South Carolina Department of Health and Human Services

FY19-20 Proviso 117.126 (C) – Telehealth Report

This report is issued pursuant to Section 117.126 (C) of Act 91 of 2019.
"The Department of Health and Human Services and the Public Employee Benefit Authority shall each review federal additions to telehealth coverage established under the Bipartisan Budget Act of 2018, the SUPPORT for Patients and Communities Act, and other recent federal legislation and/or regulation. No later than October 1, 2019, both of these agencies shall submit a report to the Governor, the Chairman of the Senate Finance Committee, and the Chairman of the House Ways and Means Committee on how they intend to broaden their service-based coverage to align with these federal changes and to improve the sustainability of telehealth services."

Background

The South Carolina Department of Health and Human Services (SCDHHS) defines telehealth as the use of medical information about a patient that is exchanged from one clinical practice site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. Telehealth provides an additional option for delivering certain covered services, when appropriate, rather than a separate set of benefits.

In determining the appropriate role of telehealth in the Medicaid benefit, SCDHHS balances the tenets of cost, quality, and access.

- *Cost*: From a cost perspective, ideal targets for telehealth provide opportunities to triage patients away from more costly sites of care or provide follow-up care that does not need to involve face-to-face interaction.
- *Quality*: While evidence supporting the use of telehealth continues to mount, care must be taken to not allow for telehealth in those instances where the quality of care is inferior to care delivered through face-to-face interaction.
- *Access*: Telehealth offers a unique opportunity to erase the geographic divides that separate many areas of our state, allowing the resources of South Carolina's metropolitan areas to serve its most underserved citizens. As these opportunities to enhance access become available, the needs to maintain the quality of care and efficiently spend the healthcare dollar must not be forgotten.

Current Coverage

Current SCDHHS coverage policy requires any healthcare professional providing medical care via telehealth be:

- Currently and appropriately licensed in South Carolina;
- Meet Medicaid credentialing requirements;
- Be enrolled with the South Carolina Medicaid program; and,
- Be located within the South Carolina Medical Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border.

SCDHHS provides coverage for the delivery of telehealth services from a consultant site to a referring site within the limitations described below.

- The consultant site is the physical location where a specialty physician or practitioner providing medical care is located at the time the service is provided via telehealth.
- The referring site is the location of a Medicaid beneficiary at the time the service is being furnished.

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment. Currently, physicians, nurse practitioners, and

physician assistants may provide care from the consulting site. Medicaid beneficiaries receiving telehealth services must be physically located at a referring site that is also within the SCMSA. Referring site providers must be proficient in the use of the telehealth-enabling technology and be present during the encounter to provide any clinical support necessary during the encounter. Referring sites currently covered by SCDHHS include:

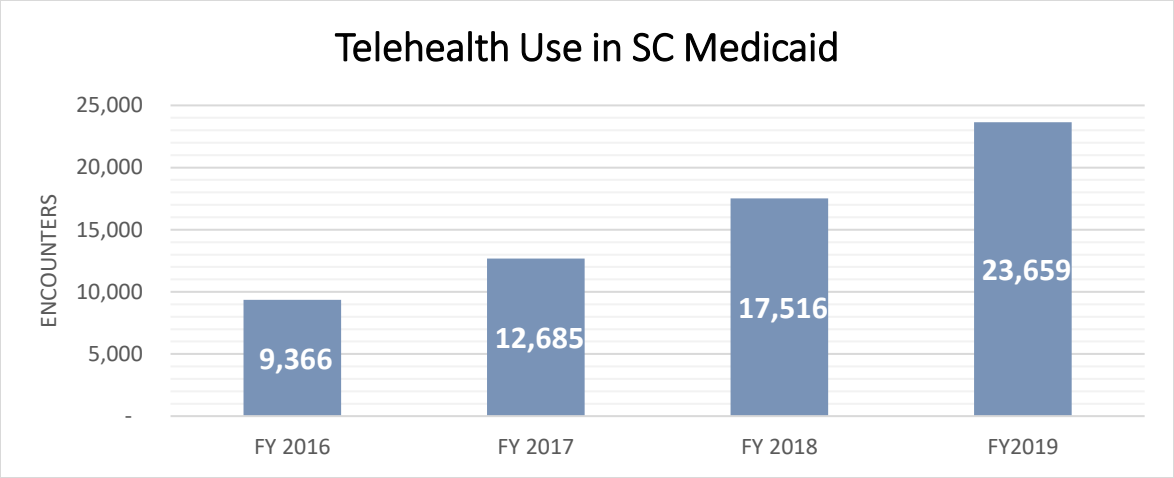
- Physician, nurse practitioner, or physician assistant office
- Hospital (inpatient and OP)
- Rural Health Clinics
- Federally Qualified Health Centers
- Community Mental Health Centers
- Public Schools
- Act 301 Behavioral Health Centers

