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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

CONTRACTOR PROJECT REPORT

State Medicaid Telehealth Coverage Policy Decisions During the COVID-19 Public Health Emergency, 2020-2022

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
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by
RAND Health Care

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Office of the Assistant Secretary for Planning and Evaluation

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ASPE Executive Summary

Telehealth is a mode of health care service delivery using technologies such as video, internet-based platforms, and audio-only telecommunication devices. It allows patients to receive clinical consultations via audio, video, or text-based communication using a device (e.g., landline phone, mobile device, computer, laptop, tablet, etc.) from their home or location of choice ("originating site"), reducing barriers to care such as traveling to the provider's office, taking time off work, and finding childcare.

Telehealth has long been a part of Medicaid. State Medicaid programs have the discretion to determine which services 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 provider payment rates.

The COVID-19 Public Health Emergency (PHE) substantially accelerated interest in and utilization of telehealth across all payers and patient characteristics, including Medicaid beneficiaries. During the PHE, both public and private payers made additional changes to telehealth coverage, payment, and access to encourage continuity of care. COVID related federal legislation (i.e., Families First Coronavirus Relief Act (FFCRA), CARES Act), HHS Departmental guidance, state emergency waivers (i.e., CMS 1135 waivers), disaster relief Medicaid State Plan Amendments, Appendix K 1915(c) waivers, and state legislation contributed to the expansion of Medicaid telehealth since 2020. Through the authorities available during the PHE, states also temporarily extended their parameters for telehealth over and above existing state policy. While many of the following were permissible prior to the PHE, states encouraged providers and beneficiaries to engage in telehealth in order to receive services when possible during the PHE through these policies:

- Expanding the definition of "originating site" to include the home, school, workplace, or other locations beyond provider offices or clinics
- Expanding the types of providers eligible to provide telehealth services beyond primary care physicians
- Expanding the types of services eligible for delivery via telehealth beyond primary care
- Expanding telehealth modalities to include audio-only, store and forward (patient data sent to provider electronically), remote patient monitoring, and text-based modalities (email, fax, patient portal)
- Permitting patients to provide verbal rather than written consent to receive telehealth services
- Permitting licensed out-of-state providers to provide telehealth services to in-state patients
- Permitting providers to prescribe controlled substances via telehealth

States made changes to their Medicaid telehealth coverage policies with some states permanently adopting expansive telehealth policies allowed during the PHE and other states rescinding them later in the PHE.

The purpose of this study was to review changes to state Medicaid telehealth policies and/or new policies enacted during the COVID-19 PHE, examining policies that were rolled back, as well as those made permanent in part or in whole. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with RAND Health Care to catalogue and assess state changes to Medicaid telehealth policies during the COVID-19 PHE through April/May 2022 and identify the driving circumstances,

motivations, and evidence supporting telehealth policy decisions during the COVID-19 Public Health Emergency (PHE). RAND Health Care reviewed state decision making processes behind Medicaid telehealth policy changes, including data or other information used for decision making, considerations for health equity and COVID-19, stakeholder experiences, barriers and facilitators to decision making, and lessons learned.

Findings from this study include:

- Fifty state policies allowed during the COVID-19 PHE (in 25 states) have become permanent and 27 policies (in 15 states) have been rolled back.
- Eleven states had Medicaid telehealth policies that had been rolled back *and* policies that had been made permanent.
- Twenty-nine states had some type of policy change following telehealth flexibilities or new policies in response to the COVID-19 PHE including policies regarding delivery requirements, modality, service type, provider type, and payment.
- The most frequent state telehealth policy change made permanent was coverage of different modalities—such as audio-only, store and forward, and remote patient monitoring.
- The next most frequent policy change made permanent was delivery requirement flexibilities such as expanding originating sites to include patients' homes.
- The policy most frequently rolled back was the flexibility to use non-HIPAA-compliant platforms to deliver telehealth services.
- Providers generally express a desire to maintain Medicaid coverage and payment parity for telehealth services.

Overall, the findings from this study show that state Medicaid policies following the COVID-19 PHE will continue to include telehealth in some capacity. The experiences and lessons learned from the qualitative discussions in this study can be instructive to other state and federal policymakers considering how to transition to the next stage of Medicaid telehealth as the COVID-19 PHE has come to an end. The perspectives shared here also highlight the importance of continuing to study the impacts of telehealth on factors including quality, cost, patient experience, and health equity, and refining the data collection and methods of analysis.