Nemours. Children's Health System

April 1, 2019

Dear Co-Chairs of the Congressional Telehealth Caucus:

Thank you for the opportunity to submit suggestions, recommendations, and relevant experiences as you work to develop a telehealth package that continues to expand access to telehealth and remote patient monitoring services. Nemours commends your interest and leadership in advancing federal telehealth policy to improve the health and health care of Americans.

Nemours is an internationally recognized children's health system that owns and operates the Nemours/Alfred I. duPont Hospital for Children in Wilmington, Del., and Nemours Children's Hospital in Orlando, Fla., along with outpatient facilities in six states, delivering pediatric primary, specialty, and urgent care to children from all 50 states. Established as The Nemours Foundation through the legacy and philanthropy of Alfred I. duPont, Nemours provides pediatric clinical care, research, education, advocacy, and prevention programs to families in the communities we serve.

In 2018, Nemours provided care to more than 450,000 children, from across the United States and more than 70 countries. Through our virtual care platform Nemours CareConnect, patients are able to access board certified pediatricians and subspecialists for urgent care, primary and specialty care patient visits. Nemours also powers the world's most-visited website for information on the health of children and teens, KidsHealth.org. We are committed to leveraging our experience on the ground to inform policies and practices nationally to benefit all children, not just those in the regions we serve. Our mission is to help all children grow up healthy and have the best chance for success in life.

As the Caucus considers legislative approaches and solutions to advance telehealth, we ask that you consider the following categories of opportunity (described in detail in the Recommendations section below), with a focus on Medicaid and CHIP:

1. Areas ripe for guidance from the federal government
2. Areas ripe for federal agency studies and data collection
3. Multi-state research and outreach
4. Demonstration model(s) within CMMI
5. Expansion of provisions of the SUPPORT for Patients and Communities Act
6. Interagency activities to expand telehealth to early care and education programs

Background

Since 2014, Nemours has conducted 18,000 virtual care encounters via our Nemours CareConnect telemedicine service, offered in most of our subspecialties directly into the home, outpatient clinics, schools and/or partner health systems.

As a children's health system with physical locations across six states, we know that telehealth is not appropriate for every health care encounter, nor should telehealth supplant in-person care when it is needed. However, our experience has led to a strong belief that the expansion of access to high-quality pediatric health care via telehealth and other virtual care services is not only the future of health care, but it is also the right thing for patients and families.

Patients and families across the country, especially those in rural and underserved communities, face access barriers to routine and emergent health care services. Some of these barriers include provider availability, time away from work, school, and other responsibilities, poor care experiences including long wait times, and transportation challenges. According to a 2019 RAND Corporation study, telehealth is viewed as an effective strategy to reduce access and quality disparities faced by Medicaid patients, improve timeliness of care, improve convenience of care, and impact care outcomes.[i]

The Case for a Focus on Children

While Congress' progress on telehealth expansion for Medicare beneficiaries is both welcome and necessary, Nemours finds that there is great opportunity to increase the attention and resources devoted to telehealth expansion in Medicaid and the Children's Health Insurance Program (CHIP), particularly for the pediatric population. According to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and CHIP enrollment data, children represent 50 percent of Medicaid and CHIP enrollees.[ii] Moreover, according to CMS data on maternal and infant health, 50 percent of all births are covered by Medicaid, and about 66 percent of Medicaid-enrolled women are in their child-bearing years.[iii] Children are also an underserved population, as outlined in a 2016 report by the Children's Health Fund, which estimated that 20.3 million children across the United States lack sufficient access to primary care.[iv]

Studies have shown that children benefit from telehealth across several specialties including oral health, behavioral health, chronic disease management, hearing and speech, and sports medicine, as well as others.[v,vi, vii, viii,ix] An emerging area in telehealth is on-demand urgent care telehealth services, which provide care for non-acute medical conditions. Recent studies have highlighted the potential cost savings associated with using on-demand pediatric urgent care telehealth. Nemours recently conducted a retrospective study with data from Nemours CareConnect. The study showed that without access to Nemours CareConnect, 64.5 percent of parents surveyed said that they would have gone to either an urgent care center or an emergency room (ER).[x] Another study that observed telemedicine utilization in a pediatric orthopedic clinic not only highlighted the potential cost savings for the families but also for the health system.[xi] Researchers discovered that families saved on average $50 in travel costs and that the clinic saved approximately $24 per patient in direct labor cost.[xii]

Barriers to Telehealth in Medicaid

Despite the opportunity for telehealth to improve children's health care, multiple systemic barriers exist within and across Medicaid programs in the U.S. This discourages many providers from offering telehealth services to Medicaid patients or extending their services across state lines, even as patients are increasingly mobile and transient. Some of these barriers include:

- Administrative, transactional, and financial burden and confusion for providers when obtaining and maintaining licensure to practice across multiple states;
- Similar burdens relating to provider enrollment in Medicaid across multiple states;
- Highly variable definitions, rules, laws, regulations, and billing/coding adoption across state Medicaid programs and each managed care contract within each state; and
- Poor patient experience due to inaccurate bills as a result of confusion around telehealth coding. Such confusion often results in denied claims, which providers and patients must work to resolve. If unresolved, the costs are ultimately absorbed by hospitals, providers or patients.

The 2019 RAND Corporation report as well as the Medicaid and CHIP Payment and Access Commission's (MACPAC) March 2018 report entitled "Telehealth in Medicaid" cite wide variation in telehealth policies among states, state Medicaid programs and Medicaid Managed Care Organizations (MCOs) as a barrier to telehealth adoption, expansion, and state-to-state learning.[xiii] The barriers outlined above represent high-level, wide-ranging challenges faced by all provider types depending on the states in which they operate. The RAND Corporation report also highlights that some of these challenges are barriers to entry altogether, meaning that willing providers cannot justify the allocation of resources to overcome these barriers given the existing policy landscape. For example, low or no reimbursement for services and/or lack of clarity around allowable services under Medicaid were cited as the key barriers to entry and program sustainability.[xiv]

While some states have made progress on certain elements of telehealth policy, the patchwork of Medicaid policies, rules and regulations will remain a barrier unless the federal government acts to bring more alignment, predictability and clarity to Medicaid telehealth policy. There are various pathways through which Congress and the Administration could effect positive change. We make several suggestions in the following section titled "Recommendations." However, **Nemours recognizes the nuance and complexity of the state-federal partnership on the Medicaid program and requests continued, deep conversation with the Congressional Telehealth Caucus and relevant House and Senate committees of jurisdiction.** The suggestions included below are a starting point for such conversations. We again commend this body for its commitment and attention to such an important policy topic.

Recommendations

As previously discussed, Nemours believes there are many opportunities to advance federal policy, through various pathways, in order to improve patients' and providers' access to and experience with telehealth and other virtual care services. We ask the Congressional Telehealth Caucus to consider the following categories of opportunity, with a focus on Medicaid and CHIP:

1. Areas ripe for guidance from the federal government
2. Areas ripe for federal agency studies and data collection
3. Multi-state research and outreach
4. Demonstration model(s) within CMMI
5. Expansion of provisions of the SUPPORT for Patients and Communities Act
6. Interagency activities to expand telehealth to early care and education programs

Areas Ripe for Guidance from the Federal Government

Several agencies share jurisdiction over health care in general, and telehealth more specifically. We focus on the areas where CMS, specifically the Center for Medicaid and CHIP Services (CMCS), could significantly and positively impact telehealth policy across all Medicaid programs through the issuance of guidance. Based on the discussion above, **we ask Congress to direct CMS to issue guidance to State Medicaid Programs** on the following topics:

a. **Clarity and alignment on covered telehealth services allowable under Medicaid with and without State Plan Amendments (SPAs) and/or 1115 Waivers.** State Medicaid programs and providers alike have cited confusion around covered/allowable telehealth services as a barrier.[xv]

b. **Clarity and alignment on billing codes, modifiers and/or place of service designations for telehealth and other virtual care services.** State Medicaid programs and providers alike have cited confusion, wide variability, and the resulting administrative burden surrounding billing and coding as both a dissatisfier and barrier. Further, unresolved billing/coding issues sometimes result in incorrect patient bills, which can dampen patient satisfaction with the health care system.

c. **Streamlining of provider licensing, credentialing and enrollment across states, state Medicaid programs, and MCOs.** Providers cite enormous administrative and cost burdens associated with obtaining and maintaining multiple state licenses to practice medicine, multiple credentialing processes across multiple state Medicaid programs and MCOs, and the inability to enroll as a Medicaid provider across multiple state Medicaid programs via a common, singular process as burdens and barriers to entry. Further, patients with complex health needs experience significant travel and cost burdens when their care team is unable to provide continuity of care across state lines. Alignment across state Medicaid programs on any or all of these issues would significantly reduce provider and patient burden and could expand provider entry, resulting in greater access to telehealth providers in Medicaid.

d. **Integrating telehealth and other virtual care services into value-based care models**. As the federal government continues to pursue goals aimed at increasing value-based and accountable care models across federal programs, Congress and the Administration should disseminate best practices related to the integration of telehealth and virtual care into such models via guidance to state Medicaid programs and MCOs. Moreover, such guidance should highlight the unique needs of children, who comprise nearly half of all Medicaid enrollees, and their providers. Value-based and accountable care models for pediatric populations must be crafted differently than those serving adult patients given the vast differences in care needs, revenue models, opportunities and time horizons for return on investment, and the need to invest more heavily in disease prevention versus sick care.

Areas Ripe for Federal Agency Studies and Data Collection

Data regarding the impact and experience of telehealth and telehealth policy across Medicaid programs is in short supply. The RAND Corporation's study, which in Nemours' view is a substantive yet preliminary and limited assessment of the problem, is the first major study to collect and analyze qualitative data related to Medicaid policy on telehealth. While organizations

routinely report state legislative and regulatory action on telehealth policy, qualitative studies on the implementation (or lack of) and impact of those policies is sorely needed**.** Nemours' experience in working with six state Medicaid programs and numerous managed care payers within each state has underscored the various barriers (identified above) to administering telehealth, particularly across states lines. As a result, **we recommend that Congress direct the Government Accountability Office (GAO) or Medicaid and CHIP Payment and Access Commission (MACPAC) to conduct studies on the following topics** in order to identify and recommend solutions to systemic barriers across states, including the following:

a. **Barriers (and potential solutions) to provider entry and participation in telehealth across multiple states.** Many providers, like Nemours, serve multiple states. Piecemeal solutions specific to each state do not solve the multi-state barriers that can be exacerbated by single state action to improve Medicaid telehealth policy. A GAO or MACPAC study on common, multi-state barriers that could be addressed through common policy change could be helpful in mitigating or eliminating such barriers.
b. **Frequency of out-of-state telehealth care for Medicaid patients, and the potential impact on access to services if state Medicaid policies were more aligned.** Few states are currently able to determine the impact of telehealth or virtual care visits across their Medicaid population due to a number of data collection shortfalls, including lack of uniformity in billing and coding. Moreover, little to no data is available regarding how often telehealth or virtual care is sought from an out-of-state provider. Studies to improve understanding of the impact of telehealth and virtual care across Medicaid, and from whom enrollees are getting care (e.g. in-state vs out-of-state) could provide various benefits to the Medicaid program nationwide. For example, state Medicaid programs could better understand the needs of their enrollees based on the frequency and type of care they access via telehealth, and could glean insights into workforce needs, access to and quality of care in their respective states.
c. **Opportunities for consistent federal policy.** There is precedent for Medicaid policy floors to be set by the federal government. For example, state Medicaid and CHIP programs are appropriately required to deliver Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits to all enrolled children, regardless of their state of residency. A GAO or MACPAC study outlining potential policy opportunities for alignment and/or consistency across states related to telehealth policy could help alleviate several previously stated barriers.

<u>Multi-state Research and Outreach</u>

Given that patients and their health care cross state lines with ever-increasing frequency, and given the common challenges and barriers experienced across states, Nemours believes there is an opportunity for multi-state research and outreach activities that directly engage state partners – such as Medicaid agencies, Medicaid providers, Medicaid enrollees and others – in the development of multi-state solutions. As cited in both the RAND Corporation and MACPAC studies, state-to-state learning is very challenging because there is no coordinating body and little federal guidance. As a result, Nemours believes **there is an opportunity for Congress to encourage or require federal agencies to jointly explore opportunities to:**

a. **Engage a variety of state partners from diverse geographic regions in any or all of the studies outlined in the section above; and**

b. **Bring together state stakeholders to better understand their experience with developing, implementing, navigating and complying with state laws, rules, regulations and managed care contracts, and working across multiple states.** Engaging a variety of stakeholders in an analysis of the "on-the-ground" experience in regulating and delivering telehealth could provide more clarity around existing barriers and uncover previously unknown barriers. Similarly, such discussions could result in potential solutions that the federal government could test for efficacy and scalability. Both providers and Medicaid agencies have indicated an interest in finding ways to improve inter-state collaboration on Medicaid telehealth policy because Medicaid patients, especially those with complex health needs, increasingly seek virtual care from out-of-state providers.

Demonstration model(s) within CMMI

To address some of the barriers and opportunities addressed above, particularly those that require alignment across multiple states, test models would provide a pathway to spur innovation and experiment with multiple approaches. Because some of the existing barriers cannot be solved by a traditional "top-down" approach (e.g. defining telehealth and virtual care across all states) and others will require financial support to state Medicaid programs (e.g. building infrastructure and structured cross-state collaborations), a more dynamic approach is necessary. Demonstration models provide the optimal balance between state flexibility and federal coordination.

Therefore, Nemours recommends that Congress encourage the Administration to launch a CMMI multi-state model test that incentivizes and supports alignment of policies critical to the expansion of telehealth across a set of states, with a focus on telehealth for children and families in Medicaid. The model should test aligned, cross-state policies, such as virtual care definitions, licensure, coverage, reimbursement, and screening/enrollment, to enable and support telehealth and digital health services and reduce the burden on patients and providers.

Metrics for success could include improving: 1) access to care, 2) health outcomes, 3) patient and/or caregiver satisfaction, 4) appropriate health care utilization, 5) improved care coordination and reduced friction between primary care providers/ patient's medical home, and specialty providers, and 6) reduction in health care costs across the Medicaid test population.

Expansion of Provisions of the SUPPORT for Patients and Communities Act

Since children spend significant amounts of time in school, school-based telehealth is an important tool to help improve access to primary, acute, and specialty care for children; improve the ability of families and youth to manage chronic conditions; facilitate health education for children, families, and school personnel; and increase the capacity of local health care providers to better meet the health care needs of children and youth. Extensive studies of these programs have shown that they are providing care to children who had previously not been utilizing health services or had been underutilizing care.[xvi]

The SUPPORT for Patients and Communities Act of 2018 (SUPPORT Act) included several provisions expanding access to telehealth for various patient populations, including children and adolescents in school, with behavioral health needs related to substance use disorder (SUD).

Nemours was proud to work with Congress on these provisions, and grateful for their inclusion. We believe there is opportunity to build on this good work, especially considering the known access gaps faced by Medicaid children and adolescents.

To this end, Congress should expand upon SUPPORT Act provisions in future telehealth legislation to broaden Medicaid coverage for children and adolescents seeking care for mental or behavioral health needs in a school clinic. The provisions of the SUPPORT for Patients and Communities Act rightly extend access to telehealth for SUD care, but many children and adolescents experience mental and behavioral health challenges that are either indirectly related to parental SUD or altogether unrelated to SUD. We are also aware of studies indicating that most children with behavioral health needs do not receive therapy because of provider shortages.[xvii] The same study also concludes that video visits are an effective approach to behavioral health treatment for children and adolescents. Ensuring broad Medicaid coverage for mental and behavioral health care while in school will help close the access gap.

Interagency Activities to Expand Telehealth to Early Care and Education Programs

Young children not yet attending school spend a significant amount of time in early care and education (ECE) setting, whether in Head Start or other ECE centers. Introducing access to telehealth services in ECE settings provides an opportunity to expand access to primary and specialty care for very young children, with parental consent and participation, and to diagnose and treat or triage health care issues, without requiring parents to take time off from work.

Examples of ECE-based telehealth are few, but one exemplary program—the Health-E-Access program in Rochester, New York—has demonstrated the value and efficacy of delivering telehealth to children in ECE programs, 73 percent of whom were covered by Medicaid.[xviii] In summary, the impacts of this program include:[xix]

- 63 percent reduction in absences from child care due to illness.[xx]
- Providers able to diagnose health problems as accurately via telehealth visits as in person.
- 97 percent of visits completed via telehealth; only 3 percent referred to higher level of care.
- 94 percent of the children would otherwise have gone to an ED, an urgent care facility, or a pediatric office.
- 93 percent of the time, the telehealth visit allowed the parent to stay at work or school with an estimated time savings of 4.5 hours per visit.

Nemours believes there is opportunity to positively impact the health and wellbeing of children, including those enrolled in Medicaid, by testing approaches to providing access to care via telehealth in ECE settings with parental consent and/or participation. **To spur innovations and realize the unmet potential of telehealth in ECE, Congress should:**

a. **Encourage or require the creation of an Interagency Task Force to explore the potential opportunities and unique challenges associated with expanding telehealth access to the ECE setting.** Such a task force should include, at a minimum, the Administration for Children and Families (ACF), the Office of Head Start (OHS), Office of Child Care (OCC), and the Center for Medicaid and CHIP Services (CMCS). Nemours is aware of many unique needs and challenges associated with the provision of health

care generally, and telehealth specifically, in ECE settings. Challenges not experienced in other care settings include but are not limited to: telepresenter licensure for ECE staff, medication administration by ECE staff, and policies governing mandatory release of sick children.[xxi] Further exploration of existing barriers and potential solutions is needed.

b. **Encourage a pilot to test the impact of telehealth expansion into Head Start programs.** Given that Head Start is a federally funded and regulated ECE program serving children nationwide, there is an opportunity to leverage existing infrastructure to utilize telehealth as a tool to meet existing, program-wide health care requirements. Eventually, such a pilot could test innovations that extend services beyond what is required by law. Such innovations could be scalable across the entire Head Start program and potentially benefit many underserved children.

Conclusion

Nemours stands ready to assist the Caucus in any way possible to advance sound telehealth policy that improves access and outcomes for all children and families, including those who are enrolled in Medicaid and CHIP. We look forward to continued collaboration, and thank you in advance for your consideration of our recommendations.

We would be grateful for the opportunity to meet with you to discuss our recommendations in more detail. In the meantime, please do not hesitate to reach out to me at Daniella.Gratale@nemours.org or Katie Boyer, Manager of Policy & Advocacy at Katie.Boyer@nemours.org with any questions or requests for additional information.

Sincerely,

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CC: Members of the Congressional Telehealth Caucus

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