Services currently eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examinations and testing, electrocardiogram (EKG) interpretation, and echocardiography (ECG). As a condition of reimbursement, an audio and video telecommunication system that is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant and that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site must be used. Visits that are conducted via telehealth are subject to benefit limitations and other requirements that apply when care is delivered through traditional models.

Additional requirements related to telehealth services are included in the relevant provider manuals, available at www.scdhhs.gov.

Current Utilization

The use of telehealth within the Medicaid program has increased steadily since its introduction, with 23,659 telehealth encounters during state fiscal year (SFY) 2019. Year-over-year growth has averaged 35 percent, as demonstrated in the graph below.



SCDHHS funding of the South Carolina Telehealth Alliance

In addition to direct claims payment for telehealth services for Medicaid beneficiaries, SCDHHS provides considerable funding to the South Carolina Telehealth Alliance (SCTA), through the Medical University of South Carolina (MUSC). Since SFY 2014, and including contract amounts for the current fiscal year, SCDHHS will have directed $90 million in funding to MUSC for the continued development and operation of the SCTA (see table below). Because this funding is not directed specifically toward Medicaid-covered services for Medicaid beneficiaries, it is not eligible for federal match and is funded fully from state revenue.

SCDHHS Proviso Funding		
FY2014	**$4,000,000**	- Proviso 33.34 Section E(3)
FY2015	**$15,000,000**	- Proviso 33.26, Section E(3)
FY2016	**$13,000,000**	- Proviso 33.22, Section E(3)
FY2017	**$15,000,000**	- Part IA, Section 33, II.A.2. Medical Contracts - $4,000,000 - Proviso 33.21, Section E(3) - $11,000,000
FY2018	**$17,350,000**	- Part IA, Section 33, II.A.2. Medical Contracts - $6,000,000 - Proviso 117.135 (B) - $9,000,000 - Proviso 33.23, Section A(1) and A(4) - $2,350,000
FY2019	**$13,000,000**	- Part IA, Section 33, II.A.2. Medical Contracts - $7,000,000 - Proviso 117.131 (B) – $5,000,000 - Proviso 33.22, Section A(1) – $1,000,000
FY2020	**$13,000,000**	- Part IA, Section 33, II.A.2. Medical Contracts - $7,000,000 - Proviso 117.126 (B) - $5,000,000 - Proviso 33.22, Section A(1) - $1,000,000
Total =	**$90,350,000**	

SCTA executes its work activities with a focus on the following:

1. Deploy a coordinated, open-access telehealth network in South Carolina
2. Understand and effectively respond to the needs of users of telehealth with an emphasis on the underserved and rural populations
3. Build and scale telehealth clinical services and programs that expand access to care
4. Broaden mental health and related telehealth clinical services and programs to increase access to care
5. Conduct statewide education, training and promotion to providers and the public to accelerate and spread adoption of telehealth
6. Develop a telehealth organization structure that encourages and facilitates statewide collaboration among providers in the delivery of health care, education and research
7. Establish the value case for telehealth through robust assessment and rigorous analysis of telehealth outcomes
8. Demonstrate to legislators, payers, providers, and the public the impact of telehealth on improving access, quality, and affordability

As models are identified and validated through the South Carolina Telehealth Alliance, funding that is currently being directed in this manner should be redirected to allow for coverage-based payment for services. Not only does this create a more sustainable source of reimbursement, but it also allows SCDHHS to leverage the federal match to fund over 70 percent of the cost of care.

Medicaid Considerations

Any pursuit of alignment between Medicaid and other payers must consider several unique characteristics of the Medicaid program. First, requirements severely limit the imposition of patient cost sharing for Medicaid beneficiaries. Whereas co-payments serve as a natural control on overutilization in the Medicare and commercial market, this dynamic is largely absent for Medicaid, creating a risk of overutilization and difficulties in estimating budget impact based on trends observed in other populations.

