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MEDICAID BEHAVIORAL HEALTH PROVIDERS DELIVERING SERVICES VIA TELEHEALTH BEFORE AND DURING THE COVID-19 PANDEMIC

KEY POINTS

- The percentage of Medicaid providers delivering any behavioral health services via telehealth increased from 6.0% in the year before the COVID-19 pandemic to 67.6% during the first year of the pandemic, and declined to 61.4% in the following year.
- The transition from in-person behavioral health services to tele-behavioral health services was more pronounced for specialty providers (psychiatrists, psychologists, therapists/counselors, peer specialists, and social workers) than non-specialty providers (non-psychiatric physicians, primary care physicians, nurse practitioners, and physician assistants). In all, 82.8% of specialty providers delivered some behavioral health services via telehealth in the first year of the pandemic compared with 56.4% of non-specialty providers.
- Along with the overall increase in the proportion of providers delivering any tele-behavioral health services, an increased proportion of behavioral health providers focused their practice primarily on telehealth. The percentage of providers delivering more than 80% of their behavioral health services via telehealth increased from 0.4% of providers in the year before the pandemic to 15.4% during the first year of the pandemic.
- The shift to delivering almost all behavioral health services via telehealth occurred across all types of providers but was more pronounced for specialty providers; 29.7% of specialty providers delivered more than 80% of their behavioral health services via telehealth in the first year of the pandemic compared with 5.4% of non-specialty providers.
- The large shift in the share of providers who delivered almost all behavioral health services via telehealth, especially among specialty providers, raises several questions about the implications for the accessibility and quality of behavioral health services. Further investigation into the types of behavioral health services delivered via telehealth and the characteristics of providers that deliver most of their behavioral health services via telehealth could help inform future policy decisions on tele-behavioral health flexibilities.

BACKGROUND

During the COVID-19 pandemic, providers who delivered mental health or substance use disorder (SUD) services (hereafter referred to as behavioral health services) rapidly transitioned their in-person services to telehealth in response to social distancing recommendations from federal and state government.[1] This shift included Medicaid providers and enrollees.[2] Even before the pandemic, Medicaid provided states with the flexibility to determine what telehealth services to cover, the types of providers who could deliver those services, and their reimbursement rates.[3] The social distancing recommendations and new telehealth

flexibilities provided to state Medicaid programs encouraged states to consider additional coverage definitions and reimbursement policies to encourage providers to deliver services via telehealth.[4]

Telehealth can help address longstanding barriers to accessing behavioral health care, including the limited availability of providers and lack of transportation options in some communities.[5,6] Tele-behavioral health services can improve patient outcomes, reduce the time and costs of receiving care, and allow people to receive confidential care when they have concerns about in-person services.[5,6,7] For providers, telehealth can offer greater flexibility in scheduling appointments, a broader reach of patients in different geographic areas, lower overhead cost, and reduced burnout.[5,6,8,9,10]

Shifting behavioral health services from in-person to telehealth could, however, have unintended consequences. Certain populations, including people with disabilities or those with limited Internet access or comfort with technology, may find it difficult to engage in telehealth, and it can limit the ability of providers and patients to develop therapeutic relationships.[5,6,11] Some populations, such as those with serious mental illness or children and adolescents with serious emotional disturbance may still require in-person services, and it is unclear whether providers who only offer tele-behavioral health services can fully meet the needs of these populations.[12,13] Telehealth might also limit providers' ability to conduct thorough clinical assessments.[11] Providers who deliver most or all behavioral health services via telehealth might also lack local connections in the communities where their patients live, which are often necessary to help refer people to in-person resources.[14]

Medicaid agencies have raised concerns about the quality of behavioral health diagnoses in the absence of in-person assessments and about the effectiveness of audio-only telehealth.[4] As states and policymakers continue to consider the role of telehealth in the delivery of behavioral health services, information on the prevalence and types of providers who shifted behavioral health services from in-person to predominantly telehealth during the pandemic could help shape future policies. This study examined the extent to which Medicaid providers who deliver behavioral health services shifted their practices to mostly tele-behavioral health services during the COVID-19 pandemic and examined differences by specialty behavioral health providers and non-specialty behavioral health providers as well as by the conditions or populations they served, including those who treated enrollees with mental health conditions or SUDs, children, and perinatal populations.

METHODS

Data Source and Study Population

This analysis used administrative data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Research Identifiable Files, including the data files from the TAF Annual Demographic and Eligibility file, the Annual Provider file, and the following claims files: Inpatient, Other Services, and Pharmacy.[a] The analysis covered March 1, 2018, to December 31, 2021. We excluded Medicaid enrollees who were also eligible for Medicare because linking their Medicaid and Medicare data was outside the scope of this study. We included the District of Columbia and 46 states. Some years of data from Alabama, Mississippi, Rhode

[a] The Other Services file includes claims for physician services, outpatient hospital institutional utilization, lab/X-ray, clinic services, home health, hospice and premium payments. For more information, see https://resdac.org/cms-data/files/taf-ot/data-documentation.

Island, and Utah were excluded either because too many claims could not be linked to enrollment records or because procedure codes on claims submitted by professionals were missing at high rates.[b]

Identification of behavioral health services. We identified behavioral health service claims as: (1) claims with a behavioral health diagnosis code; or (2) claims for medication primarily used to treat behavioral health conditions. We identified behavioral health services delivered via telehealth using place of service, Current Procedural Terminology codes, Healthcare Common Procedure Coding System codes, and modifiers on the Other Services claims (Appendix **Table A.1**). In-person services were those not delivered via telehealth.

