Medicaid Medical Directors Network:
Perspectives on Telehealth Modernization

March 2021

Overview and Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) are publicly funded assistance programs covering low-income individuals and other vulnerable populations, such as, children and adults with disabilities. Medicaid and CHIP serve as critical safety net programs for some of the most disadvantaged and disparate populations and are jointly funded by Federal and state governments. As a result of the economic impacts of the COVID-19 pandemic, reliance on Medicaid/CHIP has reached historic highs. By June 2020, Medicaid and CHIP enrollments had increased to more than 75.5 million individuals, compared to just fewer than 71 million individuals enrolled at the beginning of the pandemic in March 2020[1]. This increasing enrollment has not yet leveled off as a growing number of individuals face job loss and additional financial hardship[2].

At the outset of the COVID-19 pandemic in March 2020, Medicaid agencies recognized the need to ensure their members would continue to have access to appropriate healthcare services while minimizing their risk of acquiring the virus. As a result, Medicaid agencies changed many regulations and removed limitations in their telehealth policies. The result was an expanded spectrum of services available across numerous provider types; payment parity for in-person, audio-only and audio-visual visits; and a suspension of complex historical limitations related to the location of both the patient and the provider. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), both critical components of the Medicaid provider network, were allowed flexibilities not previously afforded in many states.

Other payers, including Medicare and commercial payers, adopted similar flexibilities for their respective populations, some ahead of state Medicaid programs.

The Centers for Medicare and Medicaid Services (CMS), under the 1135 waiver authority, more than doubled coverage for types of healthcare services delivered via telehealth[3]. The waiver also expanded the types of providers that could offer telehealth to include clinical psychologists, licensed social workers, physical therapists, and speech language pathologists, among others[4].

Accordingly, many states saw skyrocketing utilization of telehealth services. While telehealth has existed in small ways since the 1990s, and telehealth video visits were growing by about 30-50%[5] per year prior to the pandemic, these distanced clinical visits still represent but a fraction of the one billion office visits logged annually in the U.S. This pandemic pushed Medicaid agencies to rapidly expand coverage for telehealth modalities and in many cases utilization increased by thirty times.

Amidst this massive transformation to the healthcare delivery system, Medicaid Medical Directors (MMDs) have played a key role in informing their respective agencies on clinical matters related to telehealth, especially around equity, quality, and payment. MMDs are experienced physicians and clinical leaders, trained in diverse specialties, who advise their individual state agencies on medical care policies with special attention to issues of quality, utilization and access for their Medicaid, CHIP and other specified populations in their states. The Medicaid Medical Directors Network (MMDN) conducted an environmental scan to understand and synthesize the views of participating Medicaid Medical Directors (MMDs). Collectively, the network proposes telehealth policy recommendations as follows. These recommendations represent the findings of the environmental scan, and do not reflect the policy positions of any individual member, AcademyHealth or any supporting organizations.

Policy Recommendations

⚖ Equity

1	Medicaid programs should develop and communicate telehealth policies during the pandemic, and timelines for termination of temporary provisions post-pandemic, so that providers understand the permanency of specific modifications. This will create clarity among providers regarding the need to invest in virtual care over the long-term.
2	Medicaid programs should support continued expansion of telehealth services, creating policies that use the lenses of equitable access, high-quality, clinical appropriateness, and cost/value.
3	Medicaid programs should work to reduce patient and provider barriers to telehealth service usage. Examples of patient barriers include the technology divide, digital literacy, and underlying health disparities. Provider barriers include access to a secure, integrated, and user-friendly telehealth platforms and lack of experience with providing telehealth services.

