Final Report

State Medicaid Telehealth Coverage Policy Decisions Since the COVID-19 Public Health Emergency

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About This Report

The coronavirus disease 2019 (COVID-19) pandemic resulted in multiple and prolonged disruptions to the U.S. health care system. In response to nationwide stay-at-home orders, state Medicaid agencies implemented policy flexibilities to encourage telehealth expansion and adoption by both patients and providers as a means for ensuring that needed health care continued to be delivered during the public health emergency (PHE). As the COVID-19 pandemic continues to evolve, state Medicaid offices have responded by making ongoing changes, including making some of those policy flexibilities permanent and rescinding other policies or allowing them to expire.

The purpose of this project was twofold. First, we cataloged changes to state Medicaid telehealth policy flexibilities and/or new policies enacted during the COVID-19 PHE as of April–May 2022. We focused on flexibilities that were rolled back, as well as those made permanent in part or in whole. Second, we sought to better understand the decisionmaking process behind Medicaid telehealth policy changes, including data or other information used for decisionmaking, considerations for health equity and COVID-19, stakeholder experiences, barriers and facilitators to decisionmaking, and lessons learned.

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Summary

Issue

Early in the coronavirus disease 2019 (COVID-19) public health emergency (PHE), patients and medical providers were prevented from meeting face-to-face because of facility closures, appointment cancellations, and fears of contracting the virus. As a result, many turned to telehealth—defined as any clinical consultation delivered by audio-only or video modalities using any platform—as an alternative mode of care. In-person visits decreased dramatically, while telehealth visits increased (Koonin et al., 2020). Since that time, in-person visit rates have mostly recovered (Drake et al., 2021; Anderson et al., 2021), though rates of telehealth visits remain significantly elevated from pre-PHE levels (Anderson et al., 2021; Demeke et al., 2021; Chu et al., 2021).

State Medicaid agencies implemented new policies and flexibilities to ensure patient access to care through telehealth. As the COVID-19 pandemic continues to evolve, states have responded by making ongoing changes, including making some of those telehealth policies permanent and rolling back other policies or allowing them to expire.

Project Purpose and Approach

The purpose of this project was twofold. First, we cataloged state Medicaid telehealth policy flexibilities and/or new telehealth policies enacted during the COVID-19 PHE. We focused on flexibilities and new policies that have been rolled back or allowed to expire, as well as those made permanent in part or in whole. Second, we sought to better understand the decisionmaking process behind Medicaid telehealth policy changes, including data or other information used for decisionmaking, considerations for health equity and COVID-19, stakeholder experiences, barriers and facilitators to decisionmaking, and lessons learned.

To address the first question, we conducted a rapid literature scan, including peer-reviewed and gray literature, along with web searches to inventory Medicaid telehealth policies or flexibilities made during the PHE that have been rolled back or made permanent. We also searched for evaluations of state Medicaid telehealth policy changes made during the PHE, justifications for Medicaid policy changes, and stakeholder experiences with telehealth (e.g., experiences of Medicaid beneficiaries or providers). To address the second question, we conducted guided discussions with state Medicaid representatives from states with varying levels of telehealth utilization, population diversity, and Medicaid expansion status. Throughout, we also explored the impact of policies on health equity.

Literature Scan Findings

We identified 50 policies initially allowed during the PHE (representing 25 states) that have become permanent and 27 policies (representing 15 states) that have been rolled back. Eleven states had policies that had been rolled back *and* policies that had been made permanent. In total, 29 states had some type of policy change following telehealth flexibilities or new policies in response to the PHE. We categorized policies and related findings into the following types:

- **Delivery requirements.** These types of policies relate to where care is provided (i.e., distant site) or is received (i.e., originating site), allowing out-of-state providers, any restrictions to the platform on which telehealth is delivered or received (e.g., Health Insurance Portability and Accountability Act [HIPAA] requirements), and patient consent requirements needed to deliver services via telehealth.
- **Modality.** This policy type relates to allowable modalities for telehealth, including live video, store and forward (in which data from the patient are sent to a provider, who sends back diagnostic results or treatment advice, often asynchronously), remote patient monitoring (e.g., using tools such as pulse oximeters or blood glucose meters to record personal health data that is reviewed by a provider in a separate location), audio-only (i.e., telephone or other synchronous live voice communication without video), and text-based communications (such as text messages and email).
- **Service type.** This policy type describes the types of services that may be billed for when delivered through telehealth, including primary care, behavioral health care, maternity care, physical/occupational/speech therapies, dental care, long-term services or supports, patient education, and telepharmacy. This also includes limitations to the patient type (i.e., established versus new patient).
- **Provider type.** This policy type pertains to the types of providers allowed to bill for services delivered through telehealth, including medical doctors, nurse practitioners, physician assistants, other advanced practice providers, pharmacists, behavioral health providers, and dental providers.
- **Payment policies.** These policies detail provider payments and patient financial responsibilities (e.g., co-payments, coinsurance) related to telehealth. This includes payment parity—reimbursing telehealth and in-person services at the same rate.

The most frequent policy change was making coverage of different modalities—such as audio-only, store and forward, and remote patient monitoring—permanent. The next most frequent policy change was making delivery requirement flexibilities permanent, such as expanding originating sites to include patients' homes. The policy most frequently rolled back was the flexibility to use non-HIPAA-compliant platforms to deliver telehealth services. Our literature scan also found that providers generally expressed a desire to maintain Medicaid coverage and payment parity for telehealth services. Medicaid beneficiaries appreciated the flexibility and convenience of telehealth, though some noted concerns about lower-quality care. Medicaid directors typically echoed patient perspectives, noting that telehealth policies improved access to patient care while expressing concerns about quality and the potential for fraud, waste, and abuse.

We did not identify any rigorous evaluations of the impact of telehealth policy changes in the context of the Medicaid program on cost and quality of care. This constitutes a major gap in the literature, because such evaluations are critical in helping states to decide the future of their telehealth policies.

Key Informant Discussion Findings

Our discussions with state Medicaid representatives explored four domains: (1) state attitudes and perspectives on telehealth and telehealth policies, including their experiences with new telehealth policy/flexibility; (2) state telehealth policy decisionmaking processes; (3) states' future plans for telehealth; and (4) challenges and lessons learned. Across these domains, several themes emerged (see Table S.1). Highlights of these themes include the following:

- State Medicaid representatives generally felt telehealth is "here to stay." They noted large increases in telehealth utilization, particularly in telehealth delivery of behavioral health services. Although most respondents reported that the COVID-19 pandemic had sped up telehealth utilization and policy development, it was not a consideration for making permanent telehealth policy.
- States used general principles, specific processes (including legislatively required processes), and stakeholder and expert input to inform their decisions about telehealth policy. Some states tracked telehealth utilization through "data dashboards" but generally had not yet completed detailed analyses of these data. Use of peer-reviewed evidence by state Medicaid agencies in the decisionmaking process was limited.
- Most states had no current plans to make major changes to telehealth policies in the near future but were continuing to monitor utilization and make minor changes where appropriate. Most states reported plans (or hopes) for formal evaluations of the impact of telehealth policies but generally did not provide specific timelines.
- States reported challenges with implementing telehealth policies that include conflicting or unclear lines of authority and a lack of data to understand the impact of those policies. Many states called for more robust studies to guide decisionmaking.
- Lessons learned centered around the vital importance of communication, transparency, and building partnerships.

Table S.1. Domains and Associated Themes

Domains	Themes
1: State attitudes and perspectives on telehealth and telehealth policies	1.1: The COVID-19 pandemic substantially sped up telehealth utilization and policy development
	1.2: Most state Medicaid representatives felt telehealth was “here to stay”
	1.3: Although COVID-19 played an important role in telehealth policy flexibilities it did not seem to play a substantial role in determining permanent telehealth policies
	1.4: Reactions to expanding Medicaid telehealth flexibilities were generally more positive than rolling them back
2: State telehealth policy decisionmaking processes	2.1: State legislation influenced Medicaid policies in different ways
	2.2: Some states had implemented specific processes for determining whether to make telehealth flexibilities permanent or roll them back
	2.3: States also shared general principles that guided their decisionmaking
	2.4: States did not have peer-reviewed evidence to support policymaking and instead primarily relied on stakeholder input to guide decisionmaking
	2.5: States used a variety of resources to guide their decisionmaking around telehealth policy
3: States’ future plans for telehealth	3.1: As of summer 2022, states were not planning major additional changes to telehealth policy but were making minor adjustments and monitoring telehealth utilization to inform future decisions
	3.2: Although states shared concerns about fraud, waste, and abuse resulting from telehealth, none had identified significant levels to date
	3.3: Few state Medicaid agencies had evaluated the impacts of telehealth beyond reporting utilization, but most had plans to do so
4: Challenges and lessons learned	4.1: States experienced challenges in developing Medicaid telehealth policies because of the many different authorities involved
	4.2: States described challenges with their data that have affected how they have been able to understand the impact of their telehealth policies
	4.3: States called for more studies to guide their telehealth policy decisions
	4.4:State Medicaid representatives also shared the need for additional guidance on telehealth policy from the federal government
	4.5: Lesson learned: Constant communication and transparency between Medicaid agencies and stakeholders are vital
	4.6: Lesson learned: Building partnerships, even before the emergency, is key

Opportunities

At the beginning of the COVID-19 PHE, state Medicaid programs allowed substantial flexibilities to telehealth coverage policies, including allowing audio-only telehealth and expanding the types of reimbursable telehealth services. In our discussions with state Medicaid representatives, we identified the following potential opportunities for future action:

Policymakers need more peer-reviewed evidence regarding the quality, appropriateness, and effectiveness of telehealth to guide their decisionmaking.

State Medicaid representatives we interviewed corroborated our literature scan findings that they were not able to draw on rigorous evaluations of the costs, quality, or effectiveness of telehealth in their decisionmaking processes, either when implementing telehealth flexibilities or in deciding to make them permanent or roll them back. Instead, they relied on clinical guidance, national standards, coding guidelines, and stakeholder input. In particular, there is a need for scientific evidence for the effectiveness of audio-only telehealth modalities, virtual therapy, and virtual administration of assessments to qualify for specific services. Many such services that lack rigorous evidence for effectiveness are currently allowed under permanent state Medicaid policies, generally in the interest of health equity for vulnerable populations. However, states also shared plans to regularly review their telehealth policies and hoped to use ongoing data to better understand utilization and effectiveness.

Telehealth delivery for behavioral health services will likely continue to be popular following the end of the PHE, so research into best practices is needed.

Telehealth delivery for behavioral health services remains popular, even as patients return to in-person care for other types of services. Our literature scan found that in many states, audio-only telehealth delivery was made permanent only for behavioral health services, and Medicaid provider, patient, and payer perspectives repeatedly cited behavioral health as an area in which telehealth was particularly useful in improving and maintaining access to care. However, research is still needed on the effectiveness of audio-only telehealth compared with in-person or audio-visual telehealth.

When legislating telehealth policy, communication with state Medicaid offices is vital to ensure sound policymaking.

State Medicaid representatives noted the importance of engaging in discussions with their states' legislatures about changes to telehealth policy and ensuring that state Medicaid agencies have sufficient time to prepare for legislated changes to policy. This is also true for federal policymakers. Although states have discretion over their Medicaid policies within the framework of federal laws and regulations, we found that state Medicaid agencies still regularly sought guidance and direction from federal policies during the pandemic, especially those from Medicare.

State Medicaid offices and frontline providers would benefit from greater clarity regarding the future of federal telehealth policy flexibilities.

State Medicaid offices accept that they will likely need to make additional changes to their telehealth policies once final decisions are made on the remaining federal telehealth flexibilities.

However, the sooner federal policymakers are able to share insights into the decisionmaking process, including timelines and likely future directions, the better state agencies and frontline providers will be able to prepare.

State Medicaid processes for reviewing telehealth flexibilities may be instructive for others.

Several states described specific processes for reviewing their telehealth flexibilities and deciding whether they should be made permanent or not. Other states, and potentially even federal policymakers looking toward the future of telehealth policy, may gain insight from these experiences and processes that have already been implemented.

Implementation of best practices for data requirements in the context of telehealth would support better understanding of the impacts of telehealth.

Data regarding telehealth utilization, particularly audio-only utilization, remain suboptimal. Some states reported delays in implementing audio-only modifier codes and inconsistent use of the audio-only modifier codes by providers. The Centers for Medicare and Medicaid Services' (CMS's) Final Rule provided guidance for use of the audio-only modality for Medicare in certain situations (e.g., mental health services and counseling in Opioid Treatment Programs) (CMS, 2021a). Additional detail to state Medicaid programs on using audio-only modifiers in other specific scenarios would be useful. It may be useful to develop and disseminate best practices for documenting these important elements of telehealth in order to ensure high-quality data to better understand the impact of telehealth.

Conclusion

It is clear, from the perspectives of state Medicaid representatives we interviewed for this study, that the future of health care following the PHE will continue to include telehealth in some capacity. Although the specifics of permanent telehealth policies may continue to change and evolve, telehealth overall seems to be another tool that can be used to provide patient care. Some services, such as audio-only telehealth, although lacking rigorous scientific evidence on effectiveness at this time, remain vital at the moment to preserve access to care, with the hope that evidence will accumulate over time to guide their use. The experiences and lessons learned from the state Medicaid representatives in this study can be instructive to other state and federal policymakers considering how to transition to the next stage of telehealth. More work and more time are needed, particularly at the national level, to understand many aspects of telehealth outcomes that will support the crafting of future telehealth policies.

Contents

Appendixes B and C are available as Excel files.

Figures and Tables

Figures

Tables

Chapter 1. Introduction

Background

The coronavirus disease 2019 (COVID-19) pandemic resulted in multiple and prolonged disruptions to the U.S. health care system. In response to nationwide stay-at-home orders, new policies, as well as new flexibilities for existing policies, were introduced to encourage telehealth expansion and adoption by both patients and providers as a means for ensuring that needed health care continued to be delivered during the federal public health emergency (PHE). In-person visits decreased dramatically at the beginning of the PHE, followed by a rapid increase in telehealth visits, with telehealth visits provided by the four largest U.S. telehealth providers increasing 154 percent in January–March 2020 compared with the same time period in 2019 (Koonin et al., 2020). Since that time, in-person visits gradually increased as COVID-19 infection rates gradually decreased, though increases have been heterogeneous across location and specialty (Drake et al., 2021; Anderson et al., 2021). While telehealth visits tended to decrease somewhat as the PHE progressed, they remained significantly elevated from pre-PHE levels (Anderson et al., 2021; Demeke et al., 2021; Chu et al., 2021).

A wide range of policies were introduced or adopted during the PHE at the federal level, including waivers to state Medicaid programs from the Centers for Medicare and Medicaid Services (CMS) allowing flexibilities in the patient and provider's locations when engaging in telehealth, permitting different types of providers to bill for telehealth services, allowing payment for services previously not billable when delivered via telehealth, and allowing payment for audio-only services (U.S. Government Accountability Office, 2021b). Medicaid operates under federal guidance and regulations from CMS related to the implementation of federal laws related to Medicaid. However, this federal guidance is generally broad, and state Medicaid authorities have flexibility in designing and administering their own programs. For instance, although federal rules require coverage for certain services, many may cover additional services, resulting in great variation across state Medicaid programs. At the beginning of the PHE, many states requested waivers for requirements such as prior authorization and allowing telehealth provision across state lines (without state-specific licensure requirements).

State Medicaid programs also made several changes to telehealth coverage policies during the PHE, as detailed in a 2021 Assistant Secretary of Planning and Evaluation (ASPE) report (Chu et al., 2021). Prior to the PHE, no state Medicaid programs covered audio-only visits, but by May 2020, all state Medicaid agencies covered audio-only visits (Chu et al., 2021; Volk et al., 2021). State Medicaid programs also significantly expanded the types of telehealth services they reimbursed, though there was variation by state in which types of services were reimbursed. For example, from 2019 to May 2020, the number of state Medicaid agencies covering telehealth

services for physical, occupational, and speech therapy expanded from 16 to 49 states (Chu et al., 2021). Coverage for telehealth maternity services expanded to a lesser extent, from 15 to 31 states (Chu et al., 2021). Prior to the PHE, 30 state Medicaid agencies covered remote patient monitoring (Chu et al., 2021). By May 2020, 37 states covered remote patient monitoring (Chu et al., 2021). Another modality highly relevant to specialties such as dermatology and radiology is "store-and-forward" telehealth, in which providers asynchronously review messages from or images of a patient and then provide a diagnosis or medical advice. Prior to the PHE, only 18 state Medicaid agencies covered store-and-forward telehealth. This number rose to 29 by May 2020 (Chu et al., 2021).

