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IN FOCUS

October 9, 2020

Medicaid Telehealth Policies in Response to COVID-19

Medicaid, authorized in Title XIX of the Social Security Act (SSA), is a federal-state program that jointly finances primary and acute medical services, as well as long-term services and supports (LTSS), to a diverse low-income population. The 50 states, the District of Columbia (DC), and the five U.S. territories (American Samoa, the Commonwealth of Northern Mariana Islands, Guam, Puerto Rico [PR], and the U.S. Virgin Islands [USVI]) must follow broad federal rules to receive federal Medicaid funding, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. In addition, several waiver authorities allow states to operate their Medicaid programs outside of federal program rules. (For information on waivers, see CRS Report R43357, *Medicaid: An Overview*, and CRS Legal Sidebar LSB10430, *Section 1135 Waivers and COVID-19: An Overview*). This flexibility results in variability across state Medicaid programs in factors such as use of telehealth as a service delivery method.

This In Focus provides background on Medicaid telehealth and an overview of telehealth actions in response to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE). It discusses how states leveraged existing flexibilities and PHE-specific federal authorities to increase the number of services, provider types, and other telehealth coverage options under Medicaid.

Medicaid Telehealth Prior to COVID-19

While federal Medicaid statute does not recognize telehealth as a distinct service, the Centers for Medicare & Medicaid Services (CMS) defines Medicaid *telehealth* as "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." CMS provides states with broad flexibility to define which (if any) telehealth services to provide (e.g., primary care, behavioral health, LTSS), allowable modalities (e.g., live video, audio only), where services can be provided, which provider types are authorized to provide the service (subject to federal and state law), and the populations served, among other criteria. States that limit telehealth geographically, or to specific providers, must ensure that enrollees in areas without telehealth coverage have face-to-face provider access. In general, states must reimburse providers for a telehealth service at the same rate as an in-person service, unless they have CMS approval to pay a different rate or with a unique reimbursement methodology. For example, CMS approval is required for payment rates that factor in ancillary costs (e.g., equipment necessary for the delivery of telehealth services, transmission charges) or costs associated with time and resources. Medicaid managed care plans are not limited by the payment arrangements outlined in the Medicaid state plan.

A September 2019 Center for Connected Health Policy's survey of state and DC telehealth laws and Medicaid policies found that, as of April 2019, all 50 states and DC allowed telehealth as a service delivery mechanism but allowable provider types, modalities, and service categories varied by state.

Expanding Telehealth During COVID-19

The COVID-19 pandemic accelerated interest in telehealth as a way to protect health care providers and to maintain or improve patients' access to care and safety. This section identifies the federal authorities states can leverage to enhance Medicaid telehealth coverage during the PHE and provides an overview of the most commonly added services, provider types, modalities, and care delivery sites.

Summary of Certain Emergency-Related Authorities under Medicaid

Disaster Relief State Plan Amendments: Allow states to revise Medicaid eligibility, enrollment, and benefit requirements in their state plan for the duration of a disaster or emergency.

Section 1115 Waivers: Authorize the Secretary of Health and Human Services (HHS) to waive a number of Medicaid requirements to the extent necessary to allow a state to undertake an "experimental, pilot, or demonstration project." In an emergency, these waivers may be approved without regard to normal process-related requirements and do not need to be budget neutral to the federal government.

Section 1915(c) Appendix K Waivers: Appendix K is a stand-alone appendix that states may use during emergency situations to request amendments to existing 1915(c) Home and Community Based waivers.

Section 1135 Waivers: When certain emergency conditions are met, allow the HHS Secretary to temporarily waive Medicaid statutory requirements, such as provider licensure, to ensure sufficient health care items and services are available to meet the needs of enrollees in an emergency area.

CMS Guidance and Federal Authorities

CMS released a series of sub-regulatory guidance (e.g., frequently asked questions, fact sheets, tool kits) to facilitate increased state reliance on telehealth as a Medicaid service delivery tool. These materials identify existing state flexibilities available to augment telehealth and provide guidance intended to help states identify and address state-level barriers to the adoption of new telehealth delivery options. For Medicaid changes requiring CMS approval, CMS provided templates and checklists to expedite state requests for time-limited Medicaid

flexibilities through legal authorities such as Disaster Relief State Plan Amendments (SPAs) and emergency-related Sections 1115, 1915(c) Appendix K, and 1135 waivers (examples of how states used these authorities for telehealth purposes are available in the "State Activity" section). The CMS COVID-19 templates and checklists for the Disaster Relief SPA and waivers identify an effective date retroactive to March 1, 2020 (or as otherwise approved by CMS); the flexibilities generally sunset in conjunction with the end of the President's emergency declaration, but states have the option to end them earlier. After the PHE, states may seek CMS approval to continue any otherwise temporary telehealth policies adopted during the pandemic via new SPAs and Section(s) 1115 or 1915(c) waivers. Since the Section 1135 waiver flexibilities are specific to PHEs, these would not be available to states.