Identification of behavioral health providers. We limited the analytic file to servicing providers with at least 20 claims for behavioral health services in the Other Services file during each period of analysis. For example, if a provider had 20 or more behavioral health claims in the year before the pandemic and fewer than 20 claims for behavioral health services in the first year of the pandemic, the provider would be included in the count of providers in the year before the pandemic but not the first year of the pandemic.

Classification of behavioral health providers. We classified behavioral health providers into specialty providers and non-specialty providers using the servicing provider taxonomy code, specialty code, provider type code, and select procedure codes submitted on behavioral health claims (Appendix **Table A.2**). Specialty providers included psychiatrists, psychologists, therapists/counselors, peer specialists, and social workers. Non-specialty providers included non-psychiatric physicians, primary care physicians, nurse practitioners, and physician assistants.

We also identified providers who served various populations, including enrollees with mental health conditions, SUDs, children, and perinatal clients based on the inpatient, other services, and pharmacy claims files. In each time period assessed, we included providers if they had at least 20 in-person or tele-behavioral health claims that met the criteria listed in **Table 1** in the period to limit the analysis to providers who actively treated beneficiaries with behavioral health conditions in each period. The categories presented in **Table 1** are not mutually exclusive, and providers may be included in multiple categories if they meet criteria for multiple definitions. For example, providers may treat enrollees with mental health conditions as well as those with SUDs and would be included in both categories.

[b] We excluded states for the calendar year in which they have unusable data based on the following Data Quality Atlas measures: "Linking Claims to Beneficiaries" (Alabama and Rhode Island in 2019 and Mississippi in 2020-2021), and "OT Procedure Codes (Professional)" (Utah in 2018-2020). We exclude states that are unable to link claims to beneficiaries because without this linkage we cannot limit our analytic population appropriately, and we exclude states with unusable procedure codes because procedure codes are important for the identification of telehealth. Because each reporting period begins in March and goes through February of the following calendar year, we excluded states in reporting periods when the state had at least 10 months of "unusable" data quality assessments. For more information on the measures, see the Data Quality Atlas at https://www.medicaid.gov/dq-atlas/welcome.

Table 1. Definitions for Types of Providers	
Provider Type	**Criteria**
Provider who served enrollees with mental health conditions	Provider with claims for enrollees with mental health conditions. Mental health conditions were identified using CMS's standardized approach for identifying this group in claims data, which is available from the Chronic Conditions Data Warehouse. Conditions include anxiety disorders, mood disorders, personality disorders, schizophrenia and other psychotic disorders, and other mental health disorders.[a]
Provider who served enrollees with SUDs	Provider with claims for enrollees with SUDs. SUDs were identified using CMS's standardized approach for identifying this group in claims data, which is available from the Chronic Conditions Data Warehouse. SUDs include alcohol use disorder, opioid use disorder, and other drug use disorders.[b]
Provider who served children using behavioral health services	Provider with behavioral health claims for children. Children were identified as enrollees younger than age 18 on the last day of the last month of enrollment in the calendar year.
Provider who served perinatal enrollees using behavioral health services	Provider with behavioral health claims for perinatal enrollees. We used a methodology CMS developed that identifies enrollees who are pregnant by identifying pregnancy-related claims and creating pregnancy spans for the enrollee. We defined perinatal enrollees as those with a pregnancy span that overlapped with the date of service on a claim with a mental health or SUD diagnosis.
Provider by location	To classify whether providers resided in urban or rural zip codes, we used the U.S. Department of Education's EDGE data to assign a geographic indicator based on the provider's Zip code in the Annual Provider file. In cases when the provider's zip code was missing or unclear, we referenced National Plan and Provider Enumeration System data to determine the geographic indicator.[c]

Notes:

a. Other mental health disorders includes eating disorders, some sleep disorders, and diagnostic codes such as "unspecified mental disorder due to known physiological condition," "unspecified behavioral syndromes associated with physiological disturbances and physical factors," "other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence," and "unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence". More information on the Chronic Conditions Data Warehouse is available at https://www2.ccwdata.org/web/guest/condition-categories-other.

b. Other drug use disorders include cannabis, sedative, hypnotic or anxiolytic, cocaine, other stimulants, hallucinogens, inhalants, and other psychoactive substances use disorders. More information on the Chronic Conditions Data Warehouse is available at https://www2.ccwdata.org/web/guest/condition-categories-other.

c. More information about the EDGE data is available at https://nces.ed.gov/programs/edge/Geographic/ZCTAAssignments.

CMS = Centers for Medicare & Medicaid Services; EDGE = Education Demographic and Geographic Estimates; SUD = substance use disorder.

Measures

We assessed providers' delivery of tele-behavioral health services across four periods:

- **Before COVID-19 pandemic**: March 2018 to February 2019 and March 2019 to February 2020.
- **During COVID-19 pandemic**: March 2020 to February 2021 and March 2021 to December 2021.

We defined the COVID-19 pandemic as March 2020 to December 2021 when social distancing practices were still in place and death rates from COVID-19 were high. We defined the before COVID-19 pandemic period as March 2018 to February 2020. The providers in a single period might not be the same providers delivering care in the next period if one or more providers did not have at least 20 behavioral health claims in each period or was either enrolled as a Medicaid provider in a later period or at some point was no longer enrolled as a Medicaid provider.

We calculated two measures to identify providers who delivered tele-behavioral health services and providers who delivered a high proportion of tele-behavioral health services (**Table 2**).