The PHE flexibilities and new policies were designed to ensure that needed health care continued to be delivered during the PHE. Although some policies were enacted at the federal level, each state had its own context in which state Medicaid policies were being developed. Understanding those contexts and the processes, supports, and challenges in decisionmaking around Medicaid telehealth policy is important because Medicaid policy pertains to the care of the most vulnerable patients.

We know from prior work examining telehealth utilization covered by multiple payers that there are important health equity considerations in assessing telehealth-related policies. For instance, one study of a large health system before and after the PHE found that the audio-only modality was more frequently used by older, rural, and low-income patients (Drake et al., 2021). There are also important differences by race/ethnicity and primary language. One study of telemedicine visits at an urban safety-net primary care practice found that, early in the PHE, Black, Hispanic, and Asian/Pacific Islander patients were less likely to use services delivered by telehealth as compared to non-Hispanic White patients (Nouri et al., 2020). Studies have also reported that Spanish-speaking patients and Black patients were less likely to use services delivered by telehealth overall and, when they did, were more likely to use telehealth for urgent care (Chunara et al., 2021). Finally, several studies have reported lower rates of telehealth use among those for whom English was not their primary language (Chen, Andoh, and Nwanyanwu, 2021; Haynes et al., 2021; Rodriguez et al., 2021).

Beyond reviewing descriptive analyses of telehealth utilization across payers in relation to various stages of the PHE, it is also important to better characterize the underlying data and motivations for current Medicaid telehealth-related policies. This project aimed to inform policymakers' understanding of state experiences to date with COVID-19 telehealth policy flexibilities, their next steps regarding Medicaid telehealth coverage policies, why states are making certain decisions, and with what data and support. This is important because, as of summer 2022, less than two-thirds of states have made permanent decisions regarding whether to roll back or make permanent the Medicaid telehealth policy flexibilities that were enacted during the COVID-19 public health emergency. The experiences and insights of states that have already made such decisions will provide valuable insights to federal and state policymakers.

Context and Terminology

The COVID-19 pandemic, first declared by the World Health Organization in March 2020 (Cucinotta and Vanelli, 2020), is the backdrop for this report. However, because our focus is on domestic policies and flexibilities related to telehealth, and many were tied to the PHE (U.S. Department of Health and Human Services [HHS], Health Resources and Services Administration, 2021), we frame the project around the federal COVID-19 PHE that was initially signed on January 31, 2020, with an effective date of January 27, 2020 (HHS, Office of the Assistant Secretary for Preparedness and Response, 2020). The federal PHE must be renewed by the Secretary of HHS every 90 days, and as of the writing of this report in summer 2022, was set to expire on May 11, 2023 (HHS, Office of the Assistant Secretary for Preparedness and Response, undated). All 50 states and the District of Columbia also declared their own public health emergency orders related to the COVID-19 pandemic (National Academy for State Health Policy, 2022). At the time this report was finalized in May 2023, over three-quarters of states had allowed their emergency orders to expire, while other states have extended their emergency orders (National Academy for State Health Policy, 2022).

Extant research shows that, early in the COVID-19 PHE, every state implemented new Medicaid telehealth policies and/or flexibilities to existing policies (Libersky et al., 2020). As the COVID-19 pandemic continues to evolve, states have made ongoing changes, including making some of those policies permanent and rescinding other policies or allowing them to expire.

We focused specifically on Medicaid telehealth policies. Broadly defined, *telehealth* is any clinical consultation delivered in real time, either by audio alone or by video and audio, using any platform (e.g., landline phone, mobile phone, desktop computer, laptop computer, tablet device) or through asynchronous messaging or data transfer. While *telehealth* is sometimes broadly used to refer to an even wider range of activities, such as services including provider training, administrative meetings, and continuing medical education, we primarily focus on delivering clinical services directly to patients, also referred to as provider-to-patient *telemedicine*.

Finally, we noted where policies specifically pertained to behavioral health care, defined here as treatment for mental health or substance use disorders. While the term *behavioral health* was frequently used in the policies we reviewed and in our discussions with state Medicaid representatives, we note that medication-based treatment of substance use disorders is sometimes considered under separate policies, which are detailed in Appendix B.

Project Purpose

For this study, our goals were to

- catalog changes to state Medicaid telehealth policy flexibilities and/or new policies initially enacted during the COVID-19 PHE. We targeted flexibilities or new policies that have been rolled back and those made permanent in part or in whole.

- better understand the decisionmaking process behind these Medicaid telehealth policy changes:
  - reasons states adopted more-expansive telehealth policies or pulled back on Medicaid telehealth flexibilities
  - data used to inform policy decisions
  - whether (and which) stakeholders' were involved or consulted during the decisionmaking process
  - how COVID-19 influenced state actions
  - challenges states faced with telehealth policy decisions
  - lessons learned for other states contemplating similar policy decisions.

Approach

We conducted a focused literature scan to identify policy changes and lay the groundwork for our investigation of the remaining questions using a variety of qualitative data collection methods. In Chapter 2, we describe the methods and findings for the literature scan. In Chapter 3, we describe the methods for selecting, recruiting, and conducting our guided discussions. In Chapter 4, we present key themes and findings from those discussions. Finally, in Chapter 5, we present opportunities for future action.

Chapter 2. Literature Scan

Introduction

The objectives of this focused review of the literature were to

1. inventory Medicaid telehealth policies or flexibilities made during the PHE that have been either rolled back or made permanent. For each policy rolled back or made permanent, we also sought to identify the related flexibility or new policy introduced during the PHE, and the relevant prepandemic policy. Temporary policies still in effect at the time of data collection were not considered.
2. identify stakeholder experiences, challenges, successes, and satisfaction with Medicaid telehealth policy changes during the PHE.
3. identify evaluations and studies of state telehealth policies during the PHE and the impacts on access to care, utilization, and state expenditures, where such information was available.
4. identify any available evidence or justifications cited to support state decisions to change their COVID-19 related Medicaid telehealth coverage policies.

For the purposes of this report, a policy was considered "made permanent" if it was included in new legislation or regulations or when guidance documents explicitly noted that a given change was permanent, without an expiration date. A policy was considered "rolled back" if there was a notice of the policy being rescinded, if a permanent policy superseding the temporary policy was released that no longer included the specific PHE flexibility, or when a temporary policy was allowed to expire. In some cases, fee-for-service Medicaid and managed care Medicaid within a state may have different telehealth policies. For the purposes of this report, when a policy change was made permanent or rolled back for either fee-for-service Medicaid or managed care Medicaid, we included the policy change and noted how the policy change differed by Medicaid type in Appendix B.

This review was conducted on a very short and defined timeline, between April 27, 2022, and May 16, 2022. Therefore, this review represents a snapshot of a point in time. Because state Medicaid policies regarding telehealth are constantly evolving, policy changes and literature documented following that time frame will not be captured here. However, we spoke with representatives from ten state Medicaid agencies between July 14, 2022, and September 2, 2022, allowing us to verify our search results for those states and confirm their accuracy. These ten states are identified in the following chapter, and Appendix B provides information on when policy information was abstracted and/or updated based on discussions.

Methods

The literature scan strategy involved three steps:

- review of existing telehealth policy compilations supplemented with reviews of original legislative documents, policy memos, and other documentation (primarily addressing Objective 1, above)
- review of academic, peer-reviewed literature (primarily addressing Objectives 2 and 3, above)
- review of gray literature including industry and trade publications and meeting records of state advisory committees on telehealth policy (primarily addressing Objective 4, above).

Review of Policy Compilations and Original Policy Sources

To inventory policy changes for all 50 states and the District of Columbia (hereafter "states"), we reviewed three existing compilations of telehealth policy changes, focusing on Medicaid policy changes since the start of the PHE. The first compilation we reviewed was from the Center for Connected Health Policy (CCHP), which compiles and regularly updates policy documentation on state-level telehealth policy changes. As of our search, conducted between April 27, 2022, and May 16, 2022, documentation was last updated between January and April 2022, depending on the specific state. The second compilation we reviewed was from the Medicaid and Children's Health Insurance Plan (CHIP) Payment and Access Commission (MACPAC) (Libersky et al., 2020). This report examined Medicaid telehealth policies just prior to the PHE and immediately following the beginning of the PHE (current as of May 1, 2020). It was primarily used to determine prepandemic policies and flexibilities put in place early in the PHE. The final policy compilation was from the Federation of State Medical Boards, which cataloged telehealth policy changes in response to COVID-19 and was most recently updated on May 4, 2022 (Federation of State Medical Boards, 2022).

Where possible, we cross-checked information from policy compilations against the original policy documentation referenced. However, the original documentation was not always retrievable due to broken uniform resource locators (URLs) or updated language on the existing URL that did not detail changes from prior versions. Much of the original documentation was drawn directly from state Medicaid agency websites that are regularly updated, and archived versions are often not made available. In these cases, dates and other information from the MACPAC policy compilation (Libersky et al., 2020) were used. We primarily used the original sources directly cited in these policy compilations, but we also included other original sources, such as provider bulletins and news briefs, as appropriate. For example, if a state policy cited in the CCHP website or the MACPAC report recently expired, or the original link to the policy no longer worked, we separately searched for updates to the policy using a Google web search. We also searched for earlier versions of policies, where appropriate, to determine how the policy changed from pre-PHE or early PHE versions.

We note that the information about PHE policies and subsequent changes was not always clear, due to the limitations described above. In some cases, different sources cited conflicting information regarding whether a PHE policy was still active or had been rolled back. In other cases, it was not clear how recent policy changes differed from prepandemic policy. In such

instances, we made assumptions based on available information and have documented those assumptions (with relevant citations) in Appendix B.

For each state, we categorized changes to Medicaid telehealth policies into a specific policy type, as described below. In some instances, a single regulation covered multiple different types of policies. Where that occurred, we documented each different policy type separately to maintain a count of the number of different policy types. We utilized the following categorization of policy types:

- **Delivery requirements.** These types of policies relate to where care is provided (i.e., distant site) or is received (i.e., originating site), allowing out-of-state providers, any restrictions to the platform on which telehealth is delivered or received (e.g., Health Insurance Portability and Accountability Act [HIPAA] requirements), and patient consent requirements needed to deliver services via telehealth.
- **Modality.** This policy type relates to allowable modalities for telehealth, including live video, store and forward (in which data from the patient are sent to a provider, who sends back diagnostic results or treatment advice, often asynchronously), remote patient monitoring (e.g., using tools such as pulse oximeters or blood glucose meters to record personal health data that is reviewed by a provider in a separate location), audio-only (i.e., telephone or other synchronous live voice communication without video), and text-based communications (such as text messages and email).
- **Service type.** This policy type describes the types of services that may be billed for when delivered through telehealth, including primary care, behavioral health care, maternity care, physical/occupational/speech therapies, dental care, long-term services or supports, patient education, and telepharmacy. This also includes limitations to the patient type (i.e., established versus new patient).
- **Provider type.** This policy type pertains to the types of providers allowed to bill for services delivered through telehealth including medical doctors, nurse practitioners, physician assistants, other advanced practice providers, pharmacists, behavioral health providers, and dental providers.
- **Payment policies.** These policies detail provider payments and patient financial responsibilities (e.g., co-payments, coinsurance) related to telehealth. This includes payment parity, which means reimbursing telehealth services at the same rate as in-person services.

We also categorized policies as either rolled back (including policies that were allowed to expire) or made permanent. In some cases, a policy type included parts that were both made permanent and rolled back (e.g., Tennessee made coverage of behavioral health services delivered via audio-only telehealth permanent but allowed coverage of other types of services delivered via audio-only telehealth to expire). In these cases, the rescinded portion and permanent portion of each policy type were treated as separate entries in Appendix B and in subsequent analyses.

While the primary goal of this review was to create the policy inventory described in Objective 1 above, where information was available, we also noted rationales for policy changes provided in the text and included these rationales in our discussion of Objective 4.

Academic Literature Review

We conducted a structured search of academic literature using the PubMed database. The purpose of this search was to meet Objectives 2 and 3 of the literature scan to identify stakeholder experiences and evaluations of state Medicaid telehealth policies during the PHE. Search terms used are presented in Table 2.1. A full list of search terms can be found in Appendix A. We searched for articles that included both

- at least one term from the COVID-19, telehealth, Medicaid, and policy categories in the title or abstract or as a Medical Subject Heading (MeSH), where applicable
- at least one stakeholder experiences or evaluation term.

Table 2.1. Search Term Categories

Category	Search Terms
COVID-19	COVID*, Coronavirus, "corona virus", SARS-CoV-2, "2019-nCOV", "nCOV-19", "COVID-19"a, "SARS-CoV-2"a, "COVID-19 Testing"[a]
Telehealth	Telehealth, telemedicine,[a] "tele health", "tele medicine", mhealth, "m health", ehealth, "e health", telecare, "digital health", "mobile health", "virtual care", "virtual health", "remote consultation*", "tele consult*", eConsult*, teleconsult*, "telepharmacy", "telemental health"
Medicaid	Medicaid[a,b]
Policy	Policy, policies, law, laws, flexibility, flexibilities, guidance, waiver, requirement
Stakeholder experiences	Survey*, interview*, focus group*, questionnaire*, feedback, challenge*, success*, satisfaction
Evaluation	Access, utilization, expenditures, quality, evaluation
Committee	"committee", "task force", "advisory"

[a] Indicates MeSH term
[b] State-specific Medicaid program names were also included (American Council on Aging, 2021).

We conducted a title and abstract screen to determine whether articles met both of the following criteria:

- addressed telehealth policy changes during the COVID-19 PHE
- discussed a Medicaid-specific policy, discussed considerations for Medicaid populations, used Medicaid data for evaluations, or provided perspectives of Medicaid involved stakeholders (e.g., Medicaid recipients, state Medicaid agency representatives, providers who bill Medicaid).

Included articles were coded as "stakeholder experiences" if they identified stakeholder experiences, challenges, successes, and satisfaction with Medicaid telehealth policy changes during the PHE and/or "evaluation" if they identified evaluations and studies of state telehealth policies during the PHE and the impacts on access to care, utilization, or state expenditures. For each study, we also noted where important health equity issues were noted. For example, we noted whether the article discussed differential telehealth utilization or quality of care between

Medicaid and non-Medicaid beneficiaries, different racial or ethnic groups, or between rural and urban or suburban areas.

