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# State Medicaid Telehealth Policies Before and During the COVID-19 Public Health Emergency

States have embraced Medicaid telehealth flexibilities during the COVID-19 Public Health Emergency (PHE), enhancing beneficiary access to services delivered via telehealth.

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## KEY POINTS

- Some state Medicaid programs have been innovators and early adopters of telehealth for the delivery of services, often paying for care via telehealth not traditionally covered by Medicare. For instance, even before the PHE, 47 states allowed for behavioral services to be delivered via telehealth and 36 states did so for primary care.
- Since the COVID-19 PHE, states have significantly expanded beneficiary access to telehealth for the delivery of Medicaid-covered services and providers, with all states now covering primary care and behavioral health services delivered via telehealth.
- Many states have expanded coverage for telehealth modalities to include telephone-only, text-based communication, and remote patient monitoring, as well as authorizing patients' homes as an originating site.
- At least 42 states and the District of Columbia now specify that some covered telehealth services are paid at the same rate as in-person services.
- Claims data show that services delivered via telehealth increased more than 20-fold, from roughly 6 telehealth services per 1,000 Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in February 2020 to over 150 per 1,000 in April 2020. Rates declined after April but still remained far above the pre-pandemic level
- Research shows that Medicaid beneficiaries, as well as patients who are older, people of color, those with limited English proficiency, and have lower incomes, have lower rates of visits delivered via telehealth during COVID-19 than other populations, especially visits by video.

## INTRODUCTION

Medicaid services have been available to be delivered via telehealth in states for decades, and some state Medicaid programs have been innovators and early adopters of telehealth for the delivery of services, often paying for care via telehealth not traditionally covered by Medicare. The COVID-19 Public Health Emergency (PHE) has substantially accelerated the utilization and interest in telehealth within state Medicaid programs.

This Issue Brief examines state Medicaid telehealth coverage and policies before and after the COVID-19 PHE was declared in January 2020.[i]

## BACKGROUND

Telehealth is not a discrete service under Medicaid and is not defined as a benefit in federal Medicaid statute. Instead, it is a mode of service delivery. Telehealth modalities include real-time audio and/or video visits, where care is provided to the patient (located at the "originating site") by a physician or practitioner located elsewhere (at the "distant site");[ii] remote patient monitoring; asynchronous store and forward, where patient data such as lab reports and imaging studies are sent from one provider's office to another provider for review later; and texting.

States have the flexibility to determine which services and providers are allowed to be delivered via telehealth, what types of practitioners or providers may deliver services via telehealth, which specific Medicaid populations and geographic areas can be served, and what payment rates to providers will be. A separate state plan amendment (SPA) is not required if services provided via telehealth are paid at the same rate as in-person services. State Medicaid programs must follow all the applicable federal and state laws for telehealth; these laws include Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other patient privacy regulations, provider licensing, scope of practice, and drug prescribing requirements.

### Challenges with Telehealth in Medicaid Before the COVID-19 Pandemic

While many state Medicaid programs have been innovators in using telehealth, there have also been significant barriers to broader telehealth use in the program. A 2019 report commissioned by ASPE with 19 Federally Qualified Health Center (FQHC) providers in seven state Medicaid programs (Alabama, Connecticut, Iowa, New Mexico, Oregon, Pennsylvania, and Virginia) and state Medicaid officials in those states discussed a range of policy, organizational, and logistical barriers to utilization of telehealth.[1] For instance, some state Medicaid programs did not allow FQHCs to serve as distant sites with the patient receiving telehealth services at home or at another provider's office. There was a general lack of clarity regarding what services were allowed to be delivered via telehealth and telepresenter[iii] requirements, as well as insufficient reimbursement.

Other challenges for FQHC providers cited in the report included lack of reliable broadband internet, technology costs, billing challenges, lack of buy-in among clinicians, complexities in adjusting clinic workflow, inadequate supply of specialists, difficulties with credentialing and licensing, and issues with working with remote providers. Medicaid beneficiaries, especially older adults and people experiencing homelessness, had access problems with devices and reliable broadband. Other challenges included lack of common electronic health records (EHR) across hospitals or providers, inability to integrate telehealth visits into the EHR, information technology (IT) staffing and training, lack of training among providers and patients, and HIPAA privacy requirements.

### Medicaid Telehealth Service Utilization Prior to COVID-19

Tracking utilization of care delivered via telehealth in Medicaid is somewhat limited by variation in whether states routinely record a location of care in their claims or otherwise indicate which services are delivered via telehealth. Acknowledging these limitations, while all state Medicaid programs covered services delivered via telehealth prior to COVID-19, Medicaid claims data indicate few telehealth claims before the COVID-19 PHE.[2,3] Rural areas had more telehealth users than urban areas, and behavioral health services and prescriptions

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[i] Data on services delivered via telehealth was only publicly available for Medicaid and CHIP combined, but this brief focuses on Medicaid policies on telehealth, not CHIP policies, as there is less research on CHIP policies.

