Centers for Medicare & Medicaid Services
Special Open Door Forum:
Treatment for Substance Use Disorder during the Public Health Emergency
Moderator: Jill Darling
October 7, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen-only mode until the question-and-answer session of today's conference. You may press Star 1 on your phone to ask a question. I would like to inform all parties the today's conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the conference over to your host Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you (Danielle). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communication and welcome to today's Special Open Door Forum, Treatment for Substance Use Disorder During the Public Health Emergency. Before we dive into today's presentations, I have one brief announcement.

This special open door forum is open to everyone but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact cms at press at cms.hh - I'm sorry press@cms.hhs.gov. And now I will hand the call off to Kim Brandt.

Kim Brandt: Hi everyone. I'm happy to be here with you. This is Kim Brandt. I'm the Principal Deputy at CMS. And I wanted to go ahead and give you an overview of some of the work that we've been doing with respect to opioids during Public Health Emergency.

As one of the largest payers of healthcare services CMS (is) a vital role in addressing both the opioid epidemic and the COVID-19 Public Health Emergency or I'll refer to it throughout this call as the PHE. In our discussion today I want to provide an overview of the policy changes that we have made to help address the needs of our beneficiaries with substance use disorder during the PHE.

The first event is really going back to our CMS roadmap to address the opioid crisis where we establish a framework with three key areas to guide the agency's efforts in alignment with the national drug control strategy. Those are first preventing opioid misuse and abuse, second expanding access to treatment for Opioid Use Disorder or OUD and third using data to target prevention and treatment efforts and to identify fraud and abuse.

CMS is (pursuing) a broad range of activities to identify and stop inappropriate prescribing to help prevent the development of new cases of OUD that originate from opioid prescription, while we're also trying to balance the need for continued access to prescription opioids to support appropriate individualized pain management.

But with all that we still have a really long way to go. The recent preliminary CDC data shows that the number of people dying from drug overdoses has picked up again in 2019 after it had declined slightly in 2018. And as we all know from looking at the news reports it's going up even higher here in 2020 so we all know that there's a lot more work to be done.

The Public Health Emergency has transformed the healthcare landscape for the short run and we know that the SUD crisis is continuing to intensify nationwide. That is why during this PHE the most significant effort CMS is

making to help Medicare and Medicaid beneficiaries with SUD is to expand access to telehealth services.

So let me tell you a little bit about the various telehealth options and flexibilities that we put in place. Beginning back in March CMS broadened access to telehealth services to all Medicare beneficiaries by removing geographic and location restrictions for three types of virtual services. This allows all beneficiaries access to mental health counseling and preventative screening without having to go to a doctor's office or hospital.

Also a mental health visit and the medical visit can be reported on the same day for the duration of the Public Health Emergency. We also issued an interim final rule on March 30 that listed dozens of (HCPCS) and CPT codes including for which services these types of things can be furnished using two-way interactive audiovisual technology that would ordinarily be furnished in an office or facility.

In that same interim final rule with comment, we announced the flexibility for billing practitioners to remotely supervise in-person clinical staff through virtual meetings so that patients can be administered Part B drugs such as injectable buprenorphine without having to come into that practitioner's office or facility. Instead they may receive drug services from their home or another office.

Also in March we sent a memo to Part D sponsors that we are not requiring and will not audit for patient signatures as proof of delivery for any medication including for controlled substances.

Then we turn to how we've done Medicaid SUD treatment using telehealth. Under Medicaid, they really have broad flexibility to implement telehealth

reimbursement policies. In April, we released a Medicaid and CHIP tool - telehealth tool kit to help states accelerate adoption of broader telehealth coverage policies in the Medicaid and Children's Health Insurance Program during the PHE.

To further accelerate the use of telehealth we incorporated telehealth options into our disaster state plan amendment template as well. We created several templates to facilitate quick changes to states Medicaid and CHIP plans, a process that normally takes months during normal periods of time. However, during COVID and using the templates we've been able to turn them around within days.

We've also provided additional support to states to help them address the needs of beneficiaries with SUD during the PHE. In April we also released an informational bulletin that identifies opportunities for states to use telehealth delivery methods to expand access to healthcare services including said treatment for people that have Medicaid specifically in rural communities.

Also in April CMS released a Medicaid and CHIP telehealth toolkit to help states accelerate adoption of broader telehealth coverage policies in the Medicaid and Children's Health Insurance Program during the PHE. The toolkit includes a checklist so that state Medicaid leaders and go step by step through considerations like payment methodology, population served, services, technology and other types of services.

To further accelerate the use of telehealth we also incorporated telehealth options into our disaster state plan amendment template. We created several templates to facilitate quick changes to states Medicaid and CHIP plans, a process that again can take months in normal time. And using these templates once again we've been able to turn these around and a matter of days.

After the PHE we are examining all of our waivers one at a time to determine whether or not we should either make them permanent, make them permanent with a modification, terminate at the end of Public Health Emergency or whether there will be further discussion required. We had almost 150 plus different waivers that we did on Medicaid side and on the Medicare side we've had over 130 different waivers.

On the Medicaid side with our waivers though generally the states that use the disaster state plan amendments to change their state plan for telehealth in or other SUD specific activities those would expire, those approvals will expire at the end of the Public Health Emergency or earlier at state discretion. So states have a great deal of flexibility to determine whether or not they will continue the policy they implemented.

As most of you are hopefully aware the Secretary recently extended the Public Health Emergency once again. It was set to expire at the end of October on October 25 and he recently extended it through the end of the year. So that gives us additional time and another 90 days if you will to be able to determine whether or not these waivers will be made permanent or what we will do with them.

So with that I'm going to turn it over to my colleague Lindsey Baldwin who's going to discuss how CMS has helped ensure continuity of care for Medicare beneficiaries who receive care opioid treatment program. So Lindsey, over to you.

Lindsey Baldwin: Great thanks Kim. Yes so this is Lindsey Baldwin in the Center for Medicare. Before I get to opioid treatment program policies I wanted to first just

highlight a few things related to substance use disorders under the Medicare Physician Fee Schedule or the PFS as I'll refer to it throughout.

So first I'd like to highlight flexibilities that were authorized by Section 2001 of the Support Act, which expanded Medicare telehealth services for the treatment of opioid use disorder and other substance use disorders. So that has two parts to it.

First beginning July 1, 2019 the originating site geographic requirements are waived for Medicare telehealth services furnished for the purpose of treating individuals diagnosed with a substance use disorder or a co-occurring mental health disorder which means that not only beneficiaries in rural areas but beneficiaries throughout the entire country are eligible to receive these services via telehealth.

Also beginning July 1, 2019 the beneficiary's home is a permissible originating site for Medicare telehealth services furnished for the purpose of treating individuals diagnosed with a substance use disorder or a co-occurring mental health disorder.

Next in the calendar year 2020 PFS final rule CMS finalized the creation of new coding and payment for a monthly bundle of services for the treatment of opioid use disorder which was described by Codes G2086 through G2088. Those bundled payments include overall management, care coordination, individual and group psychotherapy, substance use counseling and an add-on code for additional counseling furnished. Those codes were also added to the Medicare telehealth list.

For CY 2021 we proposed to expand these codes to be inclusive of all substance use disorders. To accomplish this we are proposing to revise the

code descriptors by replacing opioid use disorder with a substance use disorder. The payment and billing rules would otherwise remain unchanged.

Next I'll go over flexibilities allowed during the current Public Health Emergency for Medicare telehealth services under the PFS. During the PHE for the COVID-19 pandemic CMS has waived the audio and video requirements for behavioral health counseling and/or educational services for the duration of the PHE in addition to making payment for audio only evaluation/assessment and management services.

Additionally the payment rate for telephone E&M services described by CPT codes 99441 through 99443 was increased to be equal to the rate for in-person E&M visit codes described by CPT codes 99212 through 99214.

Additionally for the duration of the PHE communication technology based services are allowed to be billed by licensed clinical social workers and clinical psychologists. Those services are described by HCPCS Code G2010 which describes a remote evaluation of video or images and G2012 which describes a brief virtual check and.

CMS also proposed those changes in the CY 2021 PFS propose rule. CMS also clarifies that licensed clinical social workers and clinical psychologists could bill for e-visits described by CPT codes 99421 through 99423 and HCPCS codes G2061 through G2063 and is exercising enforcement discretion. So all of these services including phone assessment/evaluation and management visits can be billed for new patients.

Next, I'll go over policies related to opioid treatment programs. So Section 2005 of the Support Act established a new Medicare Part D benefit for OUD treatment services furnished by OTPs on or after January 1, 2020. OUD

treatment services provided by OTPs includes FDA approved opioid agonist and antagonist medications for the treatment of OUD which includes methadone, buprenorphine and naltrexone, dispensing and administering of such medications as applicable, substance use counseling, individual and group therapy, toxicology testing including both preventive and definitive testing, intake activities and periodic assessments.

The codes describing OTP treatment services are not considered physician services and are paid outside of the PFS therefore they are not assigned relative value units or RVUs. Instead these services are assigned flat dollar payment amounts, which are adjusted by geographic locality.

We adopted a coding structure for OUD treatment services at OTPs that includes the non-drug services and varies by the medication administered. We established nine G codes, G2067 through G2075 and five add-on G codes G2076 through G2080 for weekly bundles describing treatment with methadone, oral buprenorphine, injectable buprenorphine, buprenorphine implants, extended release injectable naltrexone, medications otherwise not otherwise specified and a non-drug bundle.

Only one weekly G code can be billed in any seven-day contiguous period per beneficiary except in limited clinical circumstances such as for guest dosing. The threshold for billing the weekly episode is the delivery of at least one service in the weekly bundle from either the drug or non-drug component.

In the calendar year 2020 PFS final rule we finalized allowing OTPs to furnish the substance use counseling, individual therapy and group therapy included in the bundle via two-way interactive audio and video communication technology as clinically appropriate in order to increase access to care for beneficiaries.

And during the PHE for the COVID-19 pandemic CMS added additional flexibility for OTPs to furnish care using communication technology. First for the counseling and therapy, CMS revised the regulation text to allow therapy and counseling in the bundle as well as the add-on codes for additional counseling or therapy and to be furnish using audio only telephone calls rather than the two-way interactive audio and video communication technology in cases where beneficiaries do not have access to two-way audio and video technology provided all other applicable requirements are met.

Second for periodic assessments CMS also revised the regulation text to allow that the periodic assessments could be furnished during the PHE using using two-way interactive audio video communication technology. Again in cases where the (bene) does not have access to two-way audio video communication technology the periodic assessment may be furnished using audio only telephone calls rather than that two-way audio and video provided all other applicable requirements are met.

Additionally for CY 2021 we proposed to continue to allow periodic assessments to be furnished using audio and video communication technology. If finalized that will mean that that flexibility will remain in place even after such a time that the current PHE were to end.

Finally for CY 2021 we also proposed to create two new add-on codes describing payment for OTPs when they furnish beneficiaries with a take-home supply of naloxone for opioid overdose reversal. We’re proposing one add-on code for nasal naloxone, another add-on code for auto-injector naloxone, and were seeking comment on providing patients with injectable naloxone.

We also have a discussion in this proposed rule that we are exploring claims processing flexibilities that would allow OTPs to enroll on the 855A application and bill on institutional claim forms. We also proposed clarifications related to the date of service used on claims for the weekly bundles and add-on codes that allows OTPs to bill using a standard billing cycle that s consistent across all their patients if they so choose to.

And lastly we sought comment on whether we should consider further stratification of the coding and payment to account for significant differences in resource costs among patients. We're reviewing the comments received on these proposals during the public comment period and we'll finalize policies in the final rule later this fall to take effect on January 1, 2021. And with that I will pass it off to Kirsten Jensen.

Kirsten Jensen: Great thank you very much. Thank you Lindsey. This is Kirsten Jensen and I'll be talking about Medicaid today. Just as a reminder for folks on the phone, Medicaid is a federal and state run program and I'm speaking about Medicaid from the federal perspective, states operate and make decisions about their particular programs within broad federal guidelines.

Regarding telehealth states have a great deal of flexibility with respect to covering Medicaid services including behavioral health services provided via telehealth. And states use this flexibility during the course of the pandemic. This flexibility includes determining whether or not to cover services delivered via telehealth, what types of services they want to cover, what methods of communication, where in the state it can be covered, what - and what practitioners can deliver the services via telehealth. States also have flexibility in determining how the reimbursement for services furnished via telehealth will be established and structured in their state.

We found during the course of the pandemic and talking with states about telehealth that many states have adopted pieces of Medicare's rules into their state Medicaid programs but just noting that is a state decision. That is not a federal requirement and states to have the flexibility and how they set up telehealth within their states.

There are no federal Medicaid restrictions on where telehealth services can be provided including in a beneficiary's home. And as Kim mentioned during the course of the pandemic in addition to providing lots of technical assistance to states and improving the disaster relief SPAs where states were really expanding their use of telehealth we also did develop the Medicaid and CHIP toolkit for states. Where working on a supplement to that toolkit at this point that it will really help states take a look at what, you know, kind of where they were before the pandemic, where they were during the pandemic and where they expect to go when we come out of this.

We are looking at various populations and services within this toolkit. And I think it was as we were talking with states throughout the course of the pandemic it was interesting to learn about some of the services that they were providing at home that they had not traditionally done so such as maybe a consult for a - of for a chronic pain visit or an OB/GYN visit or a pediatric visit. And, I think states really learned a lot through the course of this pandemic.

In terms of chronic pain we recognize that this pandemic has led to an interruption in services including those who rely on treatment for chronic pain and that there is a linking chronic pain for those who have OUD. And, we just recognize that services can be useful for treatment of people with chronic pain such as cognitive behavioral therapy. And those types of services certainly can be provided via telehealth and are services that can be continued.

During the course of the Public Health Emergency, CMS also used a flexibility under Section 1135 which allowed us to waive a wide range of requirements within the - both the Medicare and the Medicaid programs. And we -- as part of the 1135 flexibility in terms of substance use disorder treatments -- we waived - we allowed for the ability to permit out-of-state providers to render services. We temporarily suspended certain provider enrollment and revalidation requirements to promote access to care and we allowed providers to provide care in alternative settings. And we also allowed states to waive prior authorization requirements. Again this is something that states requested from us using an 1135 disaster template. And all of those I believe are on our Web site.

So we worked with states during the pandemic to process as Kim said 150 state plan amendments, disaster state plan amendments and also a large number of these 1135 requests, which allowed states to then go ahead and provide increased access to substance use disorder treatment.

Now we do know that despite these efforts the pandemics disrupted access to treatment and Medicaid has seen a decrease in the utilization of SUD. So it’s going to be critical as we move out of this to reengage these beneficiaries and treatment. In terms of looking forward states continue to have significant flexibility to cover services to treat substance use disorder and opioid use disorder.

We have several Medicaid benefits that are utilized for this and we have the rehabilitation services benefit. We have several options for states to - we have a new option to cover Medicaid beneficiaries aged 21 to 64 who are residing in an institution for mental disease. And we also have an 1115 demonstration

opportunity to also support people that are receiving services or who may be receiving services in institutions for mental disease.

That particular opportunity also focuses on expanding community-based options for treatment. We have significant activity in that space. So we will continue and also to mention given that it's October 7 Section 1006B of the Support Act was signed - was effective October 1 of this year and this ensures that Medicaid state plans will be offering medication assisted treatment for opioid use disorder for certain categorically needy populations.

So we are underway with that and we look forward to continuing to broaden our reach and assist states with developing systems with care in their states that meet this population's needs. And with that I will turn it over to Jill.

Jill Darling: Great. Thank you Kirsten, Kim and Lindsey. We will now open the call for Q&A please. (Danielle)?

Coordinator: Thank you. We will now begin the Q&A session. If you would like to ask a question please press Star 1, unmute your line and record your name clearly when prompted. Your name is required so we can introduce your question.

If you need to cancel your question for any reason you can press Star 2. Again to ask a question, please dial Star 1. It will take a moment for those questions to come through. Please stand by.

Okay our first question today comes from Dr. John Hsu. Go ahead. Your line is now open.

Dr. John Hsu: Hi. Thank you very much for taking the call. I have a quick question to ask. I’m CEO of iPill Dispenser. And while we understand that the DEA and FDA

consider the pharmacy the end user of opioids I would like to ask whether HHS would consider using a home secure storage active control dispensing and destruction of unused pills as an option to prevent opioid usage disorder in the future?

We are ad FDA breakthrough product and we would like to consider using our product in the HHS paradigm for treatment of OUD. Thank you very much.

Anna Bonelli: (Danielle) and Jill this is Anna Bonelli. I'm a Senior Policy Advisor for Kim Brandt who had to step off the call unfortunately. So if you don't mind I'll go ahead and respond to that question.

Thank you so much for the question. I really appreciate it. That's something that we can - we'd be happy to talk more with you about. Feel free to reach out.

There is a provision in the SUPPORT Act. The number escapes me right now but there is a provision that requires CMS to provide guidance to beneficiaries on how to dispose of their medications safely. So that provision is going to be included in upcoming regulations that it will be publishing proposed in final regulations that instruct our Part B plans on the requirements for how to instruct beneficiaries again on safe disposal of their medications. So please stay tuned for that. Hopefully it's helpful.

Dr. John Hsu: Okay if you were able to send me or let me know who to contact because what I fear is, you know, I've spent 28 years in the practice of anesthesia and chronic pain management and the biggest problem I have is patient compliance. When I send a patient home with an opioid prescription, I've had more than one patient just take too many.

And I'm really having a difficult time trying to determine patient compliance at home. I've had patients go home and have their children take their opioids and overdose and die. So I'm on a quest to figure out how I can best improve my practice, protect my patient and protect the family members of the patients that are taking opioids.

And that's why I've kind of developed a system where we actually destroy the pills because when you look at the policies out there, there's no stringent instruction of how to dispose of opioids.

Some people say return them back to the pharmacy but when you - when I tried to do it the pharmacy that supposedly has these plastic bags to dispose they wouldn't take it. They made me go to the city hall and the city hall didn't know what to do with it, the pharmacist didn't know what to do with it. And so I am trying to make my practice better so I'm interested in…

Anna Bonelli: Yes.

Dr. John Hsu: …trying to make this thing...

Anna Bonelli: I...

Dr. John Hsu: ...better.

Anna Bonelli: Yes I, you know, I can really, you know, I really appreciate the passion that you have to help your beneficiaries. This is an issue that is really critical as you said. You know, patient adherence and making sure the patients have the information they need to self-administer medications safely is really important and is not an easy topic.

So like I said I'd be more than happy to meet with you. So I'm not sure if there is an easy way to post my contact information but I'm listed in the directory. That is Anna Bonelli and I'd be more than happy to hear more about your concern.

Dr. John Hsu: Okay. I'll give you my information if you - it's john@ipilldispenser.com.

Anna Bonelli: Got it.

Dr. John Hsu: B-I-N-A-L-L-I? (sic)

Anna Bonelli: Okay.

Dr. John Hsu: Okay, thank you for...

Jill Darling: Hi. This is Jill. If it makes things easier instead of getting a lot of emails to Anna you can send - I think you - you know, get - explains more through email you can send your questions and comments to partnership@cms.hhs.gov.

Dr. John Hsu: Partnership at hh…

((Crosstalk))

Jill Darling: Partnership@cms.hhs.gov. And I can forward them to Anna…

Dr. John Hsu: I'm sorry partnership at what?

Jill Darling: at cms dot hhs dot gov.

Dr. John Hsu: Okay. Thank you very much and good work. Have a nice day.

Jill Darling: Yes.

Coordinator: Our next question comes from (Robert Foreman). Go ahead. Your line is open.

(Robert Foreman): Hi. Thank you so much and first just thank you for all the hard work that you and the rest of the team have been doing on behalf of patients. We know how incredibly hard you all are working so thank you and you guys are absolutely saving lives.

My question has to do with whether any consideration might be given to expanding availability of treatment for alcohol use disorders. Understandably tremendous focus needs to be given and continued to be given to opioid use disorder. But more lives, greater mortality and morbidity has always been associated with alcohol and I'm wondering whether thought is being given to that work? Thank you very much. That's the end of my question.

Anna Bonelli: Hi...

((Crosstalk))

Anna Bonelli: Thank you so much. Oh, go ahead Lindsey.

Lindsey Baldwin: Hey and sure yes. This is Lindsey. I'm just going to chime in to say that when you mentioned alcohol use disorder one thing that does come to mind is our proposal in the CY 2021 Physician Fee Schedule proposed rule which was to expand the monthly bundled payments that we established last year for opioid use disorder.

Our proposal is to expand that to be applicable for any substance use disorder. And I have kind of seen in comments coming in so far some mention of alcohol use disorder. So that's something you can look out for addressing in the CY 2021 PFS final rule.

(Robert Foreman): Is fabulous. Thank you for that yes.

Michael Tankersley And hi. This is Michael Tankersley from CMS. And from the Medicaid perspective as we talked about earlier, states already have a lot of flexibility to cover services, treatment services for individuals with alcohol disorder. Just - and it also is part of the Section 1115 demonstration opportunity that my colleague Kirsten Jensen just discussed a few minutes ago.

You know, the reason behind that that initiative was really designed to meet the needs of OUD and other substances. And, so certain states that we've kind of participated in the demonstration that maybe you don't have quite as great of a need for the OUD population. There's still some need don't get me wrong but there are other substances are really their focus including alcohol disorder. And, so from a Medicaid perspective states are - can and are covering services to treat that population.

(Robert Foreman): That's excellent, thank you.

Coordinator: As a reminder if you'd like to ask a question please press Star 1, unmute your phone and record your name when prompted. Our next question comes from (Carol Barnes Sanders). Go ahead. Your line is now open.

(Carol Barnes Sanders): Thanks so much. Just as referenced as I believe you referenced the Support Act earlier and I believe it's Section 6103 about disposal in Medicare

plans and Part D plans. I just really wanted to ask about just to stay on the topic of disposal. We know that that is a key prevention factor.

And just wondering the roadmap is very robust. I think it is excellent and we use the material in our company. Some of us stats and some of the roadmaps we reference that. Just wondering on the prevention side why it lacks information about disposal since we know education is so critical and about this both safe storage and disposal, just wondering if that will be added down the road?

Anna Bonelli: Hi again. It's Anna Bonelli. I'm the Senior Policy Advisor to Kim and working on the opioids portfolio. Thank you so much for the question.

You know, it’s a very interesting idea and that’s something that we'll certainly take back. I can’t make any firm commitments right now because it’s something we’ll have to discuss internally. But as you point out, safe disposal is one of the important mechanisms for preventing substance use disorder along many lines. And so that is something that we can consider for future inclusion in the roadmap. Thank you.

(Carol Barnes Sanders): Yes it’s more I think now with the pandemic and the collision of the epidemic I think everything being at home people, being at home especially with Take Back Day I know that the Take Back Day in April was canceled. We’re going forward with October. But I think it’s more important than ever to remind people that safe at home disposal is critical.

Anna Bonelli: I hear you. Thank you.

Coordinator: As a reminder if you would like to ask a question please dial Star 1 from your device. We have no further questions in queue at this time.

Bear with me. We have one more question. All right our next question comes from (Sander Quisman). Go ahead. Your line is now open.

(Sander Quisman) Thank you. Speaking to many providers I'm sitting on the insurance side of things and for so many of the big burning question is how permanent are these changes? How much of my practice is going to have to get rejiggered once again when all of this goes away? You know, do we have any sense of permanence and where should we do additional advocacy to help providers and payers frankly to know where we are heading?

Anna Bonelli: Lindsey do you want to talk about the proposals in the Physician Fee Schedule that have been proposed and may become final?

Lindsey Baldwin: Sure. So for OTPs specifically there the audio only flexibilities that were authorized in the interim final rules were for the duration of the PHE. But we did separately propose for next year and ongoing to allow audio and video communication technology for furnishing the periodic assessments. That's just under OTP.

I think you're probably asking more broadly about services generally. I know there's a lot of information posted online in terms of the flexibilities during the COVID-19 PHE. If you have specific questions though that you're not finding answers to there is a resource box for those COVID-19 questions. And I can give you that email address. It's hapg_covid-19@cms.hhs.gov, because I think Kim kind of spoke to this in her presentation which is that there's kind of three different buckets of services, ones that have been added permanently, ones that are added only during this PHE and ones that are kind of requiring more thought and we'll do kind of future rulemaking on those. So check out the

information that is posted and any other questions you can send to that email address.

(Sander Quisman) Great thank you.

Lindsey Baldwin: Sure.

Anna Bonelli: Kirsten you may comment a bit on state options for making some of these changes permanent or, you know, at least put the - keep them in place for a longer period of time. Is that something you can comment on?

Kirsten Jensen: Sure, I'm happy to. We have talked to several states that - and we've had one state speak on an all state call that we had, you know, and that particular state has gone from like providing no services using telehealth to virtually opening up their whole Medicaid program to telehealth.

And, you know, we have other states that didn't move quite that far but did provide more flexibility. And we have other states that were already pretty flexible to begin with. So we expect that states will assess where they've been during the course of the PHE and determine how they'd like to proceed going forward.

I think all of their eyes have been opened with having to kind of, you know, implement telehealth so quickly for so many different providers throughout their states but that's really, that's the focus of the supplement of the toolkit that we'll be releasing is helping states assess where they've been and where they're headed.

And one other thing just to note for this audience that we heard during the course of our discussions and the pandemic with various audiences is that, you

know, providers were having a difficult time finding out what the requirements were for telehealth for their particular specialty in the state. And so we did focus on that as well in the toolkit to help improve and provide some tools and ideas for helping to improve provider communications.

So I think the states will start taking a look at this. I know some states probably already are looking at this. But we can't from the federal perspective we don't have limitations on what the state can do. They - these flexibilities exist within the PHE, beyond the PHE. They existed before the PHE so now it's just a time for assessment for states to figure out how they're going to be moving forward and then we'll support them in that if they need to submit any paperwork with us to effectuate any permanent changes or if they can just make their change and move forward without our having to bless it. That helpful?

(Sander Quisman) Very much so, thank you.

Kirsten Jensen: Yes okay.

Coordinator: As a reminder if you'd like to ask a question please press Star 1 on your device and record your name when prompted. Our next question comes from (Douglas). Go ahead. Your line is open.

(Douglas): Thank you and I will reiterate the great work that you all are doing so thank you. And my question so as you know the Public Health Emergency has affected a lot of people and I help at a couple of OTP sites. And a lot of the population because they've either lost jobs or they're - they find themselves in a particular situations they're choosing to serve jail time while they're either out of work or just get involved in other criminal activity.

And the question is regarding either continuation of or provision for a release for folks who are incarcerated very, very high risk population and continuing medications for opioid use disorder after folks who are, you know, say on a, you know, stable on a program either, you know, get incarcerated. I'm finding that beneficiaries that are either on, you know, on the Medicaid it doesn't cover them in, you know, while they're incarcerated. So I'm wondering, you know, what (thought has gone into) this - that especially during the Public Health Emergency?

Kirsten Jensen: Kirsten Jensen. In terms of individuals who are considered inmates yes Medicaid coverage it can - states can make - can decide to continue to keep people eligible, but Medicaid will not pay for any services while an individual is incarcerated. ***[CORRECTION: Medicaid will pay for inpatient hospital services for Medicaid.]*** And that has not changed with the Public Health Emergency. That is a clear statutory requirement for Medicaid.

As part of the Support Act though there was a Section 5032 that directs that HHS conduct a stakeholder group to solicit feedback and that there be a report to Congress on the subject and that ultimately CMS put out a - an 1115 demonstration authority opportunity similar to the one we've been discussing about they SUD opportunity for states.

And so those things are dependent on one another. I believe the stakeholder announcement for this – for the - I mean the announcement for the stakeholder group went out I'm going to say October 1 -- don't quote me on that -- in the Federal Register I believe. And once, you know, that needs to occur report to Congress needs to occur then CMS. And it's just the way the statute was written to have those dependencies built in. But we are actively involved in that work and (then) supporting the people that are reporting on the stakeholder group.

Anna Bonelli: Yes and I can add to that. This is Anna Bonelli. What Kirsten said was accurate known as - it's 5032 of the SUPPORT Act. And yes there was a - there was notice in the Federal Register about the stakeholder meeting that will be held later on this winter. As Kirsten said we'll be taking that information and using it.

We also at CMS are required under again the SUPPORT Act 1001 to develop guidance for states who wish to for - so that states are more enabled to suspend coverage of juveniles as they enter incarceration so that the suspension can be lifted and their benefits can be reengaged more rapidly. Kirsten you probably know more about it than I do but that guidance is scheduled for release this fall as well and so that's another one to look for.

But to your larger point, you know, this is a really important consideration. We know that folks who are incarcerated are at high risk when they exit. And unfortunately, we're prohibited from statute by covering services when they are incarcerated but were doing the best we can to reengage when they exit.

(Douglas): Thank you.

Coordinator: All right speakers we show no further questions at this time.

Jill Darling: Okay great. Well thanks everyone. You'll get some time back in your day. We greatly appreciate your questions and comments and concerns. And if you do think of anything after today's call please so free to send an email to partnership@cms.hhs.gov and we will forward it to the correct folks. So thank you again everyone and stay safe.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

End