Gray Literature Review

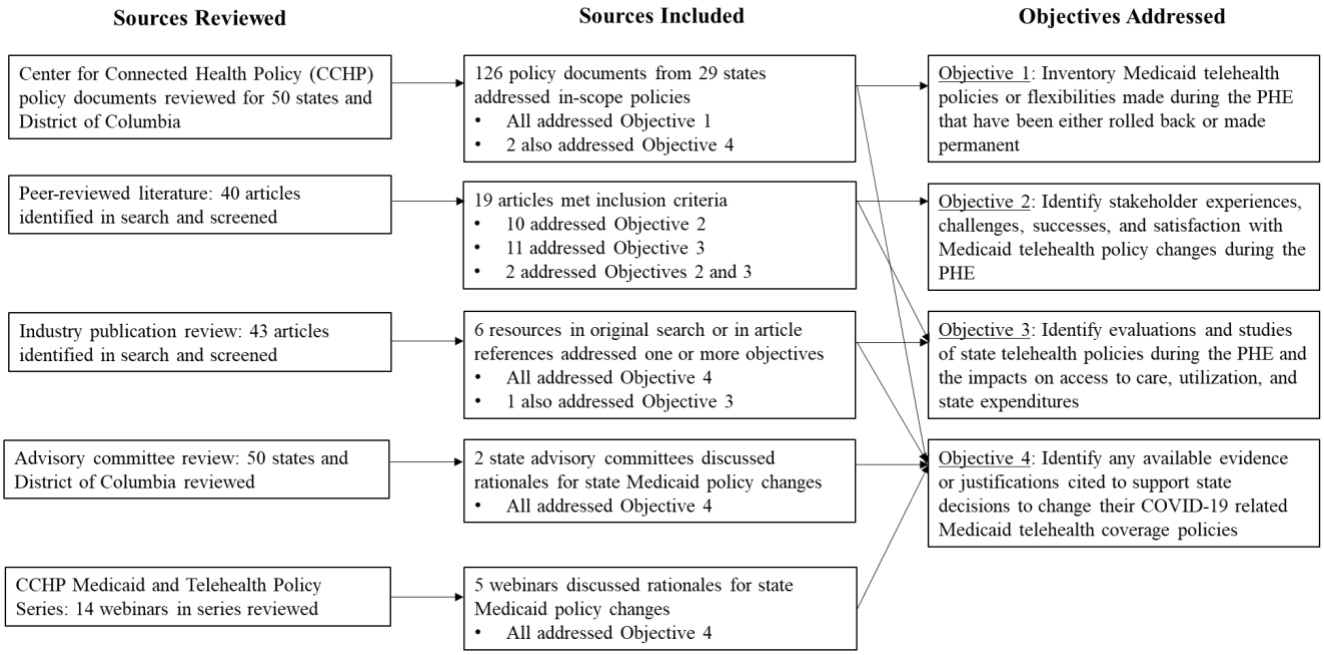
We searched Business Source Complete for insurer and other industry-focused publications to identify cited reasons for rolling back policies or making them permanent. Articles were included if they contained at least one term from each of the following categories anywhere in the record: COVID-19, telehealth, Medicaid, and policy term (as described in Table 2.1). We also used targeted Google searches to look for telehealth advisory committee meeting records for each of the states identified as having a policy rolled back or made permanent during our review of policy compilations and original sources. We searched for each state name in combination with at least one telehealth term, one Medicaid term, and one committee term (as described in Table 2.1) and reviewed the first page of results for each search. Finally, we reviewed meeting minutes and reports generated by the committees to look for justifications for rolling back or making permanent Medicaid telehealth policies.

While this review was primarily conducted to address Objective 4 above (to identify evidence cited to support state decision to change telehealth coverage policies), we also noted where articles addressed other objectives.

Findings

We describe the findings of our literature scan in three parts. First, we provide a summary of the results from our efforts to catalog changes to Medicaid telehealth policies. (In Appendix B, we provide details, by state, for those Medicaid telehealth policy changes.) Next, we present findings from our review of the academic literature documenting stakeholder experiences with Medicaid telehealth policy changes and evaluations of state telehealth policies in the Medicaid population. In the final section of this chapter, we discuss evidence and justifications supporting state policy decisions during the PHE. The number and types of sources reviewed and included for each of the four previously defined objectives are summarized in Figure 2.1.

Figure 2.1. Literature Scan Summary



Cataloging Changes to Medicaid Telehealth Policies

We identified 50 policies made during the PHE (representing 25 states) that have become permanent and 27 policies (representing 15 states) that have been rolled back (Table 2.2). Eleven states had both policies that had been rescinded and policies that had been made permanent. In total, 29 states had some type of policy change following telehealth flexibilities or new policies in response to the PHE.

Table 2.2. Number of Policies Rescinded or Made Permanent by Policy Type

Policy Type	Rolled Back (N)	Made Permanent (N)
Delivery requirements	14	13
Modalities	6	19
Service type	6	10
Provider type	1	5
Payment policies	0	3
Total	**27**	**50**

In Appendix B, we provide a complete list of policies made permanent and rolled back, including details for each such policy. The appendix can be filtered to show only a specific policy type (e.g., delivery requirements, modality, etc.) or a specific policy action (e.g., rolled back versus made permanent) so that it is easy to identify which states made changes to which

types of policies. We have also provided the date that we abstracted each policy to provide further context as the policy landscape continues to evolve. Below, we summarize some of the findings by policy type.

Modalities

Among the policy types reviewed, those expanding coverage for additional telehealth modalities (e.g., expanded coverage to audio-only telehealth or remote patient monitoring) were most frequently made permanent—by 19 states. Most of the policies that were made permanent in this category involved expanding coverage to include services delivered via audio-only telehealth, though some policy changes also included expanding coverage for store-and-forward or remote patient monitoring. Six states rolled back policies involving modalities. Some states only made audio-only delivery permanent for behavioral health services, while audio-only delivery for other types of services was rolled back or allowed only on a temporary basis during the PHE.

Delivery Requirements

Policies that regulated delivery requirements (e.g., expanding allowable sites for delivering or receiving telehealth services or allowing use of non-HIPAA-compliant platforms) were made permanent by 13 states. This most commonly involved allowing expanding originating sites to include sites such as the patient's home. Policies of the "delivery requirements" type were also rolled back by 14 states. This most commonly involved rolling back the flexibility to use non-HIPAA-compliant platforms to deliver telehealth services, noting that they would again begin enforcing requirements to use secure platforms. This flexibility was first provided at the federal level by the Office of Civil Rights (OCR), which used its enforcement discretion to suspend penalties for using non-HIPAA-compliant technology during the PHE (HHS, 2021). While this flexibility is still in effect at the federal level, some states have noted that they will again begin enforcing penalties at the state level.

Service Type

Ten states made policies related to types of services (e.g., behavioral health, physical therapy, maternity services) that could be delivered via telehealth permanent, while six states rolled back these types of policies. Policies allowing initial patient visits via telehealth (as opposed to only allowing telehealth visits with established patients) were often made permanent. Coverage of behavioral health services was also made permanent by several states. In contrast, policies that were rolled back in this category commonly meant that some types of services were no longer covered by Medicaid for telehealth delivery (e.g., physical therapy, teledentistry).

Provider Type

Five provider type policies were made permanent and generally involved expanding the types of providers that could provide telehealth. For example, Wisconsin allowed "all mental health

and substance abuse providers" to provide services via telehealth (Wisconsin Department of Health Services, 2020). In Ohio, providers such as home health and hospice aides and private duty registered nurses were permanently allowed to provide services via telehealth (Bricker and Eckler LLP, 2020). The only policy of this type that was rolled back was in Arkansas, where development therapists were temporarily allowed to deliver services via telehealth before the policy was rescinded (Arkansas Department of Human Services and Division of Medical Services, 2021).

Payment

Three payment policies were made permanent and generally involved establishing payment parity between telehealth and in-person services for services delivered via telehealth. For all three of these policies, no differences in payment rates were permitted between services delivered through audio-video or audio-only modalities in situations where both modalities were covered. No policies of this type were rolled back.

Stakeholder Experiences and Evaluations

Our search of the academic literature yielded 40 articles. Of these 40 articles, 19 met inclusion criteria: Eight were coded as stakeholder experiences, nine were coded as evaluation, and two were coded as both. One additional report from the HHS Office of Inspector General (OIG) was identified through the review of industry and trade publications that described state-initiated evaluations of Medicaid telehealth policies (HHS OIG, 2021).

Stakeholder Experiences

Most articles on stakeholder perspectives were from Medicaid providers, though two focused on Medicaid patients' experiences with telehealth during the PHE, and the HHS OIG report focused on state Medicaid directors' experiences.

Provider Perspectives

We identified six provider-focused articles. The first provider-focused article described a survey, focus groups, and interviews with Medicaid-funded behavioral health providers in Louisiana, where, early in the PHE, legislation was passed to expand coverage of behavioral health services delivered via telehealth including using audio-only modalities (Singh et al., 2022). Common themes in provider discussions included appreciation of training on telehealth service delivery, difficulties with client technological access and acceptance of telehealth services, a need to be flexible in reaching patients through multiple modalities, and optimism that telehealth will be a useful component of behavioral health treatment for some patients in the future (Singh et al., 2022). Another article discussed the experience of providers and administrators with implementing telehealth during the PHE at New York City Health + Hospitals—the largest safety-net health care delivery system in the country—in which more than

70 percent of patients either had Medicaid or were uninsured (Lau et al., 2020). The authors noted that prior to the PHE they had "scant telehealth capabilities for behavioral health, limited by state restrictions and lack of Medicaid reimbursement" (Lau et al., 2020). They noted that policy changes at the local, state, and federal level allowed them to quickly expand their telehealth services, providing over 30,000 visits via telehealth in March and April, up from only a handful in February. They cited allowing audio-only telehealth and expanded Medicaid coverage and reimbursement as key reasons they were able to expand so quickly and that these flexibilities were especially important for a safety-net health system (Lau et al., 2020).

We also identified editorials from provider groups of various specialties, some of which specifically discussed Medicaid policy changes and considerations for treating Medicaid populations. For example, a position statement from the Society of Behavioral Medicine noted that it was already difficult to find psychiatrists that accepted Medicaid prior to the PHE due to low reimbursement rates (Bean et al., 2021). The authors also noted that Medicaid payment parity for behavioral health care delivered via telehealth and allowing out-of-state practice can help ease the provider shortage for Medicaid patients (Bean et al., 2021). Another editorial from doctors from an urban academic medical institution also discussed payment parity and out-of-state practice licensing for Medicaid providers (Kaundinya and Agrawal, 2022). The authors noted, "For Medicaid, states should all have the opportunity to participate in a telemedicine expansion that provides parity in coverage between telemedicine and corresponding in-person care"; they also advocated for "permanent interstate licensure waivers for telemedicine practice" (Kaundinya and Agrawal, 2022). As a potential model for Medicaid, the authors discussed the Veterans Affairs 2018 law that allowed telemedicine to be delivered across state lines. Two editorials from the Abortion Care Network (the national association for independent community-based, abortion care providers) discussed the importance of Medicaid coverage for telehealth consultation for medication abortions (Thompson, Price, and Carrión, 2021; Thompson, Northcraft, and Carrión, 2022). Thompson, Northcraft, and Carrión (2022) noted that the U.S. Food and Drug Administration's (FDA's) lifting of in-person requirements for prescribing mifepristone (a medication that induces abortion) in December 2021 had the potential to expand medication abortion access but that state Medicaid coverage of telehealth visits for consultation and follow-up were important to ensuring patients' safety.

Beneficiary Perspectives

Two articles discussed perspectives of Medicaid beneficiaries on using telehealth during the PHE. In the first study, the authors conducted interviews with Medicaid beneficiaries receiving treatment for substance use disorder (SUD) in New York City during the beginning of the PHE (Zhen-Duan et al., 2022). Patients reported easier access to buprenorphine to treat opioid use disorder during the PHE, and participants also appreciated one-on-one telehealth visits with providers, with one participant noting appreciation of forgoing the long commute to sessions. However, participants generally did not like group telehealth sessions because they felt that

people were "talking over each other" as compared to in-person sessions. Most study participants expressed a desire for telehealth delivery for SUD care to continue in some form beyond the end of the PHE (Zhen-Duan et al., 2022).

In another study, authors conducted interviews with patients with serious mental illnesses in the Washington, D.C., area, predominantly covered by Medicaid, on their perspectives using telehealth during the PHE (Benjenk et al., 2021). Most patients transitioned to telemental health during the PHE, and many were able to do so without significant difficulty, noting that they were able to do many things the same way during telehealth visits as they did in-person. Other patients cited serious difficulties with telemental health during the PHE, including lack of technology, perceived poorer visit quality, more distractions when doing visits, and lack of privacy (Benjenk et al., 2021).

State Medicaid Director Perspectives

Finally, an HHS OIG (2021) report that surveyed 37 state Medicaid agency directors in January–February 2020 on experiences regarding oversight of telehealth for behavioral health provided payer perspectives. Agency directors noted both perceived benefits and concerns with the rapid increase in telehealth use during the PHE. Seventeen state directors believed (though generally not based on formal evaluation) that telehealth increased access to behavioral health care and reduced wait time. One director noted, "Patients are getting care quicker, especially for behavioral health, where wait time [for in-person services] can exceed four to six months" (HHS OIG, 2021). Ten state directors noted concerns about the quality of care delivered through telehealth with one saying, "It can be challenging for providers to pick up on an enrollee's social, non-verbal cues . . . which could lead to misdiagnosis" (HHS OIG, 2021). Twenty-three states reported concerns of fraud, waste, and abuse and noted examples of providers "cold-calling" patients and subsequently billing for telehealth services or upcoding telehealth visits to indicate a higher level of care than was actually provided. Despite these concerns, at the time of the survey, only 11 states reported conducting monitoring and oversight for fraud, waste, and abuse related to telehealth (HHS OIG, 2021).

Evaluations of Telehealth

We identified several articles that evaluated aspects of telehealth use during the PHE. Most of the evaluation studies we identified examined differences in how Medicaid populations use telehealth as compared with those with other types of insurance. The studies examined a range of populations and service types. Overall, most studies found that Medicaid beneficiaries were less likely to use telehealth as compared to those with commercial insurance (Gilson et al., 2020; Lewis et al., 2022; Uscher-Pines et al., 2022). When Medicaid beneficiaries used telehealth, they were more likely to use audio-only (as opposed to audio-video) telehealth than those using telehealth with commercial insurance (Gilson et al., 2020; Chen et al., 2022). However, one article that examined telehealth use in the University of Wisconsin-Madison health system had

opposite findings: that patients with Medicaid were more likely to use telehealth and more likely to use video visits as compared to those with commercial insurance (Hsiao et al., 2021).

Other studies examined utilization and access of telehealth among Medicaid populations. One study looked at use of telehealth among children enrolled in Medicaid with sickle cell anemia (Reeves et al., 2022). Telehealth visits rose sharply for these patients during the pandemic but did not make up for the decreased volume of in-person visits (Reeves et al., 2022). Usually, patients participated in both telehealth and in-person visits (as opposed to just telehealth), and older children (age 6–17) were more likely to use telehealth as compared to younger children (age 1–5) (Reeves et al., 2022). Another study examined use of medication for opioid use disorder (MOUD) in a rural North Carolina health clinic where 37 percent of study participants had Medicaid as their primary insurance (Hughes et al., 2021). The study found that patients who lived farther from the clinic were more likely to have telehealth visits and that use of telehealth increased the clinic's catchment area. Another study examined factors influencing access to telehealth among patients at a primary care clinic in Indianapolis where just over half of participants had Medicaid coverage (Webber, McMillen, and Willis, 2021). Patients with Medicaid coverage were less likely to have a mobile phone, phone with data plans, and home internet as compared to patients with commercial insurance. The study noted that factors influencing telehealth access among Medicaid patients improved modestly from the pre-COVID-19 time period in 2019 to during the COVID-19 time period in 2020, with an increasing percentage of patients having a phone with data and having home internet. The study also asked patients about awareness and interest in video visits and found a large increase in both between the pre-PHE and PHE periods (Webber, McMillen, and Willis, 2021).

Another study surveyed Louisiana Medicaid providers of behavioral health services on their experiences maintaining continuity of care during the PHE (Singh et al., 2022). Overall, 85.3 percent of providers surveyed reported continuing to provide behavioral health services through various telemental health approaches, while 14.7 percent of providers surveyed reported discontinuing behavioral health services in the first four months of the initial March 2020 stay at home order. Nearly half of the providers surveyed reported losing behavioral health clients altogether during the PHE, though larger practices were more likely to report continue providing services via telehealth. The article also noted that 76.2 percent of respondents reported using only HIPAA-compliant platforms despite the OCR decision to not impose penalties for use of non-HIPAA compliant platforms during the PHE (Singh et al., 2022).

We did not find any peer-reviewed studies that rigorously examined changes in cost or quality associated with changes in Medicaid telehealth policy. However, the HHS OIG report did include some results of internal evaluations that states performed related to these topics (HHS OIG, 2021). Only two state Medicaid directors reported evaluating effects of increased telehealth usage on access or cost of telehealth in their state (HHS OIG, 2021), Those states found that telehealth increased access to behavioral health in rural areas and reduced costs through

emergency room avoidance and reduced transportation costs, though detailed methods and results were not provided in the OIG report (HHS OIG, 2021).