[ii] Telemedicine. Medicaid.gov. Accessed at: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html.

[iii] A telepresenter is a medical professional who presents the patient at the originating site to a provider at the "distant" site.

dominated telehealth utilization. As discussed below, claims identified as being delivered via telehealth have risen dramatically during the COVID-19 PHE.

### Selected Federal Changes in Telehealth Policy During the Pandemic Related to Medicaid

The Center for Medicare & Medicaid Services (CMS) offered an accelerated approval process for SPAs related to various pre-existing state options to expand telehealth delivery in Medicaid programs, as well as updated guidance to states. States have discretion as to whether to take up the options to expand types of service, provider, modality, and site for telehealth during the PHE and whether to continue these options on a permanent basis. This Brief summarizes the decisions state Medicaid programs have made in these policy areas. However, several other federal policies regarding telehealth had important implications for Medicaid:

Office for Civil Rights (OCR): HHS and OCR issued a public notice on March 17, 2020, that penalties would not be imposed for HIPAA non-compliance in connection with the good faith provision of telehealth during the COVID-19 PHE.[4] Any non-public facing remote communication product (e.g. Apple FaceTime, Facebook Messenger video chat, Zoom, and Skype) can be used to communicate with patients in addition to HIPAA-compliant platforms. HIPAA-compliant video communication products include Skype for Business, Microsoft Teams, Zoom for Healthcare, WebEx Teams, and GoToMeeting.

Drug Enforcement Administration (DEA): DEA waived in-person medical evaluation requirements under the Ryan Haight Act of 2008 for prescriptions of controlled substances delivered via telehealth visits in response to the PHE.[5]

## METHODS

A review of CMS policies and a literature search were conducted on Medicaid telehealth coverage and policies before and after the COVID-19 public health emergency was declared on January 31, 2020. CMS provided data on utilization of telehealth in Medicaid and CHIP during the early months of the PHE.

## FINDINGS

### Medicaid Services Delivered via Telehealth

All 50 states and the District of Columbia allowed some services to be delivered via telehealth under Medicaid in 2019. As Table 1 shows, most states allowed behavioral health services (47 states) and primary care services (36 states) to be delivered via telehealth in 2019.[6] Fewer states allowed physical, occupational, and speech therapy (16 states), maternity services (15 states), and LTSS, including home and community-based services (HCBS) in 14 states to be delivered via telehealth in 2019.

During the COVID-19 PHE, however, the number of states allowing these services to be delivered via telehealth has more than doubled. In addition to the services in Table 1, many states have expanded their telehealth modalities to include specific codes for evaluation and management visits and virtual check-ins, asynchronous electronic communication, remote patient monitoring, and critical care or consults between providers provided through digital technologies.

With respect to providers, according to the Medicaid and CHIP Payment and Access Commission (MACPAC), before the PHE most states allowed physicians (42 states), behavioral health providers (41 states), and advanced practice providers (36 states) to deliver services via telehealth, but only 15 states allowed dentists. As Table 1 illustrates, coverage of telehealth services for these providers has expanded as of May 1, 2020, with the number of states allowing dentists to deliver services via telehealth services more than doubled, and all states plus the District of Columbia now allowing telehealth for physician services.

**Table 1: Telehealth Policies Before and During the COVID-19 Public Health Emergency[a]**

| | Total Number of States In 2019 | Number of States As of May 2020 |
|---|---|---|
| **Services Allowed for Delivery via Telehealth** | | |
| Behavioral Health | 47 | 51 |
| Primary Care | 36 | 51 |
| Dental | 19 | 39 |
| Physical, Occupational, and Speech Therapy | 16 | 49 |
| Maternity | 15 | 31 |
| Long-term Services and Supports | 14 | 41 |
| **Providers Allowed for Service Delivery via Telehealth** | | |
| Physicians | 42 | 51 |
| Behavioral Health Providers | 41 | 50 |
| Advanced Practice Providers | 36 | 43 |
| Dentists | 15 | 35 |

Source: Changes in Medicaid Telehealth Policies Due to COVID19. MACPAC June 2020.

[a] The types of services and providers in each category may vary by state and over time, and the states identified as not "allowing delivery via telehealth" did not show indication of any coverage before the PHE. 51 "states" are the 50 states and the District of Columbia.

There are different technologies and approaches (i.e., modalities) used in telehealth to connect patients and providers. Telehealth modalities covered by states include:

- real-time (or synchronous) video interaction between provider and patient
- store-and-forward (asynchronous) technology, which collects and sends data from the patient to be analyzed for diagnosis and/or treatment later
- remote patient monitoring, which may or may not be in real time
- telephone-only communication
- text-based communication

Table 2 shows changes in state Medicaid coverage of telehealth modalities since 2019. All states allowed real-time live video before the COVID-19 PHE, but specific information on states' coverage for other modalities is incomplete. As of May 2020:

- 29 states allowed store-and-forward services
- 37 states allowed remote patient monitoring that uses information technology to collect patient data (ex. blood pressure and glucose levels) to send to the provider.
- All states and the District of Columbia allowed telephone-only communication.
- 17 states allowed text-based communication.