Table 2. Measures Used to Assess Trends in Providers' Delivery of Tele-Behavioral Health Services

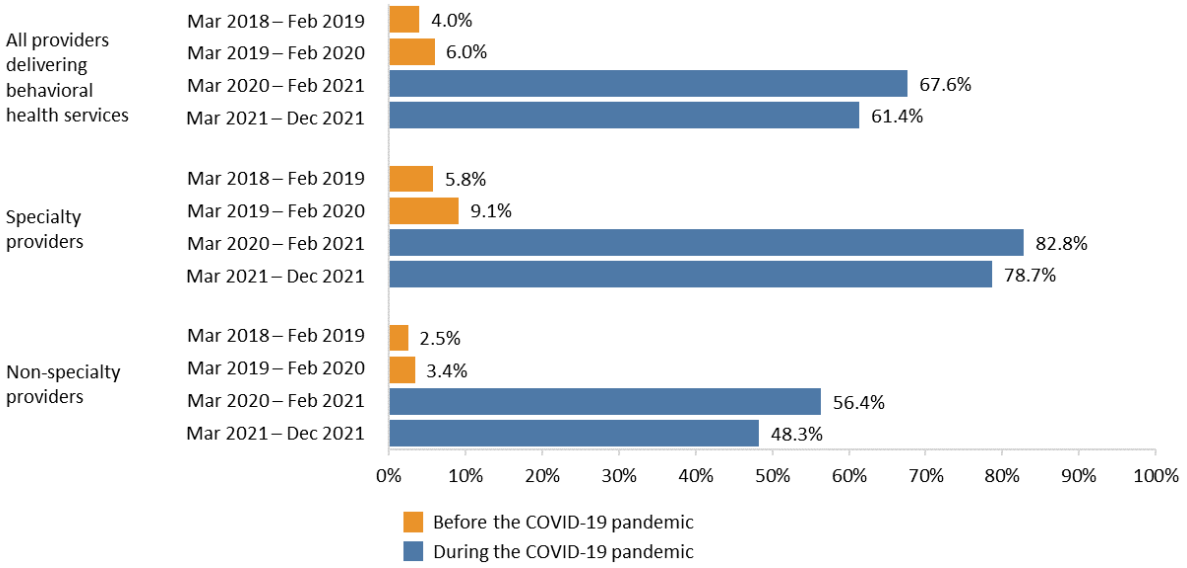
Measure	Calculation Details
1. The share of Medicaid providers delivering tele-behavioral health services	We divided the number of Medicaid providers with any behavioral health claims that indicated the service was provided via telehealth by the total number of Medicaid providers in that period of analysis. This percentage was calculated after restricting the sample of providers to who with at least 20 behavior health claims in the period.
2. The share of providers who provided most behavioral health services via telehealth	For each provider, we divided the number of tele-behavioral health claims by the number of all behavioral health claims with a service date during that period of analysis. Those providers whose tele-behavioral health claims accounted for more than 80% of their behavioral health claims were defined as providers who provided most behavioral health services via telehealth.[a]

NOTE:

a. This analysis used the servicing provider information to count the number of services. The servicing provider is reported on claim lines and not the claim header that summarizes the services receiving during a specific visit. This approach means that the count of claim lines is closely equivalent to a count of services delivered to enrollees.

FINDINGS

Figure 1. Percentage of Providers Who Delivered Behavioral Health Services via Telehealth, by Time Period and Type of Provider



Source: TAF, v5, 2018 to 2021.

Note: For each period assessed the analysis included providers who delivered at least 20 behavioral health services during the period. The assessment was based on claims for services delivered to Medicaid and CHIP enrollees between March 1, 2018, and December 31, 2021. This figure shows the percentage of providers who delivered tele-behavioral health services in each period of analysis. Specialty providers included psychiatric physicians, psychologists, therapists/counselors, peer specialists, and social workers. Non-specialty providers included non-psychiatric physicians, primary care physicians, nurse practitioners, and physician assistants.

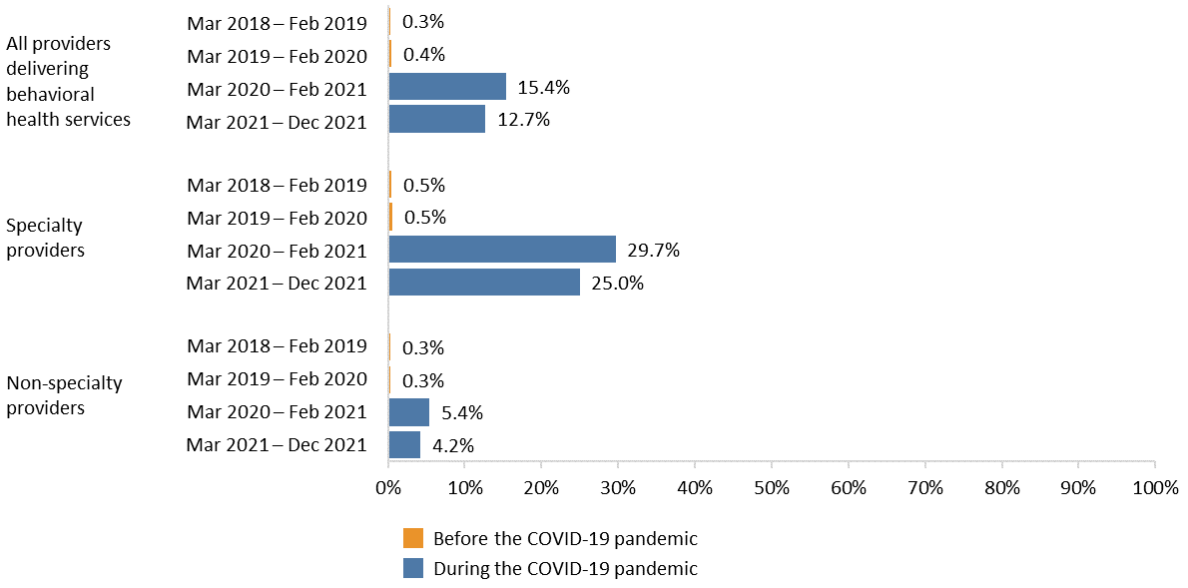
CHIP = Children's Health Insurance Program; TAF = Transformed Statistical Medicaid Information System Analytic Files.

