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State Medicaid Telehealth Policies Before and During the COVID-19 Public Health Emergency: 2022 Update

Two years into the COVID-19 pandemic, Medicaid telehealth policies varied widely across states, having evolved significantly since the beginning of the pandemic with respect to type of services, providers, and modalities.

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KEY POINTS

- Even before the COVID-19 pandemic, state Medicaid programs have had significant discretion regarding what services and provider care can be delivered via telehealth.
- Since the beginning of the pandemic, all states and the District of Columbia have taken advantage of additional Medicaid telehealth flexibilities offered by the Centers for Medicare & Medicaid Services.
- Several states have made some flexibilities permanent via state laws or regulations, while other states have ended their flexibilities by letting their state public health emergencies or executive orders expire.
- Further research is needed to determine the impact of the increased delivery of care via telehealth in Medicaid on access to care, utilization, and quality.

INTRODUCTION

Telehealth is the use of information technology by providers to deliver services.[1] The provider – located at the "distant site" – uses communications technology to meet with the patient, who is located at a separate "originating site." Telehealth is sometimes divided into two categories of modalities, synchronous and asynchronous. Synchronous telehealth modalities facilitate real-time provider-patient interaction and include audio-visual and audio-only modalities. Asynchronous telehealth modalities include "store and forward,[*]" remote patient monitoring, and text-based communication such as email or fax.

Telehealth has long been a part of Medicaid, where it is considered a mode of service delivery rather than a distinct service under federal law.[2] States have the authority to design their own Medicaid telehealth policies, including which provider and service types may make use of telehealth and how they will be paid. Prior to the

[*] "Store and forward" is a telehealth technique when patients upload medical information to a platform for a provider to evaluate if they need to be seen in-person or via telehealth.

COVID-19 public health emergency (PHE), many states were using telehealth in their Medicaid programs to reach rural beneficiaries or facilitate specialist consultations. However, there were significant challenges with respect to Medicaid telehealth before the PHE, including restrictions on originating and distant sites, lack of clarity on technology and billing requirements, and lower reimbursement compared to in-person services. There were also equity concerns that disproportionately impacted communities of color and low-income communities, such as access to internet and technology, language barriers, and privacy concerns that persist today.[3]

The COVID-19 PHE substantially accelerated interest in and utilization of telehealth across all payers and patient characteristics, including Medicaid beneficiaries.[4] However, states vary in their Medicaid telehealth policies and where they stand currently.

This issue brief is a follow-up to ASPE's July 2021 issue brief, providing updates on state Medicaid programs regarding delivery of telehealth services by provider types and modalities. [5]

BACKGROUND

Changes to Medicaid Telehealth During the COVID-19 Pandemic

Prior to the COVID-19 pandemic, states had broad flexibility to pay for Medicaid services delivered via telehealth in areas such as originating site, provider type, service type, and modality.[6] In March 2020, after the declaration of the federal PHE related to COVID-19, the Secretary of Health and Human Services (HHS) announced additional flexibilities related to provider licensing, patient consent, and privacy.[7] The HHS Office of Civil Rights announced that it was exercising its enforcement discretion and would not impose penalties for noncompliance with the regulatory requirements for telehealth communication technologies under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), meaning that providers would not be penalized for providing telehealth services via HIPAA-noncompliant platforms such as FaceTime, Facebook messenger, and Skype.[8] Also, the Drug Enforcement Agency (DEA) provided prescribing flexibilities to DEA-registered providers, allowing them to prescribe controlled substances to patients for whom they had not conducted an in-person medical evaluation via real-time audio-visual interactive communication systems. [9] During the federal PHE, states have had the option to implement any of these flexibilities in operating their Medicaid programs.

Telehealth utilization also changed during the COVID-19 pandemic. A February 2022 ASPE issue brief analyzing U.S. Census Bureau Household Pulse Survey data determined that Medicaid beneficiaries used telehealth in 2021 at a higher rate than other groups: 29.3 percent of individuals with Medicaid in the survey sample reported at least one telehealth visit in the previous four weeks, compared to 27.4 percent of Medicare beneficiaries, 20.7 percent of privately insured individuals, 25.0 percent of individuals with other health insurance, and 9.4 percent of uninsured individuals.[10]

Recent Developments in Medicaid Telehealth Policy

While federal guidance allowed for some additional state Medicaid telehealth flexibilities that are contingent upon the federal PHE being in effect, states generally have significant discretion to design their own Medicaid telehealth programs, and these flexibilities will remain after the federal PHE ends. For example, states have broad flexibility to pay for Medicaid services delivered via various telehealth modalities, including audio-only services; this policy option was available to states prior to the federal COVID-19 PHE and will continue to be available after the PHE ends.[11] By contrast, the Medicare program prior to the PHE had less flexibility in telehealth policies.[12, 13]

Additionally, states declared their own PHEs during the early part of the pandemic, which provided them with another option to suspend certain Medicaid telehealth requirements and implement flexibilities to increase

access to care. Some state PHEs have ended, while others are ongoing, and the status of many state Medicaid telehealth flexibilities mirrors this.

