State Medicaid & CHIP Telehealth Toolkit

February 2024

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Contents

Introduction

Although telehealth has been available in many states for decades, the COVID-19 public health emergency (PHE) accelerated interest in this method of service delivery.[1,2] As payers seek to improve access to care and providers continue to update approaches to care, service delivery via telehealth continues to grow nationally.[3] To facilitate this increase in the use of telehealth, states continue to change their payment and licensure laws and policies.[4] There is promising preliminary evidence of positive impacts, particularly for remote patient monitoring for individuals with chronic conditions, communication/counseling for individuals with chronic conditions, and psychotherapy as part of behavioral health.[5] However, evidence is still being collected about when and where there are unilateral positive gains on access, quality, and costs when services are delivered using telehealth.[6]

The Centers for Medicare & Medicaid Services (CMS) is committed to supporting state policymakers in their efforts to expand the use of telehealth to deliver Medicaid and Children's Health Insurance Program (CHIP) services. The intent of this document is twofold. First, it consolidates information from the **State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version,**[7] released by CMS on April 23, 2020, and the **State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1**[8], released by CMS on October 14, 2020.[9] Second, it provides additional guidance to states on how they can improve access to telehealth for services covered under Medicaid and CHIP, as required by the Bipartisan Safer Communities Act (BSCA), 2022, Division A, Title I, Section 11002(a).[10] In accordance with the BSCA, this toolkit provides information for states regarding telehealth flexibilities under Medicaid and CHIP; billing best practices; strategies for telehealth in value-based care; best practices from states during the COVID-19 PHE; strategies to promote the delivery of accessible care via telehealth; strategies to promote culturally competent care via telehealth; strategies for communications, training, and resources for providers and beneficiaries; strategies for using telehealth in schools; information about telehealth platforms; and evaluation strategies to understand how telehealth affects quality, outcomes, and cost. To support this effort, this toolkit includes state policy and operational considerations; information about common telehealth modalities; updated frequently asked questions (FAQ) for states to consider as they explore whether to expand use of telehealth; Medicaid managed care and fee-for service state checklists; and other helpful planning tools to aid those efforts. It also examines issues related to equitable access to telehealth for a range of beneficiary populations, including individuals in underserved communities.[11]

Additionally, this toolkit includes states' telehealth strategies and best practices from both before and after the COVID-19 PHE, as well as information on how telehealth can be a helpful tool for

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[1] This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[2] For purposes of this Toolkit, the term "state" refers to all U.S. states, territories, and the District of Columbia.

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/.

[4] https://www.cchpca.org/compare/.

[5] https://effectivehealthcare.ahrq.gov/products/telehealth/technical-brief?_gl=1*1kv7ojh*_ga*NDk4Mzk0NDQxLjE2NTAwMjQ0Nzg.*_ga_45NDTD15CJ*MTY4NjEzNTg0MC4xLjEuMTY4NjEzNTkzOS40Ny4wLjA.

[6] Ibid.

[7] https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.

[8] https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.

[9] The State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version , and the State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1 were both updated on December 6, 2021 to include information about telehealth modalities that are audio-only.

[10] Bipartisan Safer Communities Act (BSCA), 2022, Division A, Title I, Section 11002(a) (Public Law 117-159)): https://www.congress.gov/117/plaws/publ159/PLAW-117publ159.pdf.

[11] The term "underserved communities" refers to populations sharing a particular characteristic, including geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified in the definition of "equity." This includes members of racial and ethnic communities; people with disabilities; members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; individuals with limited English proficiency; members of rural communities; and persons otherwise adversely affected by persistent poverty or inequality.

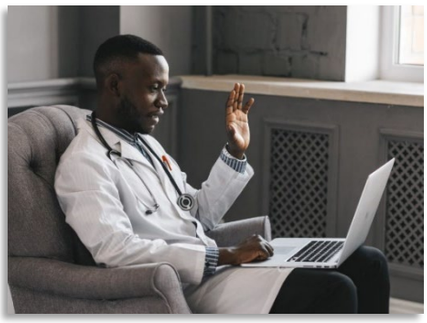
maternal health, accessing out of state providers, transitions for foster-age youth, and more.

Throughout this toolkit, references to services delivered via telehealth refers to covered Medicaid and CHIP benefits and services that are provided via telehealth rather than in person. For adults, states identify covered Medicaid benefits in the state plan, and services under those benefits may generally be delivered via telehealth. The EPSDT benefit mandates Medicaid coverage of services described in section 1905(r) of the Act for EPSDT-eligible beneficiaries, including medically necessary services that are otherwise coverable under 1905(a) of the Act, whether or not those services are included in the state plan. EPSDT services can also generally be delivered via telehealth.

Please note: The strategies and state examples provided throughout this guide are meant to illustrate how states have operationalized telehealth and to inform the development of state telehealth policy. Some examples and activities described might not be funded, or might not be eligible for federal matching funds, under title XIX or other federal program(s). CMS understands that development of processes and infrastructure to support the delivery of Medicaid and CHIP services via telehealth is an ongoing endeavor and continues to hold direct technical assistance sessions with states, as well as regular all-state calls, to answer questions and to better understand state needs. Recordings and transcripts of all-state calls, and additional information about telehealth is also available on Medicaid.gov.[12,13]

[12] https://www.medicaid.gov/resources-for-states/cmcs-medicaid-and-chip-all-state-calls/index.html.
[13] https://www.medicaid.gov/medicaid/benefits/telehealth/index.html.

Section 1: Telehealth Overview



The manner and extent to which states authorize or expand service delivery via telehealth within their Medicaid and/or CHIP programs involves examination of multiple policy, operational, and practical factors. Section 1 of this toolkit provides the following fundamental considerations for state agencies as they explore changes to their existing telehealth policies: telehealth flexibilities in Medicaid and CHIP, state policy considerations, and common telehealth modalities.

Highlights of Telehealth Flexibilities in Medicaid and CHIP

Telehealth is a delivery method, not a distinct health service. Unlike Medicare, for most Medicaid and CHIP benefits, federal laws and regulations do not specifically address telehealth delivery methods or criteria. As a result, states have a great deal of flexibility in designing the parameters of service delivery using telehealth in Medicaid and CHIP, including through various telehealth delivery methods. This broad flexibility to cover and pay for services delivered via telehealth was in place prior to the COVID-19 PHE and continues to be available to states after the COVID-19 PHE.

Telehealth is a delivery method, and not a distinct service.

States generally have the option to determine what types of covered services may be delivered via telehealth, what types of practitioners or providers may deliver covered services via telehealth, and what payment parameters will support telehealth—such as whether payment is the same for services delivered in-person and via telehealth, and alignment within and across fee-for-service and managed care delivery systems. These flexibilities generally enable states to develop their own coverage and payment requirements for services delivered via telehealth in Medicaid and CHIP. In addition, states must continue to meet any federal requirements related to coverage of the benefits and other applicable federal law, including the requirements of Title XIX of the Social Security Act (the Act) and federal regulations (as interpreted in published CMS guidance), and the parameters of a state's CMS-approved Medicaid state plan and/or demonstration projects and waivers. In the very limited circumstances where federal Medicaid law or regulations set forth telehealth delivery requirements for specific benefits, states must follow those requirements. For example, the Community First Choice (CFC) option at section 1915(k) of the Act has general requirements for using telemedicine or other information technology medium (e.g., telehealth) for performing the assessment of functional need (implemented in regulation at 42 C.F.R. § 441.535), and states must follow these requirements. However, there are no other federal statutory or regulatory requirements pertaining to other CFC activities that could be performed using telehealth, and thus states have greater flexibility with respect to those other CFC activities.

States should consider various issues before setting Medicaid and CHIP telehealth policy. Given the complex and interrelated nature of state-level regulatory frameworks governing the delivery of healthcare services—provider scope of practice, privacy regulations, definitions of telehealth, and other areas—a barrier in one area could easily block regulatory alignment in other areas, effectively preventing adoption and use of telehealth capabilities. Table 1 provides an overview of state Medicaid and CHIP telehealth flexibilities and related policy considerations. More information on these flexibilities is available in **Section 2: Frequently Asked Questions**. For questions about this information, states are encouraged to reach out to their CMS Division of Program Operations (DPO) State Lead to request technical assistance.

Table 1 – Telehealth Flexibilities and Related Policy Considerations

Flexibility	Policy Consideration
Services: States have the option to authorize delivery of many Medicaid services through telehealth to expand access to care.	• States should consider whether the full extent of each covered service can be delivered effectively though telehealth and if the efficacy could vary across populations, such as individuals with access to different modalities and technologies. • Similarly, states should consider if providers can complete the components of the visit that could not be done via telehealth (e.g., immunizations) in a follow-up visit. • States should also consider privacy and consent laws and policies. • States may want to consider where alignment of service delivery via telehealth across services provided under different authorities (e.g., waiver and state plan services) best serves their beneficiaries. • States should ensure that telehealth policies are consistent between Medicaid fee-for-service (FFS) and managed care delivery systems since state plan services covered under a managed care organization (MCO) contract are supposed to be the same services as would be covered under FFS Medicaid. • There is no requirement that state Medicaid and CHIP telehealth policies follow Medicare requirements. • States should review services for the possibility of authorizing service delivery via telehealth even if the services have not traditionally been delivered via telehealth. States can consider expanding coverage of services delivered via telehealth to additional classes of services or particular services that are underutilized. • States must deliver services statewide but have historically been permitted to authorize service delivery via telehealth in specific parts of a state, as long as the services are available through at least one delivery modality statewide. Thus, states can consider allowing services to be delivered via telehealth statewide or in a geography where increased access to providers is needed most.
Providers: Not every provider can deliver every service via telehealth, and just making a provider eligible to bill for a Medicaid service delivered using telehealth may not be enough. In addition to provider licensure and credentialing in Medicaid, states should also consider whether a provider's professional scope of services enables him or her to bill for a service provided via telehealth, and whether any changes to the scope of services are warranted.[14]	• States should consider which providers and practitioners authorized to bill Medicaid in their state, such as dentists, physical, occupational, or speech therapists, obstetricians and gynecologists, or direct support professionals, can in fact furnish specific services via one of the telehealth modalities. For example, while dentists can provide some dental services via telehealth, it would be impossible for them to provide a teeth cleaning via telehealth. • State Medicaid and CHIP agencies may want to consider reaching out to state licensing boards to discuss whether scope of practice laws can be expanded to ensure maximum utilization of telehealth flexibilities for some providers, such as optometrists. • State should consider whether telehealth can help with provider shortages by enabling additional providers or provider types (e.g., paraprofessionals) to serve beneficiaries. For instance, states could increase provider capacity and support access by allowing additional providers or provider types (e.g., paraprofessionals) to serve beneficiaries when a service is provided via telehealth. As another example, states could allow a provider to delegate some service functions to another health professional (while under the provider's supervision) when the service is provided via telehealth.

[14] https://www.ama-assn.org/practice-management/scope-practice/what-scope-practice#:~:text=Scope%20of%20practice%20refers%20to,by%20the%20appropriate%20licensing%20entity.

Flexibility	Policy Consideration
Technology: Telehealth is generally thought of as two-way, real-time audio/visual communication, or a video chat. However, telehealth is much broader than that. Other forms–such as audio-only, store-and-forward, and remote patient monitoring–are also available. (More information can be found in the **Section 1: Telehealth Overview, Common Telehealth Modalities** subsection of this Toolkit.)	• States should consider whether beneficiaries and providers have the information and technology they need to use telehealth as a means for service delivery. • States can consider allowing covered services to be delivered via multiple telehealth modalities. For instance, nothing in Federal Medicaid law and policy prohibits states from covering and paying for Medicaid services delivered via audio-only communications (although state law may prohibit this in some instances). If this is otherwise permitted under state law, states could consider covering some services when provided via audio-only communications, while covering other services delivered via telehealth only when two-way audio-video technologies are used.
Payment: States should consider whether their Medicaid and CHIP payment rates for services delivered via telehealth are adequate.	• State Medicaid agencies should review existing payment methodologies to ensure that rates for services factor in additional costs that may be incurred by providers when delivering services through telehealth that would not otherwise be incurred through a face-to-face visit (for example, additional costs to facilitate a telehealth-delivered service that are incurred at a medical facility or a beneficiary's home). • States should consider whether to cover and pay for services the same way regardless of whether they delivered via telehealth or are delivered in person. • States can consider payment methodologies that include costs associated with the time and resources spent facilitating care where the beneficiary is located, such as a medical facility or the beneficiary's home. States may include costs associated with providing services via telehealth within Medicaid payment methodologies. • States may also pay providers for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for delivering services via telehealth. A state would need an approved state plan payment methodology that specifies the ancillary costs and circumstances when those costs are payable. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth and properly allocated to the Medicaid program.

States are encouraged to make information readily available to providers, beneficiaries, and other interested parties about telehealth policies and procedures in Medicaid and CHIP, including coverage, payment, and considerations related to the technology for service delivery.

Additionally, the telehealth flexibilities discussed in this toolkit generally apply to CHIP programs operating independent of Medicaid (Separate CHIP) and to CHIP programs that operated fully or partially as part of the state's Medicaid Program. However, due to statutory, regulatory, and programmatic differences between these CHIP programs, the instances when a SPA may be required in Separate CHIP programs, and when telehealth may or may not be used, could differ. Thus, states operating Separate CHIP programs should contact their CHIP Project Officer for assistance.

Common Telehealth Modalities

Services delivered via telehealth seek to improve a patient's health and can, for example, be used for assessment, diagnosis, intervention, consultation, and supervision across distances, and can involve multiple parties. Developing telehealth policies can sometimes be a challenge for state Medicaid programs, due, in part, to confusion about the services that can be delivered via telehealth, as well as the technologies that can be used. Ultimately for Medicaid programs, the goal of a state's policy around the delivery of telehealth should be to clarify for interested

parties, such as providers, beneficiaries, and managed care plans,[15] whether and how a range of communication technologies can be used to support care delivery.

The service is the care that is delivered through the technology, not the technology itself.

The act of sending information—regardless of the modality—is not itself a billable health care encounter or Medicaid service. Providers can generally claim for a service that involves clinical decision making or advice. The covered service is NOT using technology itself; the service is the evaluation, management, diagnosis, etc., that is enabled by the technology.

Telehealth is not limited to a meeting between two parties. For instance, multiple providers, or someone to assist the beneficiary, may participate. The broad flexibility for states to permit delivery of covered services via telehealth also extends to interprofessional consultations, sometimes called e-consult.[16,17] Interprofessional consultation is defined as a situation in which the patient's treating physician or other qualified health care practitioner (hereafter referred to as the treating practitioner) requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise (hereafter referred to as the consulting practitioner) to assist the treating practitioner with the patient's care without patient face-to-face contact with the consulting practitioner.[18] To be coverable under Medicaid and CHIP, interprofessional consultation must be for the direct benefit of the beneficiary.[19] This means the services must be directly relevant to the individual patient's diagnosis and treatment, and the consulting practitioner must have specialized expertise in the particular health concerns of the patient.[20] Interprofessional consultation is intended to expand access to specialty care and foster interdisciplinary input on patient care.[21] It is not intended to be a replacement for direct specialty care when such care is clinically indicated.

Independent of the modality used, when remotely communicating with beneficiaries and delivering services via telehealth, Medicaid providers must comply with applicable Health Insurance Portability and Accountability Act (HIPAA) requirements to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security, and Breach Notification Rules ("HIPAA Rules").[22] As states approach person-centered care or case management involving multiple providers, the array of modalities and HIPAA-compliant audio and video technology platforms that enable single and multi-person video calls may help states extend reach to beneficiaries and providers and serve as tools to increase access to care.

Table 2 below describes common telehealth technology types and how they are used to support care delivery. Because telehealth terminology can vary, this section describes a technology's capabilities and common terms that are used to describe similar capabilities. While other telehealth delivery methods may exist, the methods described in Table 2 generally reflect those most commonly utilized.[23]

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[15] The term "managed care plan" refers to Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), and Primary Care Case Management (PCCM) entities when utilized.

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf.

[17] Medicaid payment for consultations between professionals regarding treatment for a patient may be available when these costs are incorporated into the rate a state pays a provider for a covered service for a beneficiary.

[18] Ibid.

[19] https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf.

[20] Ibid.

[21] Ibid.

[22] During the COVID-19 PHE, the Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS)—the office that enforces the HIPAA Privacy and Security Rules—issued enforcement discretion with regard to provider use of an audio or video communication platform during the PHE. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html States should follow the requirements in federal statute found at 45 CFR parts 160 and 164, subparts A, C, D and E.

[23] https://www.cchpca.org/what-is-telehealth/#:~:text=Today%2C%20telehealth%20encompasses%20four%20distinct,in%20detail%20to%20learn%20more.

Table 2 – Common Telehealth Modalities

Modality	Description, Uses, and Limitations
 **TWO-WAY, REAL-TIME AUDIO-VIDEO AND MULTI-PERSON VIDEO CALLS**	**Description** Two-way, real-time audio-video is the most widely available telehealth modality for different provider types. Two-way, real-time audio-video is a bi-directional, face-to-face interaction between a patient and a provider using audiovisual communication technology. This interactive technology requires a working camera, microphone, and speakers/headphones for individuals on both sides of the conversation, as well as enough internet bandwidth to support the upload/download of data for audio and moving video images. Beneficiaries and providers can use multiple devices for this modality such as smartphones, tablets, laptops, or desktop computers with the necessary components. While two-way, real-time audio-video usually involves two parties (a provider and a patient), some two-way, real-time audio-video technologies support "multi-person video calls." In a multi-person video call, three or more parties—each using a separate device potentially at different locations—can join the same call and simultaneously interact using audio and video. There are many services and software applications for this modality. Platforms must be both HIPAA-compliant and have the proper safeguarding measures to handle protected health information (PHI). **Uses** Sometimes two-way, real-time audio-video is supplemented with information from sensors or other peripheral devices (e.g., a scale, blood pressure cuff, glucometer) at the patient site to help inform diagnosis or treatment approach. Additional supplemental information could also include pictures or other still images, though, in most cases this would only enhance a two-way, real-time audio-video visit without making it materially different. Depending on the state and the device/sensor, states may have billing instructions and policies in place regarding the service that can be delivered or procedure codes (e.g., particular evaluation and management (E&M) codes) that can be billed. Two-way, real-time audio-video can also support provider-to-provider consults in which a provider reaches out to another provider to get counsel on how to treat a patient. Multi-person video calls can help family caregivers be involved in their relative's care, even when they are not physically at the same location as the patient. Likewise, this modality can facilitate the use of telehealth for individuals with disabilities (e.g., hearing impaired) or with limited English proficiency who may require an interpreter to join the video call and effectively participate in the telehealth visit. **Limitations** Not all services can be appropriately delivered via two-way, real-time audio-video, and states handle these limitations differently. Some states explicitly list the services or Current Procedural Terminology (CPT) codes that are eligible for payment when delivered via two-way, real-time audio-video; others rely on the provider scope of practice (and documentation requirements) to ensure that only those services that, in the professional estimation of the healthcare provider, can be delivered in a clinically appropriate way are delivered via this form of telehealth modality. Some beneficiaries and providers could face challenges with the broadband availability that is necessary for this telehealth modality and/or with sufficient cell phone data plans to allow for video streaming.

Modality	Description, Uses, and Limitations
 **AUDIO-ONLY**	**Description** Real-time interactive voice-only discussion, which is usually between a patient and a provider, generally only requires a working phone that supports audio-based communications. The American Medical Association has defined several CPT codes related to audio-only communication that states may consider.[24] These CPT codes can be used for specific time increments (five minutes to 30 minutes) of payable "phone-based consultations" between a provider and a patient. **Uses** Audio-only technologies may be more appropriate for individuals who do not have access to sufficient bandwidth or technology to support two-way, real-time audio-video. In this sense, utilizing "audio-only" telehealth can expand healthcare access for lower-income individuals. **Limitations** At the start of the COVID-19 PHE, nearly every state expanded the definition of "telehealth" to include "audio-only" communication. Effectively, this brought "audio-only" into the broader telehealth framework for defining and billing for healthcare services. However, even during the COVID-19 PHE, not all states allowed payment for services delivered by audio-only technology for all providers in all situations, and several states excluded certain provider types (e.g., physical therapists) from using this modality. Now that the COVID-19 PHE is over, states can generally continue to opt to cover and pay for services provided via audio-only technologies.[25] Additionally using this modality may be difficult for individuals with disabilities (for example, hearing impaired individuals). For more information about audio only telehealth, please see **Section 2: Frequently Asked Questions**, question #13.
 **ASYNCHRONOUS COMMUNICATIONS**	**Description** Asynchronous communications, also called "store and forward," reflect the most complex range of capabilities, coverage, and applicability to different providers. Asynchronous communications involve contact between two parties (patient-to-provider or provider-to-provider) in a way that does not require real-time interaction. For example, a patient sends a message to a provider, who reads the message several hours later and replies to the message. Communications could be a narrative (text-based) description, an image, a video recording, an audio recording, or responses to a survey, among other items.[26] In most cases, the electronic system functioning as the conduit of the information should be a HIPAA-compliant technology that supports encrypted communication from one party to another. Like other forms of telehealth, asynchronous communications can support billable communication between a patient and a provider (sometimes called e-visits), or between a provider and another provider (interprofessional consultation). **Uses** States should provide detailed information on when services can be delivered through this modality, including the providers that will receive payment for services delivered via this modality, and the form(s) of asynchronous communication that can be used. For example, some state

[24] https://www.ama-assn.org/practice-management/cpt/cpt-appendix-t-and-modifier-93-audio-only-medical-services.

[25] See the Office for Civil Rights (OCR) June 13, 2022, guidance on how covered health care providers and health plans can use remote communication technologies to use audio-only telehealth to deliver services when such communications are conducted in a manner that is consistent with the applicable requirements of HIPAA Privacy, Security, and Breach Notification Rules, including when OCR's Notification of Enforcement Discretion for Telehealth is no longer in effect. https://www.hhs.gov/about/news/2022/06/13/hhs-issues-guidance-hipaa-audio-telehealth.html#:~:text=Today%2C%20the%20U.S.%20Department%20of,conducted%20in%20a%20manner%20that.

[26] Other examples of asynchronous communication include: a detailed questionnaire response sent from a patient to a provider, who evaluates the questionnaire responses and provides a diagnosis and treatment; a patient sends a provider images of a skin infection with a narrative of when it began and how it has progressed, and the provider evaluates the images, provides a diagnosis, and prescribes a medication; and, a primary care provider requests an evaluation and recommendations from an endocrinologist by submitting a clinical question as a recorded voice memo and using a secure platform to submit patient information, and the endocrinologist provides an asynchronous consultation to aid the primary care provider's diagnosis and treatment.

Modality	Description, Uses, and Limitations
ASYNCHRONOUS COMMUNICATIONS (Continued)	Medicaid programs—such as Texas—allow a physician to bill for an office visit when a narrative-based message from a patient is accompanied by asynchronous audio conversation, and the provider reviews a relevant image (including a moving image), or a medical record.[27] **Limitations** States that explicitly allow for asynchronous communication often require a narrative description with an image, so a simple text message would not suffice. Other states do not have an operational definition of asynchronous communication even though it is not explicitly prohibited; as a result, it is rarely used. State Medicaid programs differ both in how asynchronous or "store and forward" technology can be used, and in how to use it as part of a billable service. Different forms of asynchronous communication—narrative only, narrative with image, etc.—can support diagnoses or evaluation of a condition, but the degree to which this is the case is highly dependent on state regulations and policies. To a greater degree than two-way, real-time audio-video, asynchronous communications are often limited to certain providers either by explicit regulation, or on the basis of a provider's scope of practice.
 **REMOTE PATIENT MONITORING**	**Description** Although Remote Patient Monitoring (RPM) could take many forms, it typically involves the deployment and use of technology to capture biometric information about the patient that is automatically shared with a remote provider. The provider can then review the data and determine the appropriate course of action. RPM typically involves the use of "peripheral devices" that are designed to capture patient biometric information such as weight, blood pressure, blood oxygen levels, etc. **Uses** In an outpatient setting, a patient with hypertension uses a web-enabled blood pressure cuff to take readings several times a day. This information is shared securely with a provider who regularly reviews readings and as needed, follows up with the patient to support diet and other behavior changes to reduce blood pressure. Providers can oversee many patients simultaneously using RPM technologies that help identify individuals who have readings that fall outside established parameters and, therefore, warrant follow-up. **Limitations** As with asynchronous communications, RPM is not widely paid for across different Medicaid programs, or there may be billing rules that specify which providers are permitted to bill. In 2018, the American Medical Association added several CPT codes to facilitate billing for RPM, but these have not been widely adopted in Medicaid programs. Several states only allow RPM under specific circumstances (e.g., for patients in home health settings; for specific clinical conditions; and/or for certain provider types). Billing for RPM can be complex and may not cover the cost of RPM hardware. In state Medicaid programs that are more advanced in the use of value-based contracting with providers, there may be more leeway and/or incentive to cover remote monitoring technologies that help patients maintain a healthy lifestyle. Generally, RPM is only for established patients who are under the active care of a provider.

[27] See sections 3.4 and 3.5 of the Texas Medicaid Provider Procedures Manual: Vol. 2: Telecommunication Services Handbook (https://www.tmhp.com/resources/provider-manuals/tmppm). Accessed 5/31/2023.

Section 2: Frequently Asked Questions

The frequently asked questions (FAQ) below provide information on topics that states commonly consider when implementing telehealth policies. These topics include:

- Benefit Flexibilities
- Financing
- Workforce
- Managed Care
- Codes, Modifiers, and Medicaid Systems
- Quality Reporting

The FAQs describe telehealth flexibilities that are always available to states. In some cases, the FAQs also include information about additional flexibilities that could become available during a PHE. FAQs specific to the telehealth flexibilities that were available during the COVID-19 PHE can be found in the **State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version,** and the **State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1**.[28]

If states have any questions on how the FAQs may apply to their specific programs, they should contact their Division of Program Operations (DPO) State Lead.

Benefit Flexibilities

1. What flexibilities exist for states to cover and pay for Medicaid state plan benefits delivered via telehealth?

For most Medicaid benefits, federal Medicaid laws and regulations do not set forth specific requirements related to delivering benefits via telehealth or specify telehealth delivery methods. As a result, states have broad flexibility in designing coverage and payment requirements for services delivered via telehealth. In addition, states must continue to meet any federal requirements related to coverage of the benefits and other applicable federal law, including the requirements of Title XIX of the Social Security Act (the Act) and federal regulations (as interpreted in published CMS guidance), and the parameters of a state's CMS-approved Medicaid state plan and/or demonstration projects and waivers. In the very limited circumstances where federal Medicaid law or regulations set forth telehealth delivery requirements for specific benefits, states must follow those requirements. For example, the Community First Choice (CFC) option at section 1915(k) of the Act has general requirements for using telemedicine or other information technology medium (e.g., telehealth) for performing the assessment of functional need (implemented in regulation at 42 C.F.R. § 441.535), and states must follow these requirements. However, there are no other federal statutory or regulatory requirements pertaining to other CFC activities that could be performed using telehealth, and thus states have greater flexibility with respect to those other CFC activities.

States are generally not required to submit a (separate) SPA for coverage or payment of Medicaid coverable services delivered through telehealth if they decide to cover and pay for services delivered through telehealth in the same way/amount that they cover and pay for face-to-face services.

States must submit a (separate) payment (attachment 4.19-B) SPA if they want to provide payment for services or components of services delivered through telehealth differently than they currently pay for face-to-face services.

If a state wishes to cover Medicaid benefits when delivered via telehealth, the state should review carefully federal statutory and regulatory requirements for their Medicaid programs to ensure the state complies with any applicable federal requirements.

2. For services authorized in 1915(c) Home and Community-Based Services (HCBS) Waivers and 1915(i) HCBS State Plans, is CMS approval necessary for states to permit

[28] https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf; https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.

telehealth/remote delivery of these services?

Yes, this would be a change that would need to be documented in the 1915(c) waiver and/or 1915(i) state plan. Under these Medicaid authorities, states have the option to cover services for populations of older adults or individuals with a disability who need HCBS to reside in the community and avoid institutionalization.

To ensure that these services are delivered in a manner that would meet the needs of these populations when provided via telehealth, and ensure that they are carried out in accordance with applicable laws, states should include the following information in the definition of the service for which the state is using telehealth for service delivery:

- A description of how the remote service will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc.;
- A description of how the telehealth service delivery will facilitate community integration;
- A description of how telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or by someone who is separated from the individual;
- A description of how the state will support individuals who need assistance with using the technology required for telehealth delivery of the service;
- A description of how the telehealth service delivery will ensure the health and safety of an individual.