Providers increased their delivery of tele-behavioral services during the COVID-19 pandemic (**Figure 1**). The percentage of providers who delivered tele-behavioral health services increased from 6.0% in the year before the pandemic to 67.6% during the first year of the pandemic and declined to 61.4% in the following year. This finding was consistent across all provider types (Appendix **Table B.1**).

During the pandemic, specialty providers were more likely to deliver tele-behavioral health services than non-specialty providers (**Figure 1**). Eighty-three percent of specialty providers delivered tele-behavioral health services in the first year of the pandemic compared with 56.4% of non-specialty providers.

The proportion of providers who delivered more than 80% of their behavioral health services via telehealth increased during the pandemic (**Figure 2** and Appendix **Table B.1**). Fifteen percent of providers delivered more than 80% of their behavioral health services via telehealth in the first year of the pandemic compared with 0.4% of providers in the year before the pandemic. This shift was more pronounced for specialty providers; 29.7% of these providers delivered more than 80% of their behavioral health services via telehealth in the first year of the pandemic compared with 0.5% of these providers in the year before the pandemic. In contrast, 5.4% of non-specialty providers delivered more than 80% of their behavioral health services via telehealth in the first year of the pandemic compared to 0.3% in the year before the pandemic. Compared to other non-specialty providers, a greater share of nurse practitioners delivered more than 80% of the behavioral health services via telehealth (12.3% in the first year of the pandemic and 9.8% in the following year; see Appendix **Table B.1**). This finding should be interpreted with caution because this analysis was not able to distinguish between psychiatric and non-psychiatric nurse practitioners, and the findings for these types of nurse practitioners may differ.

Figure 2. Percentage of Providers Who Delivered more than 80% of Behavioral Health Services via Telehealth, by Time Period and Type of Provider



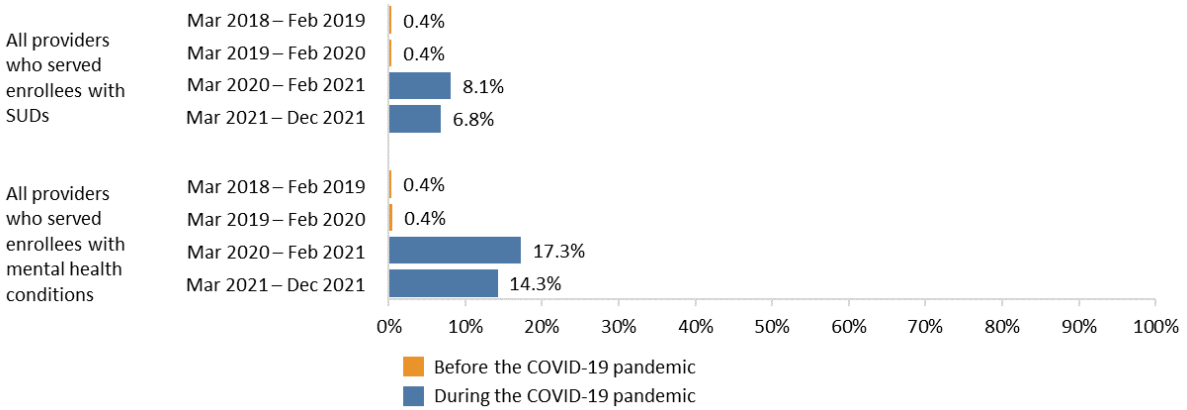
Source: TAF, v5, 2018 to 2021.

Note: For each period assessed the analysis included providers who delivered at least 20 behavioral health services during the period. The assessment was based on claims for services delivered to Medicaid and CHIP enrollees between March 1, 2018, and December 31, 2021. Specialty providers include psychiatric physicians, psychologists, therapists/counselors, peer specialists, and social workers. Non-specialty providers include non-psychiatric physicians, primary care physicians, nurse practitioners, and physician assistants.

CHIP = Children's Health Insurance Program; TAF = Transformed Statistical Medicaid Information System Analytic Files.

The proportion of providers who delivered more than 80% of their behavioral health services via telehealth during the pandemic decreased as the pandemic continued for most types of providers, except perinatal providers (**Figure 2**, and Appendix **Tables B.1 and B.2**). Among providers who delivered behavioral health services, the share of those who delivered more than 80% of their behavioral health services via telehealth declined by 2.7 percentage points between the first year of the pandemic and the second year of the pandemic (from 15.4% to 12.7%). This decline was more pronounced for providers delivering behavioral health services to children; they had a 6.1 percentage point decline during the same period (from 20.9% to 14.8%). This decline could reflect providers' or families' experiences with tele-behavioral health or preferences for care, as some studies have suggested providers felt some behavioral health services for children and youth were more effectively provided in person.[15] In contrast, the share of perinatal providers who delivered more than 80% of their behavioral health services via telehealth increased by 2.5 percentage points (from 15.4% to 17.9%) between the two periods. This increase could reflect states' efforts to promote telehealth for prenatal, postnatal, and postpartum care.[16]

Figure 3. Percentage of Mental Health and SUD Providers Who Delivered more than 80% of Behavioral Health Services via Telehealth, by Time Period



Source: TAF, v5, 2018 to 2021.

Note: For each period assessed the analysis included providers who delivered at least 20 behavioral health services during the period. The assessment was based on claims for services delivered to Medicaid and CHIP enrollees between March 1, 2018, and December 31, 2021. This figure shows the percentage of providers who delivered more than 80% of their behavioral health services via telehealth in each period of analysis. Mental health conditions include anxiety disorders, mood disorders, other mental health disorders, personality disorders, and schizophrenia and other psychotic disorders. SUD includes alcohol use disorders, opioid use disorders, and other drug use disorders. Providers may be classified in more than one category.