✦ Quality

4	Medicaid programs should hold teleservices to the same standards of care as traditional (in-person) healthcare services, including comprehensive documentation. Quality should be measured through process and outcome-based metrics. While payers may develop metrics unique to remote delivery, standardized, readily available process-based metrics (e.g., HEDIS) should be applied until outcome-based metrics are developed and validated.
5	Medicaid programs should promote robust telehealth evaluation through ongoing monitoring of utilization, fiscal impact, and outcomes. Those evaluation activities should trigger revisions to existing telehealth policies and the eventual development of telehealth best practices (including technical, policy, and clinical best practices). To the extent possible, Medicaid programs should partner with other state agencies and the academic community to conduct relevant research and disseminate results for feedback and validation.

💲 Payment

6	Medicaid programs should work with Medicaid MCOs, Medicare, and commercial payers, as well as other state Medicaid programs to simplify and standardize telehealth policies, including payment policies, across payers.
7	Medicaid rates need to be adequate to facilitate care delivered through telehealth. Payment rates should consider additional costs not associated with traditional in-person services. Alternative payment models should support telehealth services by providing sufficient flexibility.
8	When considering and implementing telehealth policies, Medicaid programs should support the continuity of care, including a requirement that telehealth providers outside of a patient's medical home foster communication with that medical home. Policies should also require a contingency plan to enable the timely transition from telehealth to an in-person visit service when indicated.

Definition of telehealth and telemedicine

There are many definitions of telehealth and telemedicine, and they are used variably between different states' regulations and laws. Federal agencies also have their own definitions.

The Health Resources Services Administration (HRSA) describes telehealth as "the use of electronic information and telecommunication technologies to support long-distance clinical healthcare, patient and professional health-related education, public health, and health administration[6]." It is intended to provide a broader scope of remote healthcare, related to clinical and non-clinical services.

Telehealth is defined by the Department of Health and Human Services (HHS) slightly differently: "Telehealth — sometimes called telemedicine — is the use of electronic information and telecommunication technologies to provide care when you (patient) and the doctor aren't in the same place at the same time[7]."

For the purposes of this paper, telehealth and telemedicine are considered interchangeable terms, and to avoid confusion, these modalities will be referenced as specifically as possible.

Synchronous: These visits can take many forms. The two primary modalities of synchronous telehealth visits are audio/visual and audio only. Additionally, visits may occur between different participants, including: one patient and one provider, clinic-to-clinic with a patient in one office being seen by a physician in another location, between a primary care physician (PCP) and a specialist, or group visits connecting several patients in one or several locations connected to a provider. Hybrid home-telehealth visits involve a home health provider or staff member for the home component, linked to a simultaneous audio-visual visit with the billing provider. The home health provider might deliver services such as a lab draw and immunizations or conduct a targeted physical exam such as fundal height during pregnancy, diabetic foot exam, or vital signs.

Asynchronous: Asynchronous or store-and-forward visits allow for electronic transmission of images, documents, and video through secure e-mail transmission. The only requirements for most visits are broadband internet access and a camera. Review of the data can occur when convenient. Store-and-forward visits are most common for radiology, pathology, dermatology, and ophthalmology. Store-and-forward is also used for electronic consultations (e-consults), which most commonly occur between a PCP and a specialist. Both providers have access to patient's medical records allowing review by the specialist, who then provides advice directly to the PCP.

⚖️ EQUITY

Policy Recommendations

Medicaid programs should develop and communicate telehealth policies during the pandemic and timelines for termination of temporary provisions post-pandemic so that providers understand what modifications will be made permanent. Doing so will create clarity among providers regarding the need to invest in virtual care over the long-term.

Medicaid programs should support continued expansion of telehealth services, crafting policies using the lenses of equitable access, high-quality, clinical appropriateness, and cost/value.

Medicaid programs should work to reduce patient and provider barriers to the use of telehealth services. Examples of patient barriers include the technology divide, digital literacy, and underlying health disparities. Provider barriers include access to a secure, integrated, and user-friendly telehealth platform and lack of experience with providing telehealth services.

Individuals covered by Medicaid include populations most affected by the COVID-19 pandemic, including racial and ethnic minorities, those in rural areas, and frail individuals living in long-term care facilities. Like all innovations in our structurally complex healthcare system, telehealth has the potential to either improve or potentially worsen pre-existing health inequities.