Rationales for Medicaid Telehealth Policy Changes

Industry Publications

We identified 43 articles in the search of the gray literature. While we did not find any articles providing justification or rationale for specific Medicaid telehealth policies made permanent or rolled back, two of these articles included some discussion or rationale of Medicaid policy changes more broadly. An additional four resources addressing this topic were identified through links or references in the articles identified in the search. We identified two state telehealth advisory committees that provided a rationale for rolling back or making permanent telehealth policies implemented during the PHE. We also identified two policies from our review of original policy documents that provided specific rationales for making policy changes.

One article noted that many state Medicaid agencies were looking to Medicare to model their telehealth policies, and a manager at Manatt Health noted that

> Medicare is often considered the pace car for telehealth and other healthcare policy. State Medicaid and other payers model their telehealth policy approaches off what Medicare does. Changes to the Medicare program have a ripple effect through the rest of the healthcare coverage landscape. (Annaswamy, Verduzco-Gutierrez, and Frieden, 2020).

Similarly, another article on proposed 2021 federal legislation noted the role of the federal government in decisions on state Medicaid telehealth policies (Office of Tom Carper, 2021). The proposed federal legislation, known as the Telehealth Improvement for Kids' Essential Services Act or "TIKES Act," "would provide guidance and strategies to states on how to effectively integrate telehealth into their Medicaid and CHIP programs and take a comprehensive look at how telehealth impacts health care access, utilization, cost, and outcomes" (Office of Tom Carper, 2021).

One article discussed comments from Xavier Becerra, the Secretary of HHS, on what state Medicaid agencies and other insurers should consider when weighing new telehealth policies (Landi, 2021). In response to permanently allowing out of state licensed doctors to provide care he said,

> The farther you go away from the direct connection from patient and provider, the more difficult it will be to provide accountability quickly and fairly for the patient. If your doctor is 30 miles away and you live in rural America, we can track down that doctor, but if your doctor is 3,000 miles away, that's a tougher sell for a consumer who is trying to get accountability for a service that was not properly provided. (Landi, 2021)

We also noted two resources developed to help state Medicaid agencies determine whether to make permanent or roll-back telehealth flexibilities. The first resource was the previously

mentioned HS OIG report, which provides several recommendations for states. The report noted that states should conduct evaluations on telehealth use, access, quality, and cost. It noted that few states have taken steps to do this and that three of the 37 states could not determine which services were conducted via telehealth, making evaluation impossible). It also recommended that states investigate cases of fraud, overuse, and abuse and to evaluate whether certain policy changes appear to contribute to these cases (HHS OIG, 2021). The second resource we noted was a 2020 State Medicaid and CHIP Telehealth Toolkit from CMS, which lays out policy options and flexibilities for state Medicaid agencies (CMS, 2020b). The resource encourages policies to increase telehealth use but does not advocate for specific policies. A follow-on 2021 supplement includes detailed descriptions of relevant telehealth flexibilities and the uses and limitations of each (CMS, 2021c). It also includes a state Medicaid telehealth assessment/action plan template to help states decide which flexibilities to discontinue or make permanent and identify needed follow-up actions and affected stakeholders. While we did not find any documentation of states that used these resources to make policy decisions, we further explored in our stakeholder discussions.

State Telehealth Advisory Committees

Our review of state advisory committees identified two that addressed rationales for rolling back or making permanent specific policies. A report from Idaho's Telehealth Task Force expressed concern that allowing providers to communicate through non-HIPAA-compliant technology "may have negative impacts to patient privacy and security" (Idaho Department of Health and Welfare, 2020). While the report did not explicitly recommend rolling this policy back, it recommended a review of "best practices and patient safety" before any permanent policies were adopted. The Pennsylvania Office of Mental Health and Substance Abuse Services convened a steering committee and commissioned a report on the future of Medicaid telehealth flexibilities in Pennsylvania (Pennsylvania Department of Human Services and Mercer Government Human Services Consulting, 2020). This report recommended that allowing audio-only telehealth and the patient's home as an originating site be permanently adopted for behavioral health care. The report noted that these two policies are important for improving access to care for patients, though cautioned that providers should regularly check with patients to ensure that they are receiving care through appropriate channels and in locations that ensure patient privacy (Pennsylvania Department of Human Services and Mercer Government Human Services Consulting, 2020). Both of these policies were made permanent in Pennsylvania in September 2021 (Pennsylvania Department of Human Services, 2021).

CCHP Webinars

Our review of CCHP webinars identified five webinars that addressed rationales for rolling back or making permanent telehealth policies implemented during the PHE.

In a session on "Permanent Policies," Shannon Dowler, the Chief Medical Officer for North Carolina Medicaid, discussed North Carolina's rationales for making permanent several of the flexibilities that they implemented early in the PHE (CCHP, 2021e). Dowler noted that there was a fear early on that telemedicine visits would cost the agency money because they would lead to duplicate visits (a telehealth visit followed by an in-person visit) rather than act as a substitute for in-person visits (CCHP, 2021e). However, she noted that their internal analyses showed that this was not true and that follow-up visits within 14 days of an initial visit were actually slightly less likely when the visit was conducted via telehealth as compared to in-person (CCHP, 2021e). In another session on "Waivers and State Plan Amendments to Address COVID-19," Dowler noted that hospital use was also lower within 14 days of an initial visit if the visit was delivered through telehealth as opposed to in-person, and this was true even when stratifying by aged, blind, and disabled (ABD) eligibility status (CCHP, 2021a). These results made the agency more confident that increased coverage of telehealth services would not have negative financial impacts, and they may have influenced North Carolina's decision to make its PHE payment parity policy permanent.

In a third session on "Audio-only Policies," Mary Shelton, Director of Behavioral Health at Tennessee Medicaid, discussed Tennessee's decisions around coverage of audio-only telehealth. She noted frequent stakeholder meetings, particularly among state managed care organizations (MCOs), and also noted receiving feedback from members (CCHP, 2021d). She said that "initially, not all decisionmakers agreed with audio-only allowance" but that there was recognition from the Medicaid agency and from providers that audio-only was sometimes necessary to maintain a provider relationship when video was not available (CCHP, 2021d). She also noted that many members did not have broadband or smartphone access and that those who had smartphones often did not have enough data to support video visits (CCHP, 2021d). These reasons contributed to Tennessee passing a law during the PHE allowing coverage for audio-only behavioral health services when audio-video was not available (CCHP, 2021d). Tennessee Medicaid also provided guidance and a toolkit on how to structure audio-only visits and special considerations for its use (CCHP, 2021b).

In a fourth session on "Telehealth Policy for Mental and Behavioral Health," Clara Filice, the Deputy Chief Medical Officer of MassHealth in Massachusetts, discussed feedback from member surveys that showed high satisfaction with telehealth visits across different demographic groups, that members had a strong preference for audio-only services in some contexts, and that the majority of members said that they would like to use telehealth again in the future (CCHP, 2021c). She also noted that the evidence base around quality is still emerging and that there may be additional changes to Medicaid telehealth policy in the future.

Finally, in a session on "Provider Engagement & Education During the Public Health Emergency," Nicole Small from Ohio Medicaid noted that "Ohio Medicaid has received overwhelming support for its rapid expansion of telehealth services from both patients and

providers." Ohio made permanent several of its telehealth flexibilities allowed during the PHE and may have been influenced by this feedback (CCHP, 2021b).

Original Policy Documents

Finally, we noted when states provided justifications for rolling back or making permanent policy changes in the original policy documents. For example, a bulletin from Massachusetts Medicaid detailing Medicaid telehealth policy changes noted that its members "have voiced a clear desire for continued flexibility to access covered services in the manner best tailored to their needs" as justification for expanding services covered by Massachusetts Medicaid (MassHealth, 2021). In another example, Washington D.C., issued an emergency rule in March 2020 with temporary changes to Medicaid-reimbursable telehealth services and invited public comment on the proposed rule (District of Columbia Municipal Regulations and District of Columbia Register, 2021). Six out of seven commenters (representing provider professional associations, health care systems, a non-profit organization, and a consulting company) on the proposed rule endorsed making the patient's home a covered originating site a permanent change, and this was cited in the Department of Health Care Finance's rationale for making the change permanent (District of Columbia Municipal Regulations and District of Columbia Register, 2021). We also note that state practices around announcing policy flexibilities that were rolled back was variable. Some states posted official announcements, memos, or updates, while others passed permanent policies that replaced the flexibilities (either making them permanent or leaving them out), and still others allowed flexibilities to expire without making any apparent notice.

Summary

Medicaid telehealth policies are changing at a rapid pace. We found that 29 states have either rolled back or made permanent telehealth policy changes initially made during the PHE. The most frequent policy change we observed was making coverage of different modalities—such as audio-only, store and forward, and remote patient monitoring—permanent. The next most frequent policy change was making delivery requirement flexibilities permanent, such as expanding originating sites to include patients' homes.

We also noted a range of stakeholder perspectives from providers, patients, and state Medicaid agencies on their experiences with Medicaid telehealth policy changes. Providers generally expressed desire to maintain Medicaid coverage and payment parity for telehealth services. Medicaid patients appreciated the flexibility and convenience of telehealth, though in some cases noted concerns about receiving lower quality care. Medicaid directors typically echoed these patient perspectives, noting that telehealth policies improved access to patient care, while expressing concerns about quality of telehealth care and the potential for fraud, waste, and abuse.

While we noted several studies examining differences in telehealth use by payer type and patient demographics, there were no rigorous evaluations of the impact of Medicaid telehealth policies on cost and quality of care. This constitutes a major gap in the literature, because such evaluations are critical in helping states to decide the future of their Medicaid telehealth policies. Perhaps because such evaluations are lacking, we found limited information on evidence cited to justify rolling back or making permanent Medicaid telehealth policy changes made during the PHE. However, we did note legislators' and other stakeholders' rationales for advocating for various policy changes, as well as resources that states may use to inform their Medicaid telehealth policy decisions moving forward.

Chapter 3. Guided Discussions

The purpose of the guided discussions was to add additional context and nuance to findings from the literature scan, as well as to address some of the information gaps that remained, as described at the end of Chapter 2. Beyond simply understanding what changes were made to Medicaid telehealth policies, we also sought to better characterize the underlying data and motivations for those changes. Below, we describe the methods for our guided discussions, including how participants were selected and recruited, and present an overview of discussion participants.

Methods

Sample Frame

Our sampling frame consisted of the 29 unique states identified in the literature scan that made some type of change (e.g., made permanent or rolled back) to Medicaid telehealth flexibilities/new policies initially introduced during the PHE. We sought to recruit a diverse sample that would allow us to capture a range of perspectives across a variety of factors. Following discussion with ASPE, we identified important factors to consider in identifying a range of perspectives related to decisions about Medicaid telehealth policies. We selected the following factors on which to conduct our purposeful sampling:

- **Geographic distribution**, in which we categorized states into one of the four U.S. Census Regions: West, Midwest, Northeast, and South (U.S. Census Bureau, undated).
- **Telehealth utilization rates among Medicaid patients** were determined using two data snapshots from CMS, presenting data from the Transformed Medicaid Statistical Information System (T-MSIS) (Medicaid.gov, undated). Because telehealth utilization fluctuated throughout the PHE, we used data snapshots from two time points: January 1, 2020, through October 31, 2020, which includes data for the early PHE time period (CMS, 2020a), and March 1, 2020, through August 31, 2021, which runs from the early PHE time period well into the second year of the PHE (CMS, 2021b) (see Figure 3.1). The data snapshots presented telehealth utilization without numerical rates but rather in a map using five shades of color. Darker shades indicated higher rates of telehealth utilization, and lighter shades indicated lower rates. We categorized states with the lightest shading as low-utilization states, those with the second and middle lightest shading as medium-utilization states, and states with the two darkest shading as high-utilization states. At both time periods, most states had medium rates of telehealth utilization. To ensure a range of utilization for selection purposes, we documented utilization rates at both time points. If a state was classified as either high or low telehealth utilization at either point in time, for the purposes of selection, that is how we categorized them. Importantly, no states went from either extreme to the other (high to

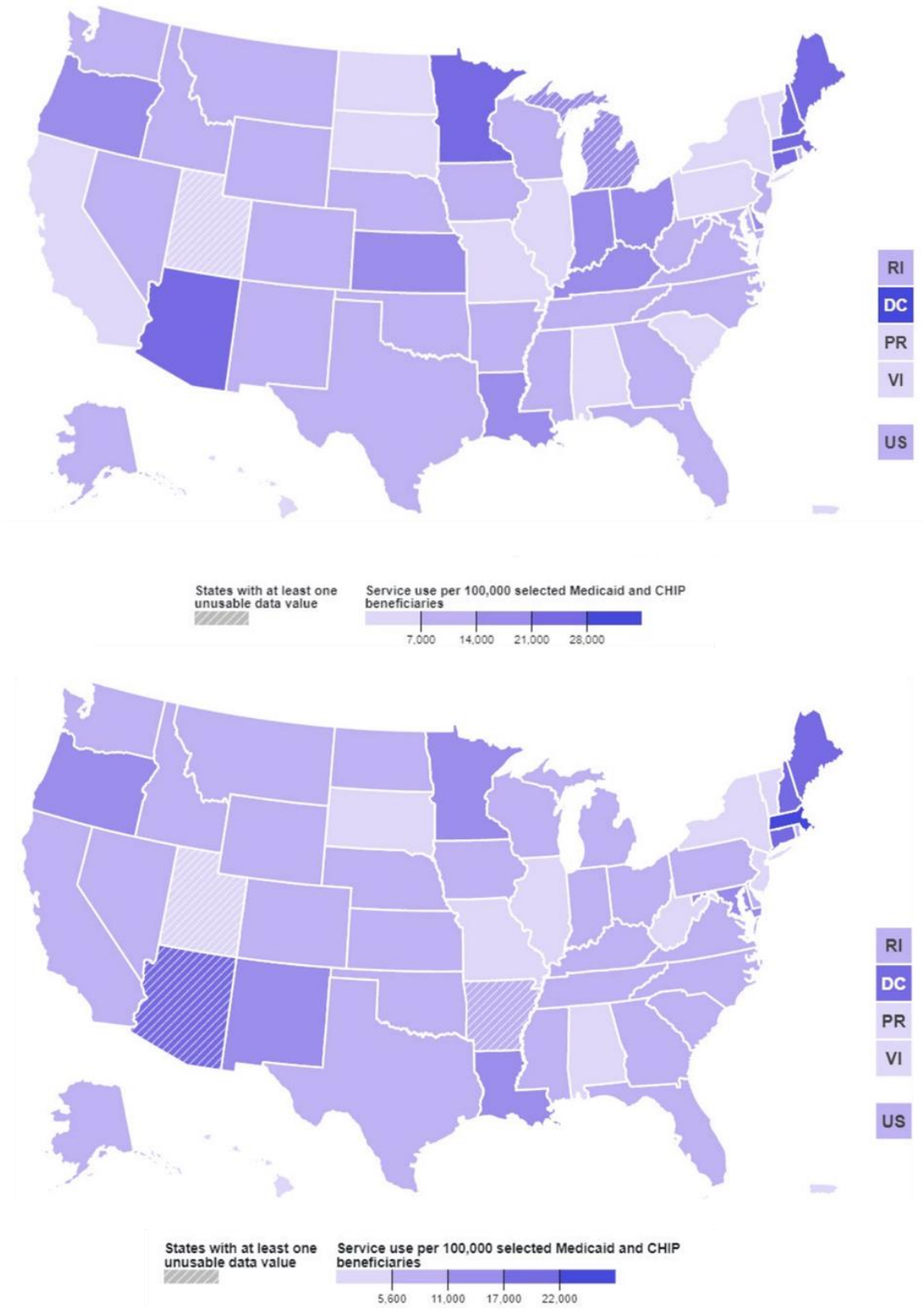
low or vice versa) between the two points in time. We also note that the T-MSIS data on which these data snapshots are based are subject to data lags, incomplete data, and inconsistent use of telehealth codes, as previously described (U.S. Government Accountability Office, 2021a).

- **Medicaid Expansion status** was determined using a data compilation from the Kaiser Family Foundation (Kaiser Family Foundation, 2022). States were categorized as having adopted Medicaid Expansion if they had adopted Medicaid Expansion wholesale as detailed in the Affordable Care Act (Pub. L. 111-148, 2010) or chose to expand Medicaid through a Section 1115 Waiver.

We also considered two contextual factors that we did not specifically select for but rather sought to ensure that our sample contained states representing a wide range of perspectives:

- **Population diversity**, as denoted by the U.S. Census Diversity Index (U.S. Census Bureau, 2021), defined as the chance that two people chosen at random from the state will be from different racial and ethnic groups
- **Rural population percentage**, using data from the U.S. Department of Agriculture (U.S. Department of Agriculture, 2022).

Figure 3.1 Snapshot of Telehealth Delivery During January 1, 2020–October 31, 2020 (top), and March 1, 2020–August 31, 2021 (bottom)



Appendix C lists each state in which Medicaid-related telehealth policies were either rolled back (including being allowed to expire) or made permanent in whole or in part. We indicated how each state was categorized across the factors of interest (geographic distribution, population diversity, telehealth utilization, and Medicaid Expansion status). With regard to the contextual factors (Diversity Index and percentage rural population), our sample ranged from a Diversity Index of 18.5 percent (Maine) to 67 percent (Texas), with an average Diversity Index of 46 percent. Finally, our proposed sample ranged from a rural population of 2 percent (Massachusetts) to 69 percent (Wyoming) with an average rural population of 29 percent.

Recruitment

We used Appendix C, along with findings from the literature scan, to inform our recruitment efforts. We sought a diverse group of states across geography, telehealth utilization, and Medicaid expansion while remaining mindful of general diversity, rurality, and whether policies were permanently adopted, rolled back, or both. We identified specific points of contact from state Medicaid websites and publicly available presentations on telehealth policy. All respondents worked in some capacity for state Medicaid agencies and included Medicaid Directors, Chief Medical Officers, managers of departments or projects related to telehealth policy, and staff involved in research and analysis of Medicaid telehealth data.

Following discussion with ASPE, we reached out to an initial group of Medicaid representatives from 13 states. Our general approach for recruitment was to reach out via email to potential guided discussion participants, with outreach attempts spaced approximately one week apart. Where we did not receive a response from a state within one week of our second outreach attempt, we reached out to Medicaid representatives from additional states with similar characteristics from Appendix C. In total, we contacted Medicaid representatives from 15 states and scheduled interviews with Medicaid representatives from ten states.

Discussion Guide Development

We developed three separate discussion guides based on what action states had taken with regards to Medicaid telehealth flexibilities during the PHE—one for states that had only rescinded their PHE flexibilities (or allowed them to expire), one for states that had only made their PHE flexibilities permanent, and one for states that had done both.

In Table 3.1, we provide an overview of the discussion guide topics—the topics for all three discussion guides were similar, with customization where appropriate based on literature scan findings. For instance, we had additional questions following the literature scan for some states' Medicaid representatives regarding whether and when a policy change was made. All discussion guides were developed in collaboration with ASPE staff. Questions were open-ended, allowing latitude for conversational discussions (e.g., exact wording, item sequencing, and use of probes) (Sofaer, 1999).

Table 3.1. Discussion Guide Topics

Topic
State experiences with policy flexibilities
Process for rescinding or making flexibility permanent
Facilitators and barriers
Data or other information used for decisionmaking
Health equity
Stakeholder experiences and input
Role of federal or other payer guidance in decisionmaking
Future plans
Evaluation(s)
Plans for other PHE flexibilities related to Medicaid telehealth
Lessons learned

Data Collection

All guided discussions were conducted virtually using the Zoom.gov web meeting application between July 14, 2022, and September 2, 2022. We provided an informed consent information sheet prior to each session and began each discussion by confirming participants had reviewed the information sheet and answering any participant questions. Each discussion was audio-recorded and professionally transcribed.

Data Analysis

Our multidisciplinary coding team included a physician, health services researchers, experts in qualitative methods, and policy analysts. We conducted cyclical coding (Saldaña, 2012), initially coding transcripts using a structure paralleling the discussion guides. Notes taken during the discussions highlighted early potential themes and were used in team meetings to further develop the codebook. As coding proceeded, team members suggested additional codes to capture relevant nuance and cycled back to ensure the codes were applied consistently to previously coded transcripts. We continued iterating on early potential themes utilizing well-established techniques, including repetition (e.g., if a concept was expressed more than three times) and emphasis (e.g., if respondents particularly engaged with or dedicated significant time to a concept). Team members maintained a running list of themes, making edits and consolidating themes when appropriate. We used Dedoose (SocioCultural Research Consultants) to manage data coding, retrieval, and analysis.

Findings

In total, we conducted guided discussions with 18 representatives from ten state Medicaid programs. Our sample had an average diversity index of 58 percent (range: 32.8 percent–67 percent) and an average rural population of 18 percent (range: 5 percent–41 percent). In Table 3.2, we summarize the states participating in the guided discussions. We also note that our guided discussions did not ultimately include a state that had only rolled back its telehealth flexibilities. We had initially recruited one such state based on findings from our literature scan. However, in the guided discussion we learned that state had actually both rolled back and made policies permanent. We did make multiple additional attempts to recruit at least one state that had only rolled back telehealth policies but were not successful. Although we did not recruit states to participate in guided discussions based on whether their state PHE had expired, we note that 7 participating states' PHEs were expired as of July 1, 2022, the date on which we began our recruitment efforts. This may provide additional nuance to readers for Chapter 4, in which we describe our qualitative findings in detail (National Academy for State Health Policy, 2022).

Table 3.2. Summary of States Participating in Guided Discussions

Policy Change		Geographic Region		Telehealth Utilization		Medicaid Expansion	
Permanent adoption	4	West	3	High	3	Adopted	7
Both	6	Midwest	1	Medium	4	Not Adopted	3
		South	5	Low	3		
		Northeast	1				

Chapter 4. Themes

We identified 18 themes from the guided discussions, organized into four domains, as shown in Table 4.1. Below, we provide more details on those themes with illustrative quotes. When the text below refers to the PHE, unless otherwise indicated, it refers to the federal PHE. However, for context, we note that as of July 1, 2022, when we began recruiting guided discussion participants, state PHEs had expired in seven out of the ten states we spoke with. In order to maintain participant confidentiality, we have not identified the specific states that we spoke with in our guided discussions. Rather, quotes are identified by the type of telehealth policy change implemented (i.e. made some telehealth policies permanent or made some telehealth policies permanent and rolled back others).

Table 4.1. Domains and Associated Themes

Domains	Themes
1: State attitudes and perspectives on telehealth and telehealth policies	1.1: The COVID-19 pandemic substantially sped up telehealth utilization and policy development
	1.2: Most state Medicaid representatives felt telehealth was "here to stay"
	1.3: Although COVID-19 played an important role in telehealth policy flexibilities, it did not seem to play a substantial role in determining permanent telehealth policies
	1.4: Reactions to expanding Medicaid telehealth flexibilities were generally more positive than rolling them back
2: State telehealth policy decisionmaking processes	2.1: State legislation influenced Medicaid policies in different ways
	2.2: Some states had implemented specific processes for determining whether to make telehealth flexibilities permanent or roll them back
	2.3: State Medicaid representatives also shared general principles that guided their decisionmaking
	2.4: State Medicaid representatives did not know of peer-reviewed evidence to support policymaking and instead primarily relied on stakeholder input to guide decisionmaking
	2.5: States used a variety of resources to guide their decisionmaking around telehealth policy
3: States' future plans for telehealth	3.1: As of summer 2022, states were not planning major additional changes to telehealth policy but were making minor adjustments and monitoring telehealth utilization to inform future decisions
	3.2: Although states shared concerns about fraud, waste, and abuse resulting from telehealth, none had identified significant levels to date
	3.3: Few state Medicaid agencies had evaluated the impacts of telehealth beyond reporting utilization, but most had plans to do so
4: Challenges and Lessons learned	4.1: States experienced challenges in developing Medicaid telehealth policies because of the many different authorities involved
	4.2: State Medicaid representatives described challenges with their data that have affected how they have been able to understand the impact of their telehealth policies

Domains	Themes
	4.3: State Medicaid representatives called for more studies to guide their telehealth policy decisions
	4.4: State Medicaid representatives also shared the need for additional guidance on telehealth policy from the federal government
	4.5: Lesson learned: Constant communication and transparency between Medicaid agencies and stakeholders are vital
	4.6: Lesson learned: Building partnerships, even before the emergency, is key

Domain 1: State Attitudes and Perspectives on Telehealth and Telehealth Policies

Although most states had minimal telehealth offerings through Medicaid prior to the PHE, a few states, particularly those with substantial rural or tribal populations, had at least developed a framework for more robust telehealth prior to the PHE and were able to lean on that framework to rapidly ramp up their telehealth capabilities in early 2020. Generally, the state Medicaid representatives we spoke with felt that telehealth was "here to stay" now that patients, providers, and payers had some time to experience it. However, there was variation in the degree to which they anticipated telehealth would be utilized in the future. While COVID-19 was cited as being the impetus for speeding up telehealth policy implementation and utilization, none of our respondents reported taking COVID-19 itself into consideration when planning for the future of telehealth.

Theme 1.1: The COVID-19 pandemic substantially sped up telehealth utilization and policy development

A few state Medicaid representatives reported making large-scale changes to Medicaid policy to allow for telehealth even prior to the PHE. In part this was due to significant numbers of rural and tribal Medicaid beneficiaries who needed telehealth to improve access to health care services. One representative from a state that permanently adopted some telehealth policies shared that they were able to parlay that experience to quickly expand their telehealth coverage policies in response to the PHE: "We were able to pivot very quickly because we had made . . . pretty significant changes back [in 2019]. . . . In March of 2020 . . . we went from about a dozen codes to close to 100 codes that we allowed coverage via audio-only."

Other states had made substantial inroads into planning for expanded telehealth prior to the PHE but had not yet implemented policy changes. Medicaid representatives from those states noted that their telehealth conversations were substantially sped up and expanded as a result of the pandemic. A representative from another state that had permanently adopted some telehealth policies told us:

> We'd been having two years' worth of conversation about what we do with this. But at the end of the day, it was just take the leap of faith. . . . The primary

> driving force was access to services, especially during this critical time. . . . If it hadn't been for the pandemic, we would have been at a much slower trajectory in expanding those services.

One representative from a state that had made some telehealth policies permanent and rolled back others described the vital need to help support providers and beneficiaries:

> [In] the beginning of the PHE we had to just get information out. We had to make quick decisions . . . to get something out to our providers and clients. . . . I do think that the public health emergency made it even easier. . . . We had to move to that so it forced it to happen much more quickly than it might have otherwise happened. I think it would have happened, but I'm not sure it would have happened so quickly and so comprehensively . . . to look at pretty much everything that you're doing and see if it can be done remotely.

In contrast, some states had only limited Medicaid coverage of telehealth and little telehealth infrastructure prior to the PHE. Even there, the pressing need to find a way to provide health care services to their beneficiaries and support health care providers initiated an avalanche of activity to implement telehealth policies and related supports such as billing codes. One representative from a state that had made some telehealth policies permanent and rolled back others said:

> We had no telehealth. . . . We had actually launched a workgroup three months before the pandemic . . . to do a telehealth modernization initiative . . . and we projected it would take us at least three years to modernize our telehealth . . . to get all the authorities we needed and the budget. . . . Instead, we did all that plus a whole lot more in six weeks.

A representative from another state that had made some telehealth policies permanent and rolled back others similarly shared: "Our response to COVID . . . was lickety-split, just within a couple of days of understanding what was going on."

Theme 1.2: Most state Medicaid representatives felt telehealth was "here to stay"

Most states that already had coverage of telehealth services to some degree prior to the PHE were confident that telehealth was now an accepted part of Medicaid policies. A representative from a state that had made some telehealth policies permanent told us: "I think folks know that telehealth is here to stay. . . . We've done that assessment around fiscal impact to our health plan around our updated policy as well as those flexibilities. And so there's not been any concerns."

Even states with relatively little telehealth use covered by Medicaid prior to the PHE perceived that telehealth would be another useful tool for healthcare delivery in the future. A representative from another state that had made some telehealth policies permanent said: "There's no intention for us to scale back on this. . . . We will continue to monitor. But we believe that it's a viable, useful tool that actually is helping to improve access."

In contrast, a representative from a state that had made some telehealth policies permanent and rolled back others was less sure about the degree to which telehealth would be utilized in the future now that in-person health care visits were readily available.

> We're looking at the trends on [telehealth]. . . . Somebody could call it just a blip. . . . I don't see how it [past telehealth utilization] helps us plan for 2023. . . . I'm going to the doctor. I'm taking my kids to the doctor. My kids go to their therapist in-person. . . . We can look at the data and go oh, hey, this is the way it was during COVID. . . . But it's not really a predictor for future service delivery.

Theme 1.3: Although COVID-19 played an important role in telehealth policy flexibilities, it did not seem to play a substantial role in determining permanent telehealth policies

When we asked state Medicaid representatives about how COVID-19 influenced their decisions on what telehealth flexibilities to make permanent and what to rescind, they most often defaulted to discussing how COVID-19 had influenced the initiation of the flexibilities at the beginning of the PHE. However, none of our respondents shared that COVID-19 had an impact on their discussions of their permanent telehealth policies. One representative from another state that had made some telehealth policies permanent and rolled back others summed up the general attitude across our respondents: "When we thought about what was permanent or not, we thought about it in the absence in a world with COVID."

Theme 1.4: Reactions to expanding Medicaid telehealth flexibilities were generally more positive than rolling them back

State Medicaid representatives reported that both patient and provider responses to both the telehealth policy flexibilities and resulting permanent policies were generally positive. Most state Medicaid representatives described little patient resistance to telehealth flexibilities that were rolled back, though a few respondents described provider complaints about some rolled back flexibilities.

As one representative from a state that had made some telehealth policies permanent described: "I think overall everyone was happy. Patients were happy, our members were happy, and then also our providers were happy with our quick response. So we heard nothing but accolades as far as our quick pivot to cover."

Similarly, a representative from a state that had made some telehealth policies permanent and rolled back others said: "Generally, everyone was grateful and appreciated that there was a way to provide care."

This representative from another state that had made some telehealth policies permanent and rolled back others described patient feedback to permanent policies allowing audio-only telehealth: "What we tend to hear is people want telephone options. They want the audio-only options to continue if possible."

Most respondents reported that rolling back PHE flexibilities, such as HIPAA compliance waivers, were met without resistance because providers never expected that those waivers would be permanent. However, one respondent from a state that had made some telehealth policies permanent and rolled back others noted that rolling back some telehealth billing codes that had

previously been allowed for some services under PHE flexibilities had garnered complaints from some providers:

> You're not going to make everybody happy. . . . You're going to have to put the genie back in the bottle. And so there's a lot of abrasion. . . . Until it happened, people didn't realize how vocal provider groups could get. People don't like things taken away from them, even if they weren't using it that much. So some of the most vocal people who were just furious that we were turning something off, when we looked at our data, they were hardly using it at all. . . . Even though we said over and over again these are temporary, these are temporary, people seemed surprised when we turned them off, and it created a tremendous amount of abrasion.

One Medicaid representative from had made some telehealth policies permanent shared advice to other states considering expanding telehealth policies, noting it is always difficult to end policies:

> I would say if there's something that another state was on the fence about, whether something would be medically appropriate or best practice or might have some fraud, waste, and abuse potential, to consider that before expanding. Because once you do expand, it's difficult to go in the opposite direction, just from a stakeholder management standpoint.

Domain 2: State Telehealth Policy Decisionmaking Processes

We spoke with state Medicaid representatives about the decisionmaking process surrounding making permanent or rolling back telehealth flexibilities first introduced during the PHE. As described in Theme 1.3, COVID-19 did not play a substantial role in the decisionmaking process for permanent policies. As shared by a representative from one state that had made some telehealth policies permanent and rolled back others, in crafting permanent policies: "We did have time to be more deliberate to look at the permanent policies, to follow the legislation, to use this framework and talk to stakeholders."

In some cases, the state Medicaid agency had broad authority to shape Medicaid telehealth coverage policies. In other cases, specific telehealth legislation was passed at the state level and the state Medicaid agency was primarily tasked with clarifying Medicaid policies within the confines of legislative mandates. States drew on feedback from a wide variety of stakeholders when making decisions, but evidence from peer-reviewed literature or data was generally not available or was difficult to utilize under the time constraints of the PHE.