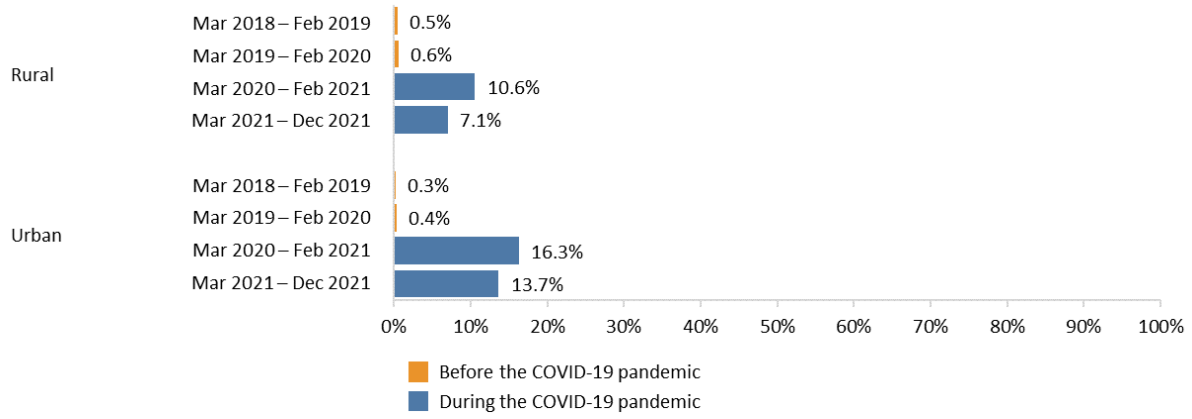
CHIP = Children's Health Insurance Program; SUD = substance use disorder; TAF = Transformed Statistical Medicaid Information System Analytic Files.

Providers who served enrollees with mental health conditions were more likely than providers who served enrollees with SUDs to deliver more than 80% of their behavioral health services via telehealth during the pandemic (**Figure 3** and Appendix **Table B.2**). Before the pandemic, 0.4% of providers who served mental health conditions and SUDs delivered more than 80% of behavioral health services via telehealth; this proportion increased to 17.3% of providers who served enrollees with mental health conditions during the first year of the pandemic compared with 8.1% of providers who served enrollees with SUDs in the same period. The proportion of providers who delivered more than 80% of their behavioral health services via telehealth during the pandemic varied by the populations served. Among providers who served enrollees with mental health conditions, 31.5% of providers who treated people with personality disorders delivered more than 80% of their behavioral health services via telehealth in the first year of the pandemic compared with 16.1% of providers who treated enrollees with schizophrenia and other psychotic disorder diagnoses (Appendix **Table**

B.2). Among providers who served enrollees with SUDs, 8.1% of those who treated alcohol and 11.1% of those who treated other drug use disorders delivered more than 80% of their behavioral health services via telehealth during the first year of the pandemic compared with 1.6% of providers who treated opioid use disorder. These differences could reflect the need for in-person monitoring of physical symptoms and medication administration and management, particularly for enrollees receiving methadone.[17]

Compared to rural providers, urban providers were more likely to deliver more than 80% of behavioral health services via telehealth during the first year of the pandemic and this difference grew during the second year of the pandemic (**Figure 4** and Appendix **Table B.2**). The proportion of providers in rural areas who delivered more than 80% of behavioral health services via telehealth increased at the onset of the pandemic (from 0.6% to 10.6%) and then decreased by 3.5 percentage points to 7.1% in the second year of the pandemic. The findings were similar for providers in urban areas, with 16.3% of these providers delivering behavioral health services via telehealth in the first year of the pandemic declining by 2.6 points to 13.7% of providers in the second year.

Figure 4. Percentage of Urban and Rural Providers Who Delivered more than 80% of Behavioral Health Services via Telehealth, by Time Period



Source: TAF, v5, 2018 to 2021.

Note: For each period assessed the analysis included providers who delivered at least 20 behavioral health services during the period. The assessment was based on claims for services delivered to Medicaid and CHIP enrollees between March 1, 2018, and December 31, 2021. This figure shows the percentage of providers who delivered behavioral health services via telehealth in each period of analysis.

CHIP = Children's Health Insurance Program; TAF = Transformed Statistical Medicaid Information System Analytic Files.

DISCUSSION

As of January 2022, all states allowed the use of telehealth for some behavioral health services during the COVID-19 pandemic.[18,19] Whether these telehealth policy flexibilities become permanent remains uncertain, and telehealth regulations vary widely across states.[18] The findings from this study highlight three important features of the well-documented shift to telehealth for behavioral health services during the pandemic.[1,2] First, almost half of non-specialists delivered at least some behavioral health services via telehealth. Second, one-quarter of specialty behavioral health providers were still delivering most behavioral health services via telehealth in the second year of the pandemic. Third, providers who deliver mental health services were more likely than SUD providers to deliver most of their services via telehealth during the pandemic. Here, we briefly expand on the potential implications of these findings for states and policymakers as the future role of telehealth in the delivery of behavioral health care evolves.

Although tele-behavioral health services can expand access to care and improve patient outcomes, research is needed to understand the potential unintended consequences of a large group of behavioral health providers delivering most or all services via telehealth. The differences in the shifts to tele-behavioral health services for specialist and non-specialist providers as well as the providers who serve rural and urban areas may reflect differences in the types of services offered and the populations these providers serve. Further investigation is needed to understand if these shifts to telehealth have impacted the availability of in-person services. If sustained over time, such a shift may have important implications for workforce shortages for in-person care, which may disproportionately impact populations who find it difficult to engage in tele-behavioral health services. The findings from this study also raise several important questions about the specific types of behavioral health services delivered via telehealth, and how behavioral health providers who deliver most of their services via telehealth may differ from behavioral health providers who offer a mix of in-person and telehealth services or only provide in-person services.