METHODS

ASPE reviewed state websites for all 50 states and the District of Columbia (DC)[†] to identify state executive orders, state Medicaid agency guidance, and other state policies regarding the evolution of Medicaid and state-wide telehealth flexibilities during the COVID-19 PHE and their status as of January 2022.

We also searched academic literature for research on Medicaid telehealth with respect to access, quality, and costs during the PHE, as well as grey literature from sources such as the Center for Connected Health Policy, the Kaiser Family Foundation, the Urban Institute, and the Medicaid and CHIP Payment and Access Commission (MACPAC). Building on our previous Medicaid telehealth issue brief, this issue brief provides an update on state coverage policies for telehealth services and providers as of January 2022 and categorizes states according to actions to either make telehealth policies permanent or allow them to expire based on state Medicaid-specific guidance and broader state telehealth policies that include Medicaid.[14] Additionally, we reviewed state procedure codes to determine the status of state coverage of specific types of services via telehealth, as of January 2022.

The results reported below represent a point in time (January 2022) and may not reflect state Medicaid telehealth policies in effect subsequently. State information is based on review of state websites and ASPE was unable to discern if changes in Medicaid telehealth policies were dependent on state PHEs or the federal PHE.

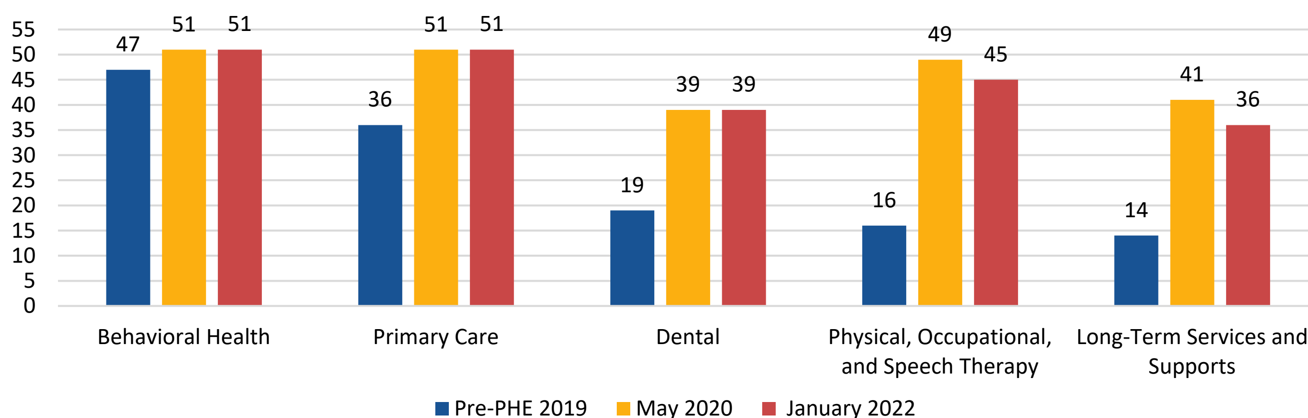
FINDINGS

Status of Medicaid Services Delivered Via Telehealth as of January 2022

As of January 2022, the status of state Medicaid telehealth flexibilities related to the COVID-19 pandemic was mixed. Some states had rescinded all or some of their telehealth flexibilities, while others were ongoing but contingent on either state or federal PHE; still others have been made permanent via state legislation or guidance. Figure 1 provides a summary of the number of states pre-PHE (2019), during the early part of the PHE (May 2020), and more recently (January 2022) that allow Medicaid services to be delivered via telehealth by type of service and provider.

[†] The five territories – American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands – are not included in this analysis.