Theme 2.1: State legislation influenced Medicaid policies in different ways

Many Medicaid policy changes were influenced, either directly or indirectly, by state-level legislation. For example, respondents from one state that had made some telehealth policies permanent and rolled back others noted that legislation passed during the PHE mandated the state Medicaid agency to review the temporary flexibilities implemented during COVID-19

using specific criteria to determine which should be made permanent: "We have a state law . . . that required us to look at all of our COVID flexibilities and . . . look to see . . . is it cost-effective, is it clinically effective, and then make them permanent [if so]."

Other states had to develop Medicaid regulations within more prescriptive legislative frameworks. A representative from another state that had made some telehealth policies permanent and rolled back others explained that the state Medicaid office had wanted to make a temporary flexibility to allow audio-only part of permanent policy, but before they were able to, the state legislature went ahead and passed a bill making it permanent:

> I would say that our intention was to continue using audio-only technology and continuing to have a way for audio-only technology to be used in the Medicaid program long-term [anyway]. Since it was included in House Bill 140, that decision was taken away from us. . . . We are required to use state statute definitions when they change. We're not allowed to modify them. We can only add to them at the regulatory level.

The same representative explained that State Medicaid agencies were sometimes able to provide input during the legislative process, as was the case for making the audio-only policy permanent: "We provided a draft that was . . . I think basically everything we asked for; we sent that along and most of what we asked for was included in there but then they did also add several things."

One representative from another state that had made some telehealth policies permanent and rolled back others described how their permanent Medicaid policy on audio-only was similarly built around legislation passed during the PHE, though in this case the legislation was more of a surprise:

> We didn't know that it [permanent audio-only for BH] was coming down the pike. It just happened and then we developed . . . the program description for audio-only because the legislation has very little detail in it, so we wanted to make sure that the providers had more guidance. It was basically pulling from those memos that we had sent out around telehealth because we still have to ensure that the service is being rendered and people are paying.

Theme 2.2: Some states had implemented specific processes for determining whether to make telehealth flexibilities permanent or roll them back

While state Medicaid agencies differed in the degree to which they needed to work within a legislative framework, all were faced with numerous decisions regarding Medicaid telehealth coverage policy and needed to provide clarity and guidance to providers in a rapidly changing environment. Early in the PHE, Medicaid agencies felt the need to provide broad flexibilities to ensure that patients could continue to access care. One representative from a state that had made some telehealth policies permanent told us:

> There was just a unanimous just jump off the cliff and see where we land. I know that sounds kind of strange for policy decisions but that's literally what it was at the beginning, just like make sure people have access to care. We don't care how they get care. And we started to then monitor it as we moved forward.

As the PHE progressed, state Medicaid agencies became more methodical in their decisionmaking process. To this end, some state Medicaid agencies put specific processes in place to determine whether policies should be made permanent. A representative from a state that had made some telehealth policies permanent and rolled back others noted,

> We put together a process. . . . Every decision we made needed to go through a rigorous process that included authority, legal, finance. We took it through multiple steps to evaluate—is this something we want to keep on permanently? . . . Is there an evidence base for it? . . . In the absence of an evidence base, is there a national standard? . . . We looked at our own data around utilization and outcomes. . . . So we've looked at it from a lot of different lenses and that helped informed some of our decisionmaking as well.

Similarly, a representative from another state that had made some telehealth policies permanent and rolled back others stated:

> We used a rubric. . . . We looked at clinical effectiveness, cost-effectiveness, health and safety, member choice and access, and then federal/state law, and licensure considerations. . . . So we used that to look at categories of services and come up with an analysis that showed we think it's appropriate or not to continue.

A representative from one state that had permanently adopted some telehealth policies described their process of incorporating various inputs:

> We have an entire process now devoted to making that process of making [permanent policy] actually functional. . . . The requests would usually come in from . . . our member call center or directly to a benefit manager, or someone in the department sometimes… through the Legislature . . . all kinds of different mechanisms. . . . And then the benefits team . . . evaluate the request for whether or not it's something that really could be performed in telemedicine, and checking with the clinical team to see if they agreed with that. And then if possible, we'd open it. We would also do a budget analysis whether or not it was appropriate to open and it would be cost-prohibitive or not.

In contrast, discussions with Medicaid representatives about decisions about rolling back flexibilities tended to be brief, usually driven by common sense, clinical guidance, or diminishing relevance as the PHE progressed. For example, while allowing non-HIPAA-compliant platforms was important initially when most patients and providers had little experience with telehealth, it became less relevant as institutions had more time to stand up and gain experience using HIPAA compliant platforms. Similarly, a representative from a state that had made some telehealth policies permanent and rolled back others discussed their decision to roll back a flexibility allowing providers to charge an originating site fee when a patient received telehealth services at home:

> Initially in the emergency rules, we had allowed . . . that originating site fee because a lot of practitioners and practices and hospitals had to change their whole delivery of service and implement telehealth kind of quickly. Before COVID, we didn't see a ton of utilization with telehealth, so we understood

> there's kind of some challenges with that, technical challenges and things like that . . . but we ended that when we implemented the permanent rule.

Theme 2.3: State Medicaid representatives also shared general principles that guided their decisionmaking

In addition to specific processes for deciding to make flexibilities permanent, state Medicaid representatives also shared guiding principles that served to orient their decisionmaking. These principles included patient choice, providing maximum flexibility, doing no harm, giving providers clarity and certainty, maintaining access for patients, and promoting health equity.

The principle of patient choice meant that Medicaid agencies wanted patients to have telehealth options without feeling that they were pushed into telehealth. One representative from a state that had made some telehealth policies permanent said: "We also want to be careful that providers are not using this as a tool to say I'll take [Medicaid] beneficiaries but I'm going to really push the telemedicine so that they're not coming into my office."

A representative from a state that had made some telehealth policies permanent and rolled back others described the importance of flexibility with an example from behavioral health:

> Providing access to behavioral health services [via telehealth], it's important without a public health emergency but there were also aspects of the public health emergency that may have contributed to people having certain behavioral health needs. . . . I don't think anyone had concerns. . . . Something we learned from the pandemic was shifting to allowing more flexibility for these services.

While state Medicaid representatives stressed the importance of expanding health care and providing flexibility, one state that had made some telehealth policies permanent and rolled back others used "do no harm" as a guiding principle as described by one representative who said: "I think there was a lot of hesitancy early on. We studied it, we set an evaluation program up. . . . I want to know . . . are we hurting people? Are we seeing outcomes worse because we're providing this modality? We don't want that to happen."

Several representatives spoke about maintaining access and continuity of care as a driving principle both in establishing flexibilities as well as in making policy flexibilities permanent. Early in the PHE, particularly, there was a fear of "losing" patients when they may need help the most. A representative from a state that had made some telehealth policies permanent and rolled back others shared this focus on maintaining access in developing a policy flexibility:

> Our residential SUD treatment facilities were having a little trouble early on because they wanted to be able to provide some of their services by telehealth too, just to kind of keep people socially distanced, and we did make that change as well. So we were trying to think out of the box as much as possible and accommodate them and moving to telehealth as quickly as possible.

In describing the decision to make audio-only policy flexibilities permanent, a representative from a state that had made some telehealth policies permanent also emphasized the importance of maintaining access, particularly for vulnerable populations:

> Given the current access to care concerns around broadband and internet capabilities, as well as the hard technical side around accessing smartphones/computers. . . . We need to continue to be flexible to make sure that our rural and Tribal regions have access to care.

This focus on vulnerable populations was reflected in several other representatives' discussion of health equity as a guiding principle for decisionmaking, primarily related to audio-only policies. One representative from another state that had made some telehealth policies permanent and rolled back others noted,

> We are trying to always ask that equity question. . . . And that's made us open to thinking about things that maybe we wouldn't have thought about in the past. Where in the past, maybe we would have said, well, how many people could benefit from audio-only, right? How big of a deal is that? Well, for certain individuals, it's a big darn deal. . . . And so because we've put this equity value front and center. . . . We're starting to think in that different way.

Another representative from a state that had made some telehealth policies permanent said,

> Audio-only was a huge lifesaver for many people. It was a lifeline for a lot of our behavioral health beneficiaries because, for whatever reason, either they didn't want to be on camera or they didn't have access to a camera. . . . We have large rural health populations, and we also have a number of people that are in areas where that access is not available. There were several crisis situations that this was a critical component.

Theme 2.4: State Medicaid representatives did not know of peer-reviewed evidence to support policymaking and instead primarily relied on stakeholder input to guide decisionmaking

Use of telehealth was not widespread prior to the PHE. Therefore, state Medicaid representatives rarely had peer-reviewed evidence on clinical or cost effectiveness to guide their decisions either regarding temporary flexibilities or permanent policies. Instead, data were often limited to stakeholder input. State Medicaid agencies sought feedback from a wide range of stakeholders including providers and patients, patient advocacy groups, professional organizations, and hospital organizations. Representatives noted that stakeholder feedback overwhelmingly supported making policy flexibilities permanent, with few voices calling for rolling policies back. A representative from a state that had made some telehealth policies permanent said:

> We started asking different provider associations and our managed care organizations and talking to our consumer groups and other stakeholders. And because we started having those conversations . . . [There was] a deluge of advocacy for not pulling back on this.

Provider feedback was generally very supportive of making flexibilities permanent, with a representative from another state that had made some telehealth policies permanent stating: "I think that a lot of the home health community . . . definitely pushed for this. . . . It was an

element that was really helpful in general. . . . A lot of the feedback we got from providers was just, 'Hey, can you open this? Is this open?'"

Patients also expressed appreciation for increased flexibilities, but patient advocacy groups wanted to make sure appropriate guardrails were in place, particularly to ensure that vulnerable patients would have equitable access to clinical services. A representative from a state that had made some telehealth policies permanent highlighted this, saying:

> Our consumer subcommittees across all of the program offices really like the telemedicine and consistently urge us to not draw back on our policy. It's interesting because they also share some of the same hesitation and reservations that we still have in making sure that there is the appropriate use of telemedicine and that it's not used to waive seeing people. . . . So there is still a lot of support for it and a lot of conversation about how it is that we continue to maintain and grow the capability for it.

A representative from a state that had made some telehealth policies permanent and rolled back others echoed this sentiment:

> We have some telehealth-specific advocacy groups. . . . Some of those groups . . . were concerned about . . . asynchronous telehealth technology and audio-only telehealth technology. They offer a lot of benefits but there's also some ways that they could be manipulated to impact how our recipients receive services. We didn't want them to be necessarily cut out of being able to go to the physician's office or the provider's office if they wanted to do that.

Although none of the state Medicaid representatives we spoke with described instances of stakeholders asking that a policy be rescinded, some did report feedback that an incremental approach would be preferable. A representative from another state that had made some telehealth policies permanent and rolled back others said:

> I just remember this specifically, somebody giving testimony kind of saying . . . maybe it should be a little bit more incremental. . . . Can we have a time limit on this or try it out first. . . . They weren't saying they didn't want teleservices at all, sort of like wanting it to be more incremental. But yeah, people for the most part are very excited about teleservices, so those bills had a lot of support.

Many state Medicaid representatives reported reviewing their utilization data, but they did not necessarily use these data to inform policy decisions. For example, a representative from a state that had made some telehealth policies permanent noted:

> We spent a ton of time in that dashboard, just slicing and dicing the data . . . trying to understand trends across the board, but then really looking at sub-populations to see what's going on, particularly in our rural . . . at members who are not White and members who speak a language other than English.

However, when asked if these data had informed policy decisions the representative noted that policy changes were generally made based on clinical guidance as opposed to review of utilization data.

Theme 2.5: States used a variety of resources to guide their decisionmaking around telehealth policy

In addition to stakeholder input, state Medicaid agencies also looked to include federal guidance (usually from CMS), guidance from professional organizations, consultants, and policies from commercial payers or other state Medicaid agencies.

At the federal level, state Medicaid representatives cited guidance from the OCR around the enforcement of HIPAA requirements for telehealth as being useful. A representative from a state that had made some telehealth policies permanent and rolled back others said:

> The OCR guidance at the beginning was significant. . . . . The waiving of enforcement and some of the clarifications that they made. . . . It was significant. . . . I think it allowed some of those platforms to be used by patients, maybe just a little bit easier. The apps that are already on people's phones are I think it's just easier for them to pick those up.

State Medicaid agencies looked to Medicare coverage policy to guide their own decisions. A representative from a state that had made some telehealth policies permanent and rolled back others said: "We can always cover more but we rarely cover more…we sort of look at Medicare and what Medicare covers, for the most part, to guide us. And I think that's true for a lot of states."

Similarly, a representative from another state that had made some telehealth policies permanent and rolled back others shared:

> CMS is flexible and has kind of left it to the states to decide in many cases. . . . We did look to Medicare. . . . [We would look to] what does Medicare allow? Oh, they allow this, this, and this. And so we did take that into consideration because we thought, oh, that's helpful to know what CMS is requiring for their own program that they administer. But it wasn't specifically like they said for Medicaid you have to do it a certain way. That was a Medicare policy that we were just looking to kind of for guidance.

Several state Medicaid representatives described engaging professional organizations and/or consultants to advise them on crafting their permanent telehealth policies. These organizations included the CCHP, the American Medical Association (AMA), national professional associations (e.g., Physical Therapy Association, American Telemedicine Association), and individual telehealth consultants, who were often academic researchers specializing in telehealth.

Several state Medicaid representatives mentioned speaking or meeting with representatives from other state Medicaid agencies to discuss policy changes. One representative from a state that had made some telehealth policies permanent and rolled back others illustrated this collaboration through their discussion of a seven-state compact, saying:

> We were working in this big group of states. . . . "What are you doing? What's working for you? What's working for us? Let's talk about our shared experiences to promote health and wellness throughout this whole incident and how we're providing that through telehealth modalities."

A representative from another state that had made some telehealth policies permanent and rolled back others said:

> We talked to the other state Medicaid agencies. . . . [our state] is farther along than some states on teleservices even pre-PHE . . . but we did look to . . . [two states] specifically because they have mature managed care, long-term services and support programs, and they are similar to us in some ways in those programs.

Although state Medicaid agencies did look to private payers, only a few garnered information that helped guide them. For instance, a representative from a state that had made some telehealth policies permanent noted that consistency among payers was important, sharing: "We've made the decision to basically mirror our policy so that there is kind of that parity around coverage between the private commercial and Medicaid. . . ." Similarly, a representative from another state that had made some telehealth policies permanent and rolled back others shared that they had compiled a spreadsheet of other payers' coverage policies, including "as many state Medicaid policies as we could get our hands on, as well as [state] commercial payers" in an attempt to better align their policies with those of other payers.

Other states shared reasons they had not looked to private payers, as described by a representative from one state that had made some telehealth policies permanent and rolled back others: "I'm not recalling that we looked at private payers. . . . Sometimes that's harder to get some of that information. . . . Medicaid just provides some unique services. So there's not always a comparable thing in the commercial space."

Domain 3: State Medicaid Programs' Future Plans for Telehealth

We inquired about state Medicaid programs' future plans for telehealth, including whether they planned any additional changes such as making more policies permanent or rolling back remaining flexibilities. No state Medicaid representative reported plans to make major additional changes to their permanent telehealth policies. Rather, state Medicaid agencies were monitoring telehealth utilization and the larger landscape for telehealth before making major future plans. Although their utilization data could, in theory, be used to identify fraud, waste, and abuse, it was not a major concern among the Medicaid representatives we spoke with. Finally, few states have conducted robust evaluations of telehealth beyond reporting utilization, though many have plans to do so, often in conjunction with local academic institutions.

Theme 3.1: As of summer 2022, states were not planning major additional changes to telehealth policy but were making minor adjustments and monitoring telehealth utilization to inform future decisions

No state Medicaid representatives we spoke with shared plans to make major additional changes to telehealth policies in the near future. Several states shared plans to annually review their telehealth codes, including data on utilization, to better understand how to adjust telehealth

coverage policies. States that still had remaining flexibilities in place generally planned to sunset those with the end of their state PHE or the federal PHE, depending on the PHE under which the flexibilities were initiated, but without much fanfare or discussion as described by a representative from a state that had made some telehealth policies permanent and rolled back others:

> We did allow non-HIPAA-compliant platforms to be used . . . for ease of access through the pandemic. That was one of the things that CMS allowed us to do. But moving forward after the end of the public health emergency, we will no longer have that flexibility. And I support that. People need to feel confident and safe in the platforms that they're using when sharing information to their providers, and it should be respected.

A representative from one state that had made some telehealth policies permanent shared that clinical appropriateness had guided the planned rollback of policy permitting well-child visits by telehealth:

> That decision was actually made . . . based on the coding. . . . The requirements in the [code] description and then the clinical guidance from our CMO [Chief Medical Officer] just saying that that's not—it's not an appropriate long-term solution.

This representative from another state that had made some telehealth policies permanent shared:

> There's no intention to roll back [current permanent telehealth policies]. We will be sensitive and follow federal guidance as to what those requirements may be, but other than that, this is something—again, we've been looking at this, trying to move this forward for a long time, and so we just see this as the pandemic was a great, I think, incentivizer for people to move on this.

A representative from one state that had made some telehealth policies permanent and rolled back others shared that, to the degree possible, they had made flexibilities permanent or rolled them back as soon as possible in order to give providers the information they need to make long-term plans. "The things that we wanted to make permanent, we just wanted to go on and let the field know, yes, we're making this permanent, so that they can invest in longer-term strategies . . . invest in the long-term solution."

Although no major changes were planned, a few states were working on finalizing Medicaid rules for some permanent telehealth policies while others were making minor tweaks to add additional guardrails to existing telehealth policies. As described in Theme 2.4, states were particularly concerned about adding guardrails to audio-only policies both to protect vulnerable populations and ensure appropriate use. A representative from one state that had made some telehealth policies permanent and rolled back others told us that they had recently added additional nuance to their audio-only policy:

> We did put in our most recent policy work just saying the clinician needs to document basically in the record the audio-only is appropriate, just because for

> some client or for some patients, they may want to . . . see them in-person once a year. So we did some things like that in the policy to make sure that the clinician was really saying yes, this is appropriate for this person, but leaning on their clinical judgment to do that.

States continue to monitor telehealth utilization among their beneficiaries with a goal of using resulting data to inform future policy decisions, including those related to health equity. One representative from a state that had made some telehealth policies permanent told us they were monitoring current use both for potential fraud, waste, and abuse (discussed further in Theme 3.2) and to understand whether there are additional policy levers to encourage desirable outcomes, particularly with regards to health equity:

> We've seen some indications . . . [of] this connection between no-show rates and telemedicine and lower no-show rates among people with telemedicine visits, particularly for non-White members and members with higher health care needs. . . . There's the part of it where we're looking for red flags, but then there's the parts of it in what can we encourage to increase access. And so not necessarily a change but I think we have our eye out on what others are doing.

This individual continued to share that they anticipate that changes on the federal level will affect their own policies: "I think we fully expect this landscape to change quickly. And so we'd rather be prepared for that change . . . as opposed to resisting moving forward at all. We're really trying to prepare for the changes that we anticipate coming ahead in the entire landscape of telemedicine."

Theme 3.2: Although states shared concerns about fraud, waste, and abuse resulting from telehealth, none had identified significant levels to date

Fraud, waste, and abuse were cited as a concern by Medicaid directors in our literature scan findings. Although several state Medicaid representatives also shared that in implementing both flexibilities and permanent telehealth policies they or their stakeholders had shared concerns about the potential for fraud, waste, and abuse, no representative reported identifying significant levels of fraud, waste, and abuse. Further, many respondents reported that they would be able to use telehealth utilization data to identify fraud, waste and abuse, but this was not a major concern. This representative from a state that had made some telehealth policies permanent said: "The analysis . . . is more like monitoring. . . . It's more like, 'This thing happened. What do we see as a result?' . . . If we were seeing something really concerning, we'd use it for that purpose too, but we haven't."

Many representatives perceived that it would be easy, given the multitude of rapidly changing rules, to inadvertently bill incorrectly for telehealth, as shared by one representative from a state that had made some telehealth policies permanent and rolled back others:

> One more thing . . . was around our ability to monitor services and to evaluate for fraud, waste, and abuse. . . . There was a sense of telehealth exceptionalism where it felt new. . . . Our thought was no, no, no, it's the same service. We're

> just delivering it in a different way. . . . People are using the same billing infrastructure and we should use the same monitoring infrastructure. . . . [Also] we make it really easy for providers who may have ten different insurers' rules that they have to follow. If we make it as simple as possible and as aligned, then they are less likely to engage in inadvertent misuse. . . . But [concerns about potential] fraud, waste, and abuse, it just came up a ton, as we were thinking about how to implement this.

A few Medicaid representatives actively resisted looking too closely at the data with the understanding that everyone was "doing their best" during a challenging time. A representative from one state that had made some telehealth policies permanent and rolled back others shared:

> You have to be careful because if we really want to look under the hood of a practice's billing and audit them, we're going to find that they weren't compliant and they're going to have to pay us back all the money we paid them. . . . We have not looked under the hood because in some ways, if we do that . . . we can't look away. . . . That would be such a burden on the provider community, who I think for the most part really was doing the best they could in the circumstances. There's always going to be outliers, but your different practices have different levels of savvy. . . . There's huge turnover in practices. People lost billing and coding team members and never were able to replace them. . . . We don't actually want to look that closely because if we do, we're going to have to do something about it.

Theme 3.3: Few state Medicaid agencies had evaluated the impacts of telehealth beyond reporting utilization, but most had plans to do so

Among the few state Medicaid agencies that had already done some level of evaluation of the impacts of telehealth, the majority of those were related to descriptive analyses of telehealth utilization over time and by different groups of interest, such as geography, race and ethnicity, and type of care (e.g., physical health versus behavioral health), or patient experiences with telehealth. One respondent from a state that had made some telehealth policies permanent shared:

> We did add specific patient satisfaction questions to our CAHPS [Consumer Assessment of Healthcare Providers & Systems] survey, and so we do have results. And overall, overarchingly, our members said services via telehealth, they were just as satisfied with services via telehealth as in-person.

Most state Medicaid agencies planned to conduct evaluations, including looking at quality and total cost of care. However, they cited challenges to conducting evaluations at this time because insufficient time has passed to be able to reliably study outcomes. One Medicaid representative from another state that had made some telehealth policies permanent said:

> People are intending to look at various pieces . . . [but] I don't think it can be done in just a quarter or two. . . . This is going to be long-term. . . . What [are] the outcomes going to be. . . . How many times did people go remote before they came in? What were some of the conditions? . . . That's something that we can't see in one or two quarters.

Similarly, a Medicaid representative from a state that had made some telehealth policies permanent and rolled back others said: "The Legislature has directed us to look at . . . clinical and cost-effectiveness [but] there is not always a clear answer to whether it is clinically effective and cost-effective because those things take time to establish."

Finally, several state Medicaid representatives had limited staff to conduct complex evaluations. Many were partnering, often with academic institutions, to support those analyses. One Medicaid representative from a state that had made some telehealth policies permanent and rolled back others shared that they were required by the State Legislature to submit an annual report on telehealth. However, they only had data for some of their beneficiaries (those enrolled in MCOs) and have engaged additional support moving forward. "For the first study that was required . . . we relied on the analysis that the MCOs made this first year. We did our own . . . in-house work. Going forward, we're going to be using a research arm of the [state university] to . . . help us crunch the data."

Others felt that national studies would also be needed, as described by a Medicaid representative from another state that had made some telehealth policies permanent and rolled back others:

> We certainly can't afford to do it [the analyses] for everything. We're going to have to rely on other people to do the research, people that have a national lens that can look—like a big commercial payer that has a national presence can look and see, if there's people that had a hip replacement that had telehealth rehab versus in-person rehab, was there a difference in their outcomes? That's what we need people to study so it can help inform us.

Domain 4: Challenges and Lessons Learned

Medicaid representatives shared challenges they faced in developing and implementing telehealth policies. Those challenges stemmed from unclear lines of authority, challenges with their own ability to understand whether and with what modality telehealth was being used by their beneficiaries, the difficulties in making decisions with a lack of rigorous evidence, and frustrations with the lack of permanent guidance from the federal government regarding some aspects of telehealth policy. They were also able to share important lessons learned, including the importance of communication and transparency, and the need to build partnerships with all stakeholders.

Theme 4.1: States have experienced challenges in developing Medicaid telehealth policies because of the many different authorities involved

State Medicaid representatives noted that developing permanent telehealth policies often required sorting through many different lines of authority depending on whether the policy was related to a change in regulation, licensing or oversight, service provided, or how the service was

paid for. One Medicaid representative from a state that had made some telehealth policies permanent and rolled back others said:

> One challenge that came up . . . was what are our lines of authority as an agency within a state apparatus? . . . The federal government approves it, wants you to do something, wonderful. If it's something different from a regulatory perspective, from a new service perspective, from a budgetary perspective, at the state level it requires different levels of approval. . . . And so that often becomes our focus point. Okay, we want to do this service. How do we do it?

A Medicaid representative from a state that had made some telehealth policies permanent and rolled back others shared that some things were out of the control of state Medicaid policymakers, which could be confusing for providers and other stakeholders:

> The things that are tied to federal authority, so a lot of our waivers . . . will end at the end of the federal public health emergency which, who knows, right? So that's been confusing for the field. Some things were tied to state authority and some things were tied to federal authority.

Theme 4.2: States described challenges with their data that have affected how they have been able to understand the impact of their telehealth policies

State Medicaid representatives described challenges understanding and analyzing their own telehealth utilization data. Some of those concerns are not new and are seen with many analyses of claims data, as described by this Medicaid representative from a state that had made some telehealth policies permanent and rolled back others: "We always have a claims lag within Medicaid . . . [of] three to four months . . ."

However, other data challenges were more unique to telehealth such as the challenges in implementing audio-only modifier codes. A representative from one state that had made some telehealth policies permanent told us: "We're not using the audio-only modifier yet. We plan to—we've had some changes and some stuff going on. We haven't been able to implement that yet." There were also many steps to ensuring that audio-only modifiers could actually be used.

One representative from a state that had made some telehealth policies permanent and rolled back others told us that even though their audio-only modifier had technically been implemented, it could not be used until billing and payment systems were updated:

> As much as we want to be using it [audio-only modifier], we simply cannot, until our systems are updated to accept it. And that takes over a year, which is a long time. . . . Other states are grappling with that same thing . . . that's part of the implementation at the state level.

Even where specific telehealth codes or audio-only modifiers have been successfully implemented and are able to be used, they are used inconsistently, making evaluation difficult. In some cases, it was difficult for states to even know whether a service was provided via telehealth or in-person, making analyses of important factors such as health equity impossible. A Medicaid representative from a state that had made some telehealth policies permanent said:

> That's a big conversation we've been having . . . considering what we see in terms of equity in telemedicine and for example thinking about audio-only right now. . . . If rural areas don't have access to broadband and they are taken to an audio-only call and what if the audio-only call like isn't as high quality, how could we use the data to just look and see what utilization looks like. But unfortunately, we don't have a way in our data to look at audio and video, so that's like one lesson learned for me would have been to figure that out way earlier, a way to differentiate in the data to see if something is audio-only or video.

The same representative also shared that because of telehealth payment parity policies, providers have not been incentivized to use the audio-only codes even though they are in place:

> There is a parity statute so we have to pay at least what we would pay in-person for telemedicine. . . . A provider is not going to choose the $15 [audio-only code] versus the $44 [telehealth E/M code]. And modifiers to identify the audio-only visits came out after the PHE started, and so they're kind of in use now but not heavily in use. And we're not going to see a consistency in our data for a long time.

Theme 4.3: States called for more studies to guide their telehealth policy decisions

As mentioned in theme 3.3, state Medicaid representatives perceived that in the long term, some aspects of telehealth need larger-scale, national studies to help guide decisionmaking. Many highlighted a need for additional studies of not only the quality of telehealth services, but also for appropriateness or effectiveness. A Medicaid representative from a state that had made some telehealth policies permanent said:

> There's reservation around how good can audio-only services be, and I understand that concern and that reluctancy. The reality is we need more studies. We need more assessment around quality of care. And until we do that, I think we are making a judgment call that's not based in science. . . . Is the judgment around audio-only service delivery not being qualitatively better, is that based in science? And if it's not, then what do we need to do to actually measure that, and I do think we need to do a better job of researching really what that looks like.

A Medicaid representative from a state that had made some telehealth policies permanent and rolled back others similarly shared:

> One of the things that I would really ask of ASPE is to invest heavily, intensively, in real world evidence generation around telehealth, audiovisual and audio-only. And part of that is . . . promoting the use of the audio-only modifier, but also dollars to invest in that. One of the challenges we had was we didn't have evidence . . . as we were making these policies, over the short term or over the long term. And so, that will remain a challenge."

Several states brought up the need for more evidence to support the provision of certain types of services, particularly high-touch services such as physical, occupational, and speech therapies as described by a Medicaid representative from a state that had made some telehealth policies permanent and rolled back others: "In the specialized therapy space, there is no evidence base

that you can provide these services in an efficacious way by telephone or by telehealth. It's not been studied so we don't know." The representative continued, sharing that developmental and/or behavioral health screenings also need additional study:

> There are other things that haven't been studied, like our standardized testing that we do for psychological testing or for developmental disability testing. . . . Those tests have been validated in an in-person environment. They've never been validated in a remote environment. They often will involve hands-on or they involve manipulatives. . . . We're hoping people will study this stuff.

One Medicaid representative from another state that had made some telehealth policies permanent and rolled back others was interested in studies of how well certain assessments that are needed to qualify for services could be conducted via telehealth:

> I think people are so focused on more acute care-type services, which makes sense because that's kind of where tele all started, or behavioral health… we just see less information from other states and less comparisons on the stuff that is really specific to Medicaid Long Term Services and Supports mostly where you're doing assessments for waiver services. . . . We found that people don't discuss that piece as much . . . we had a harder time trying to kind of compare and see what other places were doing."

Finally, a Medicaid representative from a state that had made some telehealth policies permanent noted a need for measures to assess the quality of telehealth itself:

> Nationally and federally . . . there's not really a good well-accepted quality measurement of telehealth outside of outcomes. Because we don't want to be adding these services that just cost a lot more money and don't actually fix the problem, but it's kind of hard to nail that value down at the moment. There's not really a good HEDIS measure that's telehealth-specific.

Theme 4.4: State Medicaid representatives also shared the need for additional guidance on telehealth policy from the federal government

Several state Medicaid representatives called for permanent federal guidance regarding telehealth policies, noting that providers are unable to make plans based on flexibilities dependent on the federal PHE. This Medicaid representative from a state that had made some telehealth policies permanent and rolled back others said:

> To be honest, CMS has made this harder for us because they have not come out with what they are doing permanently. They're just giving this sort of vague it will be 365 days after the end of the public health emergency or whatever their number is. . . . That's not really helpful. Our providers need to know now what to invest in for the long term so that they can start putting those things in place. And the longer that we just sort of dangle the future, the harder it is for them to prepare for the future."

Some respondents perceived that guidance from CMS changes quickly, as described by a Medicaid representative from a state that had made some telehealth policies permanent:

> Our telemedicine policy is based on CMS guidelines. And you have to watch their page because . . . at any point in time, you can pull up CMS's website and it says something different than it did the day before. So you do have to monitor.

Other state Medicaid agencies were waiting for final decisions from CMS regarding proposed changes as described by this Medicaid representative from a state that had made some telehealth policies permanent and rolled back others:

> E-consults [were] authorized at the state level but not at the level of CMCS [Center for Medicaid and CHIP Services], the federal level. We've taken our case to CMS. My understanding is they're contemplating it. . . . . working through whether that is allowable, a reimbursable service through the Medicaid program at the federal level. But on the state level, we have authorized that. So we haven't implemented it because we're waiting for colleagues at the federal level.