This rapid shift to telehealth required providers to adapt their in-person clinical skills to video or audio-only formats, with mixed success.[14,20] As providers consider how to integrate tele-behavioral health services into their practices, they will still need to decide which behavioral health services are appropriate for telehealth, how the telehealth services should be incorporated into the overall care plan, and how to adapt these services to meet the needs of the community.[21] This study did not examine the specific types of behavioral health services delivered via telehealth and future research could examine which behavioral health services are most appropriate for telehealth, which populations may benefit the most from these services, and the impact of telehealth on disparities.

Most SUD providers, including those who serve enrollees with opioid use disorder, did not deliver most behavioral health services via telehealth. This may reflect the needs for in-person treatment and medication monitoring for people with SUDs.[22] Several flexibilities, which expanded the use of telehealth for the treatment of opioid use disorders during the pandemic, have stayed in place. For example, the Drug Enforcement Administration and U.S. Department of Health and Human Services have extended flexibilities that allow initiation of controlled medications to patients via telemedicine, without having an in-person examination, through December 31, 2025.[23] The Substance Abuse and Mental Health Services Administration's flexibility to allow prescribing buprenorphine via telehealth in opioid treatment programs is permanent as of April 2024.[24] Telehealth may provide additional opportunities to reach people with SUDs, because using telehealth for SUD treatment shows improved retention in treatment and high patient satisfaction.[25,26]

LIMITATIONS

This study has several limitations. First, several states had poor quality data and could not be included in the analysis, which limits our ability to draw conclusions about national trends. Second, we examined the use of tele-behavioral health services, but we lacked the information necessary to determine whether these services reflected the appropriate level of care or modality to meet the needs of enrollees. Third, the last time period, March 2021 to December 2021, did not have 12 months of data like the other time periods in this study. Therefore, the slight declines in that time period in several analyses may be attributable to the lack of data for January 2022 to February 2022, if high service use occurred during those months. Fourth, the restrictions applied to the study to remove providers who delivered the lowest amounts of tele-behavioral health services were arbitrary: providers who had fewer than 20 claims per year were excluded. Although the exclusion served to focus the analysis on providers who delivered some minimal amount of behavioral health services, the

trade-off with a lower exclusion threshold is that we risk overestimating the number of providers who treated enrollees with behavioral health conditions during a specific period but who did not routinely deliver behavioral health treatment at that time. Finally, we used providers' location to classify them into urban and rural settings, and providers' location may not align with whether enrollees reside in an urban or rural setting and some urban-based providers may be serving relatively large number of enrollees who live in rural areas.

APPENDIX A. ADDITIONAL METHODOLOGICAL INFORMATION

Appendix Table A.1. Telehealth Codes		
Code Type	**Code**	**Description**
POS	2	Use of telecommunication technology
POS	10	Use of telecommunication technology
Modifier	93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
Modifier	FQ	Service was provided using audio-only communication technology
Modifier	95	Synchronous telemedicine A/V
Modifier	GT	Via telecommunications system (e.g., video)
Modifier	GQ	Use of asynchronous telecommunications system
Procedure (CPT)	99441	Telephone E&M services
Procedure (CPT)	99442	Telephone E&M services
Procedure (CPT)	99443	Telephone E&M services
Procedure (CPT)	98966	A non-physician provider telephone E&M services, 5-10 mins
Procedure (CPT)	98967	A non-physician provider telephone E&M services, 11-20 mins
Procedure (CPT)	98968	A non-physician provider telephone E&M services, 21-30 mins
Procedure (HCPCS)	G2552	Brief communication technology-based service (e.g., virtual check-in, by a qualified health care professional)
Procedure (HCPCS)	G2552	Brief communication technology-based service (e.g., virtual check-in, by a qualified health care professional)
Procedure (HCPCS)	G2025	RHC/FQHC distant site telehealth service
Procedure (CPT)	98970	Online digital assessment and management by non-physicians -- e-visits through patient portal
Procedure (CPT)	98971	Online digital assessment and management by non-physicians -- e-visits through patient portal
Procedure (CPT)	98972	Online digital assessment and management by non-physicians -- e-visits through patient portal
Procedure (CPT)	99421	Online digital E&M by physicians and qualified professionals such as NPs -- e-visits through patient portal
Procedure (CPT)	99422	Online digital E&M by physicians and qualified professionals such as NPs -- e-visits through patient portal
Procedure (CPT)	99423	Online digital E&M by physicians and qualified professionals such as NPs -- e-visits through patient portal
Procedure (CPT)	99444	Brief check-in or e-visit
Procedure (CPT)	98969	Brief check-in or e-visit
Procedure (HCPCS)	G0071	Communication technology-based services for 5 minutes or more of a virtual communication between a rural health clinic or federally qualified health center practitioner and patient

Appendix Table A.1. (*continued*)		
Code Type	**Code**	**Description**
Procedure (HCPCS)	G2012	Brief communication technology-based service (e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management service)
Procedure (HCPCS)	G2061	Online Assessment of established patient by Qualified Non-physician Healthcare Professional, 5-10 mins
Procedure (HCPCS)	G2062	Online Assessment of established patient by Qualified Non-physician Healthcare Professional, 11-20 mins
Procedure (HCPCS)	G2063	Online Assessment of established patient by Qualified Non-physician Healthcare Professional, 21+ mins
Procedure (HCPCS)	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward)
Procedure (HCPCS)	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward)
Procedure (HCPCS)	G2251	Brief communication technology-based service (e.g., virtual check-in, by a qualified health care professional)
Procedure (HCPCS)	G2252	Brief communication technology-based service (e.g., virtual check-in, by a qualified health care professional)

A/V = Audio/Visual; CPT = Current Procedural Terminology; E&M = Evaluation and Management; HCPCS = Healthcare Common Procedure Coding System; NP = Nurse Practitioner; POS = place of service.