Also, during the COVID-19 PHE, 47 states allowed Medicaid beneficiaries' homes to serve as an originating site to access telehealth services, as of May 2020. Provider offices and health facilities had been the only originating sites in 26 states of these states in 2019. Forty-nine states temporarily expanded settings where services may be provided to long-term care patients, including settings such as hotels, shelters, schools, and churches.[7]

Setting payment rates for services delivered via telehealth is another key policy issue within Medicaid. It is difficult to assess payment parity (i.e., telehealth payment compared to payment for in-person services) before COVID-19 because many state payment policies were unclear before 2020.[8] At least 42 states and the District

of Columbia specified that at least some services delivered via telehealth are paid at the same rate as an in-person service as of June 7, 2021.[9]

States also made changes to Medicaid managed care policies. State Medicaid programs have issued guidance to managed care plans on temporary policy changes to telehealth during the COVID-19 PHE. Some of the telehealth guidance applies to both managed care plans and FFS providers. Appendix 1 shows state examples.

See Appendix 2 for additional examples of specific states' telehealth policy changes and experiences since the COVID-19 PHE.

CMS approved more than 600 temporary waivers, state plan amendments or other temporary flexibilities in response to COVID-19 by December 2020, which included flexibilities on services delivered via telehealth.[10]

**Table 2: Covered Modalities and Originating Sites in Medicaid: Telehealth Policies Before and During the COVID-19 Public Health Emergency Declaration**

| | Number of States In 2019 | Number of States As of May 2020 |
|---|---|---|
| Modality or Originating Site | | |
| Real-time Video | 51 | 51 |
| Store and Forward | 18 | 29 |
| Remote Patient Monitoring | 30 | 37 |
| Telephone-only Communication | 0 | 51 |
| Text-based Communication | 3 | 17 |
| "Home" as an Originating Site | 21 | 47 |

Source: Changes in Medicaid Telehealth Policies Due to COVID-19. MACPAC June 2020.

## Medicaid Policy Guidance under the COVID-19 Public Health Emergency (PHE)

### CMS Guidance

The CMS State Medicaid & CHIP Telehealth Toolkit offers policy considerations for states expanding use of telehealth during the COVID-19 PHE.[11] States have the option to pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment for delivering services via telehealth. Ancillary costs associated with the site where the beneficiary is located may be included in the FFS rates or as separate administrative costs.

According to the CMS Toolkit, state considerations for expanded utilization of telehealth during the COVID-19 PHE include:

- The population to whom the service is being delivered (e.g., children, individuals with disabilities, older adults, etc.).
- Privacy and consent laws and policies.
- Services being delivered via telehealth, including coverage and reimbursement. States should review services not traditionally delivered via telehealth to determine whether they may be appropriately delivered via telehealth.
- The provider or practitioner delivering the service. States should consider whether the scope of services enable billing for telehealth services and whether the scope of services should be changed.

- The technology used to deliver the service. States have the option to cover telephone audio-only telehealth services. During the PHE, the U.S. Department of Health and Human Services (HHS) has enforcement discretion on non-HIPAA platforms.
- How to ensure equitable access to telehealth services to avoid disparities by race/ethnicity, income, geography, age, and other factors.

States are able to add or modify Medicaid utilization of telehealth through several pathways, described in more detail in Appendix 3. The pathways are: 1135 Emergency waivers, disaster relief Medicaid SPAs, or Appendix K for 1915(c) waiver home and community-based services (HCBS) and Attachment K for HCBS in 1115 demonstrations. In March 2020, CMS created streamlined templates for these authorities with multiple time-limited options.[12]