Additionally, the Medicaid benefit and provider network, especially as it relates to behavioral health and care provided by non-licensed individuals, is generally broader than both Medicare and commercial payers. Evidence that supports the use of telehealth in traditional clinical conditions may not necessarily apply to these other types of care, requiring the need for more specific considerations on which Medicaid services and providers can be appropriately provided through telehealth.

Federal Changes to Telehealth Coverage

The **Bipartisan Budget Act of 2018** broadened Medicare coverage related specifically to the treatment of end stage renal disease (ESRD) and acute stroke care. Changes included:

<u>End Stage Renal Disease (ESRD)</u>:

- Renal dialysis facilities and the patient's homes were added as Medicare telehealth originating sites for home dialysis monthly ESRD-related clinical assessment. An individual must have a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial three months of home dialysis and at least once every three consecutive months after the initial three months.
- The rural geographic requirement to originating sites that are hospital-based, critical access hospital-based renal dialysis centers, renal dialysis facilities, or the patient's home was removed. No originating site facility fee applies when the originating site for these services is the patient's home.

<u>Acute Stroke Changes</u>:

- The treatment of acute stroke through telehealth in any hospital, critical access hospital, mobile stroke unit, or any other site determined appropriate by the Secretary will be allowed without application of the geographic requirement.
- Only sites that meet the usual Medicare telehealth services criteria will be eligible for the facility fee.

- CMS has proposed to create a new modifier that would be used to identify acute stroke services delivered via telehealth. The practitioner, and where appropriate the originating site, would use this modifier to the Healthcare Common Procedure Coding System (HCPCS) code for billing or the originating site facility fee.

Provisions of the **SUPPORT for Patients and Communities Act** were designed to make medical treatment for opioid addiction more widely available by removing telehealth coverage restrictions for those with an opioid use disorder (OUD) for the purposes of treatment of OUD or a co-occurring mental health disorder.

These changes include:

- Removal of the originating site geographic requirements for telehealth services for any existing Medicare telehealth originating site.
- The patient's home was made an eligible originating site for purposes of treating these individuals. The patient's home does not qualify for the facility fee.

To address the opioid epidemic in South Carolina, the Center for Telehealth at MUSC has successfully implemented two telehealth programs for the treatment of OUD for pregnant women receiving care at an obstetric practice and adults receiving care at a county drug and alcohol treatment center. Both programs have demonstrated the feasibility of delivering OUD treatment via telehealth and are without adverse events or drug diversion. Women receiving OUD treatment via telehealth have similar rates of retention in treatment, substance use and newborn outcomes such as Neonatal Abstinence Syndrome (NAS). Given the successes of these projects, SCDHHS supports transitioning these models to more sustainable funding models that align with SUPPORT Act provisions.

Other recent changes in Medicare coverage have included:

Virtual Check-Ins**:** Brief Communication Technology-Based Service (HCPCS code G2012)

- Allows providers to use new technologies to deliver follow-up care for patients
- Enables brief, technology-based interaction between patient and provider to assess their health status and determine if an in-person visit is needed
- Can be provided to established patients (those seen by the practice within the last three years)
- Virtual check-ins cannot be billed if there was a related evaluation and management (E/M) service provided within the previous seven days or an E/M service or procedure within the next 24 hours

Store and forward telehealth services**:** Remote Evaluation of Recorded Patient Information (HCPCS code G2010)

- Remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology.

E-Consults**:** Interprofessional Internet Consultation (Current Procedural Terminology (CPT) codes 99446-99449, 99451, 99452)

- Can include telephone calls as well as live or asynchronous internet consultation or messaging through mediums such as email, or chat/messaging feature within an electronic medical record (EMR).
- Formalizes and provides payment for communications between referring and consulting providers.
- E-consults provide more efficient access to specialty care and have reduced unnecessary referrals by up to 40%.

Remote Patient Monitoring**:** Chronic Care Remote Physiologic Monitoring (CPT codes 99453, 99454, 99457)

- Provides separate payment for time spent on collection and interpretation of health data to support population health and care coordination services
- Provides real time, direct data transmitted to providers via monitoring devices for direct feedback and medication adjustment.

Alignment with Medicaid Needs

Additional opportunities exist to focus on areas of particular need for the Medicaid population, notably, behavioral health and obesity, by broadening the provider community eligible for reimbursement for care delivered via telehealth.

Behavioral Health

Telepsychiatry is one of the most successful and highly utilized telehealth services in South Carolina. Since 2007, the South Carolina Department of Mental Health (DMH) has operated an emergency department telepsychiatry program. A community telepsychiatry services program was added in 2013. These programs provide 2,000 psychiatric services via telehealth per month.

Currently, only physicians, nurse practitioners, and physician assistants can provide these services. Expanding the slate of providers eligible to provide these services, to include clinical psychologists and clinical social workers, supports the growth of resource-efficient and sustainable business models that use interdisciplinary, collaborative care teams to address the behavioral health needs of the Medicaid population. Clinical psychologists and clinical social workers are already approved providers for in-person mental health services through Medicaid. Allowing the provision of these services through telehealth would also allow SCDHHS to shift utilization from lower value services, provided by non-licensed providers, to care provided by licensed independent practitioners.

MUSC's Trauma/Telehealth Resilience and Recovery Program (TRRP) represents another model that is currently supported by state-only grant funds. Since 2015, TRRP has served more than

3,500 adult and pediatric traumatic injury patients. Prior to its launch, only about 50 patients per year would have received any mental health follow-up. In 2018, TRRP services were expanded to three other Level I and II trauma centers in South Carolina, which has allowed service to be provided to an additional 1,750 adult patients (1,000 at Palmetto Health, 400 at Greenville Memorial, 350 at Trident). As home-based tele-mental health services are expanded to the pediatric units, these numbers are likely to increase.

In yet another instance, MUSC's Telehealth Outreach Program (TOP) provides daily tele-mental health visits across South Carolina with approximately 580 visits completed in the past year and more than 1,700 visits completed since 2016.

Both the TRRP and TOP models represent opportunities to transition current funds to federally matched, service-based coverage.

Services provided by licensed dieticians: Nutrition counseling is among the interventions employed when addressing South Carolina's diabetes and obesity epidemic. A shortage of qualified registered dietitians, particularly in rural and underserved areas, creates access barriers. The use of telehealth, employed in limited-service or rural areas, or to reach high-need, high-utilizing individuals could offer an avenue to expand this access. South Carolina has employed a similar strategy to expand practice scope and distance for advanced practice nurses through Act 234 of 2018. Similar limited expansions could bear fruit for other nonphysician providers statewide, advancing efforts to improve access to care in critical needs areas. Organizations such as the South Carolina Area Health Education Consortium (AHEC) regularly produce evaluations of discipline-specific workforce strength by region that can be used to evaluate the need and appropriate use of telemedicine as an access supplement.

SCDHHS Telehealth Strategy

To ensure the adoption of effective and efficient telehealth services to the Medicaid population, SCDHHS is engaged in the following:

- *Benchmarking of Reimbursement Rates for Telehealth to Industry Standards:* In evaluating reimbursement rates currently paid for telehealth services, and as part of a global effort to modernize Medicaid reimbursement methodologies, SCDHHS has recently updated reimbursement rates for telehealth services, most notably the HCPCS code Q3014. This resulted in an increase from $14.96 to $20.92, aligning South Carolina's payment with other Medicaid programs.

- *Identifying those services most valuable to the Medicaid population*: While the telehealth benefits provided by Medicare serve as a useful benchmark for other payers, the Medicaid population is considerably different. SCDHHS plans to continue evaluating the services provided by other payers through telehealth, and adopt those services that

are evidence-based, cost-efficient, and aligned with the needs of the Medicaid population. At present, SCDHHS is most interested in exploring those additional services and providers able to enhance access to behavioral health and substance use treatment and to address access gaps that have been identified in the Medicaid provider network. SCDHHS is engaging with several provider collaboratives and trade associations in identifying those specific services and providers. To date, these collaborative efforts have identified "store and forward" and virtual check-in as initial opportunities to broaden SCDHHS telehealth coverage.

- *Transitioning funding from state-only grants to federally matched service payments:* As models are identified and validated through the *SCTA*, funding that is currently being directed in that manner should be redirected to allow for payment for services. Not only does this create a more sustainable source of reimbursement, but it also allows SCDHHS to leverage the federal match for the care provided.