and-forward teledentistry services.⁶³

⁶² Chapter 10: Individual Practitioner Services. (2018). *Arizona Health Care Cost Containment System*. Retrieved on February 26, 2019, from https://azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf

⁶³ Georgia. (2017). *Public Health Institute Center for Connected Health Policy*. Retrieved from <http://www.mtelehealth.com/wp-content/uploads/2017/11/Georgia.pdf>

Appendix B

Existing Federal Funding Opportunities for Substance Use Disorder Treatment Services and Services Delivered via Telehealth that May Compliment Medicaid Funding

Every day in the United States, 130 people die from opioid overdoses, and the number of overdose deaths involving opioids increased five-fold between 1999 and 2016.⁶⁴ The opioid epidemic is especially prevalent among children and families in specific regions and from specific racial and socioeconomic backgrounds. As of 2017, generally, states in New England and Appalachia have experienced higher overdose death rates than other regions.⁶⁵ Individuals living in rural areas are more likely to die from an opioid overdose, as are those individuals with lower education levels.⁶⁶ A 2016 study showed that in 31 states and the District of Columbia, deaths increased across all prescription and illegal opioid classifications, and that opioid use rates increased from the previous year across demographics, urbanization levels, and amongst all states participating in the study.⁶⁷

The Federal government has enacted several programs to aid states in furnishing SUD services. In 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the State Targeted Response to the Opioid Crisis Grants program, which provides Federal grant funds to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for SUD.⁶⁸ In 2018, the Health Resources & Services Administration (HRSA) launched the Rural Communities Opioid Response Program to support treatment for and prevention of SUD, including opioid use disorder, in rural counties at the highest risk for SUD.⁶⁹ Also in 2018, SAMHSA launched the State Opioid Response Program, which supports a comprehensive response to the opioid epidemic through increasing access to medication assisted treatment (MAT), reducing unmet treatment needs, and reducing opioid overdose deaths through the provision of prevention, treatment and recovery services. SAMHSA also continued the funding of MAT for the Prescription Drug and Opioid Addiction Program, first begun in 2012, to expand and enhance access to services for persons with an SUD seeking or receiving MAT.⁷⁰

In addition to new SUD specific funding opportunities being offered, existing Federal programs can also be leveraged to assist states in increasing SUD treatment and telehealth utilization. Existing funding opportunities include the Administration for Children and Families' (ACF) Regional Partnership Grants, which are grants for inter-agency collaboration and program integration between child welfare and other agencies to support families affected by SUD⁷¹; CMS' reimbursement for many SUD services through Medicaid; HRSA's Title V Maternal and Child

⁶⁴ Understanding the Epidemic. (2018). *Centers for Disease Control and Prevention*. Retrieved from <https://www.cdc.gov/drugoverdose/epidemic/index.html>

⁶⁵ Drug Overdose Death Data. (2018). *Centers for Disease Control and Prevention*. Retrieved from <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

⁶⁶ Rigg et al. (2018). Opioid-related Mortality in Rural America: Geographic Heterogeneity and Intervention Strategies. *International Journal of Drug Policy*. 57: 119-129.

⁶⁷ Seth et al. (2018). Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. *Morbidity and Mortality Weekly Report*. 67(12): 349–358.

⁶⁸ State Targeted Response to Opioid Crisis Grants. (2017). *Substance Abuse and Mental Health Services Administration*. Retrieved from <https://www.samhsa.gov/grants/grant-announcements/ti-17-014>

⁶⁹ Rural Communities Opioid Response Program. (2018). *Health Resources & Services Administration*. Retrieved from <https://www.hrsa.gov/grants/fundingopportunities/default.aspx?id=35ee358e-d42f-4c7a-ba6e-d71f228eb1a9>

⁷⁰ Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction Program. (2018). *Substance Abuse and Mental Health Services Administration*. Retrieved from <https://www.samhsa.gov/grants/grant-announcements/ti-18-009>

⁷¹ Grants & Funding. (2016). *Administration for Children and Families*. Retrieved from <https://www.acf.hhs.gov/grants>

Health Block Grants, which are state block grants to support maternal and child health, in which states have significant flexibility in how to use the funds⁷²; the IHS Alcohol and Substance Abuse Programs, which funds IHS alcohol and substance abuse treatment programs, including comprehensive care in IHS facilities⁷³; SAMHSA's Substance Abuse Prevention and Treatment Block Grants, which are funds available to all states to implement and evaluate substance abuse prevention and treatment activities;⁷⁴ and the U.S. Department of Agriculture's Distance Learning and Telemedicine Grants, which help rural residents use telecommunications and the internet to access medical service providers.⁷⁵ Through the utilization of these new and existing Federal funding streams, states can implement and sustain telehealth delivery models.

⁷² Title V Maternal and Child Health Block Grant Program. (2019). *Health Resources & Services Administration*. Retrieved from <https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program>

⁷³ Alcohol and Substance Abuse Program. (2019). *Indian Health Service*. Retrieved from <https://www.ihs.gov/asap/about/>

⁷⁴ Substance Abuse Prevention and Treatment Block Grant Fact Sheet, *Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.samhsa.gov/sites/default/files/sabg_fact_sheet_rev.pdf

⁷⁵ See <https://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants>