COVID-19 & the HCH Community:

Ensuring Access to Care Through State Medicaid Telehealth Policies

Issue Brief | November 2020

Executive Summary

In order to quickly respond to the COVID-19 pandemic, the federal government allowed temporary flexibilities to many policies related to telehealth services. This issue brief describes the temporary telehealth policies that have been especially successful for Health Care for the Homeless (HCH) health centers, and provides recommended actions at the state/local level for implementing more long-term solutions. Moving forward, making these policies permanent features of state Medicaid plans would help increase access to care for people experiencing homelessness, and improve health outcomes.

Policies that Facilitate Access to Care:

- Retain Authorization and Reimbursement for Audio-Only Visits
- Retain Flexibility in Originating & Distant Sites
- Retain Waiver of Pre-existing Patient-Provider Relationship
- Keep Ability to Obtain Patient Verbal Consent to Care
- Ensure Payment Parity Regardless of the Type of Visit
- Eliminate Prior Authorizations for Telehealth
- Facilitate Patient Access to Phones, Data & Broadband

Recommended Actions at the State and Local Level:

1. <u>State Medicaid plan</u>: Amend the state's Medicaid plan by adding telehealth policies such as recognizing audio-only visits, permitting flexibility in originating and distant sites, waiving prior authorizations and requirements for pre-existing relationships, and allowing verbal consents to care. Ensure the Medicaid plan requires payment parity regardless whether visits are in-person, via video, or audio-only.

2. <u>Health center eligibility</u>: Ensure federally qualified health centers (FQHCs) are recognized as eligible providers for all telehealth policies.

3. <u>Partnerships</u>: Actively establish partnerships between health care providers, Continuums of Care (CoCs), and homeless services providers. Develop or expand telehealth service capacity in shelters, unsheltered locations (e.g., encampments), and other venues that would enable vulnerable people to better access care.

4. <u>Phone and data access</u>: Facilitate easier access to phones and data for both patients and providers.

5. <u>Waste, fraud, and abuse</u>: Ensure measures to protect against waste, fraud and abuse do not add access to care barriers for vulnerable people or administrative burdens for providers.

6. <u>Provider training and support</u>: Make training, grants, and other resources available to community-based providers so they are able to increase their technology capacity.

7. <u>Technology literacy</u>: Facilitate training in technology literacy for health care providers, support staff, and patients so they can get more comfortable with new technologies.

Introduction

When the President declared COVID-19 a national emergency on March 13, 2020, it gave the Centers for Medicare and Medicaid Services (CMS) the authority to allow states to make changes to their Medicaid programs under an emergency authority (known as "1135 waivers"). In response, all states requested and received waivers from CMS that would give them needed flexibilities in their programs to ensure ongoing access to care during a unique public health crisis (see individual states' approved waiver requests). CMS also issued a wide range of "blanket waivers" to many policies, which did not need to be approved. However, these changes are only authorized as long as the federal government maintains an active public health emergency (currently in effect until January 20, 2021). After that, prior rules apply, *unless* states take proactive measures to make more permanent (or longer-term) changes.

A number of these temporary Medicaid flexibilities are specific to telehealth services. **This issue brief describes the temporary telehealth policies that have been especially successful for Health Care for the Homeless (HCH) health centers,[1] and provides recommended actions at the state/local level for implementing more long-term solutions.** Health center leadership should use this information to collaborate with state Medicaid agencies and other stakeholders to ensure that the newly discovered successes serving a vulnerable population remain when the public health emergency expires.

> *"If these policies roll back, it'll be harder to keep people in care. There's better care being offered now for our homeless patients. I'm concerned that they will put too many barriers back in place and that we won't be able to do this anymore."* – **Houston, TX**

> *"If it gets bogged down by going back to the old restrictions, I doubt we'll be able to sustain it. We'll have to backtrack on everything we've done."* – **Nashua, NH**

Role of Medicaid

While federal Medicare policies typically drive the national discussion on telehealth, approximately 4% of HCH patients have Medicare-only coverage, and an additional 4% are "dual-eligible" in that they receive both Medicare and Medicaid. At the same time, 51% of HCH patients receive their health coverage through Medicaid (though this ranges from 4% to 73%, depending on the state). This is why state-level Medicaid policies are critical when discussing telehealth and vulnerable populations like those experiencing homelessness.

As CMS has indicated: *"States have a great deal of flexibility with respect to covering Medicaid and CHIP [Children's Health Insurance Program] services provided via telehealth. States have the option to determine whether (or not) to utilize telehealth; what types of services to cover; where in the state it can be utilized; how it is implemented; what types of practitioners or providers may deliver services via telehealth, as long as such practitioners or providers are "recognized" and qualified according to Medicaid federal and state statute and regulation; and reimbursement rates."* Hence, states should not wait for federal Medicare policy changes in order to advance their own solutions.

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[1] Health Care for the Homeless programs are part of the HRSA-funded health center program, and are considered 'special populations' federally qualified health centers (FQHCs).

Building on Case Studies

Telehealth has increased access to care for people who are homeless. A collection of case studies based on interviews with staff at 17 HCH programs on their experience implementing telehealth highlights a number of common themes, and demonstrates why increasing access to telehealth permanently is beneficial:

- Contrary to prior belief, telehealth works well for people experiencing homelessness

- Audio-only phone visits worked best for this patient group

- Rates of missed appointments ("no-show" rates) declined, indicating greater access to care

- Some patients report telehealth feels safer and more accessible

- Policies related to reimbursements and ongoing ability to conduct audio-only visits are likely to determine the ongoing use of telehealth

- Patient access to phones, internet, and sufficient data present challenges

- Shelter partners and other homeless service providers in the community can help facilitate telehealth and access to care

Additional interviews about the policy aspects of telehealth were conducted at nine of the 17 case study sites, as well as nine additional HCH programs located in geographically diverse locations throughout the country.[2] Feedback from these programs is used in the following sections to describe how these temporary policies have been successful for delivering care to a vulnerable patient group and need to be retained permanently.

Increased Access to Care: Declining Missed Appointment Rates

Many HCH health centers throughout the country attribute the decline in missed appointments (a common measure to evaluate access to care) to new flexibilities in telehealth. Because each HCH is unique, many factors influence the level of missed appointments (aside from the impact of COVID-19). **Figure 1** shows the change in missed appointments from HCH programs in nine cities (two programs were from New York City) between fall 2019 and summer 2020. In March and April—the timeframe where health centers quickly shifted to telehealth—many sites saw a decrease in missed appointments. Similarly, as more in-person services resumed in May, increases in missed appointments re-emerged. While some HCHs witnessed a dramatic change, others saw a smaller impact. However, even a 1- or 2-percent change in this rate means that dozens more people (or hundreds, depending the size of the health center) received care they otherwise would not have received. These data are important elements of the telehealth/access-to-care story in the HCH community.

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[2] Follow up interviews at case study sites conducted in Houston, TX; Baltimore, MD; Denver, CO; Atlantic City, NJ; Coeur d'Alene, ID; Middletown, CT; New Orleans, LA; Birmingham, AL; and Appleton, WI. Additional telehealth discussions conducted at HCH programs in Lexington, KY; Nashua, NH; Portland, ME; San Diego, CA; Albuquerque, NM; Chicago, IL; Miami, FL, New York, NY; and Salt Lake City, UT.

Figure 1. Missed Appointment Rates at HCH Health Centers, October 2019-July 2020
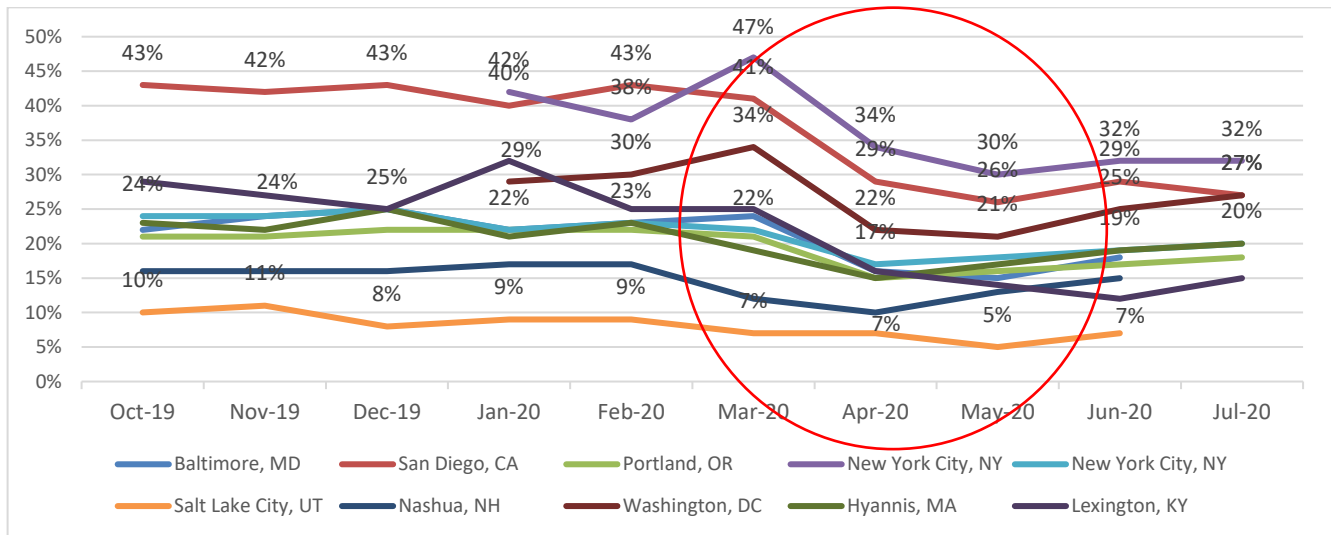
Notes: Data included here represent broader range of HCH programs than participated in interviews. Two HCH programs from New York City submitted data for this figure.

Policy #1: Retain Authorization and Reimbursement for Audio-Only Visits

Background: Traditionally, telehealth services included both an audio and visual component (typically via a video-link). In response to COVID-19, emergency waivers allowed states to temporarily reimburse telehealth visits conducted over an audio-only telephone call.

Rationale for retaining permanently: Patients who are homeless seldom have phones with video capability, or they lack sufficient data, bandwidth, or a strong enough internet connection to support streaming video. They may feel safer or disclose more information (especially those with mental health issues) in a phone call, rather than video call. For those who are uncomfortable with technology, phones were easier and more familiar to them. Many noted that privacy was easier to attain on a phone call (compared to video) for people who do not often have private spaces of their own (e.g., homeless shelters). For low-income patients who work (where many do not have paid leave to go to a doctor appointment), phone-only visits were easy to accommodate in their schedule. Finally, for those without access to hygiene facilities, phone-only offered a dignified way to access care. Overall, frontline providers said that audio-only visits give more options for care and allow for a more patient-centered approach that could be tailored to their preferences.

Frontline experiences:

- *Audio-only works great for our patients who work—it allows them to keep their job and keep their health care. The audio-only ability means they only have to step away for a few minutes to keep their appointment, which is especially important for managing diabetes and hypertension. –* **Houston, TX**

- *Our clients with mental health diagnoses tend to have a harder time with videophones and may not be tech-savvy. Without audio-only, we would have a higher suicide rate, relapses, and overdoses, and our clients with anxiety and paranoia would feel stuck and not be able to get out. – **Baltimore, MD***

- *It's a lot easier for our patients to put earbuds in and have a private conversation than find a spot for a video chat when their only privacy is a quiet corner of the shelter. – **Denver, CO***

- *Audio-only has allowed us to continue seeing patients during the pandemic, giving poor people the same right to access care that non-poor people have, reducing the barriers to not having enough money for gas, a bus ticket, and the 100 other things that cause people to miss appointments. Patients no longer delay care because we can do audio. – **Atlantic City, NJ***

- *With a phone, no one knows who you are talking to, and patients say it offers more dignity. Some of our patients can't shower for many days and are just too embarrassed about how they might smell or look to go to a provider. – **Middleton, CT***

- *For our behavioral health staff, the audio-only offers our more vulnerable clients a bit of privacy, reduces barriers and stigma, and creates new communication opportunities. – **Appleton, WI***

Policy #2: Retain Flexibility in Originating & Distant Sites

Background: 'Originating site' refers to the location of the patient, while 'distant site' refers to the location of the provider. Prior to COVID-19, if patients were engaging in a telehealth visit, they commonly were required to visit pre-approved sites equipped for video-conferencing. Similarly, providers could normally only conduct visits from specified clinical locations. In response to COVID-19, emergency waivers allowed states to temporarily waive these requirements and allow both patients and staff to call in from a wider range of venues (to include their home, a shelter, or other public space).

Rationale for retaining permanently: For patients, flexibilities in originating site policies removes transportation barriers, prevents emergency department/hospital visits because issues can be addressed/de-escalated before a crisis, and makes it easier to engage in care for those who frequently stay in different locations or have relocated to a different location (for work, family, etc.). For providers, the temporary distant site policies offers more flexible schedules and increased operating clinic hours because staff can work outside established program operating hours and are no longer constrained by limited physical space in the clinic. These are particularly important factors for non-profit community-based providers with limited staff and resources.

Frontline experiences:

- *Flexible originating site has provided an access point for those who don't know where else to go, or got shut out of housing or shelter and had to relocate with family or lost a job and had to move—we've been able to keep continuity of care and keep track of patients. – **Nashua, NH***

- *I'm actually able to see more patients this way because now I don't need a separate exam room for every provider. I can have four providers on the schedule seeing patients, but only have three in the clinic using the space. – **Salt Lake City, UT***

- *Telehealth allows us to be more flexible in our hours because you can do a visit during non-traditional hours where the provider is at home and the patient is at the shelter or another location. This works great for us to be more flexible as an employer, and it allows our clients to work and do other things in their life. – **Albuquerque, NM***

- *It doesn't matter where the provider or patient is, it's the connection that's important. There's always a barrier related to transportation so if we have the ability to be flexible in our delivery of care, we'll reach more patients. – **Coeur d'Alene, ID***

- *We've been finding patients safe, private places in public for them to call in for an appointment. It's so much easier for patients, who are much more likely to set an alarm on their phone and answer it when it rings than to find transportation, or need to cancel the appointment because the soup kitchen can't serve them lunch in time. – **Middleton, CT***

Policy #3: Retain Waiver of Pre-existing Patient-Provider Relationship

Background: Generally, a provider must first see a patient in-person in order to establish a formal relationship before subsequent telehealth services are approved. In the wake of COVID-19, this requirement has been temporarily waived.

Rationale for retaining permanently: Accessing care quickly is especially important for people who are homeless, who often have serious medical and behavioral health conditions but face significant barriers accessing care. Requiring an initial in-person visit incentivizes emergency department utilization as an alternative, which undermines most community health care goals. Finally, for those with opioid-use disorder seeking access to medication-assisted treatment (MAT), immediate access to care is vital for starting medication and avoiding overdose.

Frontline experiences:

- *The waiver of this requirement helps get new people into care and allows us to make the initial connection over the phone. – **Appleton, WI***

- *A patient was just released from prison and needed to get into a MAT program immediately. He was living in a sober house and transportation to the health center was a barrier. Having this waiver allowed me to see him right away through a virtual visit, which is important because the risk of overdose is very high at the point of release. A virtual visit allowed the person to access care much faster, initiate MAT, and then schedule him to come in person when he is able to access transportation. – **Portland, ME***

Policy #4: Keep Ability to Obtain Patient Verbal Consent to Care

Background: Typically, a patient must provide written consent to receive care from a provider. In response to COVID-19, this requirement has been waived to allow patients to give verbal consent to care.

Rationale for retaining permanently: People experiencing homelessness rarely have access to technology necessary for remote written signatures (e.g., patient portals, sophisticated phone applications, etc.). At the same time, waiving this requirement eases administrative burden for providers, allowing them to simply document the patient's verbal consent to care in the medical record. If patients cannot continue giving verbal consent and instead are required to present in-person to sign a form, this creates a barrier to care (one that higher income patients with access to more technology will not experience).

Frontline experiences:

- *If a patient has to physically go somewhere to fill out paperwork in order to get a service, it creates an unnecessary barrier to care. Even if you do it electronically, it requires technology and a level of know-how from the patients' end and still serves as a barrier to care. We need more flexibility without forcing people do to paperwork. Verbal consents to care work well. – **San Diego, CA***

Policy #5: Ensure Payment Parity Regardless of the Type of Visit

Background: There are wide disparities around reimbursements for all types of health care services, depending on many factors. Telehealth visits are often reimbursed at a lower rate than in-person visits, especially if these are audio-only calls. To date, [43 states](#) have payment parity for at least some telehealth services compared to in-person visits, but the details vary widely, and may not apply to federally qualified health centers (FQHCs).

Rationale for adopting this policy: Delivering a telehealth visit is just as intensive as an in-person one (if not more). The service being delivered is the same (e.g., medication refills, chronic disease management, behavioral health therapy, etc.). Establishing a lower reimbursement rate for telehealth, especially for audio-only visits, not only creates financial hardship for safety-net providers (who already operate on a thin margin), but likely will make it impossible for these providers to offer the service at all, despite the clear benefits. Finally, setting a lower rate for telehealth needlessly devalues the integrity and quality of the service being delivered, often to a high-need, vulnerable population.

Frontline experiences:

- *Doing an audio-only visit requires a lot of staff even though it seems straight-forward. We need a dedicated front desk person to be on the phone with the patient to help them launch the visit and walk them through the practice. You still need a medical assistant who can prepare the room and the patient, do vitals, and start the visit. So it's not like the staffing goes down because it's only a phone visit. I need the same number of staff to support a telehealth phone visit that I do for a face-to-face visit. Also, Zoom licenses [or other telehealth systems] are expensive. – **Salt Lake City, UT***

- *People who did both say they are both efficient and the care was the same. – **Middleton, CT***

- *There are plenty of other community providers who are willing to deliver 5- and 10-minute low-quality telehealth visits to anyone, anywhere. But we are focused on quality and care management to the most vulnerable—especially those who are homeless. You have to give us access to the same technologies, reimbursements and policies as others. – **Nashua, NH***

- *There's an investment in the infrastructure that includes the cost of a subscription to the telehealth service, the video capability (if that's being used), and the privacy/security technology. All these are a little extra in a telehealth visit. – **Baltimore, MD***

Policy #6: Eliminate Prior Authorizations for Telehealth

Background: Providers are often required to obtain a "prior authorization" from a patient's health plan in order for the service to be approved for reimbursement. While many insurers view prior authorizations as a needed tool to contain costs, the burden is on providers to obtain "permission" to deliver care.

Rationale for eliminating telehealth prior authorizations permanently: There is a significant administrative burden involved with tracking authorizations, determining when another is needed, coordinating the paperwork, and interfacing with the health plan to obtain the authorization in a timely manner. For telehealth specifically, visits may be scheduled very quickly without adequate time to obtain an authorization. Delaying patient care in order to obtain authorization is clearly not good practice, when in fact, the goal is to facilitate fast access to outpatient, community-based care for vulnerable populations.

Frontline experiences:

- *It would be so much easier to see patients if we did not have to get a prior authorization. It's a lot of paperwork, and we only get permission for a specific number of visits at a time, so every few months we need to go back and get another one. It's a huge administrative impact to the agency because we have to create a list every day of clients who need one. If the approval doesn't come through quickly enough, that puts us in a difficult position of not getting paid for our services, or asking the client to come back another time, which isn't an option when you serve our population. – **Baltimore, MD***

- *Removing prior authorizations allowed us to onboard new patients more quickly and allowed us to collect COVID-19 specimens and address other urgent needs more easily. – **Nashua, NH***

- *Getting a prior authorization just requires additional staff and time to submit those requests. If I'm asked to do more administrative paperwork but I get paid less for doing a telehealth visit, that's just not right. – **Salt Lake City, UT***

Policy #7: Facilitate Patient Access to Phones, Data & Broadband

Background: Engaging in a telehealth visit requires access to some kind of technology. For eligible low-income people, the Federal Communications Commission (FCC) operates a [Lifeline program](#) that provides low-cost phones, broadband internet, and monthly data service. Local jurisdictions may also [use Continuum of Care (CoC) funds](#) to purchase cell phones and wireless data plans for service recipients who are homeless.[3] While it is now common for people who are homeless to have a personal phone, access is not universal—and it is often the most vulnerable who have no communication device.

Rationale for facilitating patient access to phones: Even for patients with a phone of their own (and may participate in the Lifeline program), it remains a challenge to ensure sufficient levels of data (or call minutes) and internet connectivity, as well as a reliable venue to charge the device. Those without any phone are at an obvious disadvantage to participate in health care via telehealth. To help address this specific gap, providers have partnered with shelters to facilitate access to telehealth and invested in greater technology for outreach staff. It is important to note that limited data plans make telehealth visits requiring a video component especially difficult. Finally, the importance of a phone in today's society goes beyond health care access, and is vital for accessing employment, maintaining connection with family, and other essential responsibilities.

Frontline experiences:

- *If patients don't have a phone, they come to the shelter where they have set aside a room with a phone, a chair, a table, and some paper and pens. Then our staff preps the client for the visit, and the patients calls the provider downstairs. It's working really well with them. We also bought tablets and phones for our outreach team so when they are out at encampments, they are able to provide care in that moment and still communicate with the clinic. – **Houston, TX***

- *Along with the federal LifeLine program, many of our MCOs [managed care organizations] in KY increased access to phones, but this phone is not unlimited. The goal is to manage their health care to maintain their basic needs, but people need more than 250 minutes a month. For clients who don't have phones, our shelter partners now have a community phone or have designated*

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[3] [Continuums of Care (CoCs)](#) are HUD-funded programs tasked with coordinating local responses to homelessness.

*phone time for people to use for telehealth. Our health center has been able to provide iPads to locations that need access to video for telehealth. This flexible availability has increased access for all our patients, who are now better able to keep appointments. – **Lexington, KY***

- *Our patients are homeless and frequently worry about leaving their belongings on the street in order to access health care services. About 25% of our patients do not want to come to the clinic for this reason. For us to give them cell phones, it would allow us to reach them and open up greater access to care for them. – **Miami, FL***

- *We don't meet a lot of people without a phone, but people don't often have enough minutes. This is a reason we didn't go to the visual platform because that eats up your minutes. And then the patients can't complete the visit. – **Atlantic City, NJ***

- *We bought phones for about 200 clients, each with a 6-month service commitment and no limits on the data. The total cost was around $16,000. We encourage clients to use them to stay in touch with their social support networks (family, friends, providers, etc.). Keeping people healthy is the most important part here. – **Denver, CO***

- *We can get a phone for $30 and a $20 gift card gets them unlimited data for a month, which we just continue uploading to the phone after that. If we can get a phone into their hands, that decreases barriers. For those we've piloted with it, it's been unbelievable. They are there on time, and using it as appropriate. We're setting up charging stations also so they don't run out of charge in the middle of a visit. I'd love to just give people a year of data, but we haven't yet figured out how to do that. – **Middletown, CT***

Other Issues and Experiences

COVID-19 changed the nature of health care service delivery quite suddenly, and HCH providers have observed numerous benefits to the fast adoption of telehealth (along with other changes in service delivery). These include noting that many patients are more engaged in their care, providers are able to see more patients and spend more time delivering direct services, and services like MAT are easier to deliver. Providers also report they are better able to divert emergency department visits, nurses are spending more time on care coordination, and access to rural (or other hard-to-reach) venues is easier. While telehealth is not the preferred approach for everyone, providers appreciate having additional options to tailor patient-specific care plans. Telehealth has been especially helpful for those with disabilities who may have specific barriers to accessing services in traditional environments. Finally, ensuring health insurance coverage for this population is vital for effectively engaging vulnerable people in care. As policymakers move forward to adopt permanent changes in telehealth, these benefits have the potential to help improve access to care and health outcomes.

Frontline experiences:

- *We've noticed patients are more honest, they aren't as fearful that we are going to report their drinking or that they didn't take their meds, or that they stayed at someone's house. They are being more candid and that's been a big benefit to providing good care. The visits are longer, there's more care coordination happening, we're talking with patients more about their housing and food insecurity, and the resources they need. – **Middletown, CT***

- *One challenge is working with shelter staff to make them responsible for providing the space and the equipment, which can be difficult. But if we provide the technology and access to providers,*

*the shelter can work out the process for checking out equipment or reserving room. That's where we're currently focused. – **Middleton, CT***

- *Now that our patients have coverage, people are more willing to participate in their care. As a health care provider, Medicaid has taken the stress off the provider because now we can treat them like we would any other patient. We don't need to spend our time finding resources. – **Coeur d'Alene, ID***

- *As a nurse practitioner, having the increased access to telehealth is especially important for getting patients access to MAT, especially in a rural community. – **Portland, ME***

- *There's a chaos that goes along with homelessness, and getting somewhere at a specific time is really not realistic. Telehealth enables us to get beyond the idea of a traditional appointment in a physical location, and it ensures access for our patients so we can keep them out of the hospital, and keep them healthier. Without the flexibilities of telehealth, it's harder to take care of a patient population that experiences a lot of chaos. – **San Diego, CA***

- *Especially for behavioral health, we had people who didn't want to come to clinic because they would see their abusers or people who could trigger them, but telehealth gives them a safer option to get care and not have to be traumatized from a visit. – **Salt Lake City, UT***

- *We also have people who don't like it. One patient felt it undervalued him, and others say they can't use the telephone. So it's helpful to have both as an option so we can tailor something that's more patient-centered around their preferences. Now we can offer them more flexibility and options in their care. – **Salt Lake City, UT***

- *With mobile MAT under a telehealth approach, we can create a private area in the encampment, set up the client with a specialist right there in real time, and start delivering care. If the restrictions go back and we can't do this anymore, I won't be able to get these folks into a building to get treatment under a traditional approach. The people who live in these encampments may stay homeless until they die. This is the cycle that we see every day, but these new telemedicine rules allow us to disrupt this cycle. It's absolutely life-saving. – **Chicago, IL***

- *Because providers are now able to connect with more patients, our outreach team can spend more time working in the field with those who aren't engaged in care. – **Miami, FL***

- *We've been able to see more new patients because of the flexibilities. Reaching out to clients is faster and easier, and reduces barriers to clients coming in. So while other health care providers have seen lower patient volume, ours has gone up. – **Miami, FL***

- *For people with hearing or vision impairments or those who use mobility assistance devices, telehealth decreased the physical barriers that often impede access to care. – **Portland, ME***

- *The biggest benefits of telehealth are our new workflows, new grassroots innovations, and our relationships with shelters. – **Appleton, WI***

- *If I can do a telehealth visit, I can decrease the ER visits that our patients make. – **Houston, TX***

Addressing Concerns over Waste, Fraud, and Abuse

[Concerns have been raised](#) over the possibility that telehealth—and audio-only telehealth visits in particular—may be subject to increased opportunities for waste, fraud, and abuse. Providers expressed concerns that the desire to eliminate these opportunities will result in burdensome administrative tasks, restrictions on approved technologies that will leave vulnerable patients with no access to telehealth care, and barriers to care that only exacerbate current disparities in access and outcomes. As policymakers address the

balance between "program integrity" and access to care, it is vital to consider the needs of this population of patients and providers.

Frontline experiences:

- *The opportunity still exists and while I understand the concern over nefarious actors, I don't think that's a good reason to stop doing what's working so well. There's a way to monitor this that doesn't interfere with access to care. The same standards for medical appropriateness still apply. – **Denver, CO***

- *Concerns about fraud and abuse? Tell that to the lady under the bridge who has no other options. Tell that to the mom with four kids who can't go to a behavioral health appointment but those 30 minutes on the phone mean she can continue to be a mom and provide for her kids. Tell that to all our patients. There are ways to safeguard for waste, fraud and abuse, but we've found ways to improve access to vulnerable people who need these services. – **Lexington, KY***

- *The small level of fraud that might occur will be vastly lower than the value of the improvements we make through access to care. Even from a financial lens—what is the financial return on investment from giving good care compared to a small amount of fraud? – **San Diego, CA***

- *As a provider, we are required to do the legal and moral right thing. We have an EMR [electronic medical record] where all relevant documentation is required and verified. I find telehealth to be an immense resource that should not be bogged down by administrative policies. It's important for us to deliver this care. – **Houston, TX***

Examples of State Responses

Some states have already taken proactive measures to make some of these policies permanent. The following examples can serve as a model for others as they approach their own legislative or administrative actions to improve access to telehealth:

- **Colorado:** SB 20-212 bans requiring pre-existing patient-provider relationship, eliminates originating/distant site requirements, and requires payment parity for federally qualified health centers (FQHCs) and other safety net providers.

- **Delaware:** HB 348 allows audio-only visits.

- **Louisiana:** HB 449 adds behavioral health to the approved list of telehealth services and HB 530 requires all new health plans to cover comprehensive telehealth benefits.

- **Maine:** SP 676 requires some portion of Medicaid case management services to be available via telehealth without requiring qualifying criteria.

- **Michigan:** HB 5412 bars insurers from requiring face to face visits and HB 5416 expands originating site (patient location) to allow for telehealth at home, school, or "any established site considered appropriate by the provider."

- **New Hampshire:** HB 1623 establishes reimbursement parity, allows audio-only visits, removes restrictions on originating (patient location) and distant site (provider location), expands the types of providers who can deliver telehealth services, and eliminates barriers to SUD treatment via telehealth.

- **New York:** SB 8416 adds audio-only visits to the state's definition of telehealth.

Recommended Actions at the State and Local Level

Below are recommended actions intended to promote the promising practices that are emerging for delivering health care via telehealth to people experiencing homelessness.

1. **State Medicaid plan:** Amend the state's Medicaid plan by adding telehealth policies such as recognizing audio-only visits, permitting flexibility in originating and distant sites, waiving prior authorizations and requirements for pre-existing relationships, and allowing verbal consents to care. Ensure the Medicaid plan requires payment parity regardless whether visits are in-person, via video, or audio-only.

2. **Health center eligibility:** Ensure FQHCs are recognized as eligible providers for all telehealth policies.

3. **Partnerships:** Actively establish partnerships between health care providers, Continuums of Care (CoCs), and homeless services providers. Develop or expand telehealth service capacity in shelters, unsheltered locations (e.g., encampments), and other venues that would enable vulnerable people to better access care.

4. **Phone and data access:** Facilitate easier access to phones and data for both patients and providers.

5. **Waste, fraud, and abuse:** Ensure measures to protect against waste, fraud and abuse do not add access to care barriers for vulnerable people or administrative burdens for providers.

6. **Provider training and support:** Make training, grants, and other resources available to community-based providers so they are able to increase their technology capacity.

7. **Technology literacy:** Facilitate training in technology literacy for health care providers, support staff, and patients so they can get more comfortable with new technologies.

Conclusion and Looking Ahead

States have significant flexibility in their Medicaid plans to define telehealth in terms of services allowed, level of reimbursement, type of provider, and venues where care can be delivered and/or received. The Health Care for the Homeless (HCH) community should work together with state Medicaid officials to adopt policies that allow telehealth to be a successful service delivery model for people who are homeless. Many of the current telehealth flexibilities in Medicaid are temporary due to the COVID-19 pandemic; however, making these policies permanent will bring longer-term benefits going forward. Additionally, HCH partnerships with CoCs and homeless services providers could increase access to care by expanding venues for telehealth services. Targeted policy solutions are needed to ensure telehealth remains a viable service option for HCH health centers. Otherwise, the current successes with telehealth may end with the public health emergency.

> "We can't put the telemedicine tiger back in the bottle." – Chicago, IL

Other Resources

- National HCH Council: [Building the Plane While Flying It: Case Studies on COVID-19, Telehealth, and Health Care for the Homeless Centers](#) (August 2020)

- National Association of Community Health Centers (NACHC): [Resource Guide on Telehealth Coverage in Medicaid](#) (October 2020)

- [Center for Connected Health Policy](#): The National Telehealth Policy Resource Center

- CMS: [COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies](#)

- Kaiser Family Foundation: [Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19](#)

- CMS: CMCS Informational Bulletin on SUD Treatment/[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](#) (April 2, 2020)