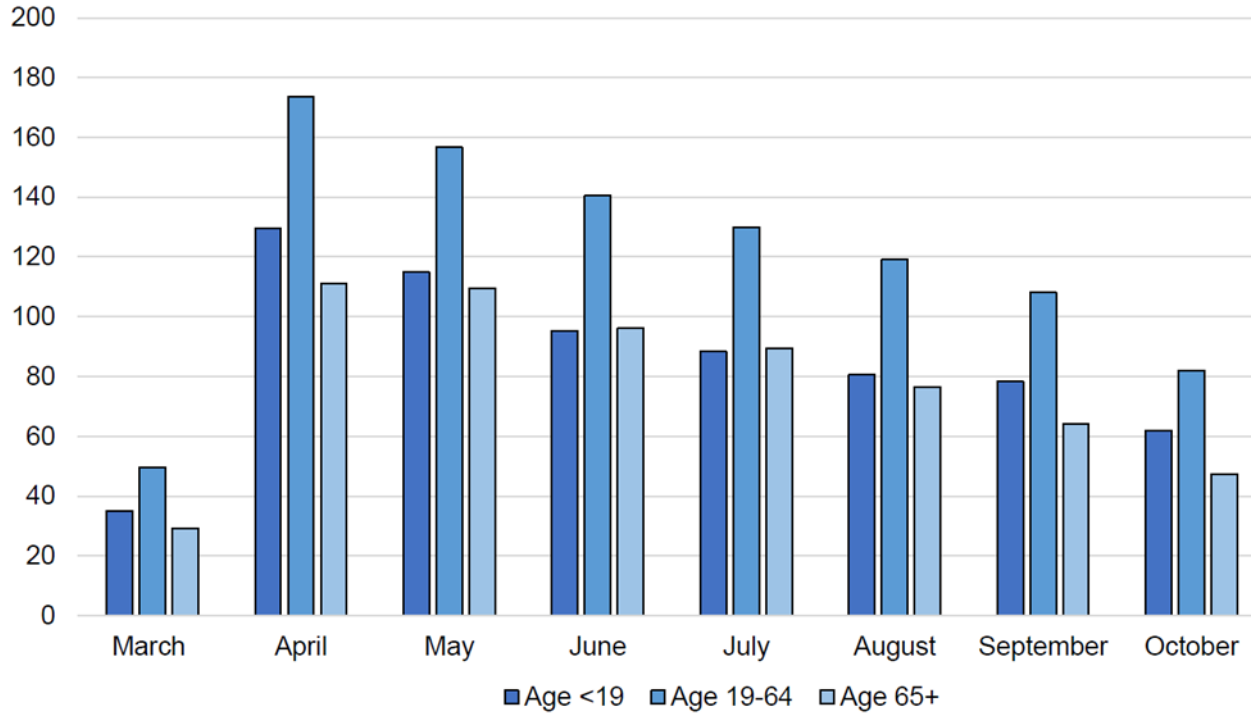
### Medicaid and CHIP Telehealth Utilization During the COVID-19 PHE

Services delivered via telehealth increased from less than 6 services per 1,000 Medicaid and CHIP beneficiaries to more than 150 per 1,000[iv] Medicaid and CHIP beneficiaries from February 2020 to April 2020.[13] Utilization then decreased to approximately 100 services per 1,000 Medicaid and CHIP beneficiaries in June 2020. Services delivered via telehealth was highest among adults ages 19-64, followed by children and then adults age 65 and older. Services delivered via telehealth varied significantly by state. Based on April 2020 data, among children, Maine had the highest monthly rate at 402 services per 1,000 children and Vermont had the lowest at 23 services per 1,000 children. Among adults age 19-64, Missouri had the highest monthly rate at 520 services per 1,000 adults, and South Carolina had the lowest monthly rate at 51 services per 1,000 adults.

Figure 1 shows Medicaid and CHIP services delivered via telehealth from March to October 2000 of the PHE. For adults ages 19-64, telehealth utilization identified in Medicaid data increased from about 50 services per 1,000 adults in March 2020 to about 173 services per 1,000 in April 2020 and decreased to about 82 services per 1,000 in October 2020.[14] For children under the age of 19, telehealth utilization increased from about 31 services per 1,000 children in March 2020 to about 135 services per 1,000 in April 2020 and decreased to about 62 services per 1,000 in October 2020. It is possible that these results understate the extent of telehealth utilization if not all Medicaid and CHIP claims identify the site of care or an indicator for delivery via telehealth.

[iv] These results are for Medicaid & CHIP only and do not represent the full set of services received by dually eligible beneficiaries. Many beneficiaries age 65 and older are likely to be dually eligible for both Medicare and Medicaid.

**Figure 1. Medicaid and CHIP Services Delivered via Telehealth Per 1,000 Beneficiaries March to October 2020**




Source: Medicaid & CHIP and the COVID-19 Public Health Emergency, Preliminary Medicaid & CHIP Data Snapshot, Services Through October 31, 2020. CMS.

Several recent population-based studies have shown that Medicaid beneficiaries, including patients who are older; black, Hispanic or Asian; who have limited English proficiency; and have lower incomes all have lower rates of telehealth visits during COVID-19 than other populations, especially telehealth visits by video.[15,16,17]

Many potential factors underlie these disparities. Federal law requires that Medicaid and CHIP providers must make language assistance available to their patients with limited English proficiency and interpretation for the hearing impaired, but state Medicaid and CHIP programs are not required to pay providers for language assistance and interpretation.[18] The state reimbursement to providers for language assistance may be inadequate,[19] and only 15 states reimbursed providers for language assistance in 2017.[20] Furthermore, households with Medicaid beneficiaries were less likely to have broadband internet access in 2018 (79.2 percent vs. 86.9 percent for households without Medicaid beneficiaries).[21]

Some state models have been launched in an effort to advance health equity through telehealth interventions.[22] For example, California issued guidance requiring Medicaid managed care plans to pay providers at the same rate for medically appropriate telephone visits as for visits by video, and all telehealth visits are to be reimbursed at the same rates as for in-person visits.[23] New Mexico paid up to $500 during the PHE (previously up to $250) for Medicaid HCBS patients to help purchase devices for remote video conferencing, training, and monitoring by clinicians.[24]

