South Carolina Department of Health and Human Services

FY24-25 Proviso 117.113 (C) – Telehealth Report

This report is issued pursuant to Section 117.113 (C) of Act 94 of 2024.

The Department of Health and Human Services shall continue to identify and implement telehealth benefits and policies that are evidence-based, cost efficient, and aligned with the needs of the Medicaid population. The department must also continue to review the temporary telephonic and telehealth flexibilities it has adopted to address the COVID-19 public health emergency and make permanent those that are suitable for inclusion in the Medicaid benefit. No later than October 1, the department 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 policy and benefit changes it has introduced in the furtherance of this goal and as part of its ongoing effort to improve the sustainability of telehealth services.

Introduction

In early 2020, the rapid spread of COVID-19 necessitated an unprecedented public health response across the United States. On Jan. 31, 2020, the U.S. Department of Health and Human Services declared a federal public health emergency (PHE), authorizing expanded resources and flexibilities critical to the national public health strategy. In addition, President Trump declared a national emergency related to COVID-19 on March 13, 2020.

South Carolina responded promptly, with Governor Henry McMaster declaring a state of emergency on March 13, 2020. The South Carolina Department of Health and Human Services (SCDHHS) swiftly implemented a range of telehealth flexibilities designed to ensure uninterrupted access to medical care for Healthy Connections Medicaid members. These rapid adaptations were crucial in mitigating the impact of the pandemic on healthcare delivery across the state.

Over the subsequent four years, SCDHHS issued more than 56 temporary telehealth service codes, directly influencing a surge in telehealth utilization among Medicaid members. Compared to baseline levels from state fiscal year (SFY) 2017, utilization increased by 5,530% in SFY 2021 with more than 714,000 recorded telehealth visits. Key service areas, including Medicaid targeted case management, early intervention services , behavioral health services, autism spectrum disorder services, dental services and services provided through Federally Qualified Health Centers and Rural Health Clinics. experienced significantly higher utilization.

During the federal PHE, which lasted from Jan. 31, 2020, to May 11, 2023, SCDHHS reimbursed 1,554,087 telehealth claims adding up to $182,527,127.22 total dollars during the federal PHE. Analysis of this data revealed that while telehealth significantly expanded access to care—reaching members in all 46 counties of South Carolina—it also highlighted persistent disparities in healthcare delivery. These findings underscore the importance of rigorous, ongoing monitoring and targeted policy adjustments to address inequities and optimize telehealth's role in the healthcare landscape.

As the federal PHE concluded, SCDHHS launched a comprehensive evaluation of the telehealth flexibilities it had implemented. This process involved data-driven assessments; stakeholder feedback; and performance reviews to determine the efficacy, safety and value of each telehealth service. Throughout this evaluation, telehealth services have been categorized into three groups: those that will be made permanent, those that will expire and those the agency will temporarily extend and continue to monitor. This strategic approach was designed to refine and sustain telehealth as an important way for Medicaid

members maintain access to quality care; and support telehealth as a core component of South Carolina's overall healthcare delivery system.

This year's proviso report reflects SCDHHS's continued commitment to evidence-based policy development. The report provides a detailed review of telehealth advancements and outlines strategic oversight plans for the telehealth services the agency intends to make permanent, effective Jan. 1, 2025. By leveraging data insights and stakeholder engagement, SCDHHS aims to enhance healthcare access, equity, and quality, positioning telehealth as a sustainable solution for the future.

Expiration of the Federal PHE and Implications for Telehealth Flexibilities

Under the Consolidated Appropriations Act (CAA) of 2023 and the CY 2024 Physician Fee Schedule (PFS) final rule, the Centers for Medicare and Medicaid Services (CMS) extended telehealth flexibilities, including the removal of site restrictions and the expansion of eligible telehealth practitioners. These changes align with SCDHHS's strategic goals to increase access to care and support comprehensive care models through telehealth. SCDHHS' strategic focus has allowed it to align with national trends, such as reimbursement for remote patient monitoring (RPM) and audio-only telehealth, while also identifying gaps and opportunities unique to South Carolina. This tailored approach ensures telehealth services are not only accessible but also aligned with the specific needs of South Carolina's diverse population.

To better utilize extended telehealth flexibilities from CMS, SCDHHS implemented a comprehensive and strategic evaluation of telehealth services. This process included an assessment of the telehealth landscape at local, state, and national levels and a high-level analysis of telehealth services that drew on national research, quality and performance reviews. The aim was to create a robust framework that ensured the continued provision of equitable, high-quality care and informed future telehealth policymaking.

In April 2022, SCDHHS issued Medicaid Bulletin 22-005 to announce updates related to the temporary telehealth flexibilities that were to take effect once the federal PHE expired. Flexibilities were grouped into three categories:

- Flexibilities that will be made permanent;
- Flexibilities that will be extended for further evaluation for one year after the expiration of the current federal PHE; and
- Flexibilities that expired at the end of the federal PHE.

Services categorized as “flexibilities that will be extended for further evaluation” were subjected to an extensive evaluation process, informed by stakeholder feedback, national payer trends and insights from leading external organizations. This in-depth analysis incorporated direct input from providers, members, and telehealth experts and moved beyond traditional utilization metrics to capture a comprehensive understanding of each service's impact and potential. SCDHHS conducted surveys, discussions, and targeted reviews to fully assess the value of these telehealth services within the evolving telehealth landscape. This methodical approach supports a strategic framework for the future integration and oversight of telehealth services in South Carolina.

South Carolina, in line with federal requirements, will finalize updates to its provider manuals and other internal repositories in preparation for making additional telehealth services permanent effective Jan. 1, 2025. Services available through telehealth that were reviewed and determined to sunset, will expire on Dec. 31, 2024.

Before and throughout the PHE, telehealth services were essential to South Carolina's Medicaid program. A total of 56 services were introduced during the federal PHE. Based on the data-driven assessments, feedback and review described above, some telehealth services have already been permanent or sunset. SCDHHS has provided consistent updates on these changes through bulletins, memos and annual reports.

National Landscape

Across the country, states differ on policies related to originating sites and subsequant restrictions. Of the 11states in the southeastern U.S., seven states, including Delaware, Maryland, West Virginia, Tennessee, Mississippi, Alabama, and South Carolina have specific policies on site restrictions. Virginia, North Carolina, Georgia and Florida do not have site restrictions. In a survey conducted between late May and early September 2024, 15 states, including South Carolina, still have limitations placed on rural and urban healthcare sites.

As of Sept. 30, 2024, 34 states, including South Carolina provide reimbursements for transmission a facility fee or both. Of the southeastern states, 11 of the 12 provide at least some reimbursement for remote care needs in support of their Medicaid program.

South Carolina, Florida and Hawaii are the only three states that have not officially adopted a uniform, Medicaid state policy on telehealth consent practices. Though within provider manuals, there are requirements for Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance, video and audio, and an expectation that providers inform

Medicaid members of their rights to conduct in-person or remote care. South Carolina is actively addressing a formal consent policy for providers to use for future telehealth services.

Forty-five states, including South Carolina, continue to support some form of audio only services prior to Oct 1, 2024. Notably, this figure may change as states finalize permanent telehealth policies.

Eight states including Georgia and Tennessee, do not allow for RPM services. South Carolina organizations and non-profits are actively engaging utilizing RMP services' hardware and software with South Carolina Medicaid reimbursement. Other agencies within South Carolina and beyond report anecdotally the benefits of RPM services and expressed a willingness in continued support for these vital services, in conjunction with home-based services.

As of this publication, all 50 states reimburse for Medicaid telehealth services, with an audio and video enabled component sufficient for communication. Seven states, including South Carolina reimburse for store and forward via Communication Technology Based Services (CTBS).

Telehealth Usage Among South Carolina Medicaid Members

Telehealth utilization within the Medicaid program showed a small but steady increase in the year leading up to the COVID-19 PHE (SFYs 2017 – 2019) with a spike then steady decline in telehealth usage from SFYs 2021 to 2024 (Figure 1). The flexibility to allow for telehealth services caused utilization to spike in SFY 2021 totaling more than 700,000 encounters in that year. The decline in utilization of telehealth services can be attributed to the a slower spread of COVID-19 transmission and relaxed social distancing guidelines as the pandemic extended into multiple years, which reduced the urgent need for remote

care. However, the slow decline indicates the need for this modality of visits with continued monitoring and review of services.

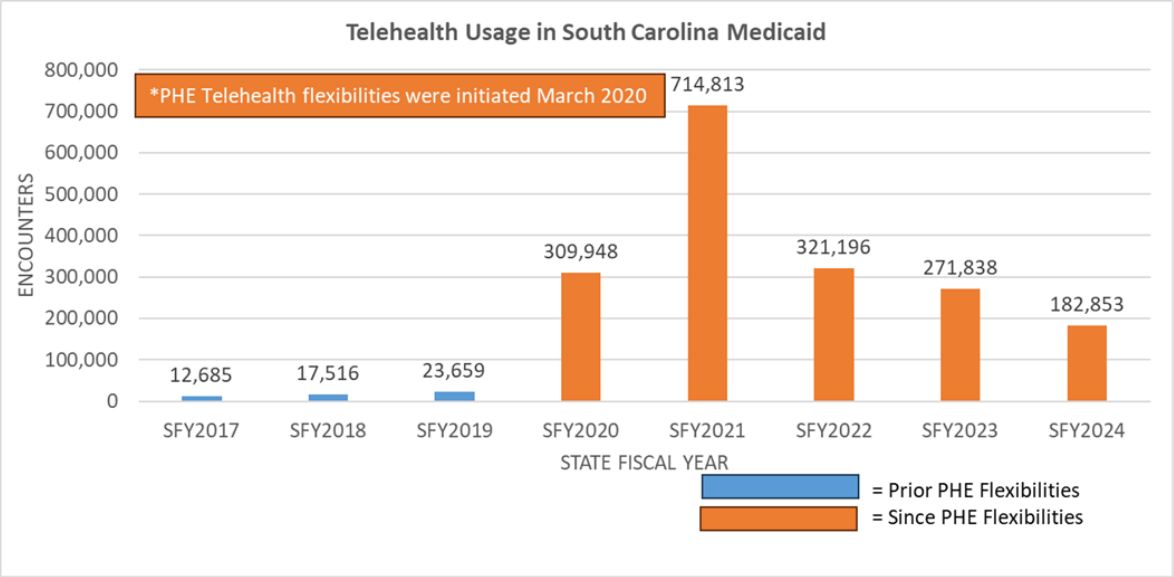

Figure 1: Telehealth Usage Among South Carolina Medicaid Members

Data on Flexibilities Made Permanent

Evaluation of the telehealth services made permanent after the PHE, referenced in Appendix A, shows a steady decline with seasonal spikes in utilization starting in fiscal year 2021 and continuing steadily through the end of fiscal year 2022 (Figure 2). Also seen in Figure 2 is the lessening of the decline in utilization starting in SFY 2023 through to the end of SFY 2024. Analyzing the amount paid for services offering both in person and telehealth options shows higher amounts paid for telehealth and lower amounts paid for in-person visits starting in SFY 2020 quarter 4 (Figure 3). Each quarter following shows an increase in in-person visits costs with fewer telehealth visit costs. However, while telehealth costs and utilization declined from the spike during the PHE, these visits remain a larger portion of visit costs than before the PHE.

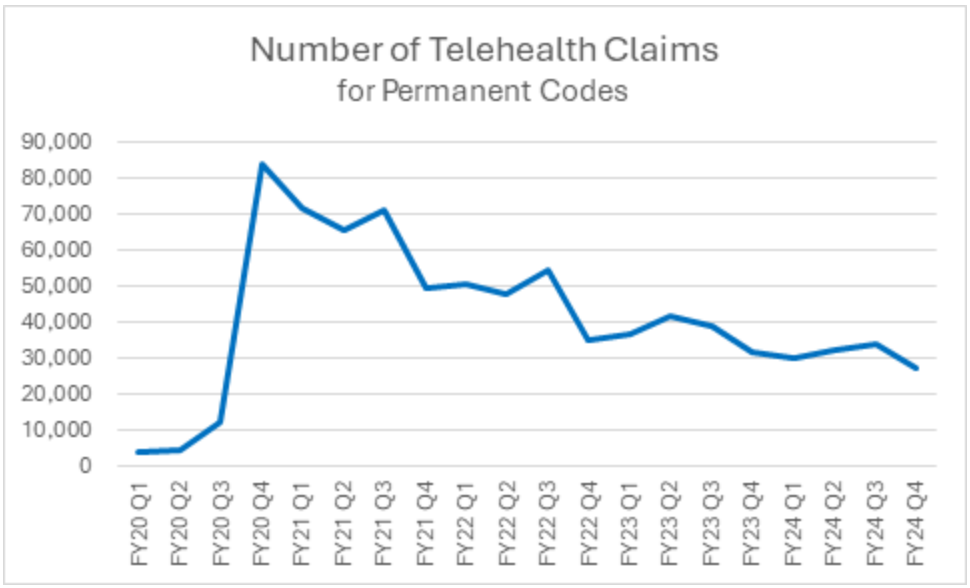

Figure 2. Number of Telehealth patients seen using procedure codes with permanent telehealth modality options.

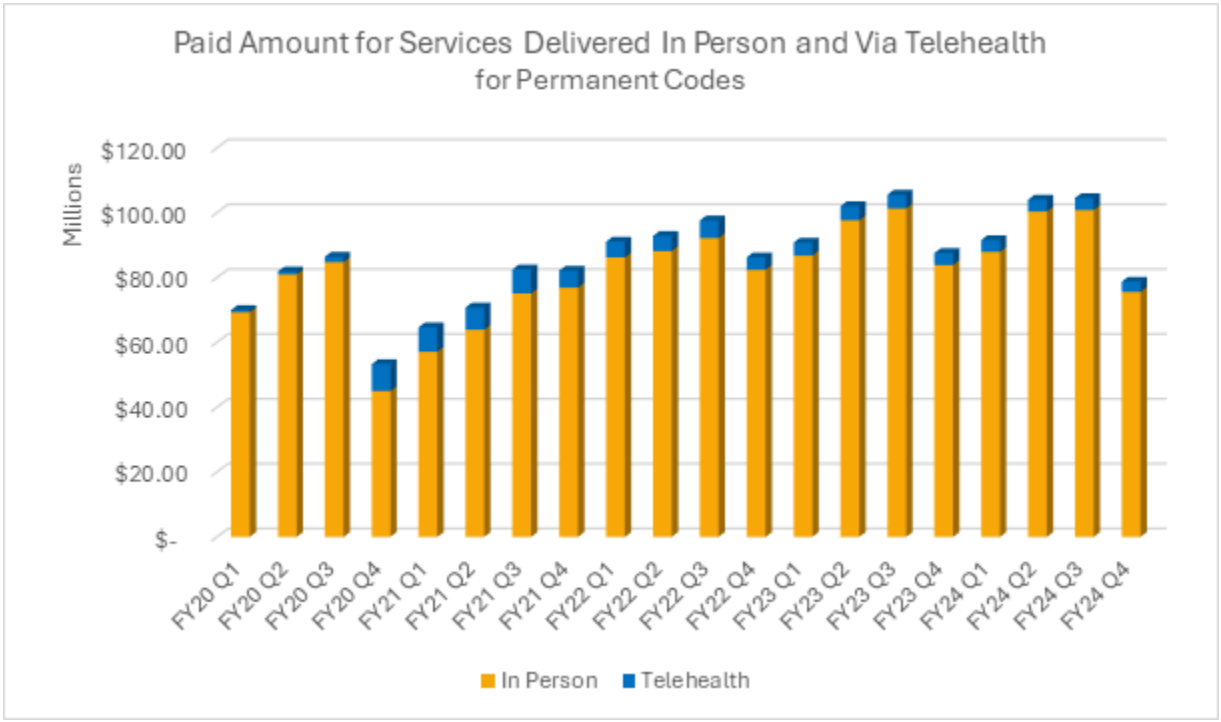

Figure 3. Paid amount for services delivered in person and via telehealth for permanent procedure codes.

Data on Telehealth Services Continued for Further Evaluation

Most of the services with telehealth flexibilities during the PHE were extended on a "continue to monitor" basis. These services, referenced in Appendix A, have a similar

utilization pattern to the services seen in Figure 2 above. Figure 4 shows the "continue to monitor" utilization. There is a distinct leveling-off of telehealth utilization for these services starting in SFY2022 quarter 4 to SFY2024 quarter 4. Only continued monitoring will allow for understanding of the usage of telehealth visits.

A cost analysis of paid claims for services on the "continue to monitor" list shows increased uptake and utilization of in-person visits since the peak of the PHE (Figure 5). Telehealth costs account for a steadily declining proportion of costs. However, costs in the last few SFY quarters of this analysis indicate persistent utilization that remains to be monitored.

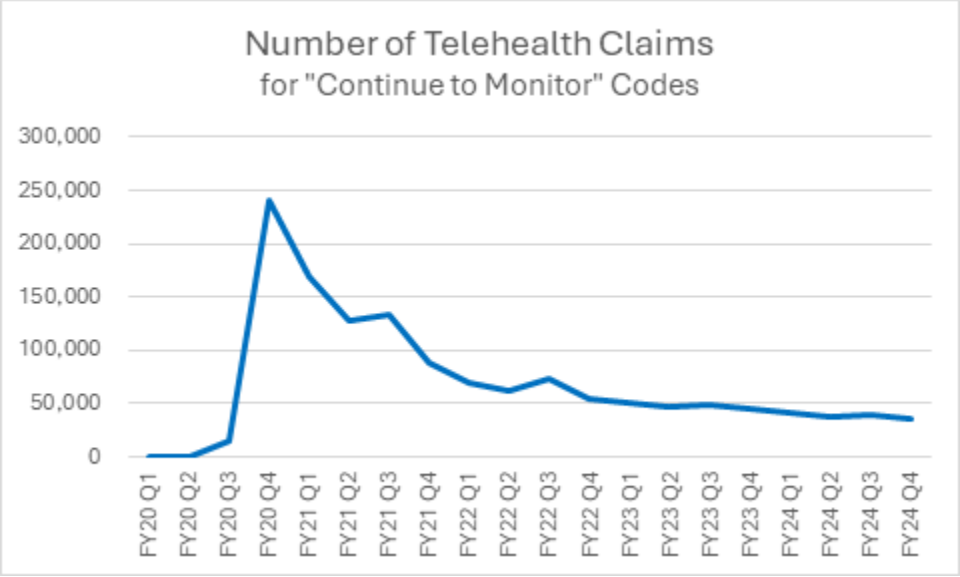

Figure 4. Number of Telehealth claims using procedure codes with "continue to monitor" telehealth modality options.

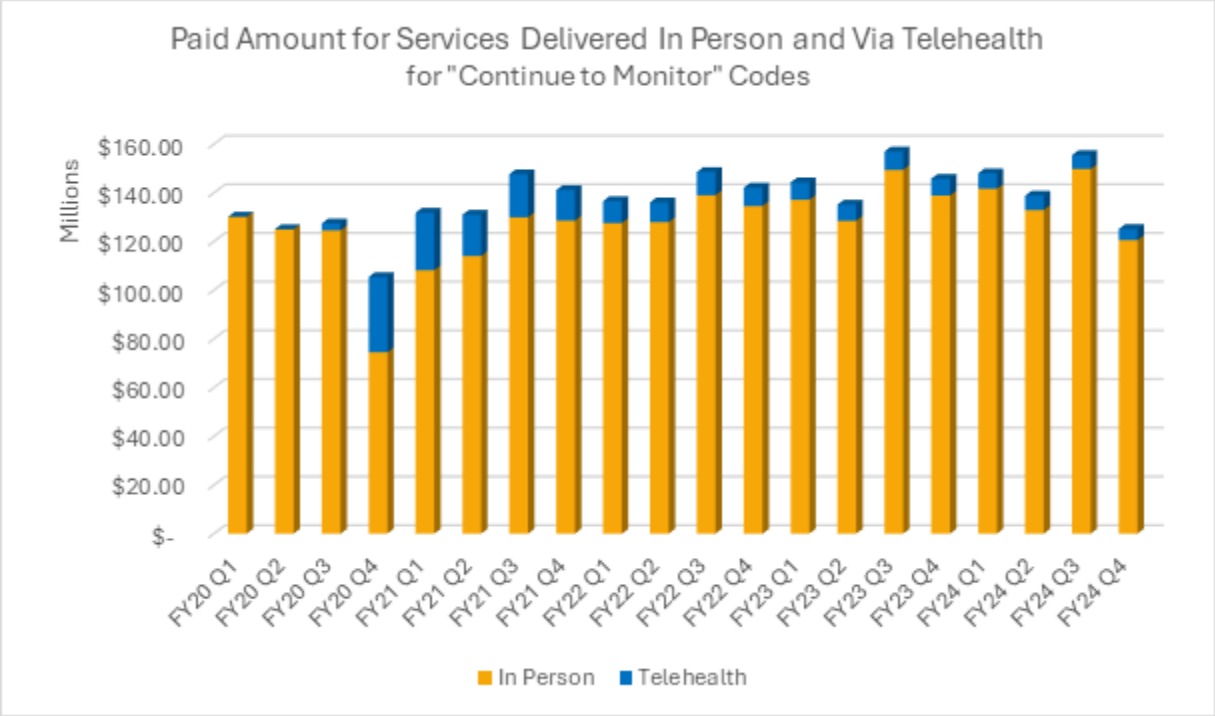

Figure 5. Paid amount for services delivered in person and via telehealth for "continue to monitor" procedure codes.

Recommendations for Jan. 1, 2025

Flexibilities that Will Be Made Permanent

Developmental and Psychological Evaluations

Developmental evaluations often require comprehensive, in-person assessments to accurately observe a child's behavior, social interactions and physical responses. There is a well-documented shortage of in-state providers who are qualified to perform these evaluations. This shortage has also produced extended wait times. Feedback indicates that providers often prefer in-person evaluations to ensure thorough assessments and accurate diagnoses. Parents and caregivers have also expressed concerns about the effectiveness of remote developmental evaluations, citing challenges in engaging young children via telehealth. Despite these concerns, ensuring access to these critical services is paramount. Providers report ongoing use and expressed a need to keep these services remote-capable.

Substance Use and Mental Health Support

These telehealth services align with South Carolina's commitment to addressing the opioid crisis and supporting mental health services. By offering telehealth options, the state can enhance care delivery, improve patient outcomes, and contribute to broader public health goals.

Evaluation and Management (E/M) Services

Telephonic E/M services provide a straightforward, accessible way for patients to connect with providers, ensuring continuity of care in areas with connectivity challenges. Notably, utilization increases for shorter time periods indicate effective physician and patient communications.

In addition, brief check-ins and remote evaluations provide vital communication channels between patients and providers. Despite lower utilization, telephonic E/M services offer additional flexibility for care delivery. Future support, monitoring, and education could enhance their adoption by highlighting their value in clinical practice.

Behavioral Health Services

Due to the high utilization and crucial role in mental health care, especially behavioral health services offered in the school setting, behavioral health telehealth services remain essential. Moving forward, SCDHHS will consider delineating thresholds where video requirements could be reinstated for complex cases, where visual cues are critical to providing more comprehensive and nuanced care. This approach would maintain audio-only as a practical, safe, and sustainable option for most scenarios, while ensuring that higher acuity cases receive the additional support that video can offer.

Pediatric Well-Child Visit Services

Well-child telehealth services for children two-years of age and older will support access to essential pediatric care, helping families navigate preventive health needs effectively and aligns with guidance from the American Academy of Pediatrics (AAP).

Flexibilities that Will Be Extended for Further Evaluation

Autism Spectrum Disorder Assessment, Diagnostic and Treatment Services

With provider shortages, extended wait times, and prior authorization delays, easily accessible care is critical. SCDHHS supports additional evaluation of any correlations between school-based behavior services and autism spectrum disorder services. Deeper provider and member engagement could also warrant a review of visit limitations and the

necessity of the video component as possibly being over-stimulating for some members, or necessary for others.

Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) Services

At the time of this report, Congress has voted to extend waivers that have allowed OTs along with PTs, STs and audiologists to provide services via telehealth under Medicare through Dec. 31, 2026. This legislation is a two-year version of the Telehealth Modernization Act, which was originally introduced to address telehealth policy on a permanent basis and also extends other important telehealth waivers that are essential to the provision of services via telehealth by all healthcare providers. This additional monitoring period will allow for further study and clarification of national perspective.

Flexibilities that Will Expire

Non-Physician Telephonic Assessment E/M Services

Non-physician telephonic assessment services which are primarily utilized by licensed independent practitioners are redundant and represent a workaround initially created to meet the emergency needs of the PHE. SCDHHS intends to educate providers on existing reimbursement pathways in advance of Jan. 1, 2025

Pediatric Well-Child Visit Services

In alignment with AAP guidelines, well-child visits conducted via telehealth for children under two years of age will not be continued due to the need for direct physical assessments and growth evaluations best conducted in-person.

Conclusion

SCDHHS is committed to continually striving for a comprehensive service array that meets the needs of South Carolina's Medicaid population. As such, continued monitoring and evaluation of services that may achieve the department's access, cost and quality goals will continue to be a priority. SCDHHS has added a staff position in its Bureau of Quality's Office of Quality Assurance to ensure that telehealth provision is considered in every provider manual review. As we transition from temporary flexibilities to more permanent pathways for telehealth utilization, it will be imperative that assessment of all service delivery models and programs include telehealth provisions.

Beyond the flexibilities described in this report, SCDHHS will continue to engage with the provider community and stakeholders to evaluate best practices and work to identify innovative solutions that will improve access to health care services while demonstrating clinical evidence that such services can be delivered with the safety and efficacy of in-person delivery. Additionally, SCDHHS will continue evaluating the telehealth services covered by other payers and adopt those services that are evidence-based, cost-efficient, and aligned with the needs of the Medicaid population.

Appendix A

SUMMARY OF CODES MADE PERMANENT:

- Evaluation and Management Services:
    - 99202 (E/M up to 30 minutes)
    - 99203 (E/M 30-44 minutes)
    - 99204 (E/M 45-59 minutes)
    - 99212 (E/M 10-19 minutes)
    - 99213 (E/M 20-29 minutes)
    - 99214 (E/M 30-39 minutes)

SUMMARY OF CODES EXTENDED FOR FURTHER EVALUATION:

- **Behavioral Health Services:**
    - 90837 (Individual psychotherapy, 60 minutes)
    - 90834 (Individual psychotherapy, 45 minutes)
    - 90832 (Individual psychotherapy, 30 minutes)
    - 90846 (Family psychotherapy, without client, 50 minutes)
    - 90847 (Family psychotherapy, including client, 50 minutes)
    - 90791 (Psychiatric diagnostic evaluation without medical)
- **Therapy and Rehabilitative Services:**
    - 97530 (Occupational therapy)
    - 97110 (Physical therapy)
    - 92507 (Speech therapy)
- **Telephonic E/M and Non-Physician Telephonic Assessment:**
    - 98966 (Telephonic assessment/management; 5-10 minutes, non-physician)
    - 98967 (Telephonic assessment/management; 11-20 minutes, non-physician)
    - 98968 (Telephonic assessment/management; 21-30 minutes, non-physician)
    - 99441 (Telephonic E/M; 5-10 minutes of medical discussion)

    - 99442 (Telephonic E/M; 11-20 minutes of medical discussion)
    - 99443 (Telephonic E/M; 21-30 minutes of medical discussion)
    - G2010 (Remote image submitted by patient)
    - G2012 (Brief check-in by provider)
- **Well-Child Visits:**
    - 99381 (New patient child well-care visit, less than 1 year old)
    - 99382 (New patient child well-care visit, 1-4 years old)
    - 99383 (New patient child well-care visit, 5-11 years old)
    - 99384 (New patient child well-care visit, 12-17 years old)
    - 99385 (New patient child well-care visit, 18-39 years old)
    - 99391 (Established patient well-care visit, less than 1 year old)
    - 99392 (Established patient well-care visit, 1-4 years old)
    - 99393 (Established patient well-care visit, 5-11 years old)
    - 99394 (Established patient well-care visit, 12-17 years old)
    - 99395 (Established patient well-care visit, 18-39 years old)
- **Care Coordination and Family Services:**
    - T1016 (Service coordination)
    - T1018 (IFSP/FSP team meeting)
    - T1027 (Family training/special instruction)
    - T1024 (Multidisciplinary team participation by IFSP team members)
    - T1023 (Neurodevelopmental evaluation and screening)
    - T1023-TF (Neurodevelopmental evaluation and screening, follow-up)
    - T1024-TF (Psychological developmental evaluation and screening, follow-up)
- **Alcohol and Drug Services:**
    - 99408 (Alcohol and drug screening and brief intervention service)
    - H0001 (Alcohol and drug assessment - initial without physical)
    - H0004 (Alcohol and drug counseling - individual)
    - H0032 (Mental health service plan development – non-physician)

- H0038 (Peer support service - individual only)