Appendix Table A.2. Provider Categorization			
Provider Type	Description	Identification	
		Provider Codes (taxonomy, specialty, type)	Procedure codes
Physician (non-psychiatric)	All physicians who have non-psychiatric, non-primary care specialties	Yes	No
Physician (psychiatric)	Physicians with psychiatric specialties	Yes	No
Physician (primary care)	Physicians with a primary care specialty (general practice, family medicine, internal medicine, geriatric medicine, pediatrics)	Yes	No
Nurse practitioner	All nurse practitioners, regardless of specialty	Yes	No
Psychologist	Psychologists with varying specializations	Yes	No
Social worker	Social workers, including clinical and school social workers	Yes	No
Physician assistant	All physician assistants, including medical and surgical	Yes	No
Therapists/counselors	Includes therapists and counselors	Yes	No
Peer specialists	Peer support workers who have been successful in the recovery process who help others experiencing similar situations	Yes	Yes
Clinics	Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Rural Health Clinics	Yes	Yes
Note: There are specific procedure codes for clinic-based services and peer support services. Peer support services codes vary by state but can be used to identify peer support services.			

APPENDIX B: SUPPLEMENTAL DESCRIPTIVE STATISTICS

Appendix Table B.1. Distribution of Providers by Volume of Behavioral Health Services Provided via Telehealth, by Provider Type

Provider Type	March 2018-February 2019				March 2019-February 2020				March 2020-February 2021				March 2021-December 2021			
	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%
All behavioral health providers, stratified by provider type																
All behavioral health providers	96.0%	3.0%	0.6%	0.3%	94.0%	4.8%	0.8%	0.4%	32.4%	22.8%	29.5%	15.4%	38.6%	26.5%	22.2%	12.7%
All physicians	96.8%	2.2%	0.6%	0.3%	95.9%	3.0%	0.7%	0.4%	44.7%	24.5%	24.3%	6.5%	52.2%	27.2%	15.4%	5.2%
Physician (non-psychiatric)	98.7%	1.1%	0.1%	0.1%	98.1%	1.6%	0.2%	0.1%	70.7%	15.0%	11.2%	3.1%	76.9%	14.0%	6.7%	2.4%
Physician (psychiatric)	87.1%	7.9%	2.8%	2.1%	83.9%	10.4%	3.3%	2.4%	22.8%	20.4%	31.5%	25.3%	27.2%	23.0%	28.5%	21.3%
Physician (primary care)	97.8%	1.6%	0.4%	0.1%	97.3%	2.1%	0.5%	0.1%	34.8%	30.7%	30.0%	4.4%	43.8%	35.6%	17.5%	3.2%
Nurse Practitioner	93.5%	3.8%	1.4%	1.3%	91.6%	5.1%	1.8%	1.5%	26.1%	29.3%	32.3%	12.3%	36.5%	31.6%	22.1%	9.8%
Psychologist	95.6%	3.7%	0.4%	0.2%	92.4%	6.7%	0.6%	0.2%	18.6%	17.0%	33.1%	31.3%	24.1%	20.1%	29.6%	26.2%
Social Worker	96.1%	3.4%	0.4%	0.1%	92.9%	6.4%	0.5%	0.2%	15.2%	15.9%	36.6%	32.3%	19.1%	22.0%	32.1%	26.9%
Physician Assistant	96.9%	2.0%	0.7%	0.2%	96.1%	2.6%	1.0%	0.3%	38.4%	25.3%	29.4%	6.9%	44.7%	31.3%	18.7%	5.4%
Therapists/Counselors	95.6%	3.9%	0.4%	0.2%	92.2%	7.0%	0.6%	0.2%	15.1%	17.4%	36.9%	30.6%	18.4%	22.9%	32.6%	26.2%
Peer specialists	90.4%	8.7%	0.3%	0.0%	88.9%	9.5%	1.1%	0.0%	30.8%	24.1%	31.7%	13.5%	39.8%	27.3%	25.3%	7.5%
Clinics	91.1%	7.4%	0.7%	0.6%	88.2%	9.4%	1.3%	1.1%	25.0%	22.7%	27.0%	25.4%	29.6%	29.4%	26.9%	14.1%
All behavioral health providers, stratified by specialty																
Specialty Providers	94.2%	4.5%	0.8%	0.5%	90.9%	7.6%	1.0%	0.5%	17.2%	17.7%	35.4%	29.7%	21.3%	22.5%	31.2%	25.0%
Non-Specialty Providers	97.5%	1.8%	0.5%	0.3%	96.6%	2.5%	0.6%	0.3%	43.6%	25.9%	25.0%	5.4%	51.7%	28.7%	15.3%	4.2%

Source: TAF, v5, 2018-2021.

Notes: This analysis includes providers who delivered behavioral health services to Medicaid and CHIP enrollees between March 1, 2018, and December 31, 2021. The categories for the distribution are inclusive of the end case. For example, the 1%-20% category included providers with a share of tele-behavioral health services greater than 0 and less than or equal to 20%. Providers with a share greater than 20% and less than or equal to 80% were included in the 20%-80% category. Similarly, the "More than 80%" category included providers with a share of tele-behavioral health services greater than 80%. Specialty providers include psychiatric physicians, psychologists, therapists/counselors, peer specialists, and social workers. Non-specialty providers include non-psychiatric physicians, primary care physicians, nurse practitioners, and physician assistants.