With regard to face-to-face assessments required for 1915(i) state plan HCBS, federal regulations at 42 C.F.R. § 441.720(a) authorize the use of telemedicine or other information technology medium (e.g., telehealth) so long as certain conditions are met, including the individual performing the assessment being independent, appropriately qualified, and trained, the beneficiary receiving appropriate support during the assessment, including the use of any necessary on-site support staff, and the beneficiary providing informed consent for the assessment being performed via telehealth.

3. Are there any available flexibilities in implementing the requirement for face-to-face encounters under Medicaid home health? Can telehealth be utilized?

Yes. For initiation of home health services, face-to-face encounters may occur using telehealth as described at 42 C.F.R. § 440.70(f)(6). A physician, nurse practitioner or clinical nurse specialist, a certified nurse midwife, a physician assistant, or attending acute or post-acute physician may perform the face-to-face encounter using telehealth for beneficiaries admitted to home health immediately after an acute or post-acute stay. Clinical findings must be incorporated into the beneficiary's written or electronic medical record. Additionally, the ordering practitioner must document that the face-to-face encounter occurred within the required timeframes prior to the start of home health services and indicate the practitioner who conducted the encounter, as well as the date of the encounter.

A SPA would only be necessary to revise existing state plan language that imposes telehealth parameters that would restrict this practice. As is discussed above and on the CMS telehealth website, states are not required to submit separate SPAs for coverage or payment of services delivered using telehealth if they decide to pay for telehealth-delivered services in the same manner or at the same rate paid for face-to-face services.[29] A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

4. Can Pre-Admission Screening and Resident Review (PASRR) Level 1 and Level 2 evaluations be conducted remotely as opposed to through a face-to-face visit?

Yes. The PASRR statutory provisions require all applicants to and residents of Medicaid-certified nursing facilities (NF) be screened for mental illness and intellectual disability, and, if necessary, be provided specialized services while in the NF.

Federal regulations do not prohibit PASRR Level 1 and Level 2 evaluations from being conducted by telephone or through another electronic medium. Unless the state has a specific requirement that PASRR Level 2 evaluations be conducted in a face-to-face interview, there is no need to amend language in the state plan.

In any future PHEs, CMS will explore specific telehealth flexibilities available to states.

[29] https://www.medicaid.gov/medicaid/benefits/telehealth/index.html.

5. How do the Medicaid flexibilities around use of telehealth as a service delivery mode interact with Medicare and commercial third-party liability (TPL) requirements, which may be less flexible around telehealth? For example, a Medicare or commercial payer may require a face-to-face physician visit to order care or supplies.

Medicaid telehealth flexibilities allow Medicaid to pay in the event Medicare or a commercial insurer denies payment. Generally, Medicaid is the payor of last resort. If the third party denied the claim for a substantive reason (e.g., service not covered) and the service is covered under the Medicaid state plan, Medicaid would review for payment accordingly. If the state is later made aware of a third party's coverage for these specific services, the state, as it currently does, would chase recovery of payment accordingly. Therefore, in the example above, once Medicare or a commercial payer reviews a claim and denies it for a substantive reason, such as a face-to-face physician visit requirement, Medicaid would review and pay accordingly.

States may exempt certain items or services from TPL requirements when submission of claims for those items or services would always result in denial because Medicare or a commercial insurer does not cover those items or services. When non-coverage has been documented, the state Medicaid agency may permit providers to use a specific code on the claim denoting non-coverage by the third party. This code could allow the state Medicaid agency to override the cost avoidance edit and pay the claim. The state would have to require providers to maintain documentation to substantiate non-coverage when using override codes and could conduct provider audits to assure that the provider has appropriate documentation of non-coverage.

6. Can states leverage telehealth to deliver Medicaid services to children in schools?

Yes. State Medicaid/CHIP agencies have the flexibility to cover Medicaid- and CHIP-covered services delivered through telehealth, including in school-based settings, and CMS encourages states to consider telehealth as an option to increase access to care in schools. School-based telehealth involves the use of telecommunications, including interactive video conferencing and store-and-forward transmissions, to deliver a variety of healthcare and other services to students while they are present in school settings.[30] In addition to covering Medicaid and CHIP services on a student's Individualized Education Program (IEP), state Medicaid/CHIP agencies may cover Medicaid and CHIP services required for students with disabilities under Section 504 of the Rehabilitation Act of 1973 (Section 504), as well as Medicaid- and CHIP-covered general medical services provided to all students including routine preventive care, mental health and SUD services, and ongoing primary care and treatment. School-based services (SBS) in Medicaid can fall into either or both of the following categories:

1. Services for Medicaid-eligible children who need general health care services.
2. Services for Medicaid-eligible children with disabilities who receive services in accordance with an IEP or Individualized Family Service Plan (IFSP) established under the Individuals with Disabilities Education Act (IDEA).[31,32]

Historically, Medicaid-covered SBS were limited to services identified in a Medicaid-enrolled student's IEP. Consequently, many states have language in their Medicaid state plans tying coverage of services to an IEP. Such states would need to amend their Medicaid state plan to

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[30] For more information see: https://telehealth.hhs.gov/providers/best-practice-guides/school-based-telehealth.

[31] IDEA in this document primarily refers to students with disabilities 3-21 years old with an IEP. However, we realize that some Local Educational Agencies (LEA) support early childhood educational programs for children with disabilities birth to 2 years old under IDEA with Individualized Family Service Plans (IFSP). (LEAs are public boards of education or other public authorities legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State. 34 C.F.R. § 300.28.) Throughout this document when IEPs are mentioned, the intent is to include IFSPs as well, as applicable, unless otherwise stated.

[32] For more information about IDEA and Section 504, please refer to the Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming at https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf. IDEA Part B services in an IEP constitute a free appropriate public education (FAPE) and therefore must be delivered at no cost to the child's parents. IDEA Part C services in an IFSP are generally provided at no cost but are subject to a state's system of payments, which may include the use of Medicaid or public benefits or insurance, private insurance and/or family fees. Between IDEA and Medicaid, Medicaid is the payer of first resort for services included in the IEP or IFSP. While students with disabilities who receive services under Section 504 likewise are entitled to FAPE, their Medicaid coverage is identical to eligible students who need general health care services. Therefore, Medicaid is not the payer of first resort for services to students covered solely by Section 504. However, when an LEA meets its Section 504 obligations to an IDEA-eligible child with a disability through an IEP, then Medicaid will be payer of first resort for any Section 504 services included in the IEP.

expand Medicaid coverage for services furnished in schools beyond what is included in an IEP in order to pay for the services provided to Medicaid-enrolled students who do not have an IEP, or for services provided to Medicaid-enrolled students with an IEP that are not specifically identified in the IEP. Services can be covered by Medicaid only if they are Medicaid services provided to a Medicaid-enrolled child by a Medicaid-participating practitioner.[33] For more information about school-based services in Medicaid, see: CMCS Information Bulletin Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services, and The Centers for Medicare and Medicaid Services (CMS) Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.[34]

As a reminder, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires states to make available to eligible children under age 21 all services included under section 1905(a) of the Act, regardless of whether they are included in the state plan, if the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

7. Would an IEP, an IFSP, Section 504 plan, or other plan that identifies Medicaid-covered services for a Medicaid-enrolled child need to expressly indicate that services can be delivered via telehealth as a pre-condition for receipt of Medicaid payment for the services?

No. Medicaid considers telehealth to be a service delivery method, not a different service than the same service provided face-to-face. States should continue to follow the requirements for other programs. For instance, under IDEA, a child's IEP must provide information about the anticipated frequency, location, and duration of special education, related services, and supplementary aids and services. [35,36] Therefore, an IEP would require information about telehealth.

As indicated above, historically, Medicaid-covered SBS were limited to services identified in a Medicaid-enrolled student's IEP. Consequently, many states have language in their Medicaid state plans tying coverage of services to an IEP. Such states would need to amend their Medicaid state plan to expand Medicaid coverage for services furnished in schools beyond what is included in an IEP in order to pay for the services provided to Medicaid-enrolled students who do not have an IEP, or for services provided to Medicaid-enrolled students with an IEP that are not specifically identified in the IEP. Services can be covered by Medicaid only if they are Medicaid services provided to a Medicaid-enrolled child by a Medicaid-participating practitioner. If these requirements are met, and there is an approved payment methodology for the services in the state Medicaid plan, then Medicaid can pay for the services, including when they are delivered via telehealth.[37] Also as described earlier, unless required by regulation or policy, states are not required to submit a (separate) SPA for coverage or payment of Medicaid coverable services delivered through telehealth if they decide to pay for services delivered through telehealth in the same way/amount that they pay for face-to-face services (unless a SPA is necessary to remove an existing exclusion of coverage or limitation on coverage or payment for services furnished via telehealth).

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[33] For more information about services covered under a state's Medicaid plan to an eligible Medicaid beneficiary in a school setting, see State Medicaid Director Letter SMD #14-006 on Medicaid Payment for Services Provided without Charge (Free Care), available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

[34] For information about school-based services in Medicaid, see: CMCS Information Bulletin Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf, and The Centers for Medicare and Medicaid Services (CMS) Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, available at: https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

[35] IDEA in this document primarily refers to students with disabilities 3-21 years old with an IEP. However, we realize that some LEAs support early childhood educational programs for children with disabilities birth to 2 years old under IDEA with IFSPs. Throughout this document when IEPs are mentioned, the intent is to include IFSPs as well, as applicable, unless otherwise stated.

[36] 34 C.F.R. § 300.320(a)(7).

[37] For information about school-based services in Medicaid, see: CMCS Information Bulletin Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf, and The Centers for Medicare and Medicaid Services (CMS) Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, available at: https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

8. Can early intervention services (EIS) under IDEA[38] Part C be paid by Medicaid when the services are delivered via telehealth?

For each EIS identified on an IFSP,[39] the child's IFSP team (including the parent) must determine whether it is appropriate to deliver the service via telehealth. The state's lead agency for administering IDEA Part C and its EIS providers may be able to provide EIS services via telehealth depending on the state's policies and procedures, whether the services can be effectively provided via telehealth, and the individualized determination made by the child's IFSP team. Early intervention services must be tailored to meet the unique needs of the individual child and family.[40]

Provided a state lead agency has incorporated the use of public benefits and insurance as part of their systems of payments for EIS, under IDEA Part C,[41] and the state chooses to provide a Medicaid-covered service via telehealth, then states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to pay for additional costs that are incurred by the provider because of telehealth delivery.

As explained previously in these FAQs, states have broad flexibility to cover services provided via telehealth under Medicaid and have flexibility regarding the telehealth modality used to provide services. Generally, no federal approval is needed for state Medicaid programs to pay providers for Medicaid services provided via telehealth in the same manner or at the same rate that states pay for those same Medicaid services when provided face-to-face. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

During a PHE, if a state's state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, CMS may explore telehealth flexibilities to temporarily lift such restrictions.[42]

9. Can Medicaid coverage be available for evaluations to determine the need for EIS under the IDEA if providers conduct the evaluation via telehealth?

Yes. If a state establishes that evaluations for EIS that Medicaid would otherwise cover can be delivered via telehealth, Medicaid qualified practitioners can bill for their time spent in conducting evaluations via telehealth as an applicable practitioner service.

10. Can pediatric clinicians receive Medicaid payment for well-child visits delivered via telehealth?

Yes. Well-child visits are covered under EPSDT, and states may establish policies that allow providers to cover well-child visits delivered via telehealth. Generally speaking, states can establish the same rate for Medicaid services delivered via telehealth that is paid when the same services are delivered face-to-face, but states may also opt to establish different rates for services delivered via telehealth. Each state has the discretion to set payment rates that are consistent with section 1902(a)(30)(A) of the Act. Accordingly, states may pay a different rate for services delivered via telehealth to account for differences between the cost of delivering the services face-to-face and the costs of delivering them via telehealth. If states choose to pay different rates for services when they are delivered via telehealth, a SPA submission would be necessary to describe and receive CMS approval for the new payment methodology, if this is not already reflected in the approved state plan.

11. May states cover Medicaid freestanding clinic services under 42 C.F.R. § 440.90 if the services are provided via telehealth when neither the patient nor clinic practitioner is physically onsite at the clinic?

CMS regulations at 42 C.F.R. § 440.90(a) require that Medicaid clinic services be furnished "at the clinic"—that is, within the four walls of the clinic facility—with an exception at 42 C.F.R. § 440.90(b) for services furnished outside the clinic by clinic personnel to people who are unhoused.

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[38] Under Part C of the IDEA, infants and toddlers (birth through age 2 years) with disabilities and their families are eligible to receive early intervention services.

[39] Early intervention services are designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant's or toddler's development, as identified by the IFSP team, in one or more of the following areas: physical development; cognitive development; communication development; social or emotional development; or adaptive development. (34 C.F.R. § 303.13(a).)

[40] 34 C.F.R. § 303.344(d).

[41] 34 C.F.R. § 303.500(b).

[42] https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html.

States can cover Medicaid clinic services that are furnished via telehealth[43] only if either the patient or the clinic practitioner is physically onsite at the clinic facility.[44]

12. Can Money Follows the Person (MFP) programs use grant funds to cover the use of telehealth as a service delivery method?

MFP grant recipients may use MFP's flexible grant funds to implement strategies in their MFP programs to address barriers to community transitions for eligible individuals in institutions, increase community transition rates, and increase the effectiveness of the MFP demonstration, which may include facilitating adoption and implementation of telehealth. MFP recipients must document through the MFP Operational Protocol which services under the demonstration can be accessed through telehealth, which providers may deliver those services, the modality they may use to deliver telehealth, and a description of how the state will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant. MFP recipients may cover the costs of services delivered through telehealth modalities as a qualified HCBS service, demonstration service, or as a supplemental service (as appropriate).

CMS approval to deliver services via telehealth under the MFP demonstration does not supersede any requirements that apply to section 1915(c) waiver programs or other Medicaid HCBS authorities. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP.

13. Does federal Medicaid law and policy allow states to cover and pay for Medicaid services delivered using audio-only telehealth technologies?

Yes. Nothing in federal Medicaid law or policy prevents states from covering and paying for Medicaid services delivered via audio-only telehealth technologies, as long as providers are enrolled in the Medicaid program and qualified according to federal and state statute and regulation. As noted above, states must continue to meet any federal requirements related to coverage of the services, including the requirements of Title XIX of the Act and federal regulations (as interpreted in published CMS guidance), and the parameters of a state's CMS-approved Medicaid state plan or a subsequent SPA and/or the state's CMS-approved demonstration projects and waivers. Additionally, when using audio-only telehealth technologies, Medicaid providers must comply with the applicable requirements of the HIPAA Rules (for more information, see **Section 1: Telehealth Overview, Common Telehealth Modalities**).

Financing

14. How can states change payments to providers for Medicaid services delivered via telehealth?

States can submit a Medicaid SPA to make changes to provider payment rates and/or payment methodologies for services delivered via telehealth. This includes, but is not limited to, increasing payments for Medicaid services delivered via telehealth. The payment increases can take the form of dollar or percentage increases to base payment rates or fee schedule amounts, rate add-ons, or supplemental payments, depending on the applicability to the state's payment methodology for the provider and service categories. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act to assure rates are sufficient to ensure adequate beneficiary access.

During a future PHE, at CMS's discretion, states may have additional avenues to change payments to providers for services delivered via telehealth. For instance, during the COVID-19 PHE, CMS made available a Medicaid disaster relief SPA template. This disaster relief SPA template allowed states to temporarily increase payments to providers during the PHE period.

15. Are "telephonic services" provided by a federally qualified health center (FQHC) or

[43] Please note: As explained in a CMCS Informational Bulletin issued on September 8, 2023, until February 11, 2025, Indian Health Service (IHS) and Tribal facilities have a grace period that permits them to continue to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate (AIR)) for services provided outside of the "four walls" of the facility. The CMCS Informational Bulletin CIB can be accessed at https://www.medicaid.gov/sites/default/files/2023-09/cib090823.pdf.

[44] States might be able to cover services furnished outside the four walls of a clinic facility by a Medicaid-enrolled clinic's employed practitioners under other benefits that have more flexibility for services delivered via telehealth, such as physician services.

rural health clinic (RHC) eligible for Federal Financial Participation (FFP)?

Yes, FFP is available for telephonic services furnished to an eligible person by a Medicaid-participating FQHC or RHC, as long as all other conditions of receiving FFP are met. If a state's approved state plan does not allow FQHC/RHC services to be delivered via telehealth or telephonically, the state can submit a SPA to lift this restriction.

16. Do states need to submit a SPA in order to pay the same rate for Medicaid FQHC or RHC services delivered telephonically as they pay when these services are delivered in-person?

No SPA is needed if a state's approved state plan does not specifically define a visit for the purpose of reimbursing FQHC or RHC services as a "face to face encounter" with a Medicaid-participating FQHC or RHC. If it does, and the state would like to pay for telephonically delivered FQHC or RHC services at the state plan rate, it would need to submit a SPA to amend the definition of a visit. States should be mindful of any limitations imposed by state law.

17. Can states pay FQHCs and RHCs an amount less than the PPS rate with an approved SPA or waiver? Additionally, if a service is provided telephonically, can the state pay the provider an amount lower than the PPS rate for the telephonic service delivered via telehealth?

Section 1902(bb) of the Act requires states to establish and pay a PPS rate (on a per visit basis) for FQHC and RHC services, including those provided via telehealth, to the extent that the service being delivered via telehealth constitutes an encounter, or to establish and pay an alternative payment methodology (APM) for those services that pays the facility at least the PPS rate.

Workforce

18. How can states address healthcare worker shortages through telehealth?

States should explore enrolling additional individual providers who can render services remotely (including potentially enrolling and paying out of state providers, subject to state enrollment and scope of practice laws and policy) to extend reach to beneficiaries.

States can also increase overall provider capacity by allowing other licensed practitioners to serve beneficiaries with remote supervision of a physician.

For state plan services, a SPA can increase the types of providers a state authorizes to deliver services. As always, states should be mindful of state-level requirements that might impact provider flexibility in delegation of authority.

Additionally, states have broad ability to authorize delivery of covered Medicaid services via telehealth, and no federal approval is needed for state Medicaid programs to pay for telehealth-delivered services in the same manner or at the same rate paid for face-to-face services, visits, or consultations. A SPA is necessary to accommodate any revisions to payment methodology to account for telehealth costs.

To address state staff shortages under state plan HCBS under section 1915(i) of the Act, our regulations at 42 C.F.R. § 441.720(a)(1)(i) explicitly provide that the required independent face-to-face assessment of needs may be performed by telemedicine or other information technology medium (e.g., telehealth) so long as certain conditions are met, including the individual performing the assessment being appropriately qualified and trained, the beneficiary receiving appropriate support during the assessment, and the beneficiary providing informed consent for the assessment being performed via telehealth. Please see FAQ #2 for more information.

In any PHEs, CMS may explore specific telehealth flexibilities available to states.

Managed Care

19. How can states implement or update Medicaid or CHIP managed care telehealth policies, including allowing remote monitoring and payment of services delivered using telehealth at the in-person clinical services rate?

The available telehealth flexibilities allow Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a healthcare facility. In fee-for-service, states are generally not required to submit separate SPAs for coverage or payment of services delivered using telehealth if they decide to pay for telehealth-delivered services in the same manner or at the same rate paid for face-to-face services. States may have laws and

regulations that restrict providers' ability to furnish services via telehealth. In fee-for-service, a SPA would be required to change existing payment methodologies to pay differently for services provided via telehealth than for services delivered in-person.

If a benefit is covered under the state plan or Medicaid waiver (e.g., section 1915(b) or 1915(c)) or a state demonstration (e.g., Section 1115), CMS encourages states to amend managed care contracts (if the services are not already included in the contract) to ensure any state policies permitting use of telehealth to deliver services as authorized under their state plan, waiver, or demonstration also apply to services covered under the managed care contract. Managed care contracts are required to specify what services are covered under the contract, and what are carved out for coverage on a fee-for-service basis. Even if the state plan or a Medicaid waiver or demonstration does not provide for covering certain services when they are furnished via telehealth, managed care plans could opt to cover these services when furnished via telehealth as:

1. In lieu of services (42 C.F.R. § 438.3(e)(2) and 42 C.F.R. § 457.1201(e)). Under these regulations, alternate services or services furnished in an alternative setting that the managed care plan or entity voluntarily agrees to cover in lieu of state plan-covered services must be: (i) authorized by the state as being a medically appropriate and cost-effective substitute for the covered service or setting under the state plan; (ii) authorized and identified in the managed care contract; and (iii) not required to be used by the enrollee in lieu of the state plan-covered service. In addition, there are specific rate development rules used when a managed care contract authorizes use of in lieu of services. Telehealth is not an in lieu of service. However, managed care plans may utilize telehealth to deliver in lieu of services.[45]
2. Additional services, beyond those in the contract, voluntarily provided by managed care plans (commonly referred to as value-added services). No contract amendment is needed; however, the cost of value-added services cannot be included when determining the capitation rates (per 42 C.F.R. § 438.3(e)(1)(i) and 42 C.F.R. § 457.1201(e)).

Regarding state payments to Medicaid managed care plans, under 42 C.F.R. § 438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. Ancillary/additional costs of furnishing services via telehealth may be incorporated into both the benefit and non-benefit components of actuarially sound Medicaid managed care rates reflecting payment for services to providers. For additional information about developing actuarially sound rates, actuaries should consult the Medicaid Managed Care Rate Development Guide.[46]

For CHIP managed care plans, rates must be based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as described in 42 C.F.R. § 457.1203(a). States that update their CHIP capitation payments due to telehealth related costs would not need to submit a rate certification.

Codes, Modifiers, and Medicaid Systems

20. How can state Medicaid systems support telehealth?

States can make system improvements to support telehealth such as adding claim edits, adding new modifier and place of service codes (POS), or other enhancements to their Medicaid Enterprise Systems (MES). Medicaid agency information technology (IT) system costs may be eligible for enhanced FFP. To receive the enhanced FFP, states must submit and receive approval from CMS for an Advance Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced match for the design, development, and/or implementation (including for enhancements) of their MES that contribute to the efficient, economic, and effective administration and operation of the program, which includes MES system changes related to telehealth.

Interested states should refer to 45 C.F.R. Part 95 Subpart F – Automatic Data Processing Equipment and Services-Conditions for FFP for the specifics related to APD submission.

[45] For additional information on in lieu of services and settings, please visit: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf.

[46] https://www.medicaid.gov/medicaid/managed-care/downloads/2023-2024-medicaid-rate-guide-05242023.pdf.

States may also request a 75/25 enhanced match for ongoing operations (including maintenance) of CMS-approved systems. Interested states should refer to 42 C.F.R. Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems for the specifics related to systems approval.

If there are questions related to IT topics and IT system funding, CMS encourages states to contact their MES State Officer.

21. How should services delivered via telehealth be reported in T-MSIS?

States should ensure that providers are educated on the correct submission of claims for services that they furnish via telehealth. States should report services delivered via telehealth to T-MSIS as they are billed on the claim form, identified through the procedure code, procedure code modifiers, and POS code claim and encounter fields. While states are not required to track whether services are delivered via telehealth or create a requirement for providers to submit claims with modifiers or POS codes specific to telehealth, CMS encourages states to consider the value of tracking these services to measure and monitor the impact of service delivery through telehealth on state Medicaid programs. Please see the "Evaluation Strategies for Services Delivered Using Telehealth" subsection of Section 5 for more information. Please contact your CMS State Systems Officer with further questions.

22. Is there a common set of procedure codes for Medicaid services delivered through telehealth that states could include on their fee schedules and require providers to use?

States have discretion in establishing billing policies and requirements regarding which codes providers may bill when reporting that covered services are delivered through telehealth.

Some states use unique procedure codes that delineate between in-person and telehealth delivery of covered services, while others add modifiers or place of service (POS) codes for a procedure code to indicate the service was delivered via telehealth. Please see **Section 5: Operational Considerations for Implementing Telehealth** for examples of billing codes, modifiers, and place of service codes that some states are using to identify services that are delivered via telehealth for billing and analysis.

23. Can states use Healthcare Common Procedure Coding System (HCPCS) code G0071 for FQHC and RHC services delivered via telehealth? Do states need to submit a SPA to activate that code?

CMS does not specify which HCPCS codes states should use. States do not need to submit a SPA or request CMS authorization to use HCPCS code G0071, or any other codes.

Quality Reporting

24. Are services delivered via telehealth included in state reporting of the Medicaid and CHIP Child and Adult Core Set measures?

Core Set reporting is voluntary for states until 2024, when reporting on the Child Core Set and the behavioral health measures of the Adult Core Set becomes mandatory. Core Set reporting guidance aligns with measure steward technical specifications with regard to defining whether or not services delivered via telehealth are included in calculating individual measures. Therefore, services delivered via telehealth should be captured in the measure only if the measure specifications allow for inclusion of data in which services delivered via telehealth are involved. Please see the most recent Core Sets measures for more information.[47] The alignment with technical specifications is in place now, and will continue with mandatory reporting.

25. Can well-child screenings provided through telehealth be included in the Form CMS-416, which provides a count of EPSDT services?

To the extent it is clinically appropriate to conduct well-child screenings through telehealth and they can be provided according to the state's periodicity schedule, these screenings can be included in the count of EPSDT services on the Form CMS-416.

No federal approval is needed for state Medicaid programs to pay providers for telehealth-delivered services that are provided in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to implement any revisions to payment methodologies to account for telehealth costs.

[47] https://www.medicaid.gov/sites/default/files/2023-08/2024-child-core-set_0.pdf; https://www.medicaid.gov/sites/default/files/2023-08/2024-adult-core-set_0.pdf.

Section 3: State Medicaid and CHIP Telehealth Trends

States have had the option to authorize delivery of covered Medicaid services via telehealth for decades, but the COVID-19 PHE substantially accelerated interest in and utilization of telehealth across all payers and patient characteristics, including Medicaid beneficiaries.[48] This section describes general trends in state Medicaid and CHIP telehealth policies before, during, and after the COVID-19 PHE, and explores more detailed trends in five states with notable telehealth developments during the same time period.

Medicaid Telehealth Trends in Recent Years

Prior to the COVID-19 PHE in 2020, all 50 states and the District of Columbia authorized delivery of some Medicaid services via telehealth, though states' telehealth policies varied widely in regards to allowable modalities, services, and provider types, as well as originating site rules.[49] For example, while some states authorized delivery of a broad scope of Medicaid covered services via telehealth, others limited service delivery via telehealth to a subset of covered services (e.g., consultation, mental health, pharmacological management).[50]

With the onset of the COVID-19 PHE, telehealth became a way for beneficiaries to continue to receive select services while maintaining social distancing to reduce their risk of infection. During this time, CMS encouraged states to consider authorizing delivery of covered services via telehealth. States' adoption of service delivery via telehealth accelerated significantly during this period.[51] All the states, the District of Columbia, and three U.S. territories expanded the types of telehealth modalities that could be used to deliver covered services, and many states added or expanded service delivery via audio-only telehealth.[52,53,54,55] Similarly, many states considered authorizing additional services for delivery via telehealth and paid additional provider types for services delivered via telehealth, relaxed originating site rules, and implemented coverage and payment parity to pay for services delivered via telehealth the same way they were covered and paid for when delivered in person.[56,57]

Beneficiary utilization of telehealth increased during the COVID-19 PHE.[58] While states still have questions about clinical effectiveness when delivering some services via telehealth (particularly when using certain modalities), many states reported the positive outcomes of telehealth expansion during the COVID-19 PHE.[59] Furthermore, according to five states with notable telehealth developments, the benefits of telehealth included: reduced no-show rates; decreased reliance on non-emergency transportation for service provision; ability to engage individuals who were historically difficult to reach in services; and greater access for beneficiaries with limitations on time, such as difficulty making appointments due to work,

[48] https://aspe.hhs.gov/sites/default/files/documents/190b4b132f984db14924cbad00d19cce/Medicaid-Telehealth-IB-Update-Final.pdf.

[49] https://www.cchpca.org/2021/04/Historical-State-Telehealth-Medicaid-Fee-For-Service-Policy-Report-FINAL.pdf.

[50] Ibid.

[51] https://aspe.hhs.gov/sites/default/files/documents/190b4b132f984db14924cbad00d19cce/Medicaid-Telehealth-IB-Update-Final.pdf. U.S. Territories are not included in this analysis.

[52] https://files.kff.org/attachment/REPORT-How-the-Pandemic-Continues-to-Shape-Medicaid-Priorities-Results-from-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2022-and-2023.pdf. U.S. Territories are not included in this analysis.

[53] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CNMI/MP-20-0002.pdf.

[54] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/PR-20-0002.pdf.