## DISCUSSION

Medicaid utilization of services delivered via telehealth expanded dramatically at the beginning of the PHE, similar to changes in Medicare and private health insurance, though in most state Medicaid programs, at least some care delivery via telehealth was already an existing option prior to the pandemic[25] A number of states added temporary authorization of telehealth delivery for additional services in response to the pandemic.[26] Telehealth offered a way for patients and providers to avoid COVID-19 exposure, especially during stay-at-home orders.[27] For patients, telehealth may be more convenient and save time and money on transportation to providers, child care, and time off from work.[28]

For providers, telehealth is a revenue source that was not used nearly as often before the PHE. After an initial spike in telehealth in April 2020, Medicaid and CHIP services delivered via telehealth started declining.[29] With in-person visits becoming more feasible and attractive to patients again, many providers have sharply reduced their utilization of telehealth. Some providers have concluded that technology and staff investments in telehealth are not worthwhile, fueled in part by uncertainty over whether telehealth service regulations during the PHE will be made permanent.[30] Many private insurers started to roll back telehealth coverage in the fall of 2020.[31]

***Key Tradeoffs and the Appropriate Role for Telehealth***

Widespread telehealth utilization may not be the optimal form of for health care delivery in all circumstances, and experts recommend a careful consideration of the tradeoffs involved. The Physician-Focused Payment Model Technical Advisory Committee (PTAC), an advisory committee created by Congress, has identified several issues and opportunities for optimizing telehealth including: [32]

- Addressing barriers related to accessibility of telehealth technologies, internet access, and language/communication needs
- Avoiding the creation of silos through interoperability and care integration
- Identifying services for which telehealth can effectively substitute for in-person care, and when telephone/audio-only access is appropriate
- Refining provider standards and understanding costs associated with telehealth adoption
- Considering program integrity issues – ranging from overuse of telehealth in low-value circumstances as well as guardrails for fraud and abuse
- Use of alternative payment models to incentivize optimal care and avoid inappropriate use

More studies are needed to identify the services that can be effectively delivered by telehealth, including by audio only. States have seen higher telehealth utilization of mental health services than other services, especially during the PHE.[33] Some patients may prefer receiving mental health services by telehealth because it carries less stigma, particularly where in-person examination is not critical.[34]

The Agency for Healthcare Research and Quality examined the evidence base for telehealth. The resulting report found that a large body of research supports the use of telehealth for remote home monitoring and communicating and counseling for patients with chronic conditions (such as chronic obstructive pulmonary disease and congestive heart failure), and also providing psychotherapy as part of behavioral health.[35] However, other services may not be effectively delivered via telehealth. For example, one study showed that telehealth visits for ear infections were associated with more antibiotic prescriptions and antibiotic management that didn't follow pediatric guidelines compared to office visits.[36] Ophthalmologists could not reliably check intra-ocular pressure for glaucoma or give intravitreal injections for retina problems by telehealth.[37] Cardiologists ordered fewer diagnostic tests and medications for telehealth patients than for patients they saw in person, which could have led to some missed diagnoses.[38] Telehealth visits make it harder

for cardiologists to understand a patient's heart condition without physical examinations and face-to-face communication.[39]

Challenges regarding provider payment for services delivered via telehealth continue and require further analysis. Telehealth companies such as Teledoc charge less ($40-$50 in 2017) for a telehealth visit with a physician than in-person visits with a physician.[40] However, adding telehealth technology and training for a physician's office is costly, especially for Medicaid providers. Most states (42 states plus the District of Columbia) have required payment parity for at least some Medicaid services during the PHE. It remains unclear whether payment parity should be made permanent, and further evidence on the effects of this policy are needed. As with in-person visits, there can be instances of fraud and abuse with services delivered via telehealth including upcoding (coding incorrectly for services reimbursed at higher rates), misrepresenting services as synchronous, and prescribing unnecessary durable medical equipment, genetic and diagnostic tests, and pain medication.[41] Overutilization without adequate clinical benefit is another potential risk in some settings, as evident in some of the studies discussed above.

***Key Equity Considerations for Telehealth***

Accessing telehealth, especially in some rural and lower-income neighborhoods, continues to be a challenge and raises concerns about adverse effects on health care equity. Language assistance for patients with limited English proficiency and communication assistance for individuals with disabilities need to be widely available and reimbursed adequately. Interoperability issues with EHRs and communication platforms makes care integration difficult. Availability of broadband internet remains a challenge in many areas. Investments in technology, internet access, and appropriate support for patients are essential for expanding access to telehealth and reducing the disparities in telehealth use that were apparent during the pandemic.

## CONCLUSION

During the COVID-19 pandemic, CMS and states significantly expanded access to telehealth to ensure that Medicaid enrollees could receive health care services outside of their regular health care delivery sites. As a result of reduced options for health care delivery and the added flexibility of telehealth policies, states report historic increases in the use of telehealth since the pandemic began. The impact of such services for enrollees and providers is an important area for research. The extent to and circumstances under which some or all of these telehealth flexibilities should continue after the public health emergency draws to a close are important questions.