Figure 1. Number of States: Medicaid Telehealth Services and Providers



Note: For the purposes of this report, states were considered as allowing delivery of specific services if they covered at least one type of the service type. 51 "states" are the 50 states and the District of Columbia. The following services and benefits are optional for state Medicaid programs to provide: Physical Therapy, Occupational Therapy, Speech Therapy, Dental, and many services included in our definitions of Behavioral Health and Long-Term Services and Supports.
Sources: Authors' analysis of state websites; Libersky, J., Soyer, E., Masaoay, T., Colt, M., and Edelberg, R., Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings, Mathematica, June 2020.

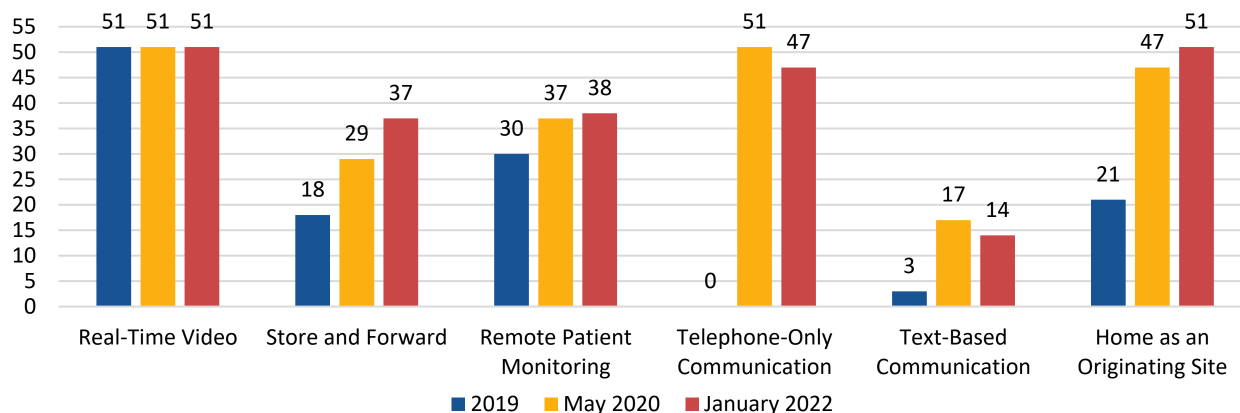
In January 2022, as was the case during the early part of the pandemic, Medicaid programs in all 50 states and the District of Columbia allowed delivery of some behavioral health and primary care services via telehealth. Some states have pulled back telehealth delivery of physical, occupational, and speech therapies and long-term services and supports. On the other hand, more states allowed speech, occupational, and physical therapists and long-term services and supports to provide Medicaid services via telehealth in January 2022 compared to May 2020. These results show that state Medicaid services delivered via telehealth were still evolving nearly two years into the COVID-19 pandemic.

Evaluations of the expansion of Medicaid telehealth during the COVID-19 pandemic found that increased telehealth flexibilities enabled patients to receive needed care but also led to provider confusion regarding reimbursement and concerns with the impact on health equity for both providers and patients. During the early part of the pandemic, New York City primary care practices identified reimbursement confusion as a top barrier to telehealth use.[15] Confusion around reimbursement for audio-only telehealth visits, in particular, impeded telehealth implementation in some provider offices and, as of February 2022, may continue to impact the use of audio-only telehealth.[16] In addition, small primary care practices faced a "digital divide" in telehealth implementation, which required them to pay high infrastructure, workflow, logistics, training, and other operating costs in order to provide new care delivery models for patients; this was a challenge for smaller practices, compared to larger practices that could spread such costs across a large number of clinicians.[17, 18] Similarly, patients needing telehealth services experienced disparities in digital access and digital literacy, which disproportionately impact older adults, low-income children and families, Black and Latino beneficiaries, individuals with less educational attainment, and patients with chronic conditions.[19, 20]

Modalities and Originating Sites

Prior to the COVID-19 pandemic, all 50 states and the District of Columbia allowed certain Medicaid services to be delivered via real-time, two-way, interactive audio-visual telehealth. As seen in Figure 2, during the pandemic, more states covered other telehealth modalities, such as store and forward, remote patient monitoring, audio-only, and text-based communications like email or fax. As of January 2022, all states still allowed real-time video, and most states allowed store and forward, remote patient monitoring, and audio-only telehealth. States also added new originating sites during the pandemic, and all states included patient homes in their lists of originating sites.