CHIP = Children's Health Insurance Program; TAF = Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files.

Appendix Table B.2. Distribution of Providers by Volume of Behavioral Health Services Provided via Telehealth, by Population Served																
Provider Type	March 2018-February 2019				March 2019-February 2020				March 2020-February 2021				March 2021-December 2021			
	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%
All providers who deliver behavioral health services, stratified by conditions treated																
All providers delivering both mental health and SUD services	94.0%	4.0%	1.1%	0.9%	92.5%	5.1%	1.5%	0.9%	32.4%	19.1%	28.6%	19.9%	37.4%	21.3%	24.8%	16.5%
All providers delivering mental health services	95.6%	3.3%	0.7%	0.4%	93.5%	5.2%	0.9%	0.4%	26.8%	23.2%	32.7%	17.3%	33.1%	27.9%	24.8%	14.3%
All providers delivering any services for enrollees with anxiety disorders	95.4%	3.3%	0.9%	0.4%	93.4%	5.0%	1.1%	0.6%	21.2%	20.3%	37.0%	21.6%	27.2%	25.4%	29.4%	17.9%
All providers delivering any services for enrollees with mood disorders	94.9%	3.6%	1.0%	0.5%	92.9%	5.2%	1.2%	0.7%	23.3%	20.7%	34.2%	21.8%	29.4%	24.3%	28.0%	18.3%
All providers delivering any services for enrollees with other mental health disorders	95.4%	3.3%	0.8%	0.4%	93.5%	5.0%	1.0%	0.5%	20.4%	18.6%	35.8%	25.2%	26.9%	24.3%	28.7%	20.1%
All providers delivering any services for enrollees with personality disorders	94.1%	4.2%	1.1%	0.6%	92.5%	5.2%	1.5%	0.8%	22.1%	14.5%	31.8%	31.5%	25.9%	16.5%	29.8%	27.8%
All providers delivering any services for enrollees with schizophrenia and other psychotic disorders	93.4%	4.2%	1.4%	0.9%	92.2%	5.0%	1.7%	1.1%	38.4%	19.6%	25.9%	16.1%	44.9%	20.4%	22.2%	12.5%
All providers delivering SUD services	97.2%	1.9%	0.5%	0.4%	96.1%	2.8%	0.7%	0.4%	59.9%	16.4%	15.5%	8.1%	64.1%	16.6%	12.5%	6.8%
All providers delivering any services for enrollees with alcohol use disorder	97.6%	1.6%	0.5%	0.3%	96.9%	2.1%	0.6%	0.3%	62.5%	14.5%	14.9%	8.1%	66.2%	14.6%	12.3%	7.0%

Appendix Table B.2. (*continued*)																
Provider Type	March 2018-February 2019				March 2019-February 2020				March 2020-February 2021				March 2021-December 2021			
	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%	0%	1-20%	20-80%	80-100%
All providers delivering any services for enrollees with opioid use disorder	98.4%	1.7%	0.0%	0.0%	98.0%	2.0%	0.0%	0.0%	78.3%	18.2%	0.7%	1.6%	76.9%	17.0%	0.6%	3.6%
All providers delivering any services for enrollees with other drug use disorders	95.8%	2.8%	0.9%	0.6%	94.5%	3.8%	1.2%	0.6%	52.5%	16.8%	19.5%	11.1%	56.1%	18.5%	16.3%	9.1%
All providers who deliver behavioral health services, stratified by treatment of special enrollee populations																
All providers delivering any services for children	95.4%	3.5%	0.7%	0.4%	93.3%	5.4%	0.9%	0.5%	21.7%	22.0%	35.3%	20.9%	29.9%	28.9%	26.3%	14.8%
All providers delivering services to perinatal clients	95.9%	3.3%	0.5%	0.0%	94.8%	4.0%	1.0%	0.0%	43.1%	17.4%	24.0%	15.4%	48.1%	15.6%	18.4%	17.9%
All health providers who deliver behavioral health services, stratified by provider geographic location																
All urban providers	96.3%	2.8%	0.6%	0.3%	94.3%	4.6%	0.8%	0.4%	32.9%	21.5%	29.3%	16.3%	38.5%	25.2%	22.6%	13.7%
All rural providers	94.5%	4.1%	0.8%	0.5%	92.4%	6.0%	1.0%	0.6%	29.0%	29.6%	30.8%	10.6%	39.4%	33.6%	19.9%	7.1%

Source: TAF, v5, 2018-2021

Notes: This analysis includes providers who delivered behavioral health services to Medicaid and CHIP enrollees between March 1, 2018, and December 31, 2021. The categories for the distribution are inclusive of the end case. For example, the 1%-20% category included providers with a share of tele-behavioral health services greater than 0 and less than or equal to 20%. Providers with a share greater than 20% and less than or equal to 80% were included in the 20%-80% category. Similarly, the "More than 80%" category included providers with a share of tele-behavioral health services greater than 80%. Specialty providers include psychiatric physicians, psychologists, therapists/counselors, peer specialists, and social workers. Non-specialty providers include non-psychiatric physicians, primary care physicians, nurse practitioners, and physician assistants.

CHIP = Children's Health Insurance Program; TAF = Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files.

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ABOUT THE AUTHORS
Laura Jacobus-Kantor, Ph.D., Tim Creedon, Ph.D., and Judith Dey, Ph.D., work in the Office of Behavioral Health, Disability, and Aging Policy in the Office of the Assistant Secretary for Planning and Evaluation.

Ruchir Karmali, Ph.D., Hamed Lahijani, D.H.Sc, Melissa Sanchez, M.P.P., Carol V. Irvin, Ph.D., Ellen Bouchery, Ph.D., Mike Rudacille, M.S., and Jonathan Brown, Ph.D., work at Mathematica.

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