[55] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VI/VI-20-0001.pdf.

[56] https://files.kff.org/attachment/REPORT-How-the-Pandemic-Continues-to-Shape-Medicaid-Priorities-Results-from-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2022-and-2023.pdf.

[57] States also set provider enrollment requirements and policies related to providing services exclusively via telehealth. For information about state-level requirements, please refer to individual state provider enrollment policies.

[58] https://aspe.hhs.gov/sites/default/files/documents/190b4b132f984db14924cbad00d19cce/Medicaid-Telehealth-IB-Update-Final.pdf.

[59] https://files.kff.org/attachment/REPORT-How-the-Pandemic-Continues-to-Shape-Medicaid-Priorities-Results-from-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2022-and-2023.pdf.

eldercare, or childcare.[60]

According to a survey of 49 states and the District of Columbia, telehealth utilization by Medicaid beneficiaries decreased and/or leveled off in fiscal year 2022 but remained above utilization levels prior to 2020.[61] As the survey describes, when the COVID-19 PHE ended, two-thirds of the states either expanded or planned to expand telehealth policies in FYs 2022 or 2023. The survey results indicated that the most common policies included expansions of allowable telehealth modalities and services allowed to be delivered via telehealth; however, other policy changes, such as expansions of telehealth providers, allowable distant/originating sites, and payment parity, were also enacted. Despite the increase in telehealth utilization since 2020, many states still report quality concerns about its use, including privacy, billing and coding challenges, and the potential for fraud and abuse.[62]

Findings from a qualitative study sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to catalogue and assess state changes to Medicaid telehealth policies during the COVID-19 PHE through April/May 2022 identified 50 temporary telehealth policies in 25 states that were established during the COVID-19 PHE but were later made permanent. However, the study also identified 27 policies in 15 states that were removed, and 11 states removed some policies and made others permanent. This study further identified 29 states that established new policies regarding delivery requirements, modality, service type, provider type, and payment after COVID-19 policies were established. The most common policies made permanent were related to coverage of modalities and delivery, such as adding audio-only or expanding originating sites to include patients' homes. The flexibility most frequently removed was the allowance of non-HIPAA-compliant platforms to deliver services via telehealth.[63]

In general, during the COVID-19 PHE, states used a number of telehealth strategies, including covering specific services within a class of services when provided via telehealth, to increase access to services and expand provider capacity. For example, many states expanded access to certain dental services by covering them when provided via telehealth (commonly known as teledentistry) during the PHE.[64] States could consider covering dental evaluations when conducted via audio-video technologies, particularly if a facilitating provider is physically located with the patient, and covering dental consultations when done through Store and Forward technology to allow radiological images taken by lower-level professionals to be evaluated and consulted from a distant site.[65] Authorizing delivery of dental services via teledentistry also has the potential to increase overall provider capacity by allowing other licensed practitioners to serve beneficiaries with remote supervision of a dentist. Asynchronous telehealth can also be used for related activities such as reading an x-ray. Examples of states that allow dental services to be delivered via telehealth are included in Table 3.

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[60] Information was provided by five states—Colorado, Idaho, Maine, Massachusetts, and Wisconsin—during interviews conducted for, and described in, the "State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth COVID-19 Version: Supplement #1." Information was also provided during follow-up interviews conducted with these same states for this toolkit.

[61] https://files.kff.org/attachment/REPORT-How-the-Pandemic-Continues-to-Shape-Medicaid-Priorities-Results-from-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2022-and-2023.pdf.

[62] https://aspe.hhs.gov/sites/default/files/documents/11bc151081feb0123fc80283874ab7af/medicaid-telehealth.pdf.

[63] Ibid.

[64] https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicaid-coverage-access-to-telehealth-in-response-to-covid-19/.

[65] Information provided by the Tribal Technical Advisory Group (TTAG). See link for more information about the TTAG: https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/tribal-technical-advisory-group.

Table 3 – State Best Practices for Dental Service Delivery via Telehealth

State	Telehealth Best Practice
California	California allows dentists who practice teledentistry to bill for services when they work with allied dental professionals for diagnostic services when those services are coordinated with an allied dental professional who also can treat and bill members within their scope of practice.[66]
Maryland and Ohio	Both states allow some limited problem-focused oral evaluations to be conducted via telehealth.[67,68]
Kentucky	Kentucky allows for screenings, assessments, and examinations provided via teledentistry.[69]

Additionally, during the COVID-19 PHE, some states recognized that covering Medicaid services delivered via telehealth by out-of-state providers further increased access to services and expanded provider capacity, and, in some cases, states have implemented this policy permanently. In these instances, states pay for covered Medicaid services delivered via telehealth by out-of-state providers subject to state enrollment requirements and scope of practice policies. Table 4 includes examples of states that pay for covered Medicaid services delivered via telehealth by out-of-state providers.

Table 4 – State Best Practices for Paying for Covered Medicaid Services Delivered via Telehealth by Out-of-State Providers

State	Telehealth Best Practice
Arizona	Providers that are not licensed in Arizona may furnish Medicaid services via telehealth if the provider registers with the state's Medicaid program and acts in compliance with Arizona laws, including scope of practice and liability insurance, among others.[70,71]
Kentucky	Kentucky does not require that a health professional or medical group maintain a physical location or address in the state to be eligible for enrollment as a Medicaid provider, if the provider or group exclusively offers services via telehealth.[72]
Wisconsin	An out-of-state provider can furnish Medicaid services via telehealth if the provider is enrolled in Wisconsin Medicaid and follow Medicaid policy for prior authorizations.[73]

Medicaid Telehealth Trends in Five States

As part of CMS's work to examine the rapid telehealth expansion states made in response to the COVID-19 PHE, five states with notable telehealth developments were interviewed. During the COVID-19 PHE and again after the COVID-19 PHE, interviews were conducted with Colorado, Idaho, Maine, Massachusetts, and Wisconsin. In addition to asking about general Medicaid telehealth best practices, each state was asked whether it allowed for the telehealth features defined below in Table 5. The information reflected below includes an example of each telehealth feature from one of the five states, supplemented in some instances with information on other states.

[66] https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-19-0028.pdf.

[67] Maryland initially allowed teledentistry for limited, problem-focused oral evaluations during the COVID-19 PHE, but, as of July 28, 2023, they have maintained this policy. See: https://health.maryland.gov/mmcp/Pages/COVID-19-Provider-Updates.aspx, and https://health.maryland.gov/mmcp/Medicaid%20COVID19/MEMO_Maryland%20Medicaid%20Telehealth%20Dentistry%20Guidance_3.30.20.pdf.

[68] https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/Telehealth-Billing-Guidelines.pdf.

[69] https://www.chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf.

[70] https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-I.pdf.

[71] As telehealth has expanded, including across Medicaid, states are taking steps to coordinate the licensure process for out-of-state providers to practice telehealth across state lines. For more information on the types of state licenses that allow an out-of-state provider to deliver services via telehealth, see: https://telehealth.hhs.gov/licensure/licensing-across-state-lines.

[72] https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=54178.

[73] https://www.dhs.wisconsin.gov/telehealth/member-faqs.htm.

Table 5 – Telehealth Features and Related State Examples

Telehealth Feature	State Example
Payment parity: Payment for a service is the same, regardless of whether the service is delivered in person or via telehealth.	During the 2021-2022 state legislative session, Massachusetts passed a law that the state Medicaid program, MassHealth, and commercial plans must pay for behavioral health services that are provided via telehealth at parity, in perpetuity. For physical health services, including facility fees for hospital providers, MassHealth paid for services provided via telehealth at parity throughout the COVID-19 PHE. In 2022, the state conducted outreach to providers regarding the policies that the providers would like to maintain. The providers advocated for payment parity in general, and specifically payment parity for audio-only telehealth, which they identified as being especially relevant for safety net providers. MassHealth clarified in July 2023 that it would continue payment parity for services delivered via telehealth, including for services delivered via audio-only and for facility fees where relevant, beyond the COVID-19 PHE.
Beneficiary home permitted: The originating site (the location of the beneficiary) for the telehealth visit can be the beneficiary's home.	Colorado offers a robust telehealth coverage policy including authorizing service delivery in the beneficiary's home, and delivery by a wide variety of providers.[74]
All providers within scope of practice: All Medicaid-enrolled providers can deliver the services they are otherwise qualified to provide via telehealth, as appropriate to the scope of their practice.	Maine's Medicaid program, MaineCare, requires providers who deliver Medicaid services via telehealth to be acting within the scope of their license, enrolled as a MaineCare provider, and otherwise eligible to deliver the service in accordance with state requirements.[75] Kentucky allows all provider types to deliver all Medicaid services they are otherwise qualified to provide via telehealth, including via audio-only technologies. If a service could have been provided via telehealth, but the individual or provider cannot deliver or participate in the service via telehealth, the service may be covered when delivered via telephone as a "telecommunication or other electronically mediated health service." If service delivery is audio-only but the service would normally require the exchange of visual information, the provider should identify a way to facilitate this exchange of information to support any treatment delivered.[76]
All services that can be effectively delivered: A state allows all services to be delivered through telehealth if the telehealth-delivered services are just as safe and effective as an in-person visit.	Wisconsin allows the following Medicaid services to be provided via telehealth[77]: • *General health services*, such as seeing a provider or getting prescriptions for supplies or equipment. • *Behavioral health services*, such as mental health screenings or treatment. • *Substance use disorder services* when the services delivered through telehealth are just as safe and effective as an in-person visit. Examples include outpatient and day treatment substance use disorder services, including group counseling. • *Dental consultations*, such as diagnosing an infected tooth and prescribing antibiotics until the beneficiary can be seen in person. • *Case management services*, including targeted case management services when the services delivered through telehealth are just as safe and effective as those provided during an in-person visit.

[74] https://hcpf.colorado.gov/telemedicine-manual.
[75] MaineCare Benefits Manual, Ch. I – Section 4: Telehealth Services at https://www.maine.gov/sos/cec/rules/10/ch101.htm.
[76] https://www.chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf.
[77] https://www.dhs.wisconsin.gov/telehealth/member-faqs.htm.

Telehealth Feature	State Example
All services that can be effectively delivered (Continued)	• *Therapy services*, such as physical therapy, speech and language therapy, and occupational therapy. • *School-based services* when the service is covered and is included in the child's IEP.
FQHC/RHC encounter billing codes: States have provided specific direction on Medicaid billing codes for FQHC/RHC encounters to indicate that the service was delivered via telehealth.	Ohio uses the GT modifier to identify FQHC services delivered via telehealth. The place of service code reported on the claim must reflect the physical location of the practitioner.[78]
Out-of-state providers allowed: Providers that are not located in the same state as the beneficiary can provide services via telehealth. In these instances, states may have allowed professional boards to issue special licenses or certificates, or have exceptions to licensing requirements related to telehealth, which may include registering with an in-state board rather than obtaining full licensure. Another licensing policy permits specific providers to practice in other states where they are not licensed as long as they hold a license in good standing in their home state, and the other state participates in interstate compacts.[79]	In Wisconsin, for out-of-state providers to deliver services via telehealth, they must be certified by the Medicaid program. The state also released a new "Border Status" policy in 2023 to leverage providers and provider networks not located in the state.[80] This new policy indicates that the following out-of-state providers, who are subject to the same provider requirements as in-state providers, may be eligible to enroll in Wisconsin Medicaid as border-status providers: • Providers in a state that physically borders Wisconsin. • Out-of-state providers not located in a state that physically borders Wisconsin who meet the definition of a border-status provider as described in the state's administrative code and who provide services only via telehealth to Wisconsin beneficiaries. • All out-of-state independent laboratories, regardless of location in the United States. Providers that are not eligible for border status include nursing homes and public entities, such as cities or counties, outside of Wisconsin, as well as providers who do not meet the state's administrative code definition of border-status providers or who do not provide services only via telehealth to Wisconsin beneficiaries. Additionally, providers will be denied border status enrollment if they were denied enrollment in their own state, unless they were denied because the services they provide are not a covered benefit in their state.
Audio-only permitted: Services can be delivered using the audio-only telehealth modality.	In addition to permitting the audio-only telehealth modality for service delivery, Colorado has identified audio-only POS codes to identify this telehealth modality.[81]
Remote patient monitoring: Services can be delivered using the remote patient monitoring telehealth modality.	Massachusetts's Medicaid program, MassHealth, created a remote patient monitoring program specific to COVID-19. For those being discharged from an inpatient unit and those who have tested positive with a high risk of hospitalization, seven days of remote patient monitoring is authorized, which may be reauthorized. Tools include, minimally, a pulse oximeter and thermometer but may include other tools as indicated. Providers assess data and symptoms daily. MassHealth expects to introduce coverage for remote patient monitoring for chronic disease management in the future.[82]

[78] https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/Telehealth-Billing-Guidelines.pdf.
[79] https://www.cchpca.org/2022/10/Fall2022_ExecutiveSummary8.pdf.
[80] https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Certification/EnrollmentCriteria.aspx?topic=12.
[81] https://hcpf.colorado.gov/provider-telemedicine.
[82] https://www.mass.gov/doc/all-provider-bulletin-374-access-to-health-services-through-telehealth-options/download.

Telehealth Feature	State Example
Store and forward: Services are covered if they are delivered using the store and forward telehealth modality.	MaineCare pays for two types of store-and-forward: 1. Virtual transfer of health information: The provider uses virtually provided information to evaluate a beneficiary's condition or render a covered MaineCare service separate from services delivered via interactive telehealth and uses a desktop computer or a mobile device to gather and send the information. 2. Remote consultation between a treating provider and specialist: This interaction includes discussion, via telephone or internet, between the treating provider and specialist regarding the specialist's assessment of the beneficiary's electronic health record and/or diagnosis/treatment. Following the remote consultation, the treating provider must inform the beneficiary of the results and conclusions. Store-and-forward is used to deliver services to established patients.[83]

Key findings from the interviews with the five states regarding these Medicaid telehealth features implemented pre-COVID-19 PHE, during the COVID-19 PHE, and post-COVID-19-PHE are described in Table 6.

See **Appendix A – Telehealth Developments in Five States Over Time** for detailed information on the telehealth features implemented by each state.

Table 6 – Number of States from Five-State Sample that Implemented Various Telehealth Features Over Time

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Payment parity	**5**	**5**	**5**
Beneficiary home permitted	**5**	**5**	**5**
All providers within scope of license	**1**	**4**	**3**
All services that can be effectively delivered	**2**	**5**	**5**
FQHC/RHC encounter billing codes	**2**	**5**	**5**
Out-of-state providers allowed	**1**	**4**	**4**
Audio-only permitted	**0**	**5**	**5**
Remote patient monitoring	**3**	**4**	**3**
Store and forward	**1**	**2**	**3**

[83] https://www.cchpca.org/maine/?category=medicaid-medicare&topic=store-and-forward.

Section 4: Strategies for Delivering Services via Telehealth to Specific Populations and for Specific Services

This section describes general trends, strategies, and notable examples on how states can leverage the ability to deliver services via telehealth to address health equity among Medicaid and CHIP beneficiaries. It discusses best practices and strategies for improving equitable access to telehealth among specific populations, such as racial and ethnic groups, American Indian and Alaska Native (AI/AN) individuals, individuals with disabilities, and children and youth. It also delves into how states can permit delivery of covered services via telehealth to address maternal mortality and morbidity disparities, and strategies for using telehealth to provide mental health and substance use disorder services.

Delivering Services via Telehealth to Improve Health Equity

Using telehealth to deliver Medicaid and CHIP services has the potential to improve health equity, which CMS defines as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."[84] Without equitable access to health care services, Medicaid and CHIP beneficiaries, who are often underserved, face a number of negative health consequences, such as higher mortality rates, rates of disease, and severity of disease or illness.

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

While telehealth can be a tool to help encourage equitable access to services, it is also important to implement both the technological and service components in an equitable fashion.[85] States should be mindful of telehealth utilization strategies that encourage building and supporting digital literacy in using technology in tandem with equitable access across beneficiary populations.

Strategies to Ensure the Technological Component of Telehealth is Equitable

Beneficiaries need varying levels of assistance to facilitate service delivery via telehealth. Some beneficiaries with disabilities require adaptive technology, while others require mechanical assistance from another person to communicate via telehealth in an interactive way. Some beneficiaries may face challenges related to comfort with telehealth technology, and there may be lower digital literacy for some beneficiaries, such as some older adults, who may be unfamiliar with the latest platforms. The high cost of internet access and handheld devices, such as cellular phones or tablets, could impact Medicaid beneficiaries whose income may not be able to support these costs, and beneficiaries in areas with poor cellular service or limited to zero broadband internet access face foundational challenges using telehealth as a reliable or available service delivery method, regardless of cost. Lack of internet access particularly impacts AI/AN individuals and beneficiaries residing in very rural areas where services are not readily available. In 2018, 94.4 percent of the U.S. population had access to both mobile broadband and broadband internet, compared to 77.4 percent of individuals residing in rural areas, 72.1 percent of individuals residing on Tribal lands, and 52.9 percent of individuals residing on rural Tribal lands.[86]

To ensure beneficiaries have knowledge about and access to technology to equitably facilitate care that is available through telehealth, states should consider the strategies described in Table 7. As indicated earlier in the toolkit, these strategies are meant to inform state development of telehealth policy. Depending on the nature of the activity, the activity described might not be

[84] https://www.cms.gov/pillar/health-equity.
[85] https://telehealth.hhs.gov/providers/health-equity-in-telehealth.
[86] Mobile broadband was defined as 4G Long Term Evolution (LTE) and broadband internet was defined as download speeds of 25 Mbps and upload speeds of 3 Mbps, which would enable the user to send and receive high-quality voice, data, graphics, and video telecommunications. See: https://docs.fcc.gov/public/attachments/FCC-20-50A1.pdf.

funded by state Medicaid programs or might not be eligible for federal matching funds.

Table 7 – Strategies for Equitably Facilitating Care Delivered Via Telehealth

Strategy	Description
Provide beneficiary education	In addition to providing information about which benefits and services are covered when delivered through telehealth, states can offer, and encourage their providers and managed care plans to offer, information about how to use telehealth technology. It is important to broadcast information in a way that reaches beneficiaries who may not be as familiar with using technology for the purposes of telehealth. For instance, states should broadcast how beneficiaries can learn about how to use telehealth technology widely, for example, in public meetings in several areas of the state, webinars, customer service contacts between beneficiaries and state or health plan staff, and interactions with case managers, community health workers, or providers. Having deliberate strategies to continuously educate is important in making access to services delivered via telehealth viable and equitable.
Assist beneficiaries with technical setup and execution of telehealth technology	Some beneficiaries will need assistance with using the technology itself. For instance, some beneficiaries may need assistance to functionally initiate the meeting or require a tele-presenter to communicate. Beneficiaries may need additional language assistance or adaptive technology. Offering assistance or providing information about community-based resources that can provide help are strategies states can employ to ensure beneficiaries with specific needs are able to access services via telehealth.
Include telehealth technology in managed care plan contracts	Managed care plan contracts with states often include value-added services such as provisioning of cell phones, broadband access or facilitating use of other technology to receive information and access Medicaid services. This can and often does include using these devices for telehealth visits.
Provide education and information about qualifying for free broadband service	Another strategy states can use is to include information about programs which can help in subsidizing or providing free access to reliable broadband internet, where it is available, such as the Federal Communications Commission (FCC) Lifeline program, which provides discounts on monthly telephone service, broadband Internet service, or bundled voice-broadband packages, or the FCC's Affordable Connectivity Program.[87,88]

Strategies to Improve Equitable Access to Providers Who Deliver Services via Telehealth

States can use telehealth policy to improve equitable access to, and continuity of, health care services by expanding beneficiaries' options for receiving those services. In addition to taking steps to help ensure that the technological component of telehealth is equitable, states should consider how health equity can be improved through access to providers who use telehealth to deliver services. When providers in a community do not offer services via telehealth, it could factor into beneficiaries' decisions to keep appointments that cannot be maintained in person and generally limits beneficiaries' options for accessing those services. For example, if a beneficiary has an established relationship with a provider who does not offer services via telehealth and the beneficiary moves far away, this might impact the beneficiary's ability to have continuity of care with that provider.

Table 8 describes a few strategies that states may consider to improve health equity by increasing the number of providers who use telehealth to deliver services.

[87] https://www.fcc.gov/general/lifeline-program-low-income-consumers.
[88] https://www.fcc.gov/acp.

Table 8 – Strategies for Addressing Health Equity by Increasing the Number of Providers who Use Telehealth

Strategy	Description
Perform analyses (e.g., using claims data, beneficiary surveys, etc.) to understand access disparities	Performing these kinds of analyses can reveal where underutilization of routine care or overutilization of emergency care may indicate patterns of inequity that could be addressed by improving the provider network, including providers who offer services via telehealth. Access to care is impacted by provider shortages as well as patient willingness to seek care. Recruiting providers who deliver services via telehealth may help close gaps in care for beneficiaries who may have difficulty accessing services from the current network of providers. State research and analysis can identify where there are statewide, regional, or community-level trends that could be addressed by increasing the number of Medicaid-enrolled providers who are able to deliver services in those areas in person or via telehealth.
Offer ongoing provider education and training on delivering services via telehealth	This is very important to initial and ongoing provider adoption of telehealth technology. In addition to providing information about which benefits and services can be delivered through telehealth, states can offer information about how providers can use telehealth technology to reach their patients. It is important to broadcast information in a way that reaches providers and beneficiaries, as appropriate, who may not be as familiar with using technology for purposes of telehealth. For instance, states can broadcast information about telehealth technology widely, such as in public meetings in several areas of the state, webinars, customer service contacts with providers, and interactions with case managers, state, or health plan staff. Having deliberate strategies to educate on a ongoing basis is important in making access to services via telehealth viable in an equitable fashion. (Please see **Section 5: Operational Considerations for Implementing Telehealth** for more information on strategies for communicating telehealth policies.)
Encourage currently enrolled Medicaid providers and managed care plans to make services available via telehealth	This is key to sustaining provider-patient relationships. Trusting relationships that are already established between beneficiaries and their providers are optimal for telehealth service delivery. Providers can build on established history and person-centered care and resources that may make the adoption of telehealth easier for both provider and beneficiary when incorporated into current care delivery options. This is important in considering how to operationalize telehealth in both fee-for-service and managed care delivery systems.

Using Telehealth to Deliver Services to Specific Populations

This subsection further describes strategies for using telehealth to deliver services to six specific populations—medically underserved urban and rural communities, racial and ethnic groups, AI/AN individuals, individuals with limited English proficiency, individuals with disabilities, and older adults—who commonly experience health disparities in service delivery. For each population, we include statistics identified through national research and provide specific telehealth strategies and/or best practices to ensure equitable telehealth access.

Telehealth and Medically Underserved Urban and Rural Communities

The U.S. Health Resources and Services Administration (HRSA) defines medically underserved populations as populations with economic, cultural, or linguistic barriers to health care.[89] Medically underserved communities exist in both rural and urban areas. Both experience similar barriers related to access to care. Approximately 60 million people live in rural areas across the United States, and while approximately one-fifth of the total population reside in rural areas, only one-tenth of clinicians practice in rural areas.[90,91] Individuals in medically underserved rural communities often experience higher rates of tobacco use, obesity, inactivity, suicide, serious mental illness, and child and young adult mortality.[92] Individuals in medically underserved urban communities experience higher rates of infant mortality, homicides, adult

[89] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups.
[90] https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/ua-facts.html.
[91] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6921587/.
[92] Ibid.

major depressive episodes, and mortality from unintended injuries.[93] While in rural communities barriers include distance and transportation, both urban and rural communities experience barriers related to lower health literacy, workforce shortages, and limited and unaffordable broadband, all of which can make widespread adoption of telehealth challenging.[94,95,96,97] While broadband access is notably lower in rural areas of the country, the lingering impacts of internet service providers limiting the deployment, maintenance, or upgrades of infrastructure or delivery of services ('digital redlining') creates significant pockets of poor broadband access and low digital literacy in medically underserved urban areas as well.[98,99,100] Technological and digital challenges in underserved urban areas can be compounded by housing insecurity and/or overcrowding that create unique privacy concerns related to using telehealth.[101,102]

Many states have recognized the benefit of authorizing the delivery of services via telehealth to help overcome challenges related to provider shortages by encouraging telehealth use for current providers and contracting with additional providers, including providers located remotely and in other states, to deliver services.[103] Examples of these state strategies to utilize telehealth policies to increase provider capacity, particularly in medically underserved urban and rural communities, are included in Table 9.

Table 9 – State Best Practices for Using Telehealth Policy to Increase Provider Capacity in Medically Underserved Urban and Rural Communities

State	Telehealth Strategy
Missouri	In partnership with the Missouri Telehealth Network, Missouri's Medicaid program (MO HealthNet) is using non-Medicaid funds (Coronavirus State and Local Fiscal Recovery Funds, authorized by Section 9901 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2)) to design and implement the Rural Citizens Access to Telehealth (RCAT) project.[104,105] This project focuses on providing equipment, education, and technical assistance to Medicaid providers and participants located in rural Missouri counties to expand primary care and/or behavioral health services delivered via telehealth.
California	California allows dental services to be delivered via teledentistry to expand capacity by reimbursing dental providers when they render services to members via synchronous and asynchronous transmission for patient visits. [106]
Wisconsin	Wisconsin implemented a permanent policy to allow providers to deliver virtual synchronous oral evaluations and assessments, among many other Medicaid services delivered via telehealth.[107]
South Dakota	South Dakota expanded the dental services that can be delivered via teledentistry, including services that are delivered using asynchronous communication (e.g., reading or interpreting radiographic images).[108]

[93] Ibid.
[94] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[95] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6921587/.
[96] https://www.ruralhealthinfo.org/topics/healthcare-access#population-health.
[97] https://www.ruralhealthinfo.org/topics/telehealth.
[98] https://docs.fcc.gov/public/attachments/FCC-20-50A1.pdf.
[99] Definition according to the National Digital Inclusion Alliance, available at: https://www.digitalinclusion.org/definitions/.
[100] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9339607/.
[101] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9434674/.
[102] Ibid.
[103] States also set provider enrollment requirements and policies related to providing services exclusively via telehealth. For information about state-level requirements please refer to individual state provider enrollment policies.
[104] ARP section 9901 provided a temporary funding source to state, territorial, local, and Tribal governments to support their response to and recovery from the COVID-19 PHE. See: https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf.
[105] https://oa.mo.gov/sites/default/files/26%20FY_2023_EB_ARPA.pdf and https://dss.mo.gov/mhd/providers/files/rcat-flyer.pdf.
[106] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477859/.
[107] https://www.dhs.wisconsin.gov/telehealth/index.htm.
[108] https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Dental/Teledentistry_Services.pdf; States can consider synchronous (billing code D9995) and asynchronous (billing code D9996) methods to implement teledentistry.

Telehealth and Racial and Ethnic Groups

It is important that states develop and implement telehealth policies in Medicaid and CHIP that do not unintentionally worsen telehealth-related challenges—such as digital literacy, privacy and trust concerns, and broadband availability. These challenges can create disparities for some racial and ethnic groups in receiving services via telehealth. An HHS study of the general population using survey data from the United States Census Bureau revealed similar telehealth utilization rates among racial and ethnic subgroups during the COVID-19 PHE. However, this same survey data indicated that video telehealth use rates were significantly lower among Latino, Asian, and Black individuals than they were among White individuals.[109]

As states implement telehealth moving forward, they should take steps to develop Medicaid and CHIP policies that expand access to telehealth equitably across racial and ethnic groups. This should include considerations around available modalities, culturally and linguistically appropriate service delivery, and efforts to support accessibility. Such efforts could include allowing services to be delivered via audio-only telehealth, where clinically appropriate, and ensuring integration of language assistance with interpreters trained in medical terminology, patient privacy, and cultural awareness.[110]

Additionally, states should implement telehealth strategies that consider the existing digital divide experienced by some racial and ethnic groups to ensure that these individuals can share in telehealth's benefits. For example, multiple studies have shown promising results for mobile phone and text messaging interventions in reducing health disparities for some racial and ethnic groups, including among Medicaid beneficiaries.[111,112,113,114] This research has also shown that the disparity in smartphone ownership among some racial and ethnic groups and White individuals is much lower than the disparity in desktop and laptop ownership.

State Medicaid agencies are already taking, or are proposing to take, unique coverage, payment, and funding approaches to mitigate potential racial and ethnic disparities as they make strides to expand access to resources that help facilitate telehealth service delivery in their Medicaid programs. These include leveraging available Medicaid authorities, such as 1115(a) Demonstration authority, and relying on managed care flexibilities, such as State Directed Payments that are used to implement delivery system and provider payment initiatives under Medicaid managed care contracts.[115] Table 10 includes related examples.