Figure 2. Medicaid Telehealth Modalities

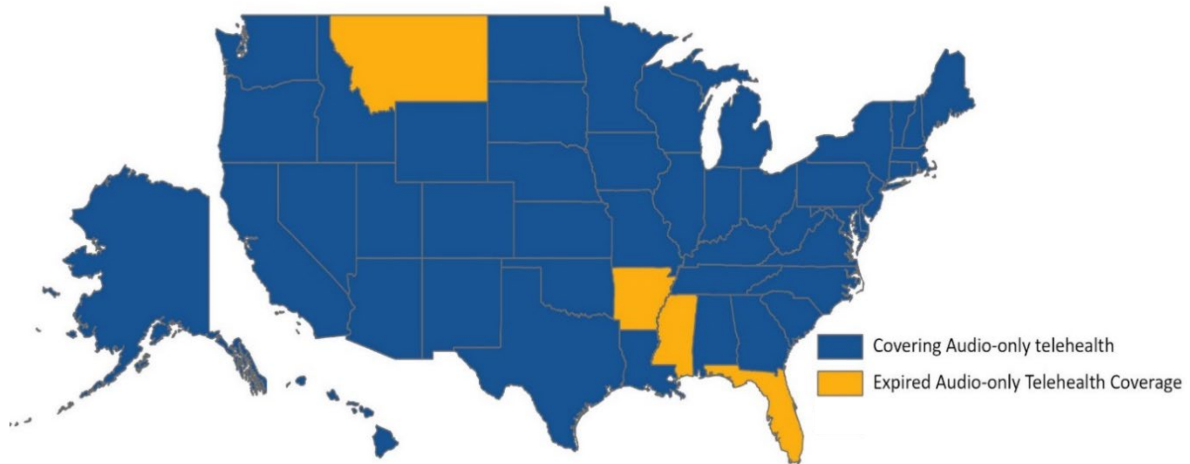


Note: 51 "states" are the 50 states and the District of Columbia.
Sources: Authors' analysis of state websites; Libersky, J., Soyer, E., Masaoay, T., Colt, M., and Edelberg, R., Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings, Mathematica, June 2020.

In the early months of the pandemic, with the knowledge that many patients did not have access to the internet or technology that would allow them to use real-time video-enabled telehealth platforms, all state Medicaid programs newly allowed audio-only telehealth to enable beneficiaries to receive needed health care services while complying with stay-at-home orders. Several states did this via state executive orders that were contingent on a state PHE being in place. As of January 2022, 46 states and the District of Columbia still allowed audio-only telehealth, but Arkansas, Florida, Mississippi, and Montana all ended this flexibility with the expiration of their state PHEs (see Figure 3).

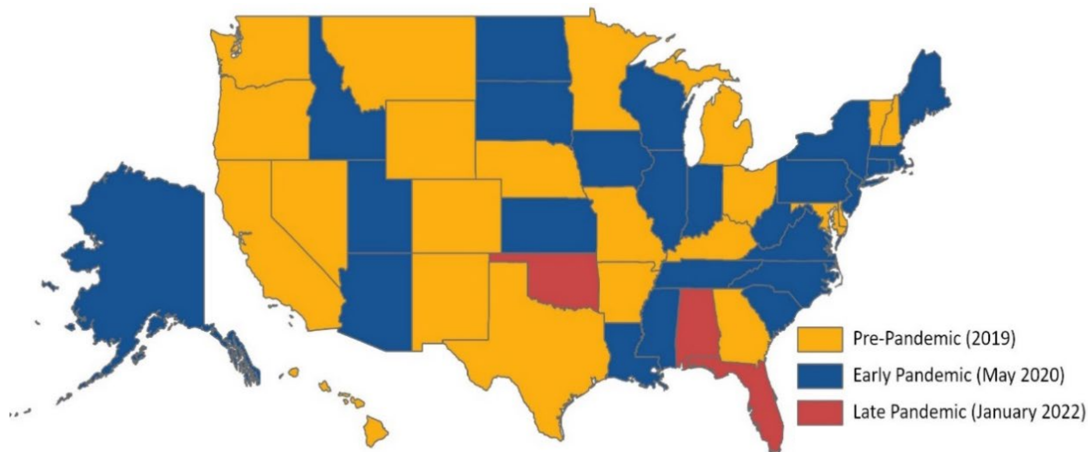
Prior to the pandemic, less than half of all states allowed patients to receive telehealth services in their homes. Many states required patients to go to another provider's office or a clinic, whose staff facilitated the virtual interaction between the patient and the telehealth provider. During the early part of the pandemic (as of May 2020), nearly all states and the District of Columbia allowed patient homes as originating sites. By the late part of the pandemic (as of January 2022), all 50 states and District of Columbia included patient homes on their lists of allowable originating sites (see Figure 4).