However, some state Medicaid representatives were also very sympathetic to the challenges that CMS and other federal agencies faced in the PHE, as described by this representative from another state that had made some telehealth policies permanent and rolled back others:

> I really have to feel for CMS in this situation. Each and every state was filing an 1135 disaster waiver or disaster relief SPAs [State Plan Amendments]. And multiple ones. I don't even know how many we submitted. . . . If you take that and multiply that by all of the other states, that's inundating CMS...with an incredible bunch of paperwork and all trying to get the same kind of flexibilities, right? And so, it takes time to compile what kind of flexibilities people are looking for . . . going through those, identifying what states are asking, what's working for other states, what we're going to offer. . . . To help inform policymakers across the nation was an incredibly steep learning curve. And I don't think that we've even come to understand quite what that means, yet. I still think that there's a lot of information that we have yet to receive.

Theme 4.5: Lessons learned: Constant communication and transparency between Medicaid agencies and stakeholders are vital

State Medicaid representatives were able to share lessons they had learned through the process of developing telehealth flexibilities for the PHE and transitioning some of them to permanent policy or rescinding others. One important lesson was around the need for constant communication and transparency with patients and providers. A Medicaid representative from a state that had made some telehealth policies permanent and rolled back others shared the various types of communication they created for patients to help them understand that telehealth was available and how to use it:

> We created, we crowdsourced a video, kind of a YouTube type video to talk to beneficiaries about telehealth and using telehealth because there was a lot of resistance [from patients] early on. They just hadn't had it. . . . So we had to kind of help them understand that this is good for all ages and this is good for all problems.

State Medicaid representatives also shared numerous ways they felt were important for communicating with the provider community. Some utilized weekly provider webinars, as described by this representative from a state that had made some telehealth policies permanent and rolled back others:

> Every week we would implement a new set of things. And I did a provider webinar every week where I'd say these are the things we did last week. These are the things we're doing this week, and this is what's coming next week. And then the next week I'd do the same recap. And we'd have 1,500 providers on our webinars trying to catch up with it.

Respondents noted the importance of consistent communication and outreach to on-the-ground stakeholders to inform policy decisions, as described by a representative from another state that had made some telehealth policies permanent and rolled back others:

> I highlight again the collaboration and the consistent communication, consistent and frequent communication, and pulling from as many stakeholders and resources as you can. Because as a policymaker and a decisionmaker, sitting here in my home office, I can't begin to understand what a community mental health provider is experiencing in rural [state] or even a member is experiencing maybe in an urban area. So I visit with the providers frequently, I talk to them frequently, and they give me anecdotes and area situations, and we pull all of that in when we're making decisions.

A few respondents also contrasted the commitment to communication of state Medicaid offices with the relative lack of communication from private payers, as described by a Medicaid representative from a state that had made some telehealth policies permanent and rolled back others:

> Commercial plans have been really slow to come out and say what they want to do, because I don't think anybody wants to be the bad guy first. And so I feel like we have been really transparent all along, but almost to a fault, whereas commercial are just kind of quietly turning things off and not necessarily making a big deal out of it.

Theme 4.6: Lessons learned: Building partnerships, even before the emergency, is key

State Medicaid representatives also cited the importance of partnerships and collaborations with others in state Medicaid offices, with other state authorities, and even with the federal government, to smooth the process of implementing telehealth policies. One Medicaid representative from a state that had made some telehealth policies permanent and rolled back others emphasized that those partnerships cannot be built overnight—they function well because they are well-established:

> [Partnerships] made everything possible. . . . I've built amazing partnerships with the Department of Mental Health, Department of Children's Services, the health plans, and the providers. So we were always texting, talking, meeting, trying to figure out what needs to happen. That made everything much easier. I didn't have to figure out who all the stakeholders were in two days, build relationships,

> and change the policy. All the background legwork had been accomplished beforehand. . . . Emergency preparedness [is about] gather[ing] your supplies. Well, also build relationships because you can't build a relationship in the middle of a crisis.

Nearly all respondents shared that during the PHE, the collaboration between staff in state Medicaid offices and relevant state authorities was exemplary and facilitated the simultaneous and rapid implementation of multiple complicated policies, as described by one Medicaid representative from a state that had made some telehealth policies permanent and rolled back others:

> During COVID . . . because it was an emergency, our administration really got that telehealth was necessary. They were very supportive of us moving as quickly as possible and they said we'll help you on the authority front. They were very helpful on navigating that what do we need authority for and what we don't and how do we move forward? So it was very positive and very helpful to facilitating rapid uptake of telehealth.

Similarly, this Medicaid representative from a state that had made some telehealth policies permanent shared how many branches of government came together to implement desperately needed telehealth policies:

> The openness and support from all branches of state government and federal government made a huge difference, and the support from our stakeholders . . . the federal flexibility through CMCS and then our legislative support . . . and then our Governor's Office support as well. So I think it's because we all kind of united on something that we did have control over. This was kind of a shining star of the pandemic, where so many people were suffering and there were so many things that we were not in control of, that this was kind of something that I think everyone banded together. So overall, it was a very positive experience.

Chapter 5. Opportunities for the Future of Telehealth

During the COVID-19 PHE, state Medicaid programs allowed substantial flexibilities to telehealth coverage policies, including allowing audio-only telehealth and expanding the types of reimbursable telehealth services. As the COVID-19 pandemic continues to evolve, those policies are undergoing ongoing changes—some have been made permanent, while others are being rolled back or allowed to expire. The experiences and insights of states that have already made such decisions will provide valuable insights to other states in the process of making those decisions while also helping to inform future policies regarding telehealth following the PHE.

Although for this study we spoke only with state Medicaid representatives, our findings are reflective of some findings from an unpublished report to ASPE on telehealth coverage policies during the COVID-19 public health emergency in which RAND researchers (Peggy G. Chen et al.) spoke with a broad range of stakeholders including patients, providers, and both public and private payers. For instance, even in the third year of the COVID-19 pandemic and following expanded use of telehealth nationwide, it is still too early to understand the impacts of telehealth and resulting outcomes given ongoing challenges with poor data quality for both telehealth modalities and overall utilization, as well as the need for more time to pass before outcomes of interest can be assessed. We also found that patient and provider feedback regarding telehealth policies has been generally positive. State Medicaid representatives continue to affirm the value of audio-only telehealth, particularly for vulnerable populations, and behavioral telehealth seems widely accepted and codified into permanent policy among our sample of respondents.

Opportunities

Below, we describe potential opportunities for action, as identified in our literature scan and guided discussions.

Policymakers need more peer-reviewed evidence regarding the quality, appropriateness, and effectiveness of telehealth to guide their decisionmaking

State Medicaid representatives we spoke with described a lack of peer-reviewed evidence to guide their decisionmaking regarding how to handle telehealth policies in the long term. Although they have made decisions to date based on other guidance, most expressed a desire for more scientific evidence on which to base future decisions. At the forefront, they noted that evidence for the effectiveness of audio-only telehealth modalities would be particularly useful, including understanding the types of care and specialties for which audio-only telehealth can be effective. Additionally, they noted that evidence on the effectiveness of virtual therapy or virtual administration of assessments to qualify for services for developmental delays or long-term care

would also be beneficial. It will be vital for states that have already made permanent decisions regarding telehealth to continue gathering evidence and data to support quality and effectiveness. Several states in our respondent sample are allowing telehealth while also collecting data to understand how it is being utilized and what the outcomes are. Some states have also implemented regular reviews of telehealth policies so that those policies can be measured against current evidence. Finally, with regard to the evidence for the quality of care delivered via telehealth, ongoing efforts to develop quality measures (National Quality Forum, 2017) for telehealth should continue to be supported along with telehealth-specific quality measures that support not only quality of care but also patient experience and health equity (Ghosh et al., 2020).

Telehealth delivery for behavioral health services will likely continue to be widespread following the end of the PHE, so research into best practices is needed

Findings from both the literature scan and discussions with state Medicaid representatives point to continued widespread use of telehealth delivery for behavioral health services, even as patients return to in-person care for other types of services. In our review of policies, we noted that in many states, audio-only delivery was made permanent for behavioral health services but not for other types of services. In our review of articles giving Medicaid provider, patient, and payer perspectives, behavioral health was repeatedly cited as an area in which telehealth was particularly useful in improving and maintaining access to care. While policy changes and stakeholder perspectives all seemed to favor continuing telehealth delivery for behavioral health services, and we found some evidence that changes to telehealth policies may have increased access to behavioral health care, we found few studies evaluating the impact of Medicaid telehealth policy changes on behavioral health outcomes. State Medicaid representatives also noted that they received very positive feedback on expanding flexibilities for telehealth delivery of behavioral health services but that research was still needed on whether comparable quality behavioral health care could be delivered via audio-visual or audio-only telehealth.

State legislatures considering legislating telehealth policy should maintain communication with their state Medicaid offices to ensure sound policymaking

Although many changes were made directly by Medicaid agencies through regulations, other changes were made through legislation at the state level. State-level legislation was helpful in providing a clear framework for Medicaid policies and ensuring that providers had clear directives for use of telehealth across patients with different sources of coverage. However, we found that Medicaid agencies and state legislatures had varying degrees of communication when crafting these policies. Medicaid agencies were not always aware of upcoming changes to statewide telehealth policies. State legislatures should ensure that state Medicaid agencies are included in discussions about changes to telehealth policy and that Medicaid staff have sufficient time to prepare. As data on telehealth utilization and effectiveness becomes more readily

available, state policymakers should consider reviewing Medicaid data to inform new telehealth legislation.

State Medicaid offices and frontline providers would benefit from greater clarity regarding the future of federal telehealth policy flexibilities

State Medicaid representatives often felt they were "on their own" in developing permanent telehealth policies because the federal PHE and related flexibilities for telehealth are still in place. Many states had gone ahead and developed permanent telehealth policies but also accepted they would likely need to make additional changes to their state policies once the federal PHE ends and long-term decisions regarding related flexibilities are made. As described by our respondents, several states have long, involved processes for changing their Medicaid policies, some that are required by state statute. These processes require substantial effort by state Medicaid staff, and many are already short-staffed. The sooner federal policymakers can provide some degree of clarity regarding the future of these policies, the better state agencies and frontline providers will be able to prepare.

State Medicaid processes for reviewing telehealth flexibilities may be instructive for others

Several states described specific processes they had established for reviewing their telehealth flexibilities and deciding whether they should be made permanent or not. These included systematically reviewing factors such as the evidence base to support the permanent policy (e.g., clinical effectiveness, cost-effectiveness, quality), national standards or professional guidance, states' own utilization data (where available), and patient preference and patient experiences. In addition, some states also laid out review processes encompassing identifying the state entity with authority over the policy, considerations of relevant federal and/or state law, as well as licensure, legal, and financial requirements. Other states, and potentially even federal policymakers looking towards the future of telehealth policy in their own jurisdictions, may gain insight from these experiences and processes that have already been implemented. In addition, the lessons learned shared by state Medicaid representatives in Chapter 4, particularly lessons about the importance of communication with stakeholders, are likely germane to federal policymakers as they prepare to transition to permanent telehealth policies. They suggest that outreach to and feedback from those who will be affected by permanent policies, including beneficiaries, providers, and payers, can be helpful not only for raising awareness of upcoming policy changes but also informing those policies with the real-world experiences of those experiencing and implementing those policies. Those stakeholders should also include state Medicaid staff who, although not directly affected by some federal policies, clearly derive guidance and direction from federal policies, such as those from CMS.

Implementation of best practices for data requirements in the context of telehealth would support better understanding of the impacts of telehealth

State Medicaid representatives shared that the data they capture regarding telehealth, particularly audio-only utilization, are suboptimal. This reflects what we heard from payers and providers in an unpublished 2021 report (by Peggy G. Chen et al.), who told us that the data that currently exist regarding telehealth utilization and related claims are of very poor quality. Even utilization of telehealth has been difficult to analyze during the PHE because of issues with missing data, inconsistent coding practices, and conflicting data requirements. Many respondents described difficulties parsing out the use of video versus audio-only modalities of telehealth. Although several best practices for telehealth have been developed at the national level (American Academy of Family Physicians, undated; U.S. Department of Health and Human Services, undated), they do not specifically address best practices for documenting specific elements, such as the modality used, that would contribute to the aggregation of data to better understand the impact of audio-only visits. A recent study assessing the current state of and gaps in documentation of telehealth in outpatient settings also identified a need for additional training for physician office staff regarding some components including the appropriateness of the visit for telehealth (Houser et al., 2022). The authors also noted that documentation standards were relaxed during the COVID-19 pandemic, and providers may need to be resocialized to the need for more rigorous documentation. There are also likely opportunities to ensure that telehealth policies themselves do not inadvertently contribute to disincentives for appropriate documentation. For instance, payment parity policies may unintentionally result in provider billing being less accurate because providers are paid the same regardless of the mode of delivery, as described by one of our respondents. The Centers for Medicare and Medicaid Services' (CMS's) Final Rule provided guidance for use of the audio-only modality for Medicare in certain situations (e.g., mental health services and counseling in Opioid Treatment Programs) (CMS, 2021a). Additional detail to state Medicaid programs on using audio-only modifiers in other specific scenarios would be useful.

Conclusion

It is clear, from the perspectives of state Medicaid representatives in this study, that the future of health care following the PHE will continue to include telehealth in some capacity. Although the specifics of the permanent telehealth policies may continue to change and evolve, telehealth overall seems to be another tool that can be used to provide patient care. The experiences and lessons learned from the representatives in this study can be instructive to other state and federal policymakers considering how to transition to the next stage of telehealth as the COVID-19 pandemic continues to evolve. The perspectives shared here also highlight the importance of continuing to study the impacts of telehealth on factors including quality, cost, patient experience, and health equity, and refining the data collection and methods of analysis

that are used. More work and more time are needed at a national level to understand many aspects of telehealth outcomes that will support the crafting of future telehealth policies.

Appendix A. Literature Review Search Terms

COVID-19 Search Terms
COVID-19 OR COVID19 OR Coronavirus OR "corona virus" OR covid OR SARS-CoV-2 OR "severe acute respiratory syndrome coronavirus 2" AND Telehealth OR telemedicine OR "tele health" OR "tele medicine" OR mhealth OR "m health" OR ehealth OR "e health" OR telecare OR "digital health" OR "mobile health" OR "virtual care" OR "virtual health" OR "remote consultation*" OR "tele consult*" OR eConsult* OR teleconsult* AND Survey* OR interview* OR focus group* OR questionnaire* OR feedback

Telehealth Search Terms
Telehealth OR telemedicine OR "tele health" OR "tele medicine" OR mhealth OR "m health" OR ehealth OR "e health" OR telecare OR "digital health" OR "mobile health" OR "virtual care" OR "virtual health" OR "remote consultation*" OR "tele consult*" OR eConsult* OR teleconsult*

Documentation of Policy Changes Search Terms
Policy OR Policies OR law OR laws OR flexibility OR flexible

Changes in Telehealth Utilization Search Terms
Uptake OR adoption OR trend*

Stakeholder Perspectives Search Terms
Survey* OR interview* OR focus group* OR questionnaire* OR feedback

Health Equity Search Terms
"health equity" OR rural OR underserved OR elderly OR geriatric OR "low income" OR disparit* OR under-resource OR vulnerable

Quality of Care Search Terms
outcome* OR quality

Future Directions Search Terms
rollback OR expir*

Abbreviations

ABD	aged, blind, and disabled
ADA	Americans with Disabilities Act
AMA	American Medical Association
ASPE	Assistant Secretary for Planning and Evaluation
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCHP	Center for Connected Health Policy
CHIP	Children's Health Insurance Plan
CMCS	Center for Medicaid and CHIP Services
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COVID-19	coronavirus disease 2019
FDA	U.S. Food and Drug Administration
FQHC	federally qualified health center
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Services and Resources Administration
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
MeSH	Medical Subject Heading
MOUD	Medication for Opioid Use Disorder
OCR	Office for Civil Rights
OIG	Office of Inspector General
OMHSAS	Office of Mental Health and Substance Abuse Services
OUD	opioid use disorder
PHE	public health emergency
SPA	State Plan Amendment
SSA	Single State Authority
SUD	substance use disorder
T-MSIS	Transformed Medicaid Statistical Information System
URL	uniform resource locator

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