[109] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf.

[110] All Medicaid and CHIP providers who receive federal funds from HHS for the provision of Medicaid or CHIP services are obligated to make language services available to those with Limited English Proficiency (LEP) under Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. States are not required to reimburse providers for the cost of language services, nor are they required to claim related costs to Medicaid or CHIP (as applicable). However, if states do claim Federal matching funds for translation or interpretation costs, they can do so as either an administration expense or as a medical assistance-related expense. For more information, see: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SHO10007.pdf; https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/Info-Bulletin-4-26-11.pdf.

[111] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8647517/.

[112] https://pubmed.ncbi.nlm.nih.gov/28051761/.

[113] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789065.

[114] https://pubmed.ncbi.nlm.nih.gov/23478028/.

[115] 42 C.F.R. §438.6(c).

Table 10 – State Best Practices for Implementing Telehealth Policies to Promote Health Equity for Medicaid Beneficiaries, Including Racial and Ethnic Groups and AI/AN Individuals

State	Telehealth Strategy
California	California's 1115(a) demonstration allows services to be delivered via non-traditional telehealth modalities (texting, e-mail consultation, etc.) under its Global Payment Program, which creates additional pathways for all beneficiaries to engage with their providers in a way that is comfortable and accessible.[116]
Oregon	Oregon leveraged the State Directed Payments option under managed care to create an enhanced payment rate increase for behavioral health services delivered by culturally and/or linguistically specific behavioral health providers, including services delivered via telehealth. These services must be delivered through Culturally Specific and Linguistic Organizations that serve particular cultural and linguistic communities and are primarily staffed and led by members of that community.[117,118,119]
Arizona	Arizona's Medicaid managed care contracts require the managed care plans to submit a "Tribal Coordinator Report" that must outline, among other things, "collaboration with tribes on building technological infrastructure for telehealth, telemedicine, teledentistry, and telepsychiatry."[120]

Telehealth and AI/AN Individuals

AI/AN individuals face a disproportionate chronic and behavioral health disease burden, and their access to telehealth, which has the potential to reduce these disparities, is hindered by a lack of internet access, geographic isolation, and resource challenges (e.g., staffing), among other barriers.[121,122]

Compared to other Americans, AI/AN individuals are disproportionately affected by many chronic conditions, including heart disease, cancer, diabetes, and stroke, and have a higher prevalence of, and risk factors for, mental health and suicide, obesity, and substance use, among others.[123] The Centers for Disease Control and Prevention (CDC) reported that, in 2015, AI/AN individuals had the highest drug overdose death rates among adults and experienced the largest percentage increase in the number of deaths over time from 1999-2015, compared to other racial and ethnic groups.[124, 125] During that time, drug overdose deaths rose more than 500 percent among the AI/AN adult population.

Allowing Medicaid and CHIP services to be delivered via telehealth has the potential to help reduce these health disparities and socioeconomic burdens by providing a more convenient, and generally lower-cost, way to access care. However, states should ensure that telehealth policies account for the unique needs of, and barriers faced by, AI/AN individuals. For example, due to the internet access issues that are common among AI/AN individuals, particularly those individuals residing in rural areas, states should consider allowing services to be delivered using audio-only telehealth.

Social distances between patients and providers (i.e., differences in cultures, languages, and ways of conceptualizing concepts of health and wellness) was identified in literature as one of the greatest barriers to effectively treating chronic conditions via telehealth in AI/AN

[116] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca2.pdf.
[117] 42 C.F.R. §438.6(c).
[118] https://www.oregon.gov/oha/HSD/OHP/Tools/BH-CLSS-Rates-Webinar0812.pdf.
[119] https://www.oregon.gov/oha/HSD/OHP/Tools/CLSS-Billing-Guide.pdf.
[120] https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Amendment13_UFC-14%20_HC%20&%20UHCCP15_MOL(YH19-0001).pdf. Section D, p. 163.
[121] https://minorityhealth.hhs.gov/nahm/health-disparities/.
[122] https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities.
[123] https://minorityhealth.hhs.gov/nahm/health-disparities/.
[124] Centers for Disease Control and Prevention. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States. Morbidity and Mortality Weekly Report. 66(19): 5-11.
[125] The IHS Launches New Opioids Website. (2018). Indian Health Service. Retrieved from https://www.ihs.gov/newsroom/ihs-blog/july2018/the-ihs-launches-new-opioids-website/.

communities.[126,127] As such, when implementing new telehealth policies, considerations should be given to delivering services in a culturally and linguistically appropriate way. Opioid use disorder (OUD) treatment, for example, could include Medication Assisted Treatment (MAT), which may be delivered via telehealth. When AI/AN individuals receive this treatment and their cultures are acknowledged as part of the treatment, it could help curb the rates of AI/AN OUD.[128] In another example, some Alaska Native beneficiaries, especially elders, may have a difficult time receiving services delivered via telehealth due to being unfamiliar with medical terminology and Western ways of thinking, being distrustful of medical providers for cultural and historical reasons, lacking fluency or proficiency in English, and having difficulty using telehealth technologies.[129] To help mitigate these barriers, states are encouraged to work with Tribal programs to develop culturally-competent solutions, which could include making it easier for family members or Tribal health-care navigators to initiate, facilitate, or participate in the beneficiary's telehealth visit.

Though not specific to telehealth, SAMHSA developed a *Culture Card Guide to Build Cultural Awareness: American Indian and Alaska Native*, which is meant to enhance cultural competence among states, providers, and other parties who are integral in providing services to AI/AN communities.[130] Similarly, HHS' *Preparing Patients for Telehealth in American Indian and Alaska Native Communities* website provides tips, summarized in Table 11, on preparing for a telehealth visit with AI/AN individuals.[131]

Table 11 – Strategies for Preparing for a Telehealth Visit with AI/AN Individuals

Preparation Element	Description
Internet access	High-speed internet is a significant barrier to telehealth adoption in AI/AN communities. According to the National Indian Health Board, only 46.6 percent of houses on Tribal lands have access to fixed terrestrial broadband at FCC standard speeds.[132,133] Having access to reliable internet from the safety of their homes is crucial to improving AI/AN individuals' health outcomes and, if reliable internet is not available, states should consider allowing other forms of non-video communication, such as audio-only, to be used to deliver services.
Cultural humility	As of 2022, there are 574 federally recognized Tribes in the United States across 37 states. Each Tribe has its own set of customs, but there are cultural values that are shared by most, if not all Tribes. Some of these values include: a sense of traditional spirituality (a connection with nature and/or ancestors), respect for elders, strong family support systems, and a historic distrust of institutions. It is important to keep these values in mind to fully understand patients' needs and make patients feel more comfortable when receiving services via telehealth.[134]

[126] https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities/telehealth-for-chronic-conditions-in-american-indian-communities.

[127] Hiratsuka V., Delafield R., Starks H., Ambrose A.J., Mau M.M.. Patient and Provider Perspectives on Using Telemedicine for Chronic Disease Management Among Native Hawaiian and Alaska Native People. *International Journal of Circumpolar Health*, 2013 Aug 5;72.

[128] https://www.medicaid.gov/sites/default/files/2020-04/cib040220.pdf.

[129] Information provided by the Tribal Technical Advisory Group (TTAG), Alaska representative. See link for more information about the TTAG: https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/tribal-technical-advisory-group.

[130] https://store.samhsa.gov/sites/default/files/sma08-4354.pdf.

[131] https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities/prepare-patients-for-american-indian-communities.

[132] https://www.nihb.org/covid-19/wp-content/uploads/2020/06/Final_HELP_6.10.20-Hearing_Telehealth.pdf.

[133] https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities/prepare-patients-for-american-indian-communities.

[134] HHS website for Do's and Don'ts in communicating virtually with AI/AN patients: https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-american-indian-communities/prepare-patients-for-american-indian-communities.

Preparation Element	Description
Conducting a telehealth visit	Providers can take several actions prior to, during, and after a telehealth appointment to ensure AI/AN beneficiaries feel comfortable: Prior to the appointment • Provide an overview of what telehealth is and what to expect. • Confirm patients have access to the internet or minutes or data available on their cellular phone plan. • Ask them to consider any concerns ahead of time. • Arrange for a translator if necessary. • Ask if they need assistive devices for the appointment. • Ask that they wear loose clothing for an exam. • Make sure they have/understand instructions on how to get online. • Make sure they have a quiet, private, safe space for the visit. During the telehealth appointment • Ask if the patient has privacy and feels safe to speak. • Ask about their questions or concerns. • Make sure they understand test results and diagnoses. • Include the patient's spouse, partner, or other family member if the patient wants to them to be a part of the visit. • Follow up on remote monitoring results or concerns. • When offering recommendations, make sure that necessary resources are accessible and culturally appropriate. After the telehealth appointment • Follow up with links or mail handouts relevant to the visit. • Send patients for referrals to specialists, mental health professionals or substance abuse counselors, if needed. • Schedule any follow-up appointments.[135]

In general, states can also consider working with Tribes and Tribal organizations to better understand the nature and scope for using telehealth for existing Tribal services and programs. This includes identifying the services that Tribes and Tribal organizations are currently furnishing via telehealth, the telehealth modalities that are being used, and the obstacles encountered in offering those services.[136]

Telehealth and Individuals with Limited English Proficiency (LEP)

States must consider the needs of individuals who do not speak or understand English well (also known as Limited English Proficiency or LEP) when implementing their telehealth policies.[137] Individuals with LEP may experience difficulty accessing services via telehealth due to a number of challenges. For example, digital platforms are not often available in all languages, creating challenges for patients with English as their second language, even if an interpreter is available once they have successfully entered the platform.

When implementing telehealth policies, states should explore additional strategies to ensure services delivered via telehealth are fully accessible and do not exacerbate health disparities for beneficiaries with LEP. Multiple federal laws and regulations require covered entities (e.g., state Medicaid agencies) to take reasonable steps to provide meaningful access to people with LEP. Recipients of federal funding must provide meaningful access for individuals with LEP through language services such as oral interpretation and written translation at no cost to the individual with LEP.[138] Under Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as well as Medicaid and CHIP regulations, Medicaid and CHIP agencies are required to provide language services, including oral interpretation and written translations, and inform

[135] Ibid.

[136] Information provided by the Tribal Technical Advisory Group (TTAG), Alaska representative. See link for more information about the TTAG: https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/tribal-technical-advisory-group.

[137] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth.

[138] 45 C.F.R. § 92.101(a)(2).

individuals that language services are available and provide taglines in non-English languages on how individuals can access these services.[139]

Enacted in 2009, Section 201(b) of the Children's Health Insurance Program Reauthorization Act (CHIPRA) provided increased administrative funding for translation or interpretation services provided under Medicaid and CHIP. Under the provision, states are given the option to claim a higher matching rate for translation/interpretation services.[140] As a result, the increased translation/interpretation matching rate has helped to support states in eliminating language barriers and promoting increased access to coverage and care. Telehealth technology has enabled remote interpretation, which offers a flexible option for providing immediate services with qualified interpreters; however, states should be mindful of potential drawbacks, including that some beneficiaries may feel remote interpretation is impersonal, and telephonic interpretation lacks the benefit of visual cues for the interpreter.[141] States should consider the interaction of language services with telehealth technology and/or modalities, and should work with providers to take additional steps to ensure effective communication with individuals with LEP.

To help providers incorporate methods into their practice to ensure equitable access to care, states may consult CMS' *Guide to Developing a Language Access Plan*.[142] Similarly, HHS provides a few tips and resources, summarized in Table 12, that states can share with enrolled Medicaid and CHIP providers to promote the delivery of accessible care through telehealth.[143]

Table 12 – Telehealth Strategies for Providing Services to Beneficiaries with LEP[144]

Strategy	Description
Identify patient's language	Identify the languages patients speak to determine what languages are the most relevant for their practice, create multilingual patient resources, and plan for interpreter support.[145]
Use accessible material to communicate	Communicate with patients using accessible materials in multiple languages. Using resources like the "I speak" cards (i.e., assistance cards listing languages, grouped by the geographical region where they are commonly spoken, that help an individual obtain interpretive services) to determine a patient's preferred language before their virtual appointment.[146]
Include qualified medical interpreters timely	Include qualified medical interpreters in LEP patient interactions as soon as possible. Ensure that interpreters are familiar with remote interpretation, ethics, and confidentiality requirements.
Use a provider who is proficient in the patient's language	Match the patient with a provider who is proficient in their preferred language when possible and when it will not delay care.
Have qualified interpreter available for post-visit questions	Have a qualified interpreter available after the visit to help translate or interpret for the patient in case of additional questions via phone or email.

Telehealth and Individuals with Disabilities

As telehealth becomes more prevalent in our health care system, beneficiaries with disabilities are at risk of facing greater disparities in health care access and outcomes if their needs are not considered when services are delivered via telehealth. If implemented carefully, telehealth policy has the potential to improve access and to enhance the health care experience of individuals with disabilities by removing common obstacles such as transportation issues or the need to rely on a caregiver's schedule. However, as is common with emerging technologies, accessibility of telehealth interventions may be problematic for some populations of beneficiaries

[139] 42 C.F.R. § 435.905; 42 C.F.R. § 457.110; and 42 C.F.R. § 457.1207.
[140] https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html.
[141] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Lessons-from-the-Field-508.pdf.
[142] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf.
[143] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth.
[144] Ibid.
[145] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/appendix-a-top-15-non-english-by-state-mm-508_update12-20-16.pdf.
[146] https://www.fns.usda.gov/civil-rights/ispeak.

with disabilities, particularly those with visual and hearing disabilities and those with limited or no use of their hands.[147] Research has shown that individuals with a disability are less likely than those without disabilities to own digital devices, particularly desktop and/or laptop computers, a trend that further challenges equitable access to telehealth for beneficiaries with disabilities.[148] To help mitigate these issues, states should consider tailored training and outreach to beneficiaries with disabilities to ensure they are comfortable accessing and using required telehealth technology.

When designing telehealth policies, states should conduct robust community engagement to inform the policies so that the policies support the inclusion of beneficiaries with disabilities. This outreach should help ensure that the authorized telehealth modalities are accessible to beneficiaries with disabilities and that services delivered via telehealth improve the quality and accessibility of needed care. Outreach to beneficiaries should include a discussion of difficulties they may have accessing services delivered using telehealth, and outreach to providers should include a discussion on any challenges they face when using telehealth to deliver services to beneficiaries with disabilities. In addition, states should conduct regular outreach to beneficiary advocacy organizations (e.g., developmental disabilities councils), managed care plans, and/or other parties involved in providing and/or ensuring care for individuals with disabilities. States' telehealth policies should strive to find agreement and alignment across all of these interested parties, with the goal of advancing informed telehealth policies for this population of beneficiaries.

Throughout the process of developing and implementing telehealth policies, states must ensure that they provide effective communication to individuals with disabilities, as required in section 1557 of the Affordable Care Act (ACA), section 504 of the Rehabilitation Act, and Title II of the Americans with Disabilities Act. Recipients of federal funding must take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in its programs or activities, including the provision of auxiliary aids and services, interpreters, and information in appropriate formats, at no cost to the individual.[149] Medicaid and CHIP regulations also require that information be provided accessibly to individuals with disabilities.[150] Also pursuant to section 504, section 1557, and Title II of the ADA, states must offer people with disabilities full and equal access to the electronic information technology (EIT) they employ, unless those individuals are provided reasonable accommodations or reasonable modifications that permit them to receive all the benefits provided by the EIT in an equally effective manner.[151]

To comply with applicable federal laws and to ensure equitable access to telehealth, states should consider encouraging providers to take the steps and provide the supports noted in Table 13 when using telehealth to provide services to individuals with disabilities.

Table 13 – Telehealth Strategies for Providing Services to Beneficiaries with Disabilities[152]

Strategy	Description
Assess beneficiary needs before the appointment and prepare accordingly	Send materials and assess patient accessibility and technology needs before the appointment. Include a way for patients to note any special needs when making the appointment or on an intake form in advance of their virtual visit. Contact the beneficiary before their appointment to work around possible technology challenges and ensure they feel comfortable with the platform. Consider whether some beneficiaries may need longer appointment times.
Provide resources in different formats	Make resources available, including those that provide information about services delivered via telehealth and telehealth options, for individuals with disabilities. These resources should be available in different formats including printed information, audio recordings, or Braille.

[147] http://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20FriedenFinalPDF.pdf.
[148] https://www.pewresearch.org/short-reads/2021/09/10/americans-with-disabilities-less-likely-than-those-without-to-own-some-digital-devices/.
[149] 45 C.F.R. § 92.102.
[150] 42 C.F.R. § 435.905; 42 C.F.R. § 457.110; and 42 C.F.R. § 457.1207.
[151] https://www.hhs.gov/civil-rights/for-individuals/disability/guidance-on-nondiscrimination-in-telehealth/index.html.
[152] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth#telehealth-for-people-with-disabilities.

Strategy	Description
Ensure online information is accessible	Make sure websites and online tools in general, including those that provide information about services delivered via telehealth and telehealth options for individuals with disabilities, are accessible. For example, make them compatible with screen readers and offer large text sizing.
Appropriately communicate with beneficiaries who are deaf or hard of hearing	Communicate with beneficiaries, family members, and beneficiary companions who are deaf or hard of hearing. For example, provide a qualified notetaker, qualified sign language interpreter, oral interpreter, cued-speech interpreter, tactile interpreter, real-time captioning, written materials, or a printed script of a stock speech.
Provide interpreter services and communication aids	Provide interpreter services and communication aids to beneficiaries with disabilities and their companions free of charge.[153] (Beneficiaries with disabilities are not required to provide their own interpreter.)
Use accessible telehealth platforms	Choose a telehealth platform that offers accessible features, like the ability to include an interpreter on the same call with the patient and provider, live captioning, high contrast displays, and automatic transcription.
Allow companion interpreters in certain situations	Make sure a qualified and unbiased interpreter is available to support service delivery via telehealth. For instance, providers should only rely on a companion interpreter (e.g., a friend or family member of the beneficiary with a disability) if there is an emergency and a qualified interpreter is not available, or if the beneficiary requests to use an adult friend or family member as an interpreter. However, providers may not rely on an adult friend or family member to interpret when there is reason to believe they may be biased, unfair, or otherwise ineffective.[154]

In addition to the steps described above, many states have leveraged funding opportunities and Medicaid authorities to implement additional policy and design approaches to promote telehealth equity for beneficiaries with disabilities, as described in Table 14.

Table 14 – State Best Practices for Using Telehealth to Deliver Services to Individuals with Disabilities

State	Telehealth Strategy
Arizona	Section 9817 of the American Rescue Plan allowed qualifying states a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS.[155] States were required to enhance, expand, or strengthen HCBS under the Medicaid program and use the Federal funds attributable to the FMAP increase to supplement, and not supplant, the level of state funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021. Arizona identified individuals with disabilities as one of its key target populations and proposed time-limited payments to incentivize providers to create new remote/telehealth delivery models for services that support independence, community integration, and employment, while mitigating social isolation.[156] Additionally, Arizona proposed to solicit a contractor to research and develop new or enhanced delivery modalities for existing covered services, such as attendant care, habilitation/skills training and development, and home health services.

[153] Recipients of federal funding must take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others, including the provisions of auxiliary aids and services, interpreters, and information in appropriate formats, at no cost to the individual. Medicaid and CHIP regulations require that information be provided accessibly to individuals with disabilities. (Section 1557 of the Affordable Care Act (ACA); section 504 of the Rehabilitation Act; Title II of the Americans with Disabilities Act; 42 C.F.R. § 435.905; 42 C.F.R. § 457.110; and 42 C.F.R. § 457.1207.)

[154] 45 C.F.R. § 92.101(b)(4).

[155] https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html.

[156] https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ARPA/AHCCCS_ARPA_HCBS_SpendingPlan_Revised.pdf.

State	Telehealth Strategy
Colorado	In its Supported Living Services 1915(c) HCBS waiver, which targets individuals with a developmental disability who are at least 18 and meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care, Colorado allows a number of services to be provided using telehealth.[157] For example, the waiver includes Homemaker services that allow for assistance with general household tasks (e.g., meal preparation and routine household care) that are provided by staff at a remote location. These staff are engaged with the individual to respond to the individual's health, safety, and other needs through technology/devices with the capability of live two-way communication. The individual's interaction with support staff may be scheduled, on-demand, or in response to an alert from a device in the technology integrated system.
Idaho	During the COVID-19 PHE, and after the end of the PHE until May 11, 2024, Idaho allowed developmental therapy and community crisis supports in its 1915(i) State Plan HCBS Benefit for Adults with Developmental Disabilities to be provided virtually (e.g., real-time telephonic or audio-visual).[158] In these instances, the services were required to be safely and effectively delivered via virtual methods, fully meet the service definitions when provided via virtual methods, and appropriate to meet the individual's needs as identified in the person-centered service plan, in addition to other assurances and information related to telehealth service delivery. Idaho also required that providers provide and document at least one in-person contact with an individual every twelve months.
New York	New York's "Crisis Services for Individuals with Intellectual and/or Developmental Disabilities" (CSIDD) are state plan rehabilitative (1905(a)(13)(d)) short-term tertiary services to help stabilize individuals with intellectual and/or developmental disabilities (I/DD) who have significant behavioral or mental health needs.[159] Services are provided within the individuals' existing care networks using specially trained behavior support professionals to build skills and deescalate behaviors. CSIDD can be provided using audio-only or any two-way, real-time communication technology that meets state, federal, and HIPAA Rules requirements.

Telehealth and Older Adults

Telehealth offers a convenient and cost-effective way to deliver health care services to older adults. The benefits of virtual visits for these patients and their caregivers include fewer trips, less exposure to illnesses, and better chances of being seen sooner.

Many older Americans are comfortable receiving services via telehealth. However, some are not digitally literate or may be less comfortable using a computer or smartphone. Furthermore, some older adults may experience physical or cognitive barriers that reduce their ability to access telehealth (e.g., limitations in hearing, vision, or cognitive impairments). States should encourage providers to consider the strategies described in Table 15 when providing services via telehealth to older adults.[160]

Table 15 – Telehealth Strategies for Delivering Services to Older Adults

Strategy	Description
Extra time for telehealth appointments	Providers should allow extra time during the first telehealth appointments as older adults may need more time to get familiar with the technology.
Use remote monitoring devices	Providers should consider using remote monitoring devices (e.g., blood pressure, heart rate, or glucose monitors), as this could minimize the need for in-person visits.

[157] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81146.
[158] https://www.medicaid.gov/medicaid/spa/downloads/ID-23-0019.pdf.
[159] https://www.medicaid.gov/medicaid/spa/downloads/NY-21-0067.pdf.
[160] https://telehealth.hhs.gov/providers/health-equity-in-telehealth/telehealth-and-older-patients.

Strategy	Description
Use non-video telehealth modalities or email	Providers should consider non-video telehealth modality options like phone calls or answering follow up questions via email. If the patient does not own a device that supports video or is experiencing a slow internet connection, providers should consider using audio-only if the state permits it. Audio-only may work particularly well for follow up appointments, reviewing lab or test results, and medication changes or refills.
Prepare for the telehealth visit prior to the appointment	Prior to the telehealth appointment, providers could assign a staff member to contact the patient to confirm that their device (e.g., phones, tablets) works, the technology works (e.g., internet connectivity), and that the device supports video calls. Staff could also ensure the patient knows how to check into the visit, how to position the camera, and how to adjust audio settings to the right volume and unmute. Finally, staff could ask patients if they would like a family member or caregiver to participate in the appointment to troubleshoot technology challenges and facilitate communication.

Using Telehealth to Deliver Services to Children and Youth

Telehealth can be an important tool for providing services to children and youth across settings, including at home and at school. To maximize the benefits of telehealth for Medicaid- and CHIP-eligible children and youth, states should consider not only the challenges common among all Medicaid and CHIP beneficiaries (e.g., low broadband accessibility), but also the circumstances and challenges unique to this younger population. For example, certain components of pediatric care require in-person care (e.g., immunizations), and adolescents may have difficulty finding private spaces to receive sensitive services (e.g., behavioral health) via telehealth.[161]

Despite these challenges, studies show that telehealth visits with children and youth are feasible for a wide range of conditions, and that patients and caregivers are generally satisfied with remote services.[162] However, emerging research indicates that telehealth utilization among children and young adults may lag other age demographics. Furthermore, among children and youth, telehealth utilization varies among demographics, with more prevalent telehealth use in urban areas, among patients with higher family incomes, and in certain geographic regions.[163,164,165]

This subsection describes strategies and best practices for expanding access to telehealth for children and youth enrolled in Medicaid and CHIP, as well as specific considerations for utilizing telehealth in schools and for individuals transitioning from foster care.

Expanding Access to Telehealth for Medicaid- and CHIP-Eligible Children and Youth

In addition to the broad telehealth expansion initiatives implemented across Medicaid and CHIP programs and discussed throughout this toolkit (e.g., use of audio-only telehealth, flexible originating site policies), children and youth could benefit from telehealth strategies specific to this population. For example, telehealth strategies specific to well-child visits could improve access to services for children and youth.

Well-child visits—a component of the Medicaid program's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for eligible children and youth under age 21—have the potential to improve children's health, support caregivers' behaviors to promote their children's health, and prevent injury and harm. These visits should include a family-centered health history, physical examination, immunizations, vision and hearing screening, developmental and behavioral assessment, an oral health risk assessment, a social assessment, maternal depression screening, parenting education on a wide range of topics, and care coordination as needed. When children receive the recommended number of high-quality visits, they are more likely to be up-to-date on immunizations, have developmental concerns

[161] https://publications.aap.org/aapnews/news/14281/Telehealth-taking-center-stage-in-many-practices.
[162] https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1.
[163] https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge.
[164] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf.
[165] https://www.cdc.gov/nchs/data/nhsr/nhsr170.pdf.

recognized early, and are less likely to visit the emergency department.[166]

Table 16 below describes telehealth strategies and policies related to well-child visits, as well as other strategies that could benefit children and youth. Although some of the strategies and policies were implemented specifically to address the COVID-19 PHE, they could continue to be helpful now that the PHE has concluded.

Table 16 – Telehealth Strategies for Services Delivered to Children and Youth

Strategy	Description
Allow components of well-child visits to be provided via telehealth	States can allow specific components of well-child visits that do not require physical touch to be delivered via telehealth, specifically for children over 24 months old.[167] For example, health risk assessments, developmental and behavioral screenings, and vaccine counseling can be provided virtually. Several states implemented this policy during the COVID-19 PHE,[168] but this option is always available to states. States that implemented this policy during the COVID-19 PHE often required that an in-person follow-up visit occur within a certain time frame so that the components of well-child visit services that do require physical touch (e.g., physical examination, vaccinations) could be provided. Additionally, some states required the providers to inform beneficiaries (or their parents/guardians) of any immunizations that would normally have been administered during an in-person well-child visit and to schedule an appointment for vaccine administration as soon as possible after the telehealth visit.
Issue bulletins on EPSDT/well-child visits	During the COVID-19 PHE, several states issued specific bulletins with information on EPSDT/well-child visits.[169] These bulletins clarified the components of a well-child visit that could be delivered via telehealth, as well as related billing guidance, to ensure children and youth could maintain healthy development by accessing these services virtually. If states allow certain components of well-child visits or other EPSDT services to be provided via telehealth, a bulletin with similar information could clarify service delivery options for both beneficiaries and providers.
Identify select services, such as early intervention services, that may be provided using telehealth	Early intervention services—which can also be covered as a component of EPSDT, if they fit under one of the Medicaid benefit categories listed at section 1905(a) of the Social Security Act—are developmental services designed to meet a child's developmental needs in physical, cognitive, communication, adaptive, and social and emotional development, for children from birth to age 3. Medicaid-covered early intervention services could include physical therapy, occupational therapy, personal care, and services for children with speech, hearing, and language disorders, for example.[170] States have the option to identify select services that, when clinically appropriate, may be provided via telehealth.
For the health home benefit for children with medically complex conditions (MCC)[171], use telehealth to facilitate treatment from out-of-state providers	Section 1945A of the Social Security Act, enacted as part of the Medicaid Services Investment and Accountability Act of 2019 (P. L. 116-16), authorizes states to cover an optional health home state plan benefit for Medicaid-eligible children under the age of 21 who have MCCs. Often, children with MCCs require specialized diagnostic or treatment services that may not always be readily available from providers within their state of permanent residence. By implementing this health home option, states can cover coordination of care, including coordination of the full range of pediatric specialty and subspecialty medical services, for children with MCC from out-of-state providers. CMS recommends the use of telehealth, when appropriate, to facilitate this treatment from out-of-state providers to improve access to care from these providers, and to enhance care coordination for these children.