Figure 3. States Allowing Medicaid Audio-Only Telehealth (as of January 2022)



Sources: Authors' analysis of state websites.

Figure 4. When States First Allowed Patient Homes as Originating Sites for Medicaid Telehealth



Sources: Authors' analysis of state websites. Libersky, J., Soyer, E., Masaoay, T., Colt, M., and Edelberg, R., Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings, Mathematica, June 2020.

Permanent Changes to State Medicaid Telehealth Policy

Some states have made some Medicaid telehealth flexibilities permanent as of January 2022, while other flexibilities are still in effect contingent on either the federal or state PHE being in effect, and still others have been rolled back with the end of some state PHEs or for other reasons (see Table 1).

Table 1. Status of State Medicaid Telehealth COVID-19 Flexibilities Based on State Executive Orders and State Medicaid Agency Guidance (as of January 2022)

Status	Number of States	States
Any telehealth flexibilities made permanent through state law during COVID-19 pandemic	13	DC, GA, IN, ME, MI, NE, NH, OK, PA, TN[‡], TX[§], WI[**], WY
Audio-only telehealth permanently allowed via state law	9	DC, GA, ME, MI, NE, NH, PA, TN*, WI
Verbal consent permanently allowed via state law	4	DC, NE, TX[§], WY
Any permanent telehealth flexibilities pre-COVID	8	AZ, CA, CO, DC, NE, NV, OH, WY
Behavioral health services allowed via telehealth pre-COVID	4	AZ, CA, DC, WY
Home allowed as originating site pre-COVID	3	CA, CO, DC
Provider flexibilities pre-COVID	4	NE, NV, OH, WY
Asynchronous telehealth services allowed pre-COVID	1	AZ
Any telehealth flexibilities expired	11	AR, FL, GA, MI, MS, MT, NE, NH, TN, VA, WY
Any open-ended or unclear telehealth flexibilities	8	DE, KS, MN, MO, NV, OH, RI, WY
Any telehealth flexibilities still in effect contingent on end of federal or state Public Health Emergency	33	AL, AK, AZ, CA, CO, CT, GA, HI, ID, IL, IN, IA, KY, LA, ME, MD, MA, MN, NJ, NM, NY, NC, ND, OH, OK, OR, SC, DC, UT, VT, VA, WA, WV

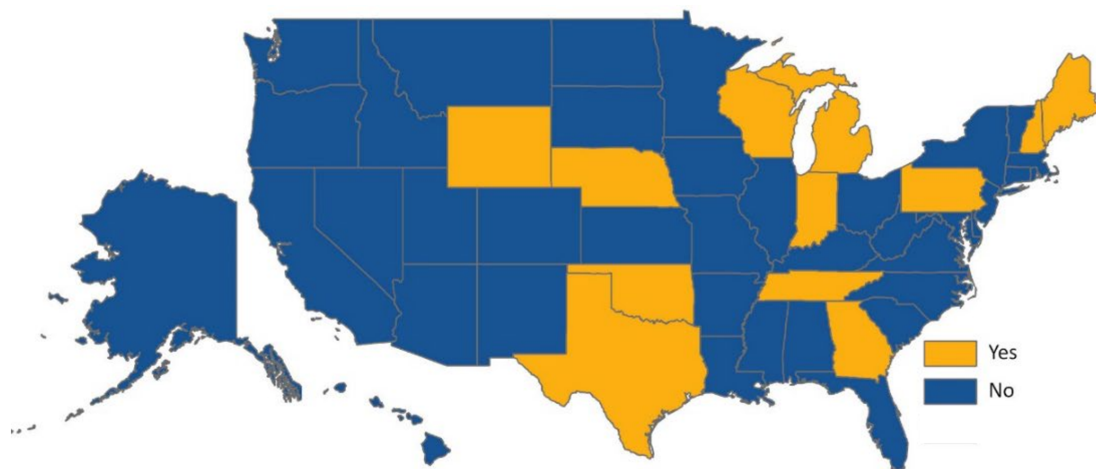
Note: Aspects of telehealth analyzed include: originating site (home); provider type (other than physician); service type (other than primary care); mode (other than real-time video); prescribing requirements (pertaining to controlled substances); licensing requirements (pertaining to out-of-state providers); and consent requirements (other than written). States that allowed any type of behavioral health services to be delivered via telehealth were included as making a permanent telehealth policy change pre-COVID-19. State information is based on review of state websites and ASPE was unable to discern if changes in Medicaid telehealth policies were dependent on state or federal PHE.