## Appendix 1
## Examples of State Guidance to Medicaid Managed Care Plans on Telehealth

***Florida***

Florida Medicaid Guidance (March 18, 2020) states that Medicaid managed care plans have broad flexibility in covering telehealth and encourages plans to maximize telehealth use.

***Illinois***

Illinois Medicaid Guidance (March 20, 2020) for both FFS and managed care plans allows any site to be an originating site (including home) and allows many providers to be distant sites. Virtual check-ins that do not meet the definition of services delivered via telehealth will be reimbursed.

***Iowa***

Iowa Medicaid Provider FAQs indicates that the state Medicaid program in collaboration with managed care plans is developing additional guidance to expand telehealth.

***New Jersey***

New Jersey issued guidance for managed care plans and FFS providers on March 22, 2020 that telehealth will be paid on parity and site of service requirements are waived. Clinicians can provide telehealth from any location, and individuals may receive services delivered via telehealth from any location and can use alternative technologies such as telephonic and video technology available on smart phones and other devices.

***New York***

New York issued May 2020 guidance on telehealth that state Medicaid managed care plans are required to cover, at a minimum, services that are covered by Medicaid FFS and are also included in the benefit package, and also must reimburse network providers for telehealth on parity. In addition, managed care plans must cover appropriate services delivered via telehealth by other network providers, not just the plan's telehealth vendors.

***Washington State***

Washington Medicaid FFS and managed care organizations are implementing temporary policies to expand telehealth.

Source: State Medicaid websites.

## Appendix 2
## Examples of State Medicaid Telehealth Policy Changes and Experience During the COVID-19 PHE

### *North Carolina*

- North Carolina's Medicaid telehealth modernization started in December 2019 (including 482 codes and 34 permanent telehealth policies). Initially expected to take 3 years to fully implement, but only took 7 weeks with the COVID-19 PHE.
- Telephonic visit payment rates were increased to 80 percent of in-patient visits rates.
- Almost a quarter of beneficiaries had at least one service delivered via telehealth by June 2020. Telehealth as a share of all claims was highest in April-May (6% of claims for 15 percent of beneficiaries)
- Telehealth use varied by race, geography and health status, with higher rates of telehealth use among whites compared to other racial and ethnic groups, urban residents compared to rural residents, and those with chronic conditions.

### *Kentucky*

- Kentucky Medicaid expanded telehealth in July 2019 with payment parity, no cost sharing, and allowing store-and-forward for more services, but had low telehealth utilization before the COVID-19 PHE.

### *District of Columbia*

- 70 percent of Medicaid visits delivered via telehealth were audio-only from March through July 2020.
- Telehealth was 0.3 percent of all Medicaid claims among 0.7 percent of beneficiaries at the beginning of 2020 (January through February 2020). These numbers increased to 25 percent of claims for 18 percent of beneficiaries for April through May 2020.
- The District of Columbia received $1.2 million from CMS for a purchase and loan program for laptops and tablets, data plans, and licenses for HIPAA-compliant platforms for providers.

### *Maine*

- Maine's home and community-based treatment and multisystemic therapy utilization was almost back to pre-COVID-19 PHE levels by May 2020 with more patients receiving services via telehealth.

Source: National Academy for State Health Policy Conference August 17-19, 2020.

## Appendix 3
## How States Can Provide Additional Flexibilities for Medicaid Coverage of Services Delivered via Telehealth during Public Health Emergencies

**1135 Emergency Waivers.** Under Public Health Emergencies, the Secretary is authorized to temporarily waive or modify certain Medicaid requirements through section 1135 waivers, including waiving provider conditions of participation, preapproval requirements, deadlines, and timetables, which can help in the delivery of Medicaid services via telehealth. CMS may approve 1135 waivers on a case by case basis or, on a "blanket" basis, which applies automatically to any entity that meets specified criteria. CMS relied on nationwide blanket waivers for provider flexibilities for the COVID-19 PHE. As of April 19, 2021, all states and the District of Columbia submitted and had 1135 waivers approved on certain provider screening requirements, postponing deadlines for provider revalidation, and allowing out-of-state providers with equivalent licensing in another state to provide care to Medicaid enrollees in the state.[42]

**Disaster Relief Medicaid State Plan Amendments (SPAs).** CMS approved disaster relief telehealth related SPAs submitted by 19 states as of July 10, 2020 and for all 50 states and the District of Columbia as of April 19, 2021.[43] Many of the states added telehealth authorization for specific service types (primary care, dental, physical, occupational, and speech therapy, and long-term services and supports (LTSS) and provider types (dentists, physicians, behavioral health providers, and advanced practice providers). (See Table 1). Some states newly allowed telephone-only visits or telehealth through store-and-forward and remote patient monitoring. A number of states changed payments for services provided via telehealth such as new COVID-19 fee schedules and adding ancillary fees for the originating site.