[166] https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html.

[167] The American Academy of Pediatrics recommends that well-child visits for infants and young children (through 24 months old) be conducted in person whenever possible. See: https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections2/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/.

[168] https://downloads.aap.org/DOCCSA/State-Telehealth-Notices.pdf.

[169] https://nashp.org/states-establish-new-telehealth-policies-to-safeguard-well-child-care-and-immunizations/.

[170] https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

[171] For more information, see: https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf; https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

Telehealth and School-Based Services

The school setting provides a unique opportunity to increase health care access for children and youth, especially those enrolled in Medicaid and CHIP, and the use of telehealth to deliver these services could further enhance their potential impact. School-based services (SBS) can be covered for any student enrolled in Medicaid or CHIP[172] for any covered health services, including routine preventive care, behavioral health, and ongoing primary care and treatment. SBS play a particularly important role in bridging equity gaps among students in low-income and rural communities where access to health care services may be more limited. These services can help enhance early identification of health needs and have been shown to improve both health and academic outcomes.[173,174] For more information about SBS, please see FAQs #6-9 in **Section 2: Frequently Asked Questions**.

Prior to the COVID-19 PHE, 24 states had policies in place allowing payment for services delivered via telehealth in schools and during the PHE, nearly every state allowed payment for at least one SBS to be provided via telehealth.[175] While the services that can be provided via telehealth in schools vary among states, the most common are audiology and speech/language therapy, behavioral health services (including mental health, SUD treatment, counseling, and/or other services), occupational therapy, physical therapy, and nursing and/or physician services.[176] About half of the states pay for all Medicaid-covered IEP[177] services or all EPSDT services provided via telehealth.[178]

While the school setting provides children and youth with access to an array of services, SBS can specifically support earlier detection of mental health and SUD symptoms and implementation of strategies that teach students emotional and behavioral regulation that can help lessen the impact of student mental health disorders on well-being and academic achievement.[179] When mental health and SUD services are available in school settings, youth with mental health and/or substance use issues are far more likely to be identified early (50 percent of adult disorders begin before age 14)[180] and to initiate and complete care. For more information on Medicaid covered mental health and SUD services delivered via telehealth to children and youth more generally, please see the **Using Telehealth to Deliver Behavioral Health Services** subsection within **Section 4: Strategies for Using Telehealth with Specific Populations and Services**.

State-specific best practice examples for delivering school-based Medicaid services, including mental health and SUD services, via telehealth, are provided in Table 17.

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[172] CHIP statutes and regulations allow states to use Title XXI funding for items and services provided to eligible students in school-based settings. Specifically, section 2103(c)(9) of the Act permits states to provide separate CHIP-covered services through school-based health centers. Additionally, the definition of child health assistance at section 2110(a) of the Act and 42 C.F.R. § 457.402 includes services provided in schools. Title XXI funds may also be used for coverage of SBS for Medicaid-enrolled students through a Medicaid expansion CHIP. Medicaid expansion CHIPs follow Medicaid coverage requirements in Title XIX of the Act and implementing regulations. Therefore, states should follow Medicaid requirements and standards for providing SBS to optional targeted low-income students enrolled in a Medicaid expansion CHIP.

[173] https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

[174] https://www.medicaid.gov/federal-policy-guidance/downloads/cib051823.pdf.

[175] https://nashp.org/states-expand-medicaid-reimbursement-of-school-based-telehealth-services/.

[176] https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2022/12/telehealth-report.pdf.

[177] For more information on school-based services in Medicaid, see: CMCS Information Bulletin on School-Based Services in Medicaid: Funding, Documentation and Expanding Services, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf, and The Centers for Medicare and Medicaid Services (CMS) Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming. Available at: https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

[178] https://nashp.org/states-expand-medicaid-reimbursement-of-school-based-telehealth-services/.

[179] Ibid.

[180] Lipari, R.N., Hedden, S., Blau, G. and Rubenstein, L. Adolescent mental health service use and reasons for using services in specialty, educational, and general medical settings. The CBHSQ Report: May 5, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

Table 17 – State Best Practice Examples for Delivering School-Based Medicaid Services, Including Mental Health and SUD Services, via Telehealth[181]

State	Telehealth Strategy
New Mexico	New Mexico has a list of facilities that can serve as an originating site for a telehealth encounter, and this list includes, but is not limited to, school-based health centers and the patient's home (in various situations including when an interactive audio and video telecommunication system is used).[182]
Colorado	Colorado has a dedicated website for SBS, referred to as school health services, that includes procedure codes for telehealth, and allows for telehealth delivery of behavioral health, personal care services, physician services, physical therapy, nursing service, occupational therapy, and speech/language therapy.[183,184]
Washington	Washington includes a separate subsection in their School-Based Health Care Services (SBHS) Program Billing Guide that outlines in detail which originating sites, such as the school but also home, daycare, or any location determined appropriate by the student or parents, are available for IEP/IFSP service delivery via telehealth, along with other important information for providers.[185] School-based providers using telehealth to deliver non-IEP services can reference the state's Telemedicine Policy and Billing Guide.[186]

When covering and paying for SBS delivered via telehealth, states should consider HIPAA Rules and privacy requirements.[187] States may need to consult with the Department of Education regarding SBS and requirements for school records or other related issues in the Family Educational Rights and Privacy Act (FERPA) or the Individuals with Disabilities Education Act (IDEA).[188]

Using Telehealth to Improve Beneficiaries' Transitions from Foster Care

Children and youth in foster care benefit from receiving a combination of targeted health services and supports. However, beneficiaries in foster care who have transitioned and lived with multiple foster families or relocated can experience fragmented care, lack of continuity of care, and higher rates of unmet health needs.[189,190] Fragmented service delivery for these beneficiaries can be further exacerbated by the transition out of foster care. Each year, more than 23,000 young people transition to independent adulthood from foster care in the United States. Youth aging out of foster care can experience barriers to health coverage and access, which can exacerbate disparities in health and social outcomes. Ensuring continued coverage for these individuals through Medicaid—a key source of health coverage for this population—as they leave the foster care system and transition to adulthood is critical to addressing these inequities.

Under the Medicaid statute and regulations, qualifying youth formerly in foster care are eligible for Medicaid coverage until age 26 in the same state in which they aged out of foster care (and in many states, regardless of the state in which they aged out), regardless of their income in the former foster care children or "FFCC group." To meet the healthcare coverage gap from potential lost Medicaid coverage for young people who relocate from the states in which they

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[181] For additional information on how various states are implementing Medicaid coverage for school-based services delivered via telehealth, see the National Academy for State Health Policy brief at https://nashp.org/states-expand-medicaid-reimbursement-of-school-based-telehealth-services/.

[182] https://www.cchpca.org/2022/10/Fall2022_ExecutiveSummary8.pdf.

[183] https://hcpf.colorado.gov/shs-man.

[184] https://nashp.org/medicaid-reimbursement-policy-for-school-based-telehealth/.

[185] https://www.hca.wa.gov/assets/billers-and-providers/SBHS-bg-20230801.pdf.

[186] https://www.hca.wa.gov/assets/billers-and-providers/Telemedicine-bg-20230701.pdf.

[187] In some circumstances, an educational agency or institution subject to FERPA may meet the definition of a covered entity under HIPAA because it electronically bills health insurance, such as Medicaid or CHIP. However, in most elementary and secondary school settings, even where the school is a covered entity, FERPA privacy protections apply instead of the HIPAA Privacy Rule. For information about how FERPA and HIPAA apply to protect the privacy of student health records, see https://studentprivacy.ed.gov/resources/joint-guidance-application-ferpa-andhipaa-student-health-records. For more information about school-based Medicaid services see https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf.

[188] See Non-Regulatory Guidance on the IDEA Part B Regulations Regarding Parental Consent for the Use of Public Benefits or Insurance to Pay for Services under the IDEA, issued February 14, 2013, and effective March 18, 2013.

[189] https://pediatrics.aappublications.org/content/136/4/e1131.

[190] https://oig.hhs.gov/oei/reports/oei-07-13-00460.pdf.

age out of foster care to another state, section 1002(a) of the SUPPORT Act amended section 1902(a)(10)(A)(i)(IX) of the Social Security Act to make two important changes to the eligibility requirements for the FFCC group. Specifically, following these amendments, section 1902(a)(10)(A)(i)(IX):

1. Requires states to cover, under the FFCC group, individuals who aged out of foster care from another state than where they currently live.
2. Eliminates the requirement that an individual not be eligible for another mandatory eligibility group (other than the Adult Group) to be eligible for the FFCC group.

These SUPPORT Act changes apply exclusively to youth formerly in foster care who turned age 18 on or after January 1, 2023.

Following the COVID-19 PHE, many state governments and state Medicaid agencies expanded cross-state licensing laws that allow an out-of-state provider to render services via telehealth in a state where they are not located.[191] As youth formerly in foster care often relocate to other areas of the state or another state, it may be possible to continue to receive services from the same provider with whom they have built a trusted relationship (if the provider participates in the respective state's Medicaid program) via telehealth. To promote continuity of coverage, states may also consider a new section 1115 demonstration (or an amendment to an existing demonstration, as appropriate) to cover youth under age 26 formerly in foster care from other states who turned 18 prior to January 1, 2023, and are not eligible under the FFCC group in the state where they are applying.[192]

Using Telehealth to Deliver Maternal Health Services

While some countries have reversed their upward trend in maternal mortality, rates in the United States have been on the rise since 2000, exceeding the mortality rates of several other peer income countries.[193] Evidence shows that in the United States, only up to 40 percent of women receive postpartum care.[194] Obstacles such as the demands of caring for a new infant, childcare availability, and travel can make attending postpartum visits challenging, particularly if a woman needs to see multiple providers.[195] The maternal mortality rate in the United States is exceptionally high for Black women. It is more than double the average rate and nearly three times higher than the rate for White women.[196] In 2019, Non-Hispanic Black and non-Hispanic AI/AN women experienced higher pregnancy-related mortality ratios (40.8 and 29.7 per 100,000 live births, respectively) than all other racial/ethnic populations.[197] Medicaid covers a significant portion of births in the United States—42 percent of all births and 65 percent of births among Black women, in 2019.[198]

Women living in rural areas are also experiencing maternal health disparities. As of 2019, 10 million women in the United States live in rural counties with provider shortages for obstetrics care requiring patients to often travel significant distances to access care. This is due in part to hospital closures.[199] A recent study found that rural residents have a 9 percent greater likelihood of severe maternal morbidity/mortality than their urban counterparts because of factors including workforce shortages, transportation barriers, the opioid epidemic and limited access to specialty care.[200] State Medicaid agencies are in a unique position to improve these outcomes and disparities and can consider whether missed opportunities for routine prenatal, postnatal and postpartum care and screenings can be alleviated by permitting these services to be furnished via

[191] In addition to being licensed to practice in another state, a provider must also be an enrolled provider with the other state's Medicaid agency.

[192] In December 2022, CMS issued guidance and additional resources about the eligibility changes under section 1002(a) of the SUPPORT Act and operational strategies to implement the changes. See https://www.medicaid.gov/sites/default/files/2022-12/sho22003_0.pdf and https://www.medicaid.gov/medicaid/eligibility/downloads/former-foster-care-coverage-changes.pdf.

[193] Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison," To the Point (blog), Commonwealth Fund, Dec. 1, 2022. https://doi.org/10.26099/8vem-fc65.

[194] https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/.

[195] https://www.ama-assn.org/about/leadership/how-new-technologies-boost-postpartum-care-fourth-trimester.

[196] https://pubmed.ncbi.nlm.nih.gov/31487273/.

[197] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

[198] https://www.commonwealthfund.org/blog/2021/improving-access-telematernity-services-after-pandemic.

[199] https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/.

[200] Ibid.

telehealth. Table 18 below includes a few strategies for delivering maternal health services via telehealth.

Table 18 –Strategies for Delivering Maternal Health Services via Telehealth

Telehealth Strategy	Practical Example
Delivering services via telehealth can help maintain established trusted relationships with providers and ensure continuity of care.	Individuals can continue to receive the same Medicaid-covered services provided by doulas whom they saw pre-delivery, during delivery, and long after the delivery and into the postpartum period, even into the child's early years. Doula services and support[201] are associated with improved outcomes for individuals, as well as babies, during pregnancy, delivery, and in the postpartum period.[202] Many ongoing doula services can be provided in person or via telehealth.
Mental health services can also be delivered via telehealth, allowing easier access to providers and support groups.	Postpartum depression, for example, is a common condition that can be effectively treated via telehealth.[203]
Services delivered via telehealth can be an effective method to provide care and monitor health in an accessible and non-intrusive way.	Telehealth visits can be used between or in concert with other in-person services, such as remote patient monitoring for blood pressure for postpartum hypertension.[204]

The COVID-19 PHE prompted some states to expand payment for pregnancy and postpartum care services delivered via telehealth for Medicaid beneficiaries. Tele-maternity visits spiked nationally, and physicians noted improved attendance in postpartum care via telehealth.[205] Additionally, research indicates that, during the COVID-19 PHE, telehealth implementation for postpartum care was associated with decreased racial disparities in postpartum care attendance.[206] While many providers and patients were able to adjust to virtual care, research shows that the transition was more difficult for patients with Medicaid.[207] According to a national survey, prior to 2020, only nine state Medicaid programs explicitly paid providers for providing maternal care via telehealth.[208] In that time, only 19 state Medicaid programs established payment policy for Medicaid services delivered using telehealth when the beneficiary was in their home, which in turn limited a pregnant and postpartum person's ability to receive at-home monitoring and lactation services via telehealth.[209,210] Given the potentially positive impact of receiving services via telehealth on maternal health, Medicaid programs could consider payment for services delivered via telehealth that are critical to the health and well-being of populations that suffer disproportionate maternal morbidity and mortality. Additionally, individuals enrolled in Medicaid are less likely to have access to the broadband internet necessary for video visits, so covering services delivered via audio-only visits, when appropriate, could be an impactful way to improve access to services.[211]

States should consider whether and how maternal care can be delivered via telehealth. Many Medicaid agencies and their managed care plans have begun taking some steps in closing gaps and reducing disparities in maternal health by incorporating telehealth innovations into their Medicaid programs. A few examples are listed in Table 19. While these programs were launched during the COVID-19 PHE, they can continue beyond that PHE at a state's option.

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[201] Medicaid coverage of doula services may be effectuated through multiple 1905(a) benefit categories, including, but not limited to, preventive services, services of licensed practitioners, clinic services, and freestanding birth center services.

[202] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[203] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8532017/.

[204] https://pubmed.ncbi.nlm.nih.gov/30825917/.

[205] https://www.urban.org/sites/default/files/publication/103126/maternal-telehealth-has-expanded-dramatically-during-the-covid-19-pandemic_5.pdf.

[206] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9726646/.

[207] https://m2hcc.com/wp-content/uploads/2021/08/M2-%E2%80%93-Telehealth-and-Maternity-Care-A-COVID-19-Policy-Crossroad-%E2%80%93-August-2021.pdf.

[208] https://www.commonwealthfund.org/blog/2021/improving-access-telematernity-services-after-pandemic.

[209] https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/.

[210] https://www.kff.org/report-section/telemedicine-in-sexual-and-reproductive-health-appendix/.

[211] https://m2hcc.com/wp-content/uploads/2021/08/M2-%E2%80%93-Improving-Access-to-Telematernity-Toolkit-for-State-Policymakers-%E2%80%93-August-2021.pdf.

Table 19 – State Best Practices for Maternal Health Services Delivered via Telehealth

State	State Best Practice Example
Hawaii	AlohaCare, a Medicaid managed care plan, partnered with Healthy Mothers Healthy Babies Coalition of Hawaii (HMHB) to implement the Mana Mama Mobile Clinic, a holistic, community-based midwifery model of care serving birthing families on Oahu Island. Mana Mama uses telehealth to deliver a range of services to pregnant and postpartum people, as well as referrals to resources and information. Services are provided by licensed midwives, lactation consultants, and a nurse practitioner and can be delivered via phone and telehealth support. The program launched during the COVID-19 PHE, which further exacerbated inequities for high-risk pregnant people and infants, especially Black, Native Hawaiian and Pacific Islander individuals, including Compacts of Free Association migrants, and other people of color.[212]
North Carolina	During the COVID-19 PHE, Medicaid providers were temporarily permitted to provide perinatal care, maternal support services, and postpartum depression screening via telehealth and, in 2023, they were permanently permitted to use telehealth for prenatal and postpartum visits.[213,214,215,216]
Alaska	Until November of 2021, to expand access to care during the COVID-19 PHE midwives were authorized to deliver a subset of services via telehealth.[217]

Telehealth and Maternal Health Services in Rural Areas

Since November 2018, the CMS Office of Minority Health (CMS OMH) has led several activities as part of its Rural Maternal Health Initiative to better understand rural maternal health disparities and improve access to high-quality maternal health services in rural communities.[218] Table 20 below provides best practice examples of telehealth innovations to improve access to maternal health in rural communities.[219]

Table 20 – Best Practices for Using Telehealth to Deliver Rural Maternal Health Services

Best Practice[220]	Practical Example
Expand remote monitoring.	Telehealth, such as remote patient monitoring, can remove the burden of frequent travel for some perinatal care.
Engage providers and patients using virtual platforms.	Telehealth brings opportunities to increase patient access to care, as well as improve ongoing engagement between providers and pregnant people throughout their pregnancy.
Implement programs using phone applications.	Phone applications (including telehealth applications) help increase engagement in perinatal services.
Increase access to virtual consultation.	Providers and specialist colleagues can confer across geographic distances to increase quality of care. Interprofessional consultation can also be an effective component of expanding access to specialty care for physical health conditions, particularly in rural and remote areas that may be lacking specialists.[221]

[212] https://q952a3.p3cdn1.secureserver.net/wp-content/uploads/2023/04/IMI-2023-Innovation-in-Perinatal-and-Child-Health-in-Medicaid-FINAL.pdf.
[213] https://medicaid.ncdhhs.gov/blog/2020/05/07/special-bulletin-covid-19-84-telehealth-and-virtual-patient-communications-clinical.
[214] https://medicaid.ncdhhs.gov/blog/2020/04/17/special-bulletin-covid-19-49-telehealth-clinical-policy-modifications-interim.
[215] https://medicaid.ncdhhs.gov/blog/2020/04/24/special-bulletin-covid-19-65-telehealth-and-virtual-patient-communications-clinical.
[216] https://medicaid.ncdhhs.gov/1e-6-pregnancy-management-program/download?attachment.
[217] https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/RA/RAMSG_2021.11.04_Telehealth_Flexibilities_Expire_for_OP_Dialysis_Vision_and_Direct-Entry_Midwife_Services.pdf.
[218] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf.
[219] Ibid.
[220] Ibid.
[221] https://www.medicaid.gov/sites/default/files/2023-01/sho23001_0.pdf.

Best Practice[220]	Practical Example
Expand training and quality improvement.	Virtual training and capacity building with existing providers can improve access to quality maternal health services in rural areas.[222]

States may consider how covered Medicaid services can be delivered via telehealth in conjunction with these best practices. For instance, two states, North Carolina and Wisconsin, have included services that integrate remote patient monitoring into billable services. North Carolina Medicaid expanded its use of remote patient monitoring to allow certain providers, including perinatal providers, to bill for Self-measured Blood Pressure Monitoring and Remote Physiologic Monitoring (i.e., tracking weight, pulse oximetry, etc., using a wirelessly-connected device where information can be evaluated in real or near-real time). The state also expanded the definition of durable medical equipment (DME) to include blood pressure monitoring devices and scales to provide enhanced pregnancy surveillance.[223] Wyoming Medicaid allows all maternity and postpartum care, including remote patient monitoring, outpatient visits, and risk assessments, as well as postpartum depression screening, to be delivered via telemedicine.[224]

Additionally, the CMS OMH Rural Obstetric Readiness Workgroup proposed solutions to help rural providers to increase their obstetric readiness.[225] States can consider strategies, policy development, and provider training materials that support solutions such as these to bolster rural maternal and infant health.

CMS OMH Rural Obstetric Work Group
Provider Strategies to Increase Obstetric Readiness

- Encourage rural emergency medical services (EMS) providers to become Medicaid providers who can furnish treatment on scene and/or during transport, using additional diagnostic equipment and telehealth to further support services.
- Use telehealth in rural areas to include nurse practitioners in antepartum care and interventions.
- Establish relationships between maternal-fetal specialists and their rural communities via telehealth to prevent or reduce medical risk.
- Include Community Health Workers in remote maternal-fetal medicine/ultrasound consults with patients to help facilitate the visit and support care coordination in the community.
- Implement tele-ultrasound programs so that rural providers can obtain ultrasound images and expert guidance from neighboring hospitals.
- Establish relationships between rural ERs and neighboring specialists for assistance on complex maternal-fetal medicine cases via real-time telemedicine consultations (e.g., in-person site visits, assessing resources, and providing education).

For more information, please refer to the Advancing Rural Maternity Health Equity Report at: https://www.cms.gov/files/document/maternal-health-may-2022.pdf.

[222] https://www.nejm.org/doi/full/10.1056/nejmp1700485.
[223] https://files.nc.gov/ncdma/covid-19/Perinatal-Telehealth-Scenarios-COVID.pdf; https://medicaid.ncdhhs.gov/1h-telehealth-virtual-communications-and-remote-patient-monitoring/open.
[224] https://www.commonwealthfund.org/blog/2021/improving-access-telematernity-services-after-pandemic.
[225] https://www.cms.gov/files/document/maternal-health-may-2022.pdf.

Behavioral Health Services Delivered via Telehealth

Telehealth coverage and payment policy development should include initiatives to integrate telehealth into mental health and SUD service delivery. The Surgeon General issued an Advisory to Protect Youth Mental Health specifically citing the need for expanded access to behavioral health services via telehealth, and the majority of Americans view the country as being in a mental health crisis, with young adults the most affected.[226,227] Telehealth can be an important strategy to combat this crisis. Behavioral health diagnoses were consistently among the top diagnoses treated via telehealth during the COVID-19 PHE, both nationally and among Medicaid beneficiaries, particularly for beneficiaries with anxiety and/or depression-related diagnoses. Importantly, emerging literature suggests no significant difference in behavioral health outcomes when services are received via telehealth as opposed to in-person.[228,229,230,231] Studies also found patient satisfaction to be high following behavioral health services received through telehealth. Reasons for enhanced patient satisfaction include the ability for LEP beneficiaries to secure a bilingual offsite provider, elimination of anxiety over leaving the house for certain patients, and a faster ability to overcome patient shyness.[232,233,234]

Telehealth's demonstrated ability to maintain or enhance access to behavioral health treatment without negatively impacting patient outcomes or satisfactions has led most states to take steps to maintain or further expand coverage for behavioral health delivered via telehealth.[235] These initiatives most commonly included expanding coverage for behavioral health services delivered via audio-only technologies, but also included coverage of group therapy, medication management, and other services when delivered via telehealth.[236]

As states develop and implement policies and initiatives to expand delivery of behavioral health services they should consider how delivering services via telehealth can support the needs of specific demographic populations, for instance, allowing services to be delivered via telehealth in school settings for children. Telehealth can help minimize disparities in access to behavioral health treatment and behavioral health outcomes faced by some ethnic groups, beneficiaries with disabilities, and beneficiaries residing in rural or medically underserved areas, by mitigating barriers to treatment such as lack of transportation and workforce shortages, and increasing access to language services and culturally competent providers.[237,238,239,240]

The pages that follow discuss strategies for successfully implementing telehealth coverage and payment policies to meet the behavioral health needs of children and youth, and beneficiaries experiencing opioid use disorder (OUD). We also discuss state efforts to incorporate telehealth within broader strategies and initiatives to enhance behavioral health access and equity and to ameliorate behavioral health workforce shortages, as well as how states may leverage managed care arrangements to equitably implement telehealth to address mental health and substance use challenges within their Medicaid programs.

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[226] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[227] https://www.kff.org/other/press-release/new-kff-cnn-survey-on-mental-health-finds-young-adults-in-crisis-more-than-a-third-say-their-mental-health-keeps-them-from-doing-normal-activities/.

[228] https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/The%20Evolution%20of%20Telehealth%20during%20the%20COVID-19%20Pandemic-A%20FAIR%20Health%20Brief.pdf.

[229] https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:~:text=In%20particular%2C%20states%20report%20that,telehealth%20utilization%20among%20Medicaid%20enrollees.

[230] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-022-04421-0.

[231] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9581698/.

[232] Ibid.

[233] https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf.

[234] https://www.medicaid.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf.

[235] https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:~:text=In%20particular%2C%20states%20report%20that,telehealth%20utilization%20among%20Medicaid%20enrollees.

[236] https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:~:text=In%20particular%2C%20states%20report%20that,telehealth%20utilization%20among%20Medicaid%20enrollees.

[237] https://link.springer.com/article/10.1007/s40615-022-01397-1.

[238] https://focus.psychiatryonline.org/doi/10.1176/appi.focus.20190028.

[239] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7681156/.

[240] https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html.

Behavioral Health Services Delivered to Children and Youth via Telehealth

Children and youth have experienced an alarming and consistent increase in the prevalence of anxiety, depression, and other behavioral health challenges in recent years, and suicide remains a leading cause of death among young people.[241] Even with these concerning statistics, between March 2020 and January 2022, nearly 27.3 million fewer Medicaid or CHIP mental health services were furnished to children and youth compared to the pre-COVID-19 period, on average. [242] However, this decline in utilization of mental health services would have been much higher if not for the exponential growth in the use of telehealth to minimize gaps in service delivery.

Much of the evidence base for the use of telehealth with pediatric patients comes from treatment of mental health disorders. Overall, programs are successfully providing services to patients who may not otherwise have access. All state Medicaid programs include some form of coverage and payment for mental health services delivered via telehealth, which has helped mitigate, but not resolve, the well-documented pediatric behavioral health workforce shortage.[243,244]

When implementing new, or expanding upon existing, telehealth coverage and payment policies for mental health and SUD services delivered to children and youth, states should consider factors specific to this population. These considerations are outlined in Table 21.

Table 21 – Considerations for Using Telehealth to Deliver Mental Health and SUD Services to Children and Youth

Consideration	Description
Consent	State Medicaid agencies should consider consent laws, regulations, procedures, and policies for pediatric populations in the development of telehealth coverage policy. Age of consent is the age at which children can provide their own consent without the parent or legal guardian and can vary by type of service. Depending on the requirements, there may be a need for reconsent, new consent, or parent/guardian involvement at some point during treatment.
Provider Licensure and Credentialing	States should review their provider licensure and credentialing requirements for pediatric providers to evaluate whether they present barriers to telehealth delivery in their states. This is particularly important for providers who may be out-of-state but providing services to individuals within the state.

OUD Services and MAT Delivered via Telehealth

Telehealth has also played an increasing role in service delivery for beneficiaries with OUD. Researchers at CMS, CDC, and NIH conducted and published a study analyzing the impact of COVID-19 PHE-related telehealth flexibilities on Medicare beneficiaries with OUD.[245] The study results showed that increased use of telehealth for OUD services, including medications for OUD, during the COVID-19 PHE was associated with a reduced overdose risk and increased length of stay for individuals in treatment.[246] Other studies report that the use of telehealth for OUD services during the COVID-19 PHE increased access and convenience for patients, particularly for historically underserved populations such as those in rural areas or individuals experiencing homelessness.[247] According to one study that analyzed 2021 data, adults who received substance use treatment through telehealth in the past year were nearly 38 times more likely to receive medication for OUD than those who were not treated virtually.[248]

Incorporating telehealth to treat OUD for Medicaid beneficiaries may include the delivery of

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[241] https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.

[242] COVID-19 Medicaid and CHIP Data Snapshot. Access at https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-01312022.pdf.

[243] https://mailchi.mp/cchpca/its-finally-here-the-updated-50-state-telehealth-laws-reimbursement-policies-report-spring-2019-edition.

[244] https://bipartisanpolicy.org/report/filling-gaps-in-behavioral-health/.

[245] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2795953?guestAccessKey=ee7219e9-7be8-4f85-bf27-6313250cfea3&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=083122.

[246] https://www.cms.gov/newsroom/press-releases/increased-use-telehealth-opioid-use-disorder-services-during-covid-19-pandemic-associated-reduced.

[247] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth.

[248] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807964.