State Activity: Increased Use of Telehealth Service Delivery Options in Response to COVID-19

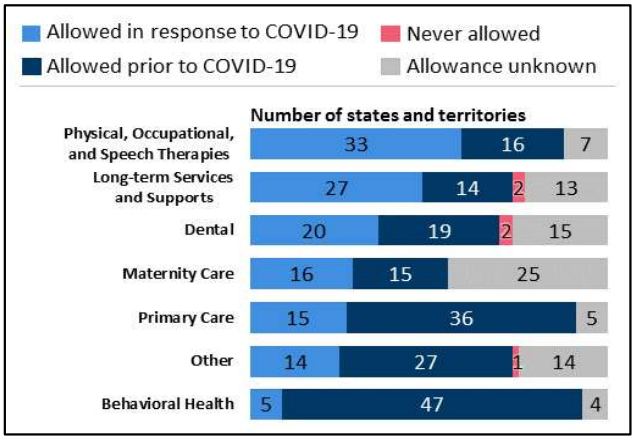
According to a Kaiser Family Foundation tracker of COVID-19-related CMS Medicaid approvals, as of September 28, 2020, CMS approved Disaster Relief SPAs in 15 states and DC to allow telehealth "payment variation" and/or reimbursement for "ancillary telehealth delivery costs." CMS allowed 47 states and DC to use Section 1915(c) Appendix K waivers to expand telehealth LTSS delivery by adding "an electronic method of service delivery to continue services remotely in home." The tracker does not specifically identify telehealth changes in the 7 states with COVID-19 Section 1115 waivers and the 50 states and DC with COVID-19 Section 1135 waivers. However, the flexibilities allowed under these CMS approvals may impact a state's telehealth capacity, since any increase in coverable services and available providers may increase opportunities for care delivery via telehealth. Notably, the COVID-19-related CMS approvals in this tracker may not capture other COVID-19-related policies that states have adopted without CMS sign-off under their existing flexibilities to define Medicaid telehealth, some of which are discussed below.

Services

According to a June 2020 Medicaid and CHIP Payment and Access Commission (MACPAC) report on changes in Medicaid telehealth policies due to COVID-19, most states, DC, and territories expanded the categories of services that are available to be delivered via telehealth. Among its key findings, the report notes that the most commonly added telehealth service categories include physical, occupational, and speech therapies (32 states and USVI), followed by LTSS (26 states and USVI), and dental services (19 states and PR) (see **Figure 1**). The report generally does not distinguish whether a state's policy change was carried out under the state's broad flexibility to define telehealth or under a COVID-19 disaster-related federal authority.

The report notes that the number of discrete services offered within the service categories referenced in **Figure 1** can vary by state. For example, Oklahoma allows telehealth delivery for a specified list of behavioral health services (e.g., psychotherapy, crisis intervention), but Wyoming broadly covers behavioral health services via telehealth. Further, not all telehealth service delivery expansions were in new service categories. Ten states expanded from a discrete list of telehealth-eligible services to broadly cover services via telehealth within existing categories ("Allowed Prior to COVID-19").

Figure 1. Number of States, DC, and Territories Allowing Various Services/Specialties via Telehealth Before and in Response to COVID-19, as of May 2020



Source: Created by CRS based on Figure 1 in MACPAC, *Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings*, June 4, 2020.

Note: Table does not reflect states that broadly expanded telehealth services within a previously allowed service/specialty category or the scope of coverage within a service/specialty category.

Providers

MACPAC also found 32 states expanded the provider types that are permitted to deliver Medicaid services via telehealth in response to COVID-19. While the largest provider type expansion is categorized as "Other" (19 states and USVI), dental providers (18 states) were the next most commonly added provider category, followed by physicians (10 states and USVI), and behavioral health providers (9 states). The type and number of providers within a category vary by state.

Modalities and Sites

Many states also added telehealth coverage for new modalities and service sites. Specifically, 42 states, PR, and USVI added telephones/audio-only to their covered telehealth modalities (previously allowed in 8 states and DC), and 25 states and DC added the use of the home as an allowable patient site (previously allowed in 21 states). The allowable services that can be delivered via an audio-only modality and in the home vary by state.

Expiration Dates

For telehealth policies that do not require CMS approval (e.g., certain service expansions), states have the flexibility to determine the period of time the policy will be in place. According to MACPAC, 12 states and USVI did not specify an end date for their COVID-19 Medicaid telehealth policies, leaving the option to continue the policies beyond the PHE. There is also potential for administrative rulemaking and/or legislative action to further shape these policies. Since the start of the COVID-19 PHE, the 116th Congress has introduced several bills to examine access, increase payment, etc. for Medicaid telehealth services.

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