Racial and ethnic minorities are among the populations at higher risk of living in poverty, having lower health literacy, needing language services, experiencing barriers in access to routine care, and experiencing more chronic medical issues. Other groups who qualify for Medicaid assistance, and whose health disparities are well-documented, include foster children, those with serious mental illness or substance use disorders, and individuals with intellectual and developmental disabilities. Medicaid agencies also fund almost half of the births in the U.S., and infant and maternal mortality more adversely affect racial and ethnic minorities who are disproportionately represented among Medicaid enrollees. The role of telehealth in improving birth outcomes and decreasing maternal morbidity and mortality are two clinical topics in need of further study and evaluation.

Addressing the digital divide

To optimize the telehealth experience, patients need to have reliable, high-quality broadband access, a device with video capabilities and a safe, private space to conduct the visit. Unfortunately, these three infrastructure needs are often barriers to successful and equitable telehealth utilization among Medicaid members.

Audio-visual visits provide greater access, without the need to travel during the pandemic, but may be limited by disparities in access to broadband and technology and/or patient comfort utilizing electronic modalities.

Although broadband access has improved over the past decade across the country, significant gaps in access persist[8]. Broadband access is particularly limited for Medicaid patients, with studies suggesting individuals are about 9% less likely to have broadband if someone in the home is on Medicaid[9]. Medicaid patients may be less likely to use video visits, perhaps in part due to lack of access[10]. Telephonic visits may therefore be more likely than with the rest of the population[11], although such evaluations are based on verbal history alone, missing out on information that could be gained via physical exam or place of service testing. Medicaid patients are also less likely to use patient portals[12]. Of note: Federal, state, and local governments have sought to address these gaps through programs such as the Federal Communications Commission's Lifeline initiative that offers patients subsidized coverage for telephone or internet access. Public-private partnerships have also been proposed to ensure such access for resource-poor areas[13].

Besides broadband access, video visits require devices with video capability, such as smartphones and tablets or laptops and personal computers outfitted with cameras. Public surveys suggest that Medicaid patients do not have significant gaps in access to such devices, suggesting broadband may be a more considerable barrier[14].

Suggested steps to level the playing field have included screening patients at high risk of a digital divide, developing patient education and training in digital skills, offering telephone visits if video is inaccessible, funding telemedicine expansion at Community Health Centers (CHCs), and ongoing monitoring of telehealth utilization by racial and demographic data.

Other equity considerations in Medicaid

- Non-English speaking: As with other service delivery models, telehealth must be delivered in a culturally and linguistically appropriate manner. In defining cultural and linguistic competency, the U.S. Department of Health and Human Services Office of Minority Health states that care should be respectful and responsive to diverse patients' health beliefs, practices, and needs.[15] To address this concern, studies have recommended that policymakers pay particular attention to the influence of culture and language on the use of technology to support appropriate care.[16] It has also been recommended that The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) be applied to telehealth.[17] The standards include communication and language assistance, continuous improvement, and accountability.[18]

- Living environment: Beyond secure connections, it is important to remember that patients may not inhabit spaces with adequate safety and privacy.[19] These barriers apply to telephonic only as well as audio-visual communication. Safety barriers to telehealth use include being homeless, living in shared spaces without privacy, and concerns about privacy and safety of being on video at home. These concerns are likely even more relevant for behavioral healthcare. Systems should institute protocols to determine the reason a patient may refuse telehealth services and address these barriers, including the social determinants of health. Tracking this data from the outset is valuable in understanding and managing equity gaps before they result in widespread disparities.