MAT. When the medications prescribed for MAT are controlled substances, the prescriber must comply with the federal Controlled Substances Act (CSA).[249]

Emerging research regarding the significant adoption and positive impact of telehealth for OUD and MAT has prompted federal agencies to reconsider guidance related to telehealth and the CSA. In May 2023, the Drug Enforcement Administration (DEA), jointly with the Substance Abuse and Mental Health Services Administration (SAMHSA), issued a temporary rule to extend certain exceptions and flexibilities to existing DEA regulations as a result of the COVID–19 PHE through November 11, 2024, to allow the prescribing of controlled medications via telemedicine encounters–even when the prescribing practitioner had not conducted an in-person medical evaluation of the patient–in order to prevent lapses in care. The temporary rule explains that there will be a final set of regulations permitting the practice of telemedicine under circumstances that are consistent with public health, safety, and effective controls against diversion.[250] As state Medicaid agencies consider implementing OUD telehealth coverage and payment policies, they can draw from research findings and lessons learned from expanded telehealth use to treat Medicaid beneficiaries with OUD. For example, Minnesota coverage and payment policies allow a wide variety of Medicaid providers (e.g., physicians, nurse practitioners, physician assistants, and mental health professionals) to deliver OUD treatment via telehealth.[251] Permitting mid-level practitioners to deliver Medicaid and CHIP services via telehealth is an important strategy for improving access to buprenorphine, as nurse practitioners and physician assistants have been central to the increase in buprenorphine prescription growth among Medicaid beneficiaries and individuals living in rural areas.[252] As state Medicaid agencies consider strategies that incorporate service delivery via telehealth to improve access to OUD treatment, they must ensure state Medicaid coverage and payment policies are consistent with current, relevant regulations and guidance from both SAMHSA and the DEA.[253, 254]

Delivering Services via Telehealth to Address Behavioral Health Provider Shortages

Access to behavioral health services is hampered by documented provider workforce shortages. Nearly half the nation's population resides in a mental health workforce shortage area. These shortages are not specific to Medicaid, however they inhibit access to necessary care and are problematic for Medicaid beneficiaries, particularly those with mental health disorders and/or SUD. Behavioral health workforce challenges in Medicaid are exacerbated by the greater reluctance of some providers to accept Medicaid compared to other payers.[255] There are innovative efforts underway to extend the behavioral health workforce, including through care coordination, co-located service models, and mobile service delivery. States should consider integrating telehealth as a strategy within these initiatives, as described in Table 22.

[249] See Sections 1262-1263 of the Consolidated Appropriations Act, 2023, Consolidated Appropriations Act, 2023, Pub. L. No. 117-328 (2022), https://www.govinfo.gov/app/details/PLAW-117publ328.

[250] https://www.federalregister.gov/documents/2023/05/10/2023-09936/temporary-extension-of-covid-19-telemedicine-flexibilities-for-prescription-of-controlled.

[251] https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008926#Telemedicine.

[252] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth#Policy%20Recommendations.

[253] https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines.

[254] https://www.federalregister.gov/agencies/drug-enforcement-administration.

[255] https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/.

Table 22 – Strategies for Delivering Services via Telehealth to Address Behavioral Health Provider Shortages

Provider	Description
Certified Community Behavioral Health Clinics (CCBHC)	SAMHSA is encouraging the use of telehealth to expand access to services and to help mitigate workforce shortages within CCBHCs.[256] CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care. They are subject to unique standards including making crisis services available 24 hours a day, 7 days a week, and providing a comprehensive array of behavioral health services to anyone who requests care, regardless of ability to pay, place of residence, or age. Telehealth is an important strategy employed by CCBHCs in order to meet these standards and mitigate existing provider shortages. HHS, through SAMHSA, awarded funding to a limited number of states for CCBHC planning grants.[257] CMS encourages states to consider integrating service delivery via telehealth for CCBHC services as these clinics play a more prominent role in Medicaid behavioral health service delivery moving forward.
Community-Based Mobile Crisis Units	Section 9813 of the ARP amends Title XIX of the Social Security Act to add a new section 1947, which authorizes a state option to cover qualifying community-based mobile crisis intervention services and creates multiple avenues for states to incorporate telehealth into this new service delivery option.[258] States may choose to include highly trained and specialized practitioners, such as psychiatrists or psychiatric nurse practitioners, as part of the mobile crisis team that connects virtually via telehealth to other members of the mobile crisis team on scene to provide screening and assessment and/or to stabilize the beneficiary and de-escalate the crisis. Community-based mobile crisis intervention team members may need to initiate safety planning interventions, make follow-up referrals, and engage in other coordination activities relating to the crisis both on scene and shortly following the crisis intervention with other community providers, including recovery centers. Additionally, telehealth may also be used at either the outset of the crisis as part of screening, assessment, and stabilization, or in near term follow-up to the crisis with the beneficiary regarding coordination and referrals. Twenty state Medicaid Agencies also applied for and received planning grants to support their implementation of these community-based mobile crisis units.[259] States may also submit an APD to request a 90/10 enhanced match for a number of IT initiatives to support mobile crisis units, including the provision of cell phones or iPads to state-staffed mobile crisis teams to facilitate

[256] https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/care-coordination/telehealth-telemedicine.

[257] Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) was signed into law on April 1, 2014, to provide for: (1) the establishment and publication of criteria for clinics to be certified by a state as a certified community behavioral health clinic (CCBHC) to participate in a demonstration program; (2) the issuance of guidance on the development of a Prospective Payment System (PPS) for testing during the demonstration program; and (3) the awarding of planning grants for the purpose of developing proposals to participate in a time-limited demonstration program. On October 19, 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary of Planning and Evaluation (ASPE), awarded a total of $22.9 million to support 24 states in their efforts to improve behavioral health of their citizens by providing community-based mental health and substance use disorder treatment. Expanded funding for these state planning grants was authorized by the Bipartisan Safer Communities Act (BSCA) in 2022 to address the country's mental health crisis. For more information see: https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223, https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html, https://www.hhs.gov/about/news/2023/03/16/hhs-awards-cchbc-planning-grants-to-15-states-help-address-ongoing-mental-health-crisis.html, and https://www.samhsa.gov/newsroom/press-announcements/20230921/biden-harris-administration-awards-grants-to-expand-certified-community-behavioral-health-clinics-across-united-states#:~:text=Under%20BSCA%2C%20HHS%20will%20enable,as%20part%20of%20John%20F.

[258] https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf.

[259] https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html.

Provider	Description
Community-Based Mobile Crisis Units (Continued)	telehealth with a clinician at another location during a crisis intervention.[260] States covering, or planning to cover, community-based mobile crisis intervention services should consider telehealth as a strategy to augment mobile crisis units, and to prevent workforce shortages from inhibiting the model's success.
Collaborative Care Model with Telepsychiatry	Interprofessional consultation is one of the components of the Collaborative Care Model (CoCM), a team-based approach in which a treating practitioner addresses patients' mental health and substance use disorder issues while supported by a behavioral health care manager and a psychiatric consultant.[261] Numerous state Medicaid agencies pay for CPT and HCPCS codes for the Psychiatric Collaborative Care Model, which has demonstrated success in expanding access to and improving outcomes in behavioral health care by integrating a behavioral health care manager with a primary care provider at an office location. These providers then collaboratively manage a psychiatric caseload through weekly consultations with a psychiatrist, most commonly through telepsychiatry.[262,263,264,265] The integration of telepsychiatry within the collaborative care model both improves access to psychiatrists for Medicaid beneficiaries and increases the caseload that can successfully be managed by a limited behavioral health workforce.

Role of Managed Care Arrangements

Managed care plans can be an effective and strong partner in facilitating and supporting service delivery via telehealth in the same way as in-person services. Managed care plans have a role in supporting all services, including behavioral health services, in ensuring providers and beneficiaries are aware of their options and in helping to facilitate service delivery. States should explore working with their managed care plans to engage and retain patients in behavioral health treatment using telehealth. Medicaid managed care plans have increasingly recognized service delivery via telehealth as a service delivery option to customize services to patient needs and expand access to care. All contracts contain at least some reference to telehealth, with some states discussing managed care plan care delivery via telehealth.[266] For example, Pennsylvania's HealthChoices MCOs are responsible for coordinating the care of children, especially those children in foster care, who require therapeutic interventions and medication to treat mental health conditions. The MCOs are required to contract with a telephonic Psychiatric Consultation Team (PCT) that provides real-time telephonic consultative services to primary care providers and other prescribers of psychotropic medications for children, and all behavioral health and physical health MCOs worked together to choose one PCT for each region.[267]

Often Medicaid beneficiaries with behavioral health conditions have physical health needs as well, and initially present in a primary care setting seeking behavioral health services. Many of these patients are experiencing limited coordination between the providers who serve them in fragmented systems of care, which can have an impact on quality of care and often results in higher cost of care.[268] Integrating telehealth into behavioral health and primary care through Medicaid managed care offers the potential to increase access to behavioral health care and

[260] For more inforamtion, please see State Health Official (SHO) Letter #21-008 at https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf.
[261] https://www.medicaid.gov/sites/default/files/2023-01/sho23001_0.pdf.
[262] https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-Best-Practice-for-Reimbursing-CoCM-in-Medicaid.pdf.
[263] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegrationPrint-Friendly.pdf.
[264] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2771405.
[265] https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Medicaid-Payment-Collaborative-Care-Model/CCM-for-MH-One-Pager.pdf.
[266] https://www.commonwealthfund.org/blog/2021/how-states-are-using-medicaid-managed-care-advance-telehealth
[267] https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/2023%20HealthChoices%20Agreement%20including%20Exhibits%20and%20Non-financial%20Appendices.pdf.
[268] https://www.mahp.org/wp-content/uploads/2021/04/BH-Integration-Brief_041316.pdf.

improve health outcomes for patients.[269]

As states consider incorporating telehealth coverage and payment policies within managed care arrangements, they must remain compliant with mental health parity requirements at 42 C.F.R. Part 438 Subpart K.[270] This includes ensuring that financial requirements (e.g., cost-sharing), quantitative treatment limitations (e.g., service limits), and non-quantitative treatment limitations (e.g., prior authorization, standards for provider admission to participate in a network) applied to telehealth for mental health and SUD services delivered through managed care arrangements are in parity with requirements and limits applied to telehealth for medical and surgical services.

[269] https://www.chcs.org/resource/integrating-behavioral-health-care-into-primary-care-through-medicaid-managed-care/.

[270] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-K.

Section 5: Operational Considerations for Implementing Telehealth

Previous sections of this toolkit focused on key policy areas that states should consider as they design new or expand existing coverage and payment policies for Medicaid-covered services delivered via telehealth. Section 5 discusses operational considerations for states during and after policy implementation. This section describes approaches that states can take to evaluate telehealth, and highlights existing frameworks used by state and federal agencies to perform such evaluations. The section also includes considerations for integrating telehealth into value-based care models and measuring its impact on value. Lastly, the section describes strategies and approaches for conveying information about telehealth to both providers and beneficiaries.

Evaluation Strategies for Services Delivered Using Telehealth

Telehealth is a complex health care intervention, and the rapid increase in telehealth utilization poses important research questions regarding health care quality, cost, and outcomes, as well as questions regarding whether telehealth has made a positive impact on access, equity, and beneficiary experience. Numerous state Medicaid agencies have or are planning to study the impact of telehealth on their Medicaid populations. Two-thirds of states responding to a Kaiser Family Foundation survey on State Fiscal Years 2022 and 2023 reported that assessment initiatives were either in place or that they planned to assess telehealth quality.[271] These planned and ongoing efforts are critical to ensuring that the impacts of telehealth are measured and properly understood.

To comprehensively evaluate telehealth, both qualitative and quantitative research is needed, as well as consistent data sets.

Telehealth Coding and Data Strategies to Support Implementation and Evaluation

States that have implemented telehealth billing and encounter reporting policies have employed a number of different approaches to capture and delineate between services delivered in-person and via telehealth, including billing codes, modifiers, and POS codes. Identifying and reporting telehealth codes, modifiers, and POS codes on a claim or encounter not only ensures the correct rates are associated with services (in circumstances where the state has a different payment methodology or rate for services delivered via telehealth than it has for when the same services are delivered in person), but also helps create a consistent data set to examine services and evaluate telehealth.

States and providers should keep the following promising practices in mind when reporting telehealth on claims and analyzing related data.

1. **Develop goals and related analytic questions related to services delivered through telehealth.** States should consider how they will study beneficiaries, providers, and services, and what quantitative and qualitative domains they will assess. For example, states could use solicited and unsolicited feedback, surveys, and grievances and appeals to evaluate the experience of those delivering and receiving services via telehealth; access to services such as the available provider network; and service utilization, including any potential trends or disparities, cost of care, quality of care, and any other potential elements.[272,273] For instance, it may be beneficial to understand not only which services were delivered via telehealth, but what modality was used (e.g., audio-only) or where services were initiated (e.g., POS code for beneficiary's home or kiosk, in combination with a procedure code or modifier indicating the service was delivered via telehealth).

   Analytic questions can:

   - examine impacts on cost and quality of care;
   - seek answers about the providers who deliver services via telehealth and those who do not, by provider type, location, or another characteristic;

[271] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-telehealth/.
[272] https://publications.aap.org/pediatrics/article/146/5/e20201781/75357/Strategies-for-Evaluating-Telehealth.
[273] These characteristics are illustrative examples and not meant to describe an all inclusive list.

- include questions that address and stratify answers, for example, by beneficiary demographic, racial, ethnic, geographic, gender identity, age, language, disability, and other cohorts[274] to understand telehealth's impact on Medicaid's diverse beneficiary populations, and to identify potential barriers to and/or disparities in access; and
- ascertain whether communication and education efforts are successful.

Table 23 includes descriptions of two states' models for analyzing telehealth use.

Table 23 – State Best Practices for Analyzing Services Provided via Telehealth

State	Analysis Description
Colorado	Colorado published a telehealth evaluation in 2021 analyzing the impact of telehealth during the COVID-19 PHE on Colorado's Medicaid FFS program. The evaluation explored a number of research questions across four topics: utilization and access to care; health equity (with a focus on age, language, and ability; race and ethnicity will be analyzed in subsequent evaluations); quality and member outcomes, and payment. Colorado also performed quantitative analyses on Medicaid FFS claims data. The evaluation included analyzing trends on the percent of visits conducted via telemedicine, the most common diagnoses associated with telehealth, the most common provider types utilizing telehealth, and more. Colorado also performed numerous quantitative stratifications, including telehealth modality, urban/rural, child/adult, and adult beneficiaries enrolled in HCBS waivers.[275]
Iowa	Iowa has employed targeted promotion of telehealth to members and providers in counties with lower utilization of behavioral health care. Iowa's evaluations of telehealth include utilization by geography and race/ethnicity to identify and address barriers.[276]

2. **Identify the information and data that are needed to enable the analysis.** States can analyze data only if it is collected. Establishing data requirements up front can help in making informed decisions regarding CPT procedure codes, modifiers, and POS codes needed for claims and encounters and in developing instructions for providers in billing manuals. Examples of states that have established data requirements for telehealth analyses are included in Table 24.

Table 24 – State Best Practices for Establishing Telehealth Data Requirements

State	Telehealth Data Requirements
Missouri	Missouri permanently added audio-only as a telehealth modality for service delivery for Medicaid mental health services and provided instruction to providers to bill using the FQ modifier to signify services were rendered using this modality.[277]
Ohio	Ohio instructed providers to use the GT modifier to indicate services that are delivered via telehealth, along with a POS code that reflects the location of the provider, and an additional modifier that indicates the location of the beneficiary, including home or other residence such as homeless shelter or residential facility other than a nursing facility (U1), school (U2), inpatient hospital (U3), outpatient hospital (U4), nursing facility (U5), or ICF/IID (U6). They have also provided practical examples so that providers understand how to apply these codes to minimize errors.[278]

[274] These characteristics are illustrative examples and not meant to describe an all inclusive list.
[275] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Telemedicine%20Evaluation%20March%208%2C%202021.pdf.
[276] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-telehealth/.
[277] https://dmh.mo.gov/media/pdf/guidance-and-clarification-definition-and-use-telemedicine-and-audio-only-services.
[278] https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/Telehealth-Billing-Guidelines.pdf.

State	Telehealth Data Requirements
Massachusetts	Massachusetts added the following CPT procedure codes specific to remote therapeutic monitoring in January of 2022 to their fee schedule: • 98975 - Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment. • 98976 - Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days. • 98977 - Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days. • 98980 - Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (list separately in addition to code for primary procedure).[279]
Maine	• Maine added a specific code for FQHCs to bill (G0071) for a five-minute check-in visit delivered virtually.[280]

3. **Consider adopting a billing and coding approach that is standard and consistent across several or all services**, so that it is easy for providers to understand, more likely to be known and adopted, less prone to error, and easy to apply in creating queries and reports. Examples of state coding approaches are included in Table 25.

Table 25 – State Best Practices for Standard Telehealth Coding

State	Telehealth Coding
Several states	Several states use a single POS 10 to indicate that services are delivered to a beneficiary's home via telehealth.[281]

[279] https://www.mass.gov/doc/administrative-bulletin-22-09-101-cmr-31600-rates-for-surgery-and-anesthesia-101-cmr-31700-rates-for-medicine-101-cmr-31800-rates-for-radiology-cpthcpcs-2022-coding-updates-effective-january-1-2022-0/download.

[280] MaineCare Benefits Manual, Ch. I – Section 4: Telehealth Services at https://www.maine.gov/sos/cec/rules/10/ch101.htm.

[281] https://www.cchpca.org/2022/10/Fall2022_ExecutiveSummary8.pdf.

State	Telehealth Coding
Massachusetts and Colorado	Both states direct providers to utilize POS 02 when the member is receiving services via telehealth in a place that is not their home, as well as several other modifiers such as FQ, FR, 93, and 95 which can be added to claims in addition to POS 2 and 10. In Massachusetts, instructions to providers explain when these can vary by claim or service type: • FQ indicates a counseling and therapy service was furnished using audio-only communication technology. • FR indicates the supervising practitioner was present through two-way, audio/video communication technology. • 93 indicates a synchronous counseling and therapy telemedicine service was rendered via telephone or other real-time interactive audio-only telecommunications system. • 95 indicates a synchronous telemedicine service was rendered via a real-time interactive audio and video telecommunications system. • GQ indicates a service was delivered via asynchronous telehealth.[282,283]
Indiana	Indiana adopted a standard approach using standard procedure codes accompanied by modifiers. When the services as outlined in policy are delivered as telehealth, POS code 02 or 10 is required on the claim. Additionally, modifier 95 for telehealth (or modifier 93 as audio-only, if indicated as allowable) must be included on the claim, unless the service is delivered through an HCBS or Money Follows the Person (MFP) program.[284]

4. **Recognize that some services and service components could be delivered in-person, and others via telehealth, and that coding data may not be enough to evaluate services.** Lack of information could drive restrictions on service delivery and states may want to think about ways to package services and establish billing policies that recognize multiple places of service or service delivery methods for each component. States can also add a qualitative analysis component to the quantitative analysis for a more complete picture of the results and drivers of quality or utilization of services delivered through telehealth. Many states have conducted comprehensive, mixed-methods evaluations of telehealth within or including their Medicaid programs so they can understand more about the quality and clinical effectiveness or outcomes of services delivered via telehealth beyond what is currently captured in claims and encounters. For instance, multiple states have leveraged their Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to understand beneficiaries' experience of care with telehealth in Medicaid. Examples of states that have considered additional qualitative data to gain a more complete view of services delivered via telehealth are included in Table 26.

Table 26 – State Best Practices for Telehealth Qualitative Data Considerations

State	Telehealth Qualitative Data Considerations
Colorado	Colorado's evaluation involved engagement with interested parties inclusive of both direct provider discussions and a survey sent to members of the state's "Virtual Member Network." The survey was sent to over 1,000 beneficiaries and had a 26 percent response rate. It included questions on beneficiary telehealth use before and after the COVID-19 PHE, the types of services for which telehealth was utilized, challenges faced in accessing telehealth, and how beneficiaries would rate their experience. [285]
Maine	Maine added a telehealth section to its CAHPS survey.[286]

[282] https://www.mass.gov/doc/all-provider-bulletin-374-access-to-health-services-through-telehealth-options/download. .
[283] https://hcpf.colorado.gov/provider-telemedicine.
[284] https://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Telehealth_Services_Codes.pdf.
[285] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Telemedicine%20Evaluation%20March%208%2C%202021.pdf.
[286] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-telehealth/.

State	Telehealth Qualitative Data Considerations
Arizona	Arizona added supplemental telehealth questions to its CAHPS survey.[287]
North Carolina	North Carolina is stratifying its CAHPS data by beneficiaries utilizing telehealth to compare results to beneficiaries who do not use telehealth.[288]
South Carolina	South Carolina solicited and published telehealth feedback and recommendations from additional interested parties such as their managed care plans and the South Carolina Telehealth Alliance.[289] South Carolina also hired additional staff to improve oversight and monitoring, including differences in service quality between services delivered via telehealth and in-person.[290]
Several states	In a recent national survey, many states indicated they are looking for ways to follow up on concerns about the quality of diagnoses when delivered via telehealth, as well as the impact of telehealth on receipt of other services, most commonly preventive services (such as immunizations and screenings, for children and adults). For example, some states noted concerns that audio-only telehealth may be less effective than in-person visits or audio-visual telehealth and several noted a lack of adequate data to assess the effectiveness of audio-only services. In some cases, lack of data coupled with concerns about audio-only quality have resulted in limitations to coverage or payment of services delivered via this modality, or states are considering such limitations in the future.[291]
Maryland	Maryland and its contractor completed a mixed methods study of multiple payers including Medicaid. It aimed to address research questions across three topics: access to care, utilization, and cost. The study included a literature review, qualitative analyses, and quantitative analysis. The literature review aimed to compile existing evidence on access, utilization, and cost of services delivered via telehealth as compared to services delivered in-person. Qualitative analyses included data collection and analysis from consumer interviews, provider and consumer organization behavioral health care focus groups, and a provider survey. Consumers surveyed were selected to achieve representation across multiple demographics including age, sex, race and ethnicity, region, income, education level, insurance coverage, and language spoken. Provider surveys targeted providers with a valid National Provider Identifier that were involved in primary care or behavioral health care delivery with a practice location in Maryland, on a range of topics including the telehealth modalities they commonly use, the setting in which they practice, and whether they utilize telehealth within a value-based care arrangement. Maryland's study noted limitations in all components of the study. The literature review was limited by the fact that most articles were published prior to the COVID-19 PHE. The qualitative analyses were limited by the intrinsically small numbers in qualitative data collection, as well as that the focus groups were not randomly sampled. The claims data analysis had multiple limitations, including that only evaluation and management (E&M) services could be analyzed, a high volume of "unknown" race/ethnicity fields prevented meaningful stratification, and there was little clarity on potential mis-billing or whether the provider coding process changed over time. The study also noted the need for additional study in a post-pandemic environment.[292]

5. **Prior to analyzing claims and encounters, quality, completeness, and accuracy checks should be a prerequisite to conducting analyses.** Limitations to evaluating services delivered via telehealth have already been identified and include data quality, completeness, accuracy, and the volume of data to analyze. It is also challenging to determine an appropriate look-back time period. Studies aiming to evaluate the delivery of services delivered via telehealth should continue to be thoroughly vetted to ensure a comprehensive

[287] Ibid.
[288] Ibid.
[289] https://www.scdhhs.gov/sites/default/files/FY21-22%20Proviso%20117.119%20%28C%29%20%20Telehealth%20Report%20Test.pdf.
[290] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-telehealth/.
[291] Ibid.
[292] https://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/hit_norc_technical_rpt.pdf.

methodology that accounts for these and other challenges. Quality checks that are being applied as part of the Transformed Medicaid Statistical Information System (T-MSIS) are included in CMS Guidance: Overview of Data Quality Top Priority Items.[293]

6. **Set a timeline and interval for evaluation and measurement and consider formalizing this in a measurement and monitoring plan.** States may want to look at baseline measurements and establish an initial period with consideration of claims lag, seasonal trends for certain services, annual year to year changes, or other periods of study longer term.
7. **Refine and update the data collection, analysis methods, and evaluation approach** to ensure that it is inclusive of current practices and helpful in ascertaining results. Evaluation approaches need to be refined over time.

The federal U.S. Government Accountability Office (GAO) also performed a study on Medicaid services delivered via telehealth before and during the COVID-19 PHE to understand the extent to which selected states allowed services to be delivered via telehealth, how many beneficiaries were using telehealth to access services, what types of services were accessed, and state operational and oversight experiences, among other aspects studied.[294] Similar to state evaluations, the GAO noted limitations in its study. In particular, it described limitations with T-MSIS Analytic Files data, including a lack of reported race/ethnicity information and indications of underreporting for telehealth service delivery in certain settings. Additionally, one state's T-MSIS Analytic Files data could not fully link services to individual beneficiaries and, as a result, the state's data were excluded from the analysis.

Example Evaluation – The U.S. Government Accountability Office's Analysis on Medicaid Telehealth Use Before and During the COVID-19 PHE

GAO's study included six states based, in part, on variation in geography, Medicaid program size, and percent of the population living in rural areas. They explored four topics: 1) the extent to which Medicaid service delivery via telehealth changed from before to during the COVID-19 PHE; 2) states' experiences using telehealth in Medicaid during the COVID-19 PHE and plans for future use; 3) state and CMS efforts to oversee program integrity risks associated with Medicaid telehealth service delivery; and 4) state and CMS efforts to oversee quality of care provided via telehealth. To conduct its study, the GAO performed a document review, as well as the following analyses:

- Qualitative analyses: The qualitative analysis involved interviews with both state and federal Medicaid officials, as well as interested parties, including provider groups, a beneficiary advocacy group, and an organization that endorses quality measures. Interviews with state Medicaid officials were open-ended and addressed all research topics. States were also asked about their telehealth coding and billing.
- Quantitative analyses: The quantitative analyses were performed on Medicaid claims, encounter, and demographic data from T-MSIS Analytic Files. Service data analyses looked at a range of health care services (e.g., physician services, outpatient hospital, clinic services) across both FFS and managed care delivery systems, but excluded inpatient hospital, long-term care facility, pharmacy, and dental services. The GAO also analyzed procedure codes, modifiers, and POS codes to categorize all services as being delivered via telehealth or in-person. The data analysis explored the number and percentage of services delivered via telehealth, the type of services delivered via telehealth, and the number and percentage of beneficiaries receiving services via telehealth, and stratified these analyses by age, gender, race/ethnicity, and rural/urban area.

These telehealth data and evaluation best practices, examples, and strategies can help states as they measure service delivery via telehealth in their state Medicaid assessments and evaluations. As states continue to evaluate the impact of telehealth on their Medicaid programs, CMS encourages states to continue working to address the challenges and limitations with telehealth evaluation. For example, CMS encourages states to work with providers to identify claims and encounters delivered via telehealth through consistent and accurate coding. CMS similarly encourages states to continue their efforts to bolster collection of beneficiary race and ethnicity

[293] CMS Guidance: Overview of Data Quality Top Priority Items. https://www.hhs.gov/guidance/document/cms-guidance-overview-data-quality-t-msis-priority-items.
[294] https://www.gao.gov/assets/gao-22-104700.pdf.

data to ensure any health disparities related to telehealth can be identified through evaluation and addressed through subsequent policymaking.

Telehealth and Value-Based Care Models

When incorporating service delivery via telehealth into value-based care as a design component, it is critical that states develop a sound quality measurement strategy that includes a plan to identify telehealth claims and encounters and assess their impact.

Value-based care (VBC) seeks to hold providers accountable for providing high quality care and can also be a part of the solution to reduce health disparities in the healthcare system. VBC ties the aspects of service delivery such as the quality, equity, and cost of care to provider earnings.[295] Under VBC arrangements, providers are rewarded based on quality measures that demonstrate specific evidence of performance.[296] Telehealth may be integrated into VBC as a service delivery option to allow providers to deliver high-quality care, improve outcomes, and reduce costs through increased provider capacity, reduced barriers to beneficiary access, and improved beneficiary experience of care.

Research suggests that VBC models that incorporate service delivery via telehealth may be promising when tied to Alternative Payment Models (APM) with downside financial risk. For example, a study looking at telehealth utilization among Medicare Advantage enrollees during the COVID-19 PHE used contract data to identify the payment arrangements under which providers were paid for patients' care and classified those payment models according to the following taxonomy: fee-for-service; shared savings with upside only financial risk; shared savings with downside financial risk; or capitation. The study classified shared savings with downside financial risk and capitation to represent APMs. Findings showed telehealth utilization was higher during the COVID-19 PHE for patients attributed to APMs than it was for patients attributed to traditional FFS or upside only payment arrangements. This was particularly notable because deferred in-person care at the onset of the COVID-19 PHE created the greatest near-term financial incentive for FFS providers to leverage telehealth to maintain their revenue.[297]

Delivering services via telehealth can be a helpful component of a VBC model's design to support an increase in provider capacity and reduce health care costs, particularly when there are barriers with accessing care in general and with accessing care at an appropriate acuity level. As such, it can reduce costs associated with emergency department utilization, address chronic and complex conditions, and eliminate the need for some transportation.[298]

The National Academy of Medicine "has developed a widely accepted approach that describes high-value health care as: safe, timely, effective, efficient, equitable and patient-centered – STEEP for short."[299] Telehealth can play a significant role in advancing each of these VBC elements. Table 27 below provides information about how service delivery via telehealth can be integrated into VBC design to promote high-value, high-quality care.