[‡] For behavioral health only.

[§] State law requires the state health department to study telehealth to determine if it is cost-effective and clinically effective before permanently implementing flexibilities.

[**] Permanent beginning the first day of the first month after the end of the federal PHE.

Figure 5. States with New Permanent Medicaid Telehealth Policies (as of January 2022)



Sources: Authors' analysis of state websites.

For example, Florida's state PHE expired on June 26, 2021, and some of its Medicaid telehealth flexibilities that were in place earlier in the pandemic have now ended.[21] In March 2020, Florida's Medicaid program allowed audio-only, remote patient monitoring, and store and forward modalities, along with some specific behavioral health services such as individual and group psychotherapy, psychotropic medication management, and medication assisted treatment for substance use disorders (SUD). However, the state ended these flexibilities in June 2021 with the expiration of the state PHE.[22]

In Indiana, on the other hand, most flexibilities implemented by May 2020 were still in effect as of January 2022, contingent on the ongoing state PHE. These flexibilities include specialists and dentists to provide telehealth services; allowing home health and physical, occupational, and speech therapy services to be provided via telehealth; and reimbursing providers for audio-only telehealth services.[23] However, Indiana made its originating site flexibility permanent on April 20, 2021, via a state law that prohibits the Medicaid program from specifying originating sites, thereby allowing patients to receive telehealth services from any location.[24]

Massachusetts extended its originating site, provider type, service type, and modality flexibilities through December 31, 2022, via a Medicaid All Provider Bulletin in October 2021.[25] This document states that MassHealth – the state's Medicaid program – has seen "robust utilization" of telehealth services during the pandemic supported by the state's permissive Medicaid telehealth flexibilities, which have ensured beneficiaries continue to receive medically necessary health care services. The bulletin describes the state's extension of its Medicaid telehealth policies through the end of 2022 as aimed at meeting MassHealth's mission, ensuring continued access to telehealth for medically necessary covered services, and promoting equity. Through December 31, 2022, MassHealth will reimburse any MassHealth-enrolled provider for any MassHealth service provided to beneficiaries at any originating site via any telehealth modality, except for a short list of excepted services available in the bulletin.[26]

Finally, all Medicaid telehealth flexibilities that Idaho has implemented (including with respect to originating sites, service types, and modalities) were in effect until the end of the state PHE, which ended on April 15, 2022.[27] The governor stated that this date "provides an important bridge for hospitals and other healthcare providers to plan for the transition" out of the PHE.[28]

DISCUSSION

State Medicaid telehealth policies vary widely and have been changing frequently throughout the pandemic. This may cause confusion for both patients and providers. Patients may not be sure whether they can have their telehealth visit over the phone or whether they need to get to a clinic to have their telehealth visit, while providers may be unclear on how to bill for various telehealth visits and what services they will be paid for providing.

There are also numerous equity implications for Medicaid beneficiaries in a telehealth landscape that is constantly shifting. As of January 2022, 46 states and the District of Columbia still allowed audio-only telehealth, but in more than half of these states, telehealth policy changes are contingent on the existence of a state or federal PHE. When the federal and state PHEs expire, millions of beneficiaries will be impacted by decreased access to this modality, especially communities with historically low broadband access. Similarly, all 50 states and the District of Columbia allowed patient homes as originating sites as of January 2022, but nearly half of all states indicated that they will end this flexibility at the conclusion of the federal or state PHE. To help improve access to affordable broadband, beginning in May 2021, the Federal Communications Commission (FCC) began accepting applications for the Emergency Broadband Benefit (EBB) program to help cover broadband expenses for eligible households.[29]

The wide variation surrounding Medicaid telehealth policies suggests further consideration of telehealth policies and improved communication at the federal and state levels would benefit providers and beneficiaries, and the disparities evident in telehealth utilization must remain at the forefront of future work on this topic. Future research should evaluate telehealth in Medicaid populations to help policy makers determine its impact on access, equity, and quality of care.

CONCLUSION

States implemented Medicaid telehealth flexibilities available in federal regulations at various levels before the COVID-19 pandemic. The pandemic accelerated the adoption of Medicaid telehealth flexibilities by states and the utilization of telehealth by beneficiaries, yet states were at different stages of implementation in early 2022. ASPE will continue to study telehealth through the end of the federal and state PHEs and afterwards to determine how Medicaid telehealth flexibilities have impacted telehealth services, utilization, and access to services across states, and states' motivations regarding permanently adopting or rolling back telehealth flexibilities going forward.

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