- Rural: Geography is a significant factor in health equity and the use of telehealth. Most rural counties lack adequate numbers of both primary care and mental health providers.[20] There are frontier areas that are even more remote, posing additional access challenges.[21] While some towns may look close on the map, there can be, for example, a mountain pass that is inaccessible in the winter requiring detours of hundreds of miles for half the year. Paradoxically, telehealth adoption is often lower in rural areas than in urban areas, despite the potentially higher need,[22] due to barriers such as poor access to broadband. While telehealth has the potential to reduce disparities in access to healthcare in rural and sparsely populated frontier areas, lack of broadband must be considered by Federal and state policymakers when determining whether to maintain payment for telephone-only care beyond the COVID-19 pandemic.[23]

Emerging solutions to address equity

Innovative projects are being implemented across the country to address the issues described above. For example, the U.S. Department of Veterans Affairs (VA) recognized similar barriers regarding access to broadband and devices in their population, as well as concerns with ease of use of technologies. The VA Accessing Telehealth through Local Area Stations (ATLAS) program seeks to bridge that gap by setting up VA remote access clinics in needed communities. In these clinics, patients can walk in with a scheduled appointment and find a safe and private location, well-equipped for a secure video visit with a VA clinician[24].

Similar partnerships may be useful for states with extensive rural populations. Some clinics have installed free Wi-Fi in their parking lots. Patients can drive to their appointment and conduct the entire visit from their car, ensuring privacy and a high-quality signal. If patients do not have access to the hardware, tablets can be loaned to patients for the visit and sanitized after each use. Another benefit of this approach is that if patients require more in-person care, such as a check of vital signs, immunization, or a more extensive in-person visit, it can be arranged more easily.

⭐ QUALITY

Policy Recommendations

Medicaid programs should hold teleservices to the same standards of care as traditional (in-person) healthcare services, including comprehensive documentation. Quality should be measured through process and outcome-based metrics. While payers may develop metrics unique to remote delivery, standardized, readily available process-based metrics (e.g., HEDIS) should be applied until outcome-based metrics are developed and validated.

Medicaid programs should promote robust telehealth evaluation through ongoing monitoring of utilization, fiscal impact, and outcomes. Those evaluation activities should trigger revisions to existing telehealth policies and the eventual development of telehealth best practices (including technical, policy, and clinical best practices). To the extent possible, Medicaid programs should partner with other state agencies and the academic community to conduct relevant research and disseminate results for feedback and validation.

While we believe the above considerations strike a balance between maintaining access for patients without reliable broadband and incentivizing providers to invest in audio-visual modalities of care, we also recognize that this may inadvertently discourage any provider-delivered virtual care for a subset of the population without reliable broadband or video capability.

Clinical appropriateness

Clinical appropriateness addresses the optimal delivery model for an individual's specific situation and needs. In the context of telehealth, this concept speaks to recognizing the limitations of telehealth technologies. The American Medical Association addresses these issues in its Ethical Practices in Telemedicine opinion, emphasizing that providers are held to the same ethical standards of practice despite the care delivery model[25]. Thus, providers using telehealth will be held to the same standard of care as those engaging in more traditional care delivery models, such as in-person

care[26]. Medicaid agencies play an important role in defining clinical appropriateness and creating new delivery models for Medicaid clients, identifying potential telehealth services based on utilization, select quality metrics, and provider input among vulnerable populations.

In general, the use of a telehealth service in primary care should enhance the relationship between the patient and provider and improve the patient's overall health outcomes. It can be especially valuable in improving continuity of care or acute care, potentially reducing unnecessary emergency department (ED) utilization as well as school and work absenteeism. Similarly, chronic disease follow-up and remote patient monitoring through telehealth, as a substitute for some in-person visits, should also improve outcomes, reduce complications, and decrease ED visits as well as re-admissions to the hospital.

Audio only services

There appears to be consensus among MMDs that some services are less appropriate than others for delivery via telehealth, especially where a comprehensive physical examination and point of care testing or other service is indicated. Providers, advocates, and policy-setting organizations recommend that clinicians use professional judgment to determine whether the service delivery via telehealth is suitable for a specific patient[27].