Table 27 – Telehealth by VBC Element

VBC Element	Telehealth Integration with VBC
High value	States can reduce the inappropriate use of emergency department services by designing VBCs that provide financial incentives to utilize more appropriate care pathways with some service delivery through telehealth. Recognition of and payment for both direct care provided to beneficiaries and interprofessional consultation can be implemented as part of a VBC payment strategy.[300]

[295] https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed#:~:text=What%20is%20value%2Dbased%20care,equity%2C%20and%20cost%20of%20care.
[296] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.
[297] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2782059.
[298] https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1.
[299] https://www.ama-assn.org/practice-management/payment-delivery-models/what-value-based-care-these-are-key-elements#:~:text=The%20National%20Academy%20of%20Medicine,%2Dcentered%E2%80%94STEEEP%20for%20short.
[300] https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1.

VBC Element	Telehealth Integration with VBC
Safe	Delivering some services via telehealth rather than in person when beneficiaries have a compromised immunity or are medically fragile can reduce infection risk. Assessments and case management can be conducted virtually from a beneficiary's home, or in combination with intermittent in-person visits.[301]
Timely	Remote consultation can be particularly important when time is of the essence and an expert in a particular discipline is needed. For instance, emergency departments, critical care units, and labor and delivery room settings can benefit from real-time interprofessional consultation from other offsite experts.[302]
Effective	Synchronous or asynchronous telehealth visits and remote patient monitoring can reduce barriers to care by providing additional avenues for more providers to reach more patients. Shifting some care to delivery via telehealth could also allow providers to target in-office visits to people with more complex needs.[303] Remote patient monitoring solutions are emerging to often include wearable devices and patient-entered data. These data provide multiple inputs that can then be subject to the additional data analytics and predictive modeling. Medicaid covered services, including person-centered case management and care coordination may also be delivered via telehealth and incorporated into VBC models.[304]
Equitable	Implementation of service delivery via telehealth can improve some disparities caused by geographic distances and expand the reach of general and specialty care into communities that otherwise would not have access to care. Expanding access through service delivery via telehealth relies on adequate broadband connectivity and beneficiary access to the appropriate technology.[305] Without awareness and a plan to mitigate the technological, experiential, and educational barriers associated with age, race, location, language, and income, telehealth could have the unintended consequence of reinforcing existing inequities in healthcare access in the most underserved communities.[306] While services delivered via telehealth using the two-way, real-time audio-video modality have some advantages over services delivered via the audio-only modality, only those beneficiaries with sufficient access to telehealth technology, internet bandwidth and connectivity, and digital literacy will be able to experience those visits. However, audio-only visits can still provide crucial health care access for many beneficiaries whose alternative might be no care at all.[307] Developing a digital community vulnerability index could be a useful tool to identify barriers where telehealth may not currently be a viable or effective tool in reducing disparities and inequities due to technology, connectivity, and digital literacy barriers.[308] VBC payment models can be leveraged to eliminate some of those barriers. For instance, capitated payments for telehealth could be risk adjusted on such an index to incentivize programs to focus on patients at highest risk of experiencing those barriers.[309]

[301] Ibid.
[302] Harvey JB, Yeager BE, Cramer C, Wheeler D, McSwain SD. The impact of telemedicine on pediatric critical care triage. Pediatr Crit Care Med. 2017;18(11):e555–e560 accessed via https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1.
[303] https://www.healthaffairs.org/content/forefront/seizing-moment-telehealth-policy-and-equity.
[304] https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1.
[305] Ibid.
[306] https://www.healthaffairs.org/content/forefront/seizing-moment-telehealth-policy-and-equity.
[307] Ibid.
[308] Ibid.
[309] Ibid.

VBC Element	Telehealth Integration with VBC
Patient Centered or Person-Centered	According to multiple surveys, patients report high levels of satisfaction with telehealth visits. When patients prefer to receive some care delivered via telehealth, that can help reduce barriers associated with receiving in-person care. Patient portal activity can improve person centeredness and reduce burdens on practices by giving patients the ability to perform online self-service activities such as scheduling appointments, requesting medication refills, viewing test results, and sending providers secure asynchronous messages. Service delivery through telehealth can also provide flexibility for low-acuity care and chronic disease management which do not necessitate in-person interaction with providers.[310] For patients with medical complexity, especially those who require the assistance of technology at home, providers can coordinate with other in-person staff, such as home health aides, to incorporate physical assessments and certain diagnostic services in the home environment. Service delivery via telehealth can include multiple providers, and multiple interdisciplinary participants can synchronously collaborate with individuals and families to develop care plans based on shared decision-making. These types of telehealth activities can incentivize and increase access to pediatric care and transition to adult care.[311] States should consider how to leverage such models for adult beneficiaries as well.

These examples can be integrated into care delivery and should be incorporated into evaluation of telehealth and a sound quality measurement strategy for VBC that includes a plan to identify which telehealth-associated services, providers, and beneficiaries are experiencing positive and negative impacts.

Example VBC Models – Maternal Opioid Misuse and Integrated Care for Kids

Preliminary research on Medicaid VBC, such as the Center for Medicare & Medicaid Innovation's (CMMI) Maternal Opioid Misuse (MOM) and Integrated Care for Kids (InCK) models, suggests telehealth can play a constructive role in VBC to enhance value and reduce health care disparities.[312,313] The MOM model aims to improve health outcomes and the experience of care for mothers and their infants through the integration of maternity care with behavioral health and OUD treatment, and support with access barriers such as transportation, childcare, and stigma related to OUD. The InCK model focuses on early intervention for at-risk children by enhancing care coordination and case management among community partners (e.g., schools, foster care) to enable the provision of care within home and community-based settings and to reduce emergency department utilization. Notice of Funding Opportunities for both the MOM and InCK models included telehealth as a potential strategy to enhance provider capacity and support model aims, and the MOM model explicitly listed telehealth infrastructure development as a potential use for model implementation funds. However, the onset of the COVID-19 PHE immediately amplified the role of telehealth within both models, and the initial assessment of both models suggests telehealth has been successful in advancing model aims. For example, future model evaluations

Promising Preliminary Results from the MOM and InCK Models

Medicaid providers in West Virginia's MOM model reported that no-show rates among patients dropped from 50 percent to between 20 and 30 percent following the transition to virtual care at the onset of the COVID-19 PHE. The state attributed the change to telehealth's ability to reduce common access barriers, such as lack of transportation or reliable childcare.

For the InCK model, using telehealth in New York and other states helped to somewhat mitigate insufficient access to children's behavioral health providers for model participants.

Although these results are from the respective models' pre-implementation evaluations that analyzed a time period primarily within the COVID-19 PHE, the findings suggest telehealth can be successful in meeting model aims, such as reduced access barriers and enhanced provider capacity.

[310] Ibid.
[311] https://publications.aap.org/pediatrics/article/149/3/e2021056035/184902/Telehealth-Opportunities-to-Improve-Access-Quality?searchresult=1.
[312] https://innovation.cms.gov/data-and-reports/2022/mom-preimp-report.
[313] https://innovation.cms.gov/data-and-reports/2022/inck-model-pre-imp-first-eval-rpt.

should shed light on telehealth's impact on beneficiary health outcomes and experience of care and offer insight on the potential value of both including telehealth within Medicaid VBC model design and making funding available to enhance telehealth infrastructure.[314,315,316,317]

CMS encourages states to consider telehealth in VBC model design and to develop a plan to evaluate its effect on model results and outcomes. It is critical that the important work of assessing and evaluating the impact of telehealth continues. As telehealth service delivery continues to become more commonplace, this work will provide necessary evidence to policymakers to ensure that Medicaid programs develop and implement policies and VBC models that have a positive impact on health care cost, quality, and outcomes, as well as beneficiary equity, access, and experience of care.

Strategies for Communicating Telehealth Information to Providers and Beneficiaries

When making changes to telehealth policies, processes, or procedures, states rely on communication, training, and feedback as useful elements for successful implementation. Each of these elements creates the potential for dialogue among the state, providers, managed care plans, and beneficiaries, and provides an opportunity for closing information gaps to ensure interested parties are aware of state Medicaid and/or CHIP requirements. These elements also allow managed care plans, providers, and beneficiaries to have input on policy and program improvements on an ongoing basis, including prior to any formal changes made by the state, and ensure these interested parties understand how service delivery via telehealth is available under individual state Medicaid and CHIP programs.

When states proactively communicate with interested parties regarding the development of, or revision to, telehealth service delivery and payment requirements, it can help support:

- awareness of the telehealth changes or updates;
- managed care plan and provider education on operational and billing requirements;
- buy-in from providers who are willing to adopt new methods of delivering care but who may also need assistance using telehealth technologies; and
- a call to action when there are gaps that telehealth may help fill.

This subsection describes strategies and best practices for states to communicate information to providers regarding requirements related to services delivered using telehealth, as well as communication strategies and highlights for beneficiaries regarding the availability of services delivered via telehealth.

Conveying Information to Providers about Telehealth

Providers have shared feedback with CMS and states about their experience with new or changing requirements for delivering services via telehealth. Most notably, providers have expressed that they have found it easier to search for and comprehend policies about which services may be delivered via telehealth, as well as billing instructions for those services, when the information is organized by clinical area or provider specialty. Additionally, these communications are useful when they include information on:

- the specific services that providers can deliver via telehealth (by description and billing code) and requirements related to in-person visits,
- the types of providers (e.g., physicians, nurse practitioners, physician assistants, psychologists) permitted to bill for specific services when delivered via telehealth,
- the rules for billing for services delivered via telehealth (e.g., CPT billing codes, modified codes, and POS codes),
- the modality of telehealth (e.g., audio-video, audio-only, store-and- forward, remote patient monitoring) that is permitted when delivering covered services,

[314] https://www.inckmarks.org/docs/InCKNoticeofFederalOpportunity.pdf.
[315] https://www.highergov.com/document/mom-nofo-final-2019-0206-v3-pdf-281112/.
[316] https://innovation.cms.gov/data-and-reports/2022/mom-preimp-report.
[317] https://innovation.cms.gov/data-and-reports/2022/inck-model-pre-imp-first-eval-rpt.

- any originating or distant site limitations (e.g., the patient's/beneficiary's home) that may apply, or
- any geographic limitations (e.g., urban or rural health professional shortage area) that may apply.

States have taken various approaches on organizing, tailoring, and making needed telehealth resources accessible and comprehensible to Medicaid providers, and many have taken unique approaches to developing resources that extend beyond traditional written guidance materials. Examples from various states are included in Table 28 below.

Table 28 – State Best Practices for Telehealth Resources for Providers

State	Telehealth Resources for Providers
Arizona	Arizona maintains a Telehealth Advisory Committee website, which includes recommended best practice telehealth guidelines for different specialties (e.g., neurology) and provider types (e.g., nurses).[318]
California and Wisconsin	Both states' telehealth websites include general telehealth information and guidance such as telehealth FAQs, relevant portions of the provider handbook, information on required patient consent, and phone numbers and/or e-mails for providers to pose questions regarding telehealth policy.[319,320] In addition, California's telehealth website includes a reference sheet for telehealth modifiers organized by delivery system (e.g., managed care, FFS, local education agency, etc.). Wisconsin's telehealth website is a resource to locate and navigate the state's permanent telehealth policies.
Tennessee	Tennessee utilizes various strategies to promote member education about the availability of telehealth to deliver services, including newsletters, social media, text messages, outbound calls, on-hold messages, and mail. Additionally, Tennessee's MCOs identify members who have gaps in care that could be addressed through telehealth and send these members customized and targeted messages about the importance of obtaining the appropriate services. These messages highlight the convenience and privacy of services delivered via telehealth.[321]
Maryland	Maryland developed a Telehealth Virtual Resource Center for providers that offers telehealth trainings and resources in a number of modalities and on a variety of topics.[322] These resources include a telehealth readiness assessment tool and a telehealth technology vendor portfolio that allows practices to filter over 70 vendors by desired technology features (e.g., compatibility with medical devices), as well as educational materials for providers to disseminate to consumers, and a range of written informational resources on topics such as technology and cybersecurity, payer policies and liability, and virtual care delivery.[323]
Louisiana	Louisiana includes information about the Medicaid services that can be delivered via telehealth, as well as related telehealth modality and coding requirements, in its provider billing manuals, informational bulletins, and MCO manual.[324]

In addition to maintaining up-to-date and accessible telehealth resources, virtual or in-person provider trainings are a critical component in educating providers on telehealth policies and ensuring the implementation of these policies is successful. Trainings are also an opportunity for providers to ask questions or seek clarification, and they allow providers to share feedback about their experiences with service delivery via telehealth, implementation considerations, or even the training itself. Provider trainings and resources are especially helpful when they are

[318] https://www.azahcccs.gov/AHCCCS/CommitteesAndWorkgroups/telehealthadvisorycommittee.html.
[319] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
[320] https://www.forwardhealth.wi.gov/WIPortal/cms/public/covid19/telehealth-expansion-resources.
[321] https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-telehealth/.
[322] https://mhcc.maryland.gov/mhcc/Pages/hit/hit_telemedicine/hit_telemedicine_virtual_resource.aspx.
[323] Ibid. Marlyand's list of telehealth vendors represent that they are HIPAA-compliant. However, please note OCR does not certify vendors for HIPAA-compliance and CMS does not confirm and does not verify HIPAA-compliance of this list.
[324] https://www.lamedicaid.com/provweb1/Providermanuals/manuals/PS/PS.pdf; https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2019/IB19-11/IB19-11_Revised_5.18.22.pdf; https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-1_revised20220520.pdf; and https://ldh.la.gov/assets/medicaid/MCO_Manual_2022-05-10_published.pdf.

State Best Practice – Colorado's Medicaid Telehealth Website

Since the beginning of the COVID-19 PHE, Colorado has held and posted a series of webinars on both temporary and permanent telehealth policies. The trainings include general information on telehealth and updates on enacted telehealth legislation. The state also offered provider-specific trainings, which included an overview of telehealth, recent legislative changes, training on relevant billing provisions (allowable HCPCS/CPT codes, codes/modifiers required for institutional and professional service claims delivered via telehealth, originating site codes/claims, patient consent), and an overview of telehealth utilization over time by provider type, beneficiary diagnosis/condition, beneficiary age, beneficiary eligibility category, procedure code, and location in the state. The webinar recordings, slide decks, and transcribed provider questions and answers are all posted on Colorado Medicaid's website.

comprehensive and easily accessible, which could include posting recorded webinars on state websites along with other training materials. States can also consider breaking out provider trainings by provider type or by provider experience with telehealth (e.g., trainings targeted to providers who have not been exposed to telehealth alongside trainings targeted to experienced providers who only need to be made aware of policy or payment changes). Colorado, for example, has utilized a number of these training approaches to educate providers on telehealth policies.[325]

Many states, including those noted in Table 29, also partner with other interested parties to offer trainings to providers as new telehealth policies are adopted and/or implemented.

Table 29 – State Best Practices for Leveraging Partnerships for Provider Telehealth Trainings

State	Provider Telehealth Trainings Offered by Partners
North Carolina	North Carolina has a Provider Telehealth Education website that includes links to recorded, on-demand, and upcoming telehealth trainings provided by a range of organizations, such as the North Carolina Area Health Education Centers, the Mid-Atlantic Telehealth Resource Center, and Community Care of North Carolina.[326]
Arizona and California	Arizona's and California's Medicaid websites both include links to provider training opportunities on telehealth being offered through state universities.[327,328,329,330]

In addition to resource websites and trainings, states can consider a variety of telehealth technical support options for providers. Some states provide support directly, while others have relied on contracted vendors to help train providers and troubleshoot billing and technical questions related to delivering services using telehealth. Some states may designate a help desk; others might train or utilize existing provider services staff who support multiple provider service needs. Still others could utilize a dedicated or existing email address for troubleshooting and addressing issues and concerns. Informational materials, such as policy guides, provider handbooks, and billing guides or manuals, websites, informational email blasts, and other resource documents could serve as supports if the documents include links to other helpful resources, including, for example, the HRSA's Office for the Advancement of Telehealth,[331] where FQHCs can access information about grant opportunities and resource centers; state licensing boards that may have additional requirements for specific provider types; or technical help desks for technology vendors whose platforms are being used by providers to deliver services. Whatever the mode of support, it is imperative that the pathway is apparent and known to providers.

Finally, states could consider establishing a coordinated support process and system for providers under both fee-for-service and managed care. For instance, managed care plans and associations (hospital and provider) may incorporate messages into their own newsletters,

[325] https://hcpf.colorado.gov/stakeholder-telemedicine.
[326] https://www.ncdhhs.gov/about/department-initiatives/telehealth/provider-telehealth-education.
[327] https://www.azahcccs.gov/AHCCCS/Initiatives/Telehealth/.
[328] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
[329] https://telemedicine.arizona.edu/.
[330] https://health.ucdavis.edu/cht/.
[331] https://www.hrsa.gov/telehealth.

meetings, e-mail blasts/listservs, etc. These types of organizations will know how best to convey information to their providers and members. Engaging with partners early on not only extends the reach of communication but also garners support from these organizations as all parties work toward a common goal. It also ensures that these organizations are delivering the same clear and consistent messages regarding telehealth use. Additionally, while telehealth use may vary among managed care plans, communications may be linked on the state website or in a resource document to direct providers to the appropriate policy reference material.

Conveying Information to Beneficiaries on Telehealth Availability and Requirements

In order for telehealth to be an effective tool in reducing health disparities and expanding access to services, beneficiaries may need help understanding the telehealth options available to them, and education on ways to access and use the technology required to conduct a telehealth visit. Beneficiaries should also be made aware of their rights as they pertain to service delivery via telehealth. States could consider directly offering educational opportunities to beneficiaries on a regular basis in order to keep beneficiaries apprised of evolving coverage policies. Information could be delivered informally, such as through an update during public meetings (e.g., telephone conference calls or virtual meetings), or more formally through informational videos or resources posted on a website. Examples of state approaches for conveying information about telehealth to beneficiaries are highlighted in Table 30.

In order for telehealth to be an effective tool in reducing health disparities and expanding access to services, beneficiaries may need help understanding the telehealth options available to them, and education on ways to access and use the technology required to conduct a telehealth visit.

Table 30 – State Best Practices for Conveying Information on Telehealth to Beneficiaries

State	Beneficiary Resources
Maine	Maine maintains a telehealth website within the Member Resources section of its Medicaid website that addresses topics that may be of concern to Medicaid beneficiaries. It includes general information on what telehealth is and when and how it can be used, as well as more specific guidance on how beneficiaries can request an appointment for services delivered via telehealth, telehealth options for beneficiaries without smartphone or internet access, strategies for avoiding significant data use, information on accessing an interpreter if needed, and guidance on ensuring services delivered via telehealth are accessed safely. The website also provides several links to both state-developed FAQs and telehealth educational materials developed by third parties.[332]
Massachusetts	Massachusetts developed and distributed a resource to both members and providers about federal programs available to help subsidize both broadband (the Affordable Connectivity Program) and phone service (the Lifeline Program) to help ensure the accessibility of services delivered via telehealth.[333,334,335] The resource includes information on program eligibility requirements and enrollment processes.

States could also rely on established partnerships with managed care plans, providers, or other third parties to engage beneficiaries around telehealth utilization and to disseminate training and education. Trainings and educational resources provide a platform to explain the types of visits or interactions that are covered when accessed via telehealth and could include information on the technologies beneficiaries must possess to participate in a telehealth visit. Similar to resources aimed at providers, beneficiary educational materials could include information about the ongoing resources available to support beneficiaries' use of telehealth, as well as information explaining the process for submitting questions.

[332] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs_doc/Telehealth/Telehealth-Questions-Answers.pdf.
[333] https://www.mass.gov/doc/masshealth-provider-resource-telephone-and-internet-connectivity-for-telehealth/download.
[334] https://www.fcc.gov/acp.
[335] https://www.fcc.gov/general/lifeline-program-low-income-consumers.

Examples of states that have leveraged such partnerships are described in Table 31.

Table 31 – State Best Practices for Leveraging Partnerships to Support Beneficiary Telehealth Use

State	Best Practice for Commutating to Beneficiaries
Arizona	Arizona leverages managed care plans to convey information and educate beneficiaries on telehealth service delivery. Through contractual language, the state Medicaid program mandates that managed care plans develop and implement a strategic plan to engage and educate their membership about telehealth and web-based applications.[336]
Kansas	Kansas adopted the use of telehealth monitoring within its 1915(c) waivers during the COVID-19 PHE, and the state required that the provider and/or the equipment supplier train the beneficiary on how to use designated equipment such as a cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation, web applications, phone apps.[337]

[336] https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Amendment13_UFC-14%20_HC%20&%20UHCCP15_MOL(YH19-0001).pdf.

[337] https://www.medicaid.gov/state-resource-center/downloads/ks-combined-appendix-k-appvl.pdf.

CMS Contact Information

Kirsten Jensen, Director, Division of Benefits and Coverage, Kirsten.Jensen@cms.hhs.gov.

Appendix A: Telehealth Developments in Five States Over Time

As part of CMS's work to examine the rapid telehealth expansion states made in response to the COVID-19 public health emergency (PHE), five states with notable telehealth developments were interviewed during the COVID-19 PHE and again after the COVID-19 PHE. The state-specific tables in this appendix describe telehealth features in Colorado, Idaho, Maine, Massachusetts, and Wisconsin prior to the COVID-19 PHE, during the COVID-19 PHE, and after the COVID-19-PHE.

Table 32 – Colorado's Telehealth Flexibilities Over Time

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Payment Parity	✓	✓	✓
Beneficiary Home Permitted	✓	✓	✓
All Providers Within Scope of License	-	-	-
All Services That Can Be Effectively Delivered	-	✓	✓
FQHC/RHC Encounter Billing Codes	-	✓	✓
Out-of-State Providers Allowed	-	-	✓
Audio-Only Permitted	-	✓	✓
Remote Patient Monitoring	✓	✓	✓
Store and Forward	-	-	-

Table 33 – Idaho's Telehealth Flexibilities Over Time

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Payment Parity	✓	✓	✓
Beneficiary Home Permitted	✓	✓	✓
All Providers Within Scope of License	-	✓	-
All Services That Can Be Effectively Delivered	✓	✓	✓
FQHC/RHC Encounter Billing Codes	✓	✓	✓
Out-of-State Providers Allowed	-	✓	✓
Audio-Only Permitted	-	✓	✓
Remote Patient Monitoring	-	-	-
Store and Forward	-	-	-

Table 34 – Maine's Telehealth Flexibilities Over Time

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Payment Parity	✓	✓	✓
Beneficiary Home Permitted	✓	✓	✓
All Providers Within Scope of License	✓	✓	✓
All Services That Can Be Effectively Delivered	✓	✓	✓
FQHC/RHC Encounter Billing Codes	✓	✓	✓
Out-of-State Providers Allowed	-	✓	✓
Audio-Only Permitted	-	✓	✓
Remote Patient Monitoring	✓	✓	✓

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Store and Forward	-	✓	✓

Table 35 – Massachusetts's Telehealth Flexibilities Over Time

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Payment Parity	✓	✓	✓
Beneficiary Home Permitted	✓	✓	✓
All Providers Within Scope of License	-	✓	✓
All Services That Can Be Effectively Delivered	-	✓	✓
FQHC/RHC Encounter Billing Codes	-	✓	✓
Out-of-State Providers Allowed	-	✓	-
Audio-Only Permitted	-	✓	✓
Remote Patient Monitoring	-	✓	-
Store and Forward	-	-	✓

Table 36 – Wisconsin's Telehealth Flexibilities Over Time

Telehealth Feature	Pre-PHE	PHE	Post-PHE
Payment Parity	✓	✓	✓
Beneficiary Home Permitted	✓	✓	✓
All Providers Within Scope of License	-	✓	✓
All Services That Can Be Effectively Delivered	-	✓	✓
FQHC/RHC Encounter Billing Codes	-	✓	✓
Out-of-State Providers Allowed	✓	✓	✓
Audio-Only Permitted	-	✓	✓
Remote Patient Monitoring	✓	✓	✓
Store and Forward	✓	✓	✓

Appendix B: State Checklist

The following checklist of policy questions is intended to serve as a tool for states to assess telehealth policies in their state. Consideration should be given to populations, services, providers, payment rates, technology, and other areas as noted below.

Category	Questions	State Policy Reference (Statute, Regulation, etc.), if Applicable	Next Step
Populations	Can a new patient-provider relationship be established via telehealth?	Enter state policy references for populations.	Enter next steps for populations.
	Are there limitations on what type of technology can be used to obtain consent?	Enter state policy references for populations.	Enter next steps for populations.
	Are there language or other communication needs unique to different populations?	Enter state policy references for populations.	Enter next steps for populations.
	Are there limitations on the populations who may receive services delivered via telehealth?	Enter state policy references for populations.	Enter next steps for populations.
Services	What specific services are eligible for reimbursement via telehealth? – Are there some CPT codes that cannot be billed for telehealth? – Does ability to bill differ by service provider type, such as behavioral health provider or by telehealth modality?	Enter state policy references for services.	Enter next steps for services.
	Are Medicaid managed care plans obligated to cover the same service/provider/telehealth modality as Medicaid FFS?	Enter state policy references for services.	Enter next steps for services.
	Is it necessary to address the needs of Federally Qualified Health Centers, especially when dealing with Ambulatory Patient Grouper (APG), Diagnosis Related Grouper (DRG), or other bundled codes?	Enter state policy references for services.	Enter next steps for services.
	How are direct support professionals being utilized? Are these practitioners eligible to use telehealth in service delivery?	Enter state policy references for services.	Enter next steps for services.
	Are there any additional documentation requirements associated with delivering services via telehealth? Should there be? Do those additional requirements negatively affect the utilization of telehealth?	Enter state policy references for services.	Enter next steps for services.

Category	Questions	State Policy Reference (Statute, Regulation, etc.), if Applicable	Next Step
Services	How does telehealth service delivery affect Medicaid services addressing Social Determinants of Health?	Enter state policy references for services.	Enter next steps for services.
Providers	Are there any state definitions or restrictions on which specific providers or practitioners are eligible to bill for services when delivered via telehealth? Does this differ by the telehealth modality?	Enter state policy references for providers.	Enter next steps for providers.
	Does the specific scope of practice for any provider or practitioner type preclude delivery of care via telehealth? What could change to facilitate telehealth adoption?	Enter state policy references for providers.	Enter next steps for providers.
	What training is necessary for providers or practitioners to be able to deliver services via telehealth? Does this training vary based on provider or practitioner and/or technology? How often is re-training available and/or required?	Enter state policy references for providers.	Enter next steps for providers.
	Are there any limitations in your state statutes/regulations on what out of state providers or practitioners can do via telehealth in your state?	Enter state policy references for providers.	Enter next steps for providers.
	Are there any limitations in your state statutes/regulations on what providers or practitioners in your state can deliver services via telehealth in other states?	Enter state policy references for providers.	Enter next steps for providers.
Payment Rates	Are there limitations or restrictions on the ability of providers to receive payment for services delivered via telehealth?	Enter state policy references for payment rates.	Enter next steps for payment rates.
	Are rates for telehealth adequate to ensure that additional costs associated with telehealth care are covered?	Enter state policy references for payment rates.	Enter next steps for payment rates.
	Do rates factor in appropriate expenses that may be incurred at the beneficiary's location? For example, medical devices used to measure and transmit automated blood pressure readings.	Enter state policy references for payment rates.	Enter next steps for payment rates.
	Are providers aware that they may be paid for services delivered via telehealth?	Enter state policy references for payment rates.	Enter next steps for payment rates.
Technology	Are there any state-based privacy laws that have additional requirements related to the HIPAA Rules standards?	Enter state policy references for technology.	Enter next steps for technology.