**Appendix K:** Appendix K is a standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) HCBS waivers. A total of 50 states permit virtual evaluations, assessments, and person-centered planning meetings.[44] Seven states added coverage for assistive technology and 47 states added electronic method of service delivery to continue services remotely in home. A total of 49 states temporarily expanded settings where services may be provided to include sites such as hotels, shelters, schools, and churches.

Attachment K: Emergency Preparedness and Response. This standalone appendix may be used by states to request amendment to 1915(c) home and community-based waivers, 1115 demonstrations or the Section 1135 authorities.

## REFERENCES


[1] Uscher-Pines, L., Bouskill, K., Sousa, J., Shen, M., and Fischer, S. Experiences of Medicaid Programs and Health Centers in Implementing Telehealth. ASPE Research Reports 2019. Accessed at: https://aspe.hhs.gov/system/files/pdf/260886/Medicaid-Telehealth.pdf.

[2] Douglass, M., Xu, J., Heggs, A., Wrenn, G., Mack D.H., and Rust, G. Assessing Telemedicine Utilization Using Medicaid Claims Data. Psychiatr Serv, February 2017; 68: 173-178; PMID: 27691371; DOI: 10.1176/aapi.ps.201500518.

[3] Talbot, J.A., Burgess, A.R., Thayer, D., Patenteau, L., Palusa, N., and Coburn, A.F. Patterns of Telehealth Use Among Rural Medicaid Beneficiaries. J Rural Health 2019; 35: 298-307; DOI: 10.111jrh.12324.

[4] Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. HHS Office of Civil Rights, March 18, 2020. Accessed at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

[5] How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency. Drug Enforcement Administration, March 2020. Accessed at: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf.

[6] Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings. MACPAC, June 2020. Accessed at: https://www.macpac.gov/publication/changes-in-medicaid-telehealth-policies-due-to-covid-19-catalog-overview-and-findings/.

[7] Kaiser Family Foundation. Medicaid Emergency Authority Tracker Approved Section 1915 (c) Waiver Appendix K Strategies to Address COVID-19 as of January 19, 2021 and April 19, 2021. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table5.

[8] Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings. MACPAC, June 2020. Accessed at: https://www.macpac.gov/publication/changes-in-medicaid-telehealth-policies-due-to-covid-19-catalog-overview-and-findings/.

[9] Kaiser Family Foundation. Medicaid Emergency Authority Tracker, SPA and Other Administrative Action to Address COVID-19 as of June 7, 2021. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table2.

[10] Farb, J and Yocom, C.L. COVID-19 Program Flexibilities and Considerations for Their Continuation. Government Accountability Office Testimony, May 19, 2021. Accessed at: https://www.gao.gov/assets/gao-21-575t.pdf.

[11] State Medicaid & CHIP Telehealth Toolkit COVID-19 version. CMS, October 2020. Accessed at: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf..

[12] Medicaid State Plan Disaster Relief State Plan Amendments. Medicaid.gov. https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html

[13] Medicaid and CHIP COVID-19 Summaries. CMS Preliminary Medicaid & CHIP Data Snapshot Services through July 31, 2020. Centers for Medicare & Medicaid Services. Accessed at: https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf.

[14] Medicaid & CHIP and the COVID-19 Public Health Emergency, Preliminary Medicaid & CHIP Data Snapshot, Services Through October 31, 2020. CMS. Accessed at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot.pdf.

[15] Eberly, L. et al. Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. JAMA Network, December 29, 2020.

[16] Patel, S., Mehrotra, A., Huskamp, H., Uscher-Pines, L., Ganguli, K. and Barnett, M.L. Variation in Telemedicine Use and Outpatient Care During the COVID-19 Pandemic in the United States. Health Affairs, February 2021.

[17] Pierce, R. and Stevermer, J. Disparities in use of telehealth at the onset of the COVID-19 public health emergency. Journal of Telemedicine and Telecare, October 2020.

[18] Translation and Interpretation Services. CMS. Accessed at: https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html.

[19] Shah, S., Velasquez, D.E., and Song, Z. Reconsidering Reimbursement for Medical Interpreters in the Era of COVID-19. JAMA Health Forum, October 12, 2020. Accessed at: https://jamanetwork.com/channels/health-forum/fullarticle/2771859.

[20] Youdelman, M. Medicaid and CHIP Reimbursement Models for Language Services. National Health Law Program, February 7, 2017. Accessed at: https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf.
[21] Internet Access Measures Impact of the Digital Divide and COVID-19. SHADAC, March 27, 2020. Accessed at: https://www.shadac.org/news/internet-access-measures-impact-digital-divide-and-covid-19.
[22] Taylor-Penn, L and Ruff E. Advancing Health Equity through Telehealth Interventions during COVID-19 and Beyond: Policy Recommendations and Promising State Models. Families USA, July 22, 2020. Accessed at: https://www.familiesusa.org/resources/advancing-health-equity-through-telehealth-interventions-during-covid-19-and-beyond-policy-recommendations-and-promising-state-models/,
[23] Emergency Telehealth Guidance – COVID-19 Pandemic. Memo to all Medi-Cal Managed Care Plans, March 18, 2020. State of California Health and Human Services Agency. Department of Health Care Services. Accessed at: https://www.dhcs.ca.gov/Documents/COVID-19/APL19-009-Supplement-Telehealth-031820.pdf.
[24] New Mexico's Appendix K: Emergency Preparedness and Response and COVID-19 Addendum, March 2020. Accessed at: https://www.medicaid.gov/state-resource-center/downloads/nm-combined-appendix-k-appvl.pdf.
[25]Bosworth, A. et al. Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic. ASPE Issue Brief, July 28, 2020. Accessed at: https://aspe.hhs.gov/pdf-report/medicare- beneficiary-use-telehealth.
Telehealth Growth During COVID-19. AHIP, July 7, 2020. Accessed at: https://www.ahip.org/telehealth-growth-during-covid-19/.
[26] Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings. MACPAC, June 2020. Accessed at: https://www.macpac.gov/publication/changes-in-medicaid-telehealth-policies-due-to-covid-19-catalog-overview-and-findings/.
[27] Mehrotra, A., Linetsky, D., and Hatch, H. This is supposed to be telemedicine's time to shine. Why are doctors abandoning it? Statnews, June 25, 2020. Accessed at: https://www.statnews.com/2020/06/25/telemedicine-time-to-shine-doctors-abandoning-it/.
[28] Mehrotra, A., Bhatia, R.S., and Snoswell, C.L. Paying for Telemedicine After the Pandemic. JAMA, February 2, 2021.
[29] Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19. CMS Preliminary Medicaid & CHIP Data Snapshot. CMS, October 14, 2020. Accessed at: https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf.
[30] Mehrotra, A. et al. This is supposed to be telemedicine's time to shine. Why are doctors abandoning it? Statnews, June 25, 2020. Accessed at: https://www.statnews.com/2020/06/25/telemedicine-time-to-shine-doctors-abandoning-it/.
[31] Mallow, J. and Davis, S. The Conversation, October 27, 2020. Accessed at: https://theconversation.com/health-insurers-are-starting-to-roll-back-coverage-for-telehealth-even-though-demand-is-way-up-due-to-covid-19-147648.
[32] Meetings of the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Accessed at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.
Environmental Scan on Telehealth in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMS), September 9, 2020, Physician-Focused Payment Model Technical Advisory Committee (PTAC). Accessed at: https://aspe.hhs.gov/system/files/pdf/261946/Sep2020TelehealthEnvironmentalScan.PDF.
[33] Telehealth and Telemedicine during the COVID-19 Pandemic. Minnesota Department of Human Services, December1 6, 2020. Accessed at: https://mn.gov/dhs/assets/telemedicine-utilization-report-2020_tcm1053-458660.pdf.
[34] Warren, J. and Smalley, K.B. Using Telehealth to Meet Mental Health Needs During COVID-19 Crisis. Commonwealth Fund Blog, June 18, 2020. Accessed at: https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis.
[35] The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic. Agency for Healthcare Research and Quality, May 14, 2020. Accessed at: https://effectivehealthcare.ahrq.gov/products/telehealth-expansion/white-paper.
[36] Ray, K.N. Antibiotic prescribing during pediatric direct-to-consumer telemedicine visits. Pediatrics, May 2019.
[37] Patel, S., Hamdan, S., and Donahue, S. Optimising telemedicine in ophthalmology during the COVID-19 pandemic. Journal of Telemedicine and Telecare, August 2020.
[38] Yuan, N., Pevnik, J., and Botting, P. Patient Use and Clinical Practice Patterns of Remote Cardiology Clinic Visits in the Era of COVID-19. JAMA Network, April 5, 2021.

[39]Albert NM, Prasun MA. Telemedicine in heart failure during COVID-19: like it, love it or lose it? Heart Lung, Nov-Dec 2020.
[40] Ashwood, A.S. et al. Direct-To-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending. Health Affairs, March 2017. Accessed at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1130.
[41] Giancola, P. and Stedman, C. Telehealth Fraud Triggered by COVID-19. JDSupra, February 16, 2021. Accessed at: https://www.jdsupra.com/legalnews/telehealth-fraud-triggered-by-covid-19-8657616/.
[42] Medicaid Emergency Authority Tracker, Approved Section 1135 Waivers to Address COVID-19 as of April 19, 2021. Kaiser Family Foundation, April 19, 2021. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table4.
[43] Kaiser Family Foundation. Medicaid Emergency Authority Tracker, SPA and Other Administrative Action to Address COVID-19 as of April 19, 2021. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table2.
[44] Medicaid Emergency Authority Tracker, Approved Section 1915 (c) Waiver Appendix K Strategies to Address COVID-19 as of January 19, 2021 and April 19, 2021. Kaiser Family Foundation. Accessed at: https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table 5.

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