Some of those services closely scrutinized for clinical appropriateness include telephone-only care (more often in the physical health space) and well-child visits, especially for younger children. While telephone only care does not require broadband access, several MMDs expressed concern that the quality of the care delivered by phone may not be commensurate with audio-visual or in-person care.

Medicaid Medical Directors also discussed concerns about patient choice and the possibility of Medicaid patients' access being limited to only telephone or audio-visual visits. In effect, this over-dependence on telehealth, without the option of in-person care, or in-person follow-up when such a need is identified during a telehealth visit, might further exacerbate inequities. For example, will select providers offer only telephone or telehealth visits to those individuals covered by Medicaid due to low payment or other concerns? When determining if telephone care is adequate or appropriate, Federal and state policymakers must consider and evaluate if a service, delivered via audio-visual or telephone, instead of an in-person evaluation and treatment, might worsen disparities in the future if the root causes of access to broadband and technology gaps are not addressed.

The need for ongoing evaluation

Medicaid Medical Directors recognize that the evidence base for telehealth is evolving, and while there is emerging evidence on certain modalities, there is also a need for greater evaluation of the impact of telemedicine policies as they relate to the goals of equitable access to high-quality healthcare, at a reasonable cost.

During the pandemic, decisions regarding relaxed coverage of services, provider types, modalities, and payment decisions were made to maintain access without available data on cost, quality, or outcomes. Adding to the complexity was ongoing uncertainty around provider and patient technology literacy, capacity, and sustained utilization. Durable decisions made about future telehealth policies should be data-driven, and the current Public Health Emergency holds tremendous promise for enhanced measurement and analysis. Evaluation should be ongoing and supported by research conducted by all payers including Medicaid agencies and academia.

Over the past five years, there have been efforts to better define quality in telehealth services. Specific telehealth delivery models for specific conditions and disease processes have been shown to produce positive outcomes. These include the use of telemedicine consultation for acute stroke[28], wound care[29], counseling for certain chronic conditions[30], and telehealth delivery of psychotherapy for depression[31]. Despite these efforts to focus on quality, telehealth's generalizability continues to be limited by poor quality and outcome standards. A key example is the relative lack of evidence supporting the use of teleservices in primary care. Some studies have found telemedicine may be as effective as traditional in-person care for some conditions[32], and uniquely suited to address many of the pandemic's challenges.

Telehealth quality metrics also need to be established to ensure appropriate utilization of services. Examples of such quality metrics in need of further investigation include patient experience/satisfaction, duration and timeliness of visits, and user-friendliness. Using telehealth should not increase utilization of other services; it should augment an in-person visit and enhance the patient's care and experience. Ideally, telehealth outcome measures should show improvement in a patient's ability to manage chronic conditions, reduce school and work absenteeism, decrease ED visits and hospitalization, and increase satisfaction.

Compliance and program integrity

Privacy and safety issues are also critical to the successful utilization of telehealth. During the pandemic, The U.S. Department of Health and Human Services Office of Civil Rights stated that, "[c]overed healthcare providers will not be subject to penalties for the good faith provision of telehealth during the COVID-19 nationwide public health emergency[33]." Following the pandemic, care delivered via telehealth will again be expected to meet HIPAA requirements

in full, which is especially important given the potential for privacy violations through video chats, among other concerns.[34]

The U.S. Department of Health and Human Services (HHS), in collaboration with state Medicaid agencies, is required by statute to ensure the Medicaid program's integrity through combatting fraud, waste, and abuse[35]. These oversight activities are necessary to ensure quality patient care and the judicious use of limited resources.

Like traditional in-person services, it is understood that telehealth services raise program integrity concerns. One of the potential challenges with telephonic only care is the inability to verify the person receiving care is the intended beneficiary. Whereas in-person and audio-visual modalities can confirm identity visually, telephonic care relies on a verbal-only confirmation, which could be an area for potential fraud and abuse. The National Committee on Quality Assurance has established a task force on telehealth policy, specifically examining patient safety and program integrity[36]. In addition, HHS is conducting a review of telehealth services in Medicare to identify program integrity risks[37].

Telehealth services should certainly be implemented in the context of program integrity, but this would ideally not hamper implementation. States may consider leveraging existing oversight mechanisms to examine telehealth program integrity. Strategies include monitoring utilization, expenditures, and quality outcomes. That data should be analyzed for trends and comparisons made with other states, within regions, across sub-populations, and provider types.

💲 PAYMENT

Policy Recommendations

Medicaid programs should work with Medicaid MCOs, Medicare, and commercial payers, as well as other state Medicaid programs to simplify and standardize telehealth policies, including payment policies, across payers.

Medicaid rates need to be adequate to facilitate care delivered through telehealth. Payment rates should consider additional costs not associated with traditional in-person services. Alternative payment models should support telehealth services by providing sufficient flexibility.

When considering and implementing telehealth policies, Medicaid programs should support the continuity of care, including a requirement that telehealth providers outside of a patient's medical home foster communication with that medical home. Policies should also require a contingency plan to enable the timely transition from telehealth to an in-person visit service when indicated.

Payment policy is essential to ensuring that telehealth is utilized to advance the triple aim[38]. The specifics of payment policy established during and after the pandemic will help shape the future of telehealth delivery and practice. For patients, telehealth payment policies should increase equitable access to services while supporting quality. For providers, telehealth payment policies should provide sufficient incentives and certainty to sustain providers' interest and willingness to invest in and offer telehealth services.

Given the pandemic's disruptive force and its implications for access, telehealth payment policy may be reassessed once the pandemic is over. During pandemic and post-pandemic, the relative weights of equitable access, quality, and cost will each vary. For example, pandemic policy may be focused on maintaining access to care, whereas post-pandemic policy may concentrate more on quality and value. In both situations, equity must remain of paramount importance.

During the pandemic, it is crucial to recognize the imperative of virtual care to minimize the spread of COVID-19 and the uncertain choices providers and patients may face if in-person care is delivered. Indeed, inpatient and outpatient visits declined significantly during the first few months of the pandemic[39]. Although many payers quickly expanded telehealth, many patients went without necessary care and may have suffered adverse health consequences.

The State Medicaid & CHIP Telehealth Toolkit developed by CMS states that "Medicaid rates need to be available and adequate to facilitate care delivered through telehealth." That toolkit further states that payment rates should consider "additional costs that may be incurred by providers when delivering services through telehealth that would not otherwise be incurred through an in-person visit[40]."

Regarding payment parity

Many states have maintained payment parity during the pandemic between traditional (in-person) visits and telehealth services. Payers may wish to extend payment parity for some time after the pandemic to ensure that providers are incentivized to continue to invest in virtual care workflows and technology. Following the pandemic, it appears that some states will maintain parity, and others may consider paying a decreased rate for services delivered through telehealth. There seems to be greater consensus that a reduced rate is appropriate for telephone-only services. However, it should be noted that some telephone-only services have demonstrated efficacy, especially in the behavioral health arena[41].

During and after the pandemic, states should consider providing payment for asynchronous provider-to-provider consultations, including e-consults, which appear to increase access to specialty expertise, especially in rural areas[42].

Payers must acknowledge the necessary initial provider investment in virtual care workflows and technology; the decreased marginal cost of providing a telehealth visit after initial investments; the lack of reliable broadband in urban and rural areas across the country; the differential quality of certain clinical services delivered in-person versus audio-visual versus audio-only; and the lack of evidence on how expansion of telehealth services will impact equitable access, quality, and cost over the long-term.

Other principles for payment

MMDs believe that state Medicaid agencies should adopt specific principles for payment:

- A guiding principle for payment should be consistency and alignment among payers. The inclusion of MMDs in these discussions will add a rich perspective to the resulting state and national policy decisions. Currently, there are many examples of health insurance companies with disparate coverage of telemedicine services for their Medicaid and non-governmental insurance products. This lack of consistency across payers and programs confuses providers who are then more reluctant to invest in HIPAA-compliant telehealth platforms — especially those with limited administrative support and infrastructure.

- Healthcare in the U.S. has been transitioning from fee-for-service payment to alternative payment models (APMs), and those transitions continue to accelerate. Alternative payment models should be designed to support high-quality, outcomes-based telehealth service delivery models. While APMs may have quality/outcome measures similar to traditional in-person care, these models should ensure sufficient flexibility related to telehealth. APMs and payers must prioritize and promote continuity of care, using integration, and shared medical records to avoid care fragmentation.

Scope of managed care in Medicaid

As of July 2019, 40 states and the District of Columbia began ensuring delivery of services to at least some of their beneficiaries through Medicaid managed care organizations (MCOs). Nationally, nearly 70% of Medicaid beneficiaries are enrolled in managed care plans. Six health insurance firms have a large footprint in Medicaid managed care, with a presence in 10 or more states – and those firms account for 47% of all MCO enrollments. All have commercial and/or Medicare books of business in addition to their work in the Medicaid space.

Role of the Medicaid Managed Care Organization

Health plans have great flexibility and have expended considerable energy to ensure access to needed services and to support the creation of robust provider networks. Ensuring access to high-quality telehealth services should become an increasing focus

of such efforts. Plans are uniquely suited to improve underserved populations' access to telehealth-capable devices (e.g., smartphones, tablets) and broadband. They can help provide guidance, technical assistance, and financial incentives to encourage providers to "level-up" telehealth capabilities. Plans should actively consider how to bolster networks of care through telehealth services, ensuring timely access to traditional in-person services, when indicated based on clinical presentation, or as a matter of member preference.

Over time, the expansion of managed care in Medicaid has focused on quality and outcomes. Pay-for-performance, shared savings, risk-based arrangements, and other APMs are increasingly common. Health plans should seek alignment of quality metrics for telehealth services and similarly align payment policies (as indicated above).

Conclusion

Telehealth technologies for the delivery of healthcare services bear great potential in resolving barriers to social determinants and improving access to care. Even before the COVID-19 pandemic, much of the focus on expanding telehealth services was designed to increase access, and now, during the pandemic, access has received critical attention. It is not unreasonable to withhold support for telehealth expansion, if it does not afford at least equal, if not better, quality of care than in-person care. While telehealth should continue to be embraced as a critical way to deliver needed health services during the pandemic, moving forward, it is imperative to determine which services are clinically appropriate for telehealth, consider ongoing evaluation needs, and enforce compliance to address program integrity concerns.

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Acknowledgement

About the Medicaid Medical Directors Network (MMDN)

The MMDN seeks to advance more equitable, high-quality, accessible healthcare for all Medicaid beneficiaries by providing a forum for senior clinical leaders to discuss their most pressing needs and evidence-based solutions. As the professional home of the MMDN, AcademyHealth maintains a strategic partnership with more than 40 state Medicaid Medical Directors (MMDs) – committed to participating in multi-state data projects on pressing policy topics, hosting yearly convenings, and leveraging their collective experience to bolster both state and national Medicaid program initiatives. With support from several partner organizations including the Agency for Healthcare Research and Quality (AHRQ), the Patient Centered Outcomes Research Institute (PCORI), and the Centers for Disease Control and Prevention (CDC), the MMDN is committed to synthesizing and disseminating relevant findings to policymakers in a timely and translatable manner.

About AcademyHealth

AcademyHealth is a leading national organization serving the fields of health services and policy research and the professionals who produce and use this important work. Together with our members, we offer programs and services that support the development and use of rigorous, relevant and timely evidence to increase the quality, accessibility, and value of health care, to reduce disparities, and to improve health