Category	Questions	State Policy Reference (Statute, Regulation, etc.), if Applicable	Next Step
Technology (Continued)	Are there state laws that may impact telehealth such as a functional limitation on a specific distant/originating site, or additional state privacy laws?	Enter state policy references for technology.	Enter next steps for technology.
	Does the state permit school-based health centers to be originating sites for telehealth visits?	Enter state policy references for technology.	Enter next steps for technology.
	Which providers or practitioners can provide care, including therapy via telehealth?	Enter state policy references for technology.	Enter next steps for technology.
Managed Care	Are managed care plans required to cover all services delivered via telehealth that are available in fee-for-service Medicaid?	Enter state policy references for managed care.	Enter next steps for managed care.
	Are there any cost sharing requirements in Medicaid? Are they the same/different in Medicaid Managed Care? Do they apply to telehealth visits, too?	Enter state policy references for managed care.	Enter next steps for managed care.
	Do managed care rates and contracts need to be amended to reflect utilization of telehealth?	Enter state policy references for managed care.	Enter next steps for managed care.
Additional Telehealth Considerations	Are there any limitations on the use of telehealth by geographic location and/or proximity to provider locations? This could include references to metropolitan statistical areas, Health Provider Shortage Areas, or other geographic limitations on the use of telehealth.	Enter state policy references for additional considerations.	Enter next steps for additional considerations.
	Do originating sites include a patient's home?	Enter state policy references for additional considerations.	Enter next steps for additional considerations.
	Do originating sites—especially a licensed facility—require a tele-presenter? If so, how is the service billed and by whom?	Enter state policy references for additional considerations.	Enter next steps for additional considerations.
	Do distant sites include physician's home or other non-licensed facilities?	Enter state policy references for additional considerations.	Enter next steps for additional considerations.
	Do eligible distant sites differ by provider type (e.g., primary care provider vs. psychiatrist)?	Enter state policy references for additional considerations.	Enter next steps for additional considerations.
	Can either an originating or a distant site bill a facility fee? Under what circumstances?	Enter state policy references for additional considerations.	Enter next steps for additional considerations.

Category	Questions	State Policy Reference (Statute, Regulation, etc.), if Applicable	Next Step
Additional Telehealth Considerations (Continued)	What accessibility requirements exist for delivering care via telehealth, particularly with regard to language or disability? Are these requirements incumbent on all providers or are there differences based on provider type, licensure, or location?	Enter state policy references for additional considerations.	Enter next steps for additional considerations.

Appendix C: Comparison Tool – Fee-for-Service/Managed Care Telehealth Policies

States that use Medicaid managed care plans (MCP)[338] to deliver services may encourage MCPs to explore options for delivery of services via telehealth during the contracting process and to make use of the flexibilities that states already have. By formalizing telehealth delivery methods within their managed care contracts, states can ensure MCPs participate in telehealth policy expansions.

When using a managed care delivery system, MCPs are not limited by the payment arrangements outlined in the state plan and could pay alternate fees for additional provider types or for services delivered through other telehealth modalities in order to improve access and increase provider capacity. In addition, states may implement delivery system and provider payment initiatives under Medicaid managed care contracts, including for providers furnishing services through telehealth delivery methods, consistent with 42 C.F.R. Section 438.6(c).

Ref #	Potential State Coverage Policies	FFS: Policy (Yes/No)	FFS: Detail	MCP 1: Policy (Yes/No)	MCP 1: Detail	MCP 2: Policy (Yes/No)	MCP 2: Detail	MCP 3: Policy (Yes/No)	MCP 3: Detail	MCP 4: Policy (Yes/No)	MCP 4: Detail
1.0	**General Policies**	**---**	---	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	---	---	---	---	---	---	---	---	---	---
1.2	Established patient provider relationship required prior to telehealth	---	---	---	---	---	---	---	---	---	---
1.3	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---
2.0	**Originating/Distance Site Policies**[339]	---	---	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	---	---	---	---	---	---	---	---	---	---
2.2	Originating site permitted to be in an urban area	---	---	---	---	---	---	---	---	---	---
2.3	Originating site: any limitations	---	---	---	---	---	---	---	---	---	---
2.4	Distant site: Clinicians permitted to provide care via telehealth while outside of the clinical setting	---	---	---	---	---	---	---	---	---	---

[338] The term "managed care plan" refers to Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), and Primary Care Case Management (PCCM) entities when utilized in this document.

[339] State-level policies will be listed here because originating and distant sites are not defied by federal policy or regulations.

Ref #	Potential State Coverage Policies	FFS: Policy (Yes/No)	FFS: Detail	MCP 1: Policy (Yes/No)	MCP 1: Detail	MCP 2: Policy (Yes/No)	MCP 2: Detail	MCP 3: Policy (Yes/No)	MCP 3: Detail	MCP 4: Policy (Yes/No)	MCP 4: Detail
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	---	---	---	---	---	---	---	---	---	---
2.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---
3.0	**Payment, Cost Sharing and Billing**	---	---	---	---	---	---	---	---	---	---
3.1	Payment parity for services delivered via telehealth	---	---	---	---	---	---	---	---	---	---
3.2	Originating site payments made to providers waived	---	---	---	---	---	---	---	---	---	---
3.3	Beneficiary cost-sharing suspended for all services delivered via telehealth	---	---	---	---	---	---	---	---	---	---
3.4	Providers required to use a telehealth-specific 'place of service' code on all telehealth claims	---	---	---	---	---	---	---	---	---	---
3.5	Providers billing for services delivered via telehealth must use a telehealth-specific 'modifier' code on all telehealth claims	---	---	---	---	---	---	---	---	---	---
3.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---	---	---
4.1	Coverage parity for services delivered via telehealth relative to in-person services	---	---	---	---	---	---	---	---	---	---
4.2	Telehealth for Evaluation & Management services (standard office visits)	---	---	---	---	---	---	---	---	---	---
4.3	Emergency medical services	---	---	---	---	---	---	---	---	---	---
4.4	Telehealth for Gynecological Services	---	---	---	---	---	---	---	---	---	---
4.5	Telehealth for Pediatric services	---	---	---	---	---	---	---	---	---	---

Ref #	Potential State Coverage Policies	FFS: Policy (Yes/No)	FFS: Detail	MCP 1: Policy (Yes/No)	MCP 1: Detail	MCP 2: Policy (Yes/No)	MCP 2: Detail	MCP 3: Policy (Yes/No)	MCP 3: Detail	MCP 4: Policy (Yes/No)	MCP 4: Detail
4.6	Telehealth for Behavioral Health Services	---	---	---	---	---	---	---	---	---	---
4.7	Telehealth for Physical Therapy	---	---	---	---	---	---	---	---	---	---
4.8	Telehealth for Occupational Therapy	---	---	---	---	---	---	---	---	---	---
4.9	Telehealth for Speech Pathology	---	---	---	---	---	---	---	---	---	---
4.10	Telehealth for Home Health services	---	---	---	---	---	---	---	---	---	---
4.11	Telehealth for Hospice services	---	---	---	---	---	---	---	---	---	---
4.12	Telehealth for Personal Care and Home and Community-based Services[340]	---	---	---	---	---	---	---	---	---	---
4.13	Telehealth Visits for Medication Assisted Treatment (MAT)	---	---	---	---	---	---	---	---	---	---
4.14	Telehealth Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	---	---	---	---	---	---	---	---	---	---
4.15	*Add additional services to be evaluated*	---	---	---	---	---	---	---	---	---	---
5.0	**Eligible Providers**	---	---	---	---	---	---	---	---	---	---
5.1	Primary care physicians	---	---	---	---	---	---	---	---	---	---
5.2	Behavioral Health service providers	---	---	---	---	---	---	---	---	---	---
5.3	Occupational therapists	---	---	---	---	---	---	---	---	---	---
5.4	Physical therapists	---	---	---	---	---	---	---	---	---	---
5.5	OBGYN	---	---	---	---	---	---	---	---	---	---
5.6	*Add additional providers to be evaluated*	---	---	---	---	---	---	---	---	---	---

[340] States may add lines to this section if they wish to delineate specific home and community-based services in addition to personal care.

Ref #	Potential State Coverage Policies	FFS: Policy (Yes/No)	FFS: Detail	MCP 1: Policy (Yes/No)	MCP 1: Detail	MCP 2: Policy (Yes/No)	MCP 2: Detail	MCP 3: Policy (Yes/No)	MCP 3: Detail	MCP 4: Policy (Yes/No)	MCP 4: Detail
6.0	**Modality of telehealth**	---	---	---	---	---	---	---	---	---	---
6.1	Audio-only visits	---	---	---	---	---	---	---	---	---	---
6.2	Audio-video visits	---	---	---	---	---	---	---	---	---	---
6.3	Virtual Check-ins (brief patient-provider two-way audio-video correspondence)	---	---	---	---	---	---	---	---	---	---
6.4	E-visits (online portal)	---	---	---	---	---	---	---	---	---	---
6.5	Store and Forward (emails of text)	---	---	---	---	---	---	---	---	---	---
6.6	Inter-professional consultations	---	---	---	---	---	---	---	---	---	---
6.7	Remote Patient Monitoring	---	---	---	---	---	---	---	---	---	---
6.8	Direct-to-consumer telehealth provider contracted	---	---	---	---	---	---	---	---	---	---
6.9	*Add additional modalities to be evaluated*	---	---	---	---	---	---	---	---	---	---
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---	---	---
7.1	Licensure of clinicians: Permits out-of-state clinicians to practice in-state (physicians, nurses, social workers) via telehealth	---	---	---	---	---	---	---	---	---	---
7.2	Licensed professionals permitted to bill for telehealth visits	---	---	---	---	---	---	---	---	---	---
7.3	Managed care plans must incorporate all Medicaid FFS telehealth requirements	---	---	---	---	---	---	---	---	---	---
7.4	State Medicaid Telehealth Provider Training Provided	---	---	---	---	---	---	---	---	---	---
7.5	Telehealth Specific Fraud and Abuse Policies	---	---	---	---	---	---	---	---	---	---
7.6	*Add additional policies to be evaluated*	---	---	---	---	---	---	---	---	---	---

Sample: Cells within the matrix marked with a dash (-) indicate there is no applicable telehealth policy in place, while cells marked with an asterisk (*) indicate the applicable telehealth policy associated with the MCP is consistent with FFS.

Ref #	Potential State Coverage Policies	FFS: Policy (Yes/No)	FFS: Detail	MCP 1: Policy (Yes/No)	MCP 1: Detail	MCP 2: Policy (Yes/No)	MCP 2: Detail	MCP 3: Policy (Yes/No)	MCP 3: Detail	MCP 4: Policy (Yes/No)	MCP 4: Detail
1.0	**General Policies**	---	---	---	---	---	---	---	---	---	---
1.2	Established patient-provider relationship required prior to telehealth	---	Only behavioral health services	---	Applies to all types covered services	---	*	---	*	---	*
2.0	**Originating/Distance Site Policies**	---	---	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	---	Any Medicaid covered service	---	*	---	*	---	*	---	*
3.0	**Payment, Cost Sharing and Billing**	---	---	---	---	---	---	---	---	---	---
3.5	Providers billing for services delivered via telehealth must use a telehealth- specific 'modifier' code on all telehealth claims	Yes	Use claim modifier code = '95'	Yes	*	Yes	*	Yes	Use claim modifier code = 'GT'	Yes	Use claim modifier code = 'GT'
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---	---	---
4.7	Telehealth for Physical Therapy	---	---	---	---	---	Any PT service	---	---	---	---
5.0	**Eligible Providers**	---	---	---	---	---	---	---	---	---	---
5.2	Behavioral Health service providers	---	Psychiatrists and psychologists	---	Adds LCSWs	---	*	---	Adds LCSWs, and LCADAC	---	Adds LCSWs, and LCADAC
6.0	**Modality of telehealth**	---	---	---	---	---	---	---	---	---	---
6.1	Audio-only visits	---	Behavioral health services only	---	Permitted for all services	---	Permitted for all services	---	*	---	*
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---	---	---

Appendix D: State Medicaid Telehealth Assessment/Action Plan

As states implement updates to coverage and payment policies for services delivered via telehealth and make decisions on which policies to continue following a PHE or disaster, this Assessment/Action Plan can serve as a tool to aid in decision making.

The following Assessment/Action Plan Template outlines a list of potential policy areas to consider in addressing the appropriate use of telehealth for Medicaid and CHIP populations after a PHE expires. The list can be used to capture policies related to your Medicaid and/or CHIP program that were in place prior to the PHE and the policy changes that will be adopted during the PHE. The Assessment/Action Plan will also help focus and capture discussions of which coverage and payment policies for services delivered via telehealth can/should be continued in your state; which could be modified, better defined, or eliminated; and which should be given further consideration. These decisions will be affected by your experience with telehealth during the PHE and the feedback you have received from interested parties.

There are two versions of the State Medicaid Telehealth Assessment/Action Plan template. (Please note that additional rows can be added to reflect state policies not specifically noted in the prepopulated list; likewise, items on the list can be removed if not considered relevant to state policy considerations):

1. **Blank Version:** The first template is a blank version configured for state policy and operations teams to use in summarizing your current and proposed plans related for service delivery via telehealth. Note that this blank version not only provides space to capture descriptive information (see columns D through F), but also allows for the opportunity to capture specific decision points, dates, and action items (see columns G through I). The Potential State Coverage Policies cited in the template on Column A are not exhaustive and states are encouraged to include any additional, relevant, and state-specific policies they consider to be appropriate to capture in the document or remove any policies that do not apply.
2. **Sample Version:** The second table includes policy-specific samples of how a state might complete each of the fields in the template depending on the telehealth policies in place in your state prior to and during a PHE period, as well as how you plan to cover and pay for services delivered via telehealth in your Medicaid and CHIP programs going forward.

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed[341]	H. Affected Stakeholders[342]	I. Proposed Effective Date of Change
1.0	**General policies**	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	---	---	---	---	---	---	---	---
1.2	Established patient-provider relationship required prior to telehealth	---	---	---	---	---	---	---	---
1.3	Add additional policies to be evaluated	---	---	---	---	---	---	---	---
2.0	**State-level Originating/Distant Site Policies**[343]	---	---	---	---	---	---	---	---
2.1	Originating site permitted to be the patient's residence	---	---	---	---	---	---	---	---
2.2	Originating site permitted to be in an urban area	---	---	---	---	---	---	---	---
2.3	Originating site: any limitations	---	---	---	---	---	---	---	---
2.4	Distant site: Clinicians permitted to provide care via telehealth while outside of the clinical setting	---	---	---	---	---	---	---	---

[341] Such as legislation, regulation, state Medicaid policy change, state plan amendment (SPA), system change, managed care organization (MCO) contract amendment.

[342] Such as providers, beneficiaries, state licensing agencies, MCOs.

[343] State-level policies will be listed here because originating and distant sites are not defined by federal policy or regulations.

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed[344]	H. Affected Stakeholders[345]	I. Proposed Effective Date of Change
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	---	---	---	---	---	---	---	---
2.6	Add additional policies to be evaluated	---	---	---	---	---	---	---	---
3.0	**Payment, cost-sharing, and billing**	---	---	---	---	---	---	---	---
3.1	Payment parity for services delivered via telehealth	---	---	---	---	---	---	---	---
3.2	Originating site payments made to providers suspended	---	---	---	---	---	---	---	---
3.3	Beneficiary cost-sharing suspended for all services delivered via telehealth	---	---	---	---	---	---	---	---
3.4	Providers required to use a telehealth-specific 'place of service' code on all telehealth claims	---	---	---	---	---	---	---	---

[344] Such as legislation, regulation, state Medicaid policy change, state plan amendment (SPA), system change, managed care organization (MCO) contract amendment.

[345] Such as providers, beneficiaries, state licensing agencies, MCOs.

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed[344]	H. Affected Stakeholders[345]	I. Proposed Effective Date of Change
3.5	Providers billing for services delivered via telehealth must use a telehealth-specific 'modifier' code on all telehealth claims	---	---	---	---	---	---	---	---
3.6	Add additional policies to be evaluated	---	---	---	---	---	---	---	---
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---
4.1	Coverage parity for services delivered via telehealth relative to in-person services	---	---	---	---	---	---	---	---
4.2	Telehealth for Evaluation & Management services (standard office visits)	---	---	---	---	---	---	---	---
4.3	Emergency medical services	---	---	---	---	---	---	---	---
4.4	Telehealth for Gynecological Services	---	---	---	---	---	---	---	---
4.5	Telehealth for Pediatric services	---	---	---	---	---	---	---	---
4.6	Telehealth for Behavioral Health Services	---	---	---	---	---	---	---	---
4.7	Telehealth for Physical Therapy	---	---	---	---	---	---	---	---
4.8	Telehealth for Occupational Therapy	---	---	---	---	---	---	---	---

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed[344]	H. Affected Stakeholders[345]	I. Proposed Effective Date of Change
4.9	Telehealth for Speech Pathology	---	---	---	---	---	---	---	---
4.10	Telehealth for Home Health services	---	---	---	---	---	---	---	---
4.11	Telehealth for Hospice services	---	---	---	---	---	---	---	---
4.12	Telehealth for Personal Care and Home and Community- based Services[346]	---	---	---	---	---	---	---	---
4.13	Telehealth Visits for Medication Assisted Treatment (MAT)	---	---	---	---	---	---	---	---
4.14	Telehealth Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	---	---	---	---	---	---	---	---
4.15	Add additional services to be evaluated	---	---	---	---	---	---	---	---
5.0	**Eligible providers**	---	---	---	---	---	---	---	---
5.1	Primary care physicians	---	---	---	---	---	---	---	---
5.2	Behavioral Health service providers	---	---	---	---	---	---	---	---
5.3	Occupational therapists	---	---	---	---	---	---	---	---

[346] States may add lines to this section if they wish to delineate specific home and community-based services in addition to personal care.

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed[344]	H. Affected Stakeholders[345]	I. Proposed Effective Date of Change
5.4	Physical therapists	---	---	---	---	---	---	---	---
5.5	OBGYN	---	---	---	---	---	---	---	---
5.6	Add additional providers to be evaluated	---	---	---	---	---	---	---	---
6.0	**Modalities**	---	---	---	---	---	---	---	---
6.1	Audio-only visits	---	---	---	---	---	---	---	---
6.2	Audio-video visits	---	---	---	---	---	---	---	---
6.3	Virtual Check-ins (brief patient-provider two-way audio-video correspondence)	---	---	---	---	---	---	---	---
6.4	E-visits (online portal)	---	---	---	---	---	---	---	---
6.5	Store and Forward (emails of text)	---	---	---	---	---	---	---	---
6.6	E-consults (inter-professional consultations)	---	---	---	---	---	---	---	---
6.7	Remote Patient Monitoring	---	---	---	---	---	---	---	---
6.8	Direct-to-consumer telehealth provider contracted	---	---	---	---	---	---	---	---
6.9	Add additional modalities to be evaluated	---	---	---	---	---	---	---	---
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed[344]	H. Affected Stakeholders[345]	I. Proposed Effective Date of Change
7.1	Licensure of clinicians: Permits out-of-state clinicians to practice in-state (physicians, nurses, social workers) via telehealth	---	---	---	---	---	---	---	---
7.2	Licensed professionals permitted to bill for telehealth visits	---	---	---	---	---	---	---	---
7.3	Managed care plans must incorporate all Medicaid FFS telehealth requirements	---	---	---	---	---	---	---	---
7.4	State Medicaid Telehealth Provider Training Provided	---	---	---	---	---	---	---	---
7.5	Telehealth Specific Fraud and Abuse Policies	---	---	---	---	---	---	---	---
7.6	Add additional policies to be evaluated	---	---	---	---	---	---	---	---

Sample Version

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed	H. Affected Stakeholders	I. Proposed Effective Date of Change
1.0	**General policies**	---	---	---	---	---	---	---	---
1.1	Patient consent for the service	Yes	Yes	Regardless of category, services that allow for a temporary telehealth option require documented consent from the beneficiary agreeing to this as a service delivery option	10/23/20	Yes	Regulation, policy, SPA, Waiver Amendment, managed care plan agreement, FFS provider agreements	All providers and beneficiaries; managed care plans	Already Implemented
2.0	**State-level Originating/Distant Site Policies**	---	---	---	---	---	---	---	---
2.5	Distant site: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) permitted as distant sites	No	Yes	Allow any site within the US or territories to be a distant site, including FQHCs & provider residences	10/23/20	Yes with modifications: Allow FQHCs & provider residences as distant sites; post-PHE, any distant site must be within the state	Legislation change, regulation, policy, SPA, systems, managed care plan agreement, FFS provider agreements	Providers, beneficiaries, managed care plans, legislature	Upon passage of legislation
3.0	**Payment, cost-sharing, and billing**	---	---	---	---	---	---	---	---
4.0	**Service Coverage Policies**	---	---	---	---	---	---	---	---
4.2	Telehealth for Evaluation & Management services (standard office visits)	No	Yes	Allow telehealth for any clinically appropriate, medically necessary covered service	10/23/20	Yes	Regulation, policy, SPA, systems, managed care plan agreement, FFS provider agreements	Providers, beneficiaries, managed care plans, licensing board/ agency	10/23/20

Ref #	A. Potential State Coverage Policies List to be used as reference in documenting state policies; states' own policies may vary	B. Permanent Policy (Yes/No)	C. Temp Emergency Policy (Yes/No)	D. Description of Temporary Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable	E. Date Temp Policy Expires	F. Continue Temp Policy or Consider Modifying Policy Differentiating between Physical Health, Behavioral Health, and Long-term Services and Supports as applicable (Yes, Yes with modifications - explain, No)	G. Follow-Up Action Needed	H. Affected Stakeholders	I. Proposed Effective Date of Change
5.0	**Eligible providers**	---	---	---	---	---	---	---	---
5.5	OBGYN	No	Yes	OBGYNs may bill for telehealth in place of in-office visits. Specific to state plan physical health services	10/23/20	Yes	Regulation, policy, SPA, systems, managed care plan agreement, FFS provider agreements	Providers, beneficiaries, managed care plans, licensing board/ agency	Already implemented
6.0	**Modalities**	---	---	---	---	---	---	---	---
6.2	Audio-video visits	Yes	Yes	Temporarily allow two-way audio only telehealth visits for all services delivered via telehealth	10/23/20	Yes: After PHE, allow audio-only telehealth for limited services	Regulation, policy, SPA, systems, managed care plan agreement, FFS provider agreements	Providers, beneficiaries, managed care plans, licensing board/ agency	10/23/20
7.0	**Other Related Policies**	---	---	---	---	---	---	---	---

Appendix E: State Medicaid Telehealth Communication Strategies

As states collect the information needed, or already shared with providers, beneficiaries, and other interested parties, it can be helpful to create an inventory to ascertain where there are opportunities for enhancement in both developing and communicating changes. The table below provides a potential template that states may use to collect and record this information. This table is not all-inclusive; rather, it is provided as a reference document. States may adapt this list by adding, changing, or removing items as appropriate for their state-specific implementation and communications plans. Following the blank version of the template table are a few completed illustrative example rows (see sample version) to provide insight into how a state may use this table.

Clinical Service	Description of new rule	Source (regulation or guidance)	Expiration date of policy	Provider Type/Specialty	Billing Codes/Ranges	Geographic Limits	Billing Changes	Other
Evaluation and management services	---	---	---	---	---	---	---	---
Emergency medical services	---	---	---	---	---	---	---	---
Gynecological services	---	---	---	---	---	---	---	---
Pediatric	---	---	---	---	---	---	---	---
Behavioral health	---	---	---	---	---	---	---	---
Physical therapy	---	---	---	---	---	---	---	---
Occupational therapy	---	---	---	---	---	---	---	---
Speech pathology	---	---	---	---	---	---	---	---
Home health	---	---	---	---	---	---	---	---
Hospice services	---	---	---	---	---	---	---	---
Personal Care and Home and Community-based Services	---	---	---	---	---	---	---	---
Medication Assisted Treatment	---	---	---	---	---	---	---	---

Clinical Service	Description of new rule	Source (regulation or guidance)	Expiration date of policy	Provider Type/Specialty	Billing Codes/Ranges	Geographic Limits	Billing Changes	Other
Prescription/Prescribing Authority Limits/Restrictions for Opioids or Other Controlled Substances	---	---	---	---	---	---	---	---
Add additional rows as needed	---	---	---	---	---	---	---	---

Sample Version

Clinical Service	Description of new rule	Source (regulation or guidance)	Expiration date of policy	Provider Type/Specialty	Billing Codes/Ranges	Geographic Limits	Billing Changes	Other
Behavioral health	Licensed Clinical Social Worker (LCSW) added to the list of eligible providers	state website	10/23/2020	Psychiatrics, LCSWs, psychiatrists	List all billing codes	Urban and Rural	Place of service = 02 Modifier = 95	Audio-only and audio-video permitted
Home and Community-based Services	Permits certain aspects of services to be conducted via telehealth	state website	10/23/2020	Any type of home and community based provider	List all billing codes	Urban and Rural	Place of service = 02 Modifier = 95	Audio-video only
Emergency medical services	Nurse practitioners added to the list of eligible providers	state website	10/23/2020	Physicians and nurse practitioners	List all billing codes	Urban and Rural	Place of service = 02 Modifier = 95	Audio-video permitted

Appendix F: Telehealth Resources

Focus Area	Resources
Medicaid	• Medicaid Telehealth Website: https://www.medicaid.gov/medicaid/benefits/telehealth/index.html • CMCS, *CMCS Informational Bulletin, Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth*, (August 18, 2022): https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf • Managed Care Adequacy and Access Toolkit (See page 53): https://www.medicaid.gov/medicaid/downloads/adequacy-and- access-toolkit.pdf • Policy Options for Paying Medicaid Providers: https://www.medicaid.gov/medicaid/benefits/telehealth/reimbursement-for-telehealth-and-provider-and-facility-guidelines/index.html • SUPPORT Act Section 1009 - Services and Treatment for Substance Use Disorders delivered via telehealth (including in School-Based Health Centers): https://www.medicaid.gov/medicaid/benefits/telehealth/support-act-section-1009-services-and-treatment-for-substance-use-disorders-delivered-telehealth-including-school-based-health-centers/index.html • CMCS Informational Bulletin: Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf • Report to Congress: Reducing Barriers to Using Telehealth and Remote Patient Monitoring for Pediatric Populations under Medicaid: www.medicaid.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf
Medicare	• CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule with comment period establishing permanent policy allowing clinical staff of hospital outpatient departments including Critical Access Hospitals to provide certain remote behavioral health services to patients in their homes. https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2 • Telehealth policy changes after the COVID-19 public health emergency: https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency

Focus Area	Resources
Related Federal Regulation and Legislation	• HHS, Health equity in telehealth, (June 3, 2022): https://telehealth.hhs.gov/providers/health-equity-in-telehealth • Consolidated Appropriations Act of 2023 - extending many of the Medicare telehealth flexibilities authorized during the COVID-19 public health emergency through December 31, 2024: https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf
Office for Civil Rights (OCR)	• Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html • Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons: https://www.hhs.gov/civil-rights/for-individuals/disability/guidance-on-nondiscrimination-in-telehealth/index.html • OCR HIPAA Guidance: https://www.medicaid.gov/medicaid/benefits/telehealth/office-of-civil-rights-hipaa-guidance/index.html • Guidance on How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio Only Telehealth: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html
Office of Inspector General (OIG)	• Telehealth landing page: https://oig.hhs.gov/reports-and-publications/featured-topics/telehealth/ • Toolkit: Analyzing Telehealth Claims to Assess Program Integrity Risks: https://oig.hhs.gov/oei/reports/OEI-02-20-00723.pdf
Medicaid and CHIP Payment and Access Commission (MACPAC)	• MACPAC Chapter on Telehealth in Medicaid: https://www.macpac.gov/wp-content/uploads/2018/03/Telehealthin- Medicaid.pdf • Panel Discussion: What States are Learning from Expanded Use of Telehealth: https://www.macpac.gov/publication/panel-discussion-what-states-are-learning-from-expanded-use-of-telehealth/

Focus Area	Resources
Technical Assistance for Providers	• Office of the National Coordinator for Information Technology: https://healthit.gov • HHS, For Providers (Telehealth resources for health care providers, including doctors, practitioners, and hospital staff): https://telehealth.hhs.gov/providers • Coverage to Care (C2C) Telehealth for Providers (provider facing, how to get started, tips for certain populations): https://www.cms.gov/priorities/health-equity/c2c#access-care • National Consortium of Telehealth Resource Centers: https://www.telehealthresourcecenter.org/resources/ • Telehealth Basics: https://telehealthresourcecenter.org/collections/telehealth-basics/
Substance Abuse and Mental Health Services Administration (SAMHSA)	• SAMHSA guidance on telehealth for medication assisted treatment: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication assisted/telemedicine-dea-guidance.pdf
Technical Assistance for Families	• C2C Telehealth for Families (available in eight languages): https://www.cms.gov/priorities/health-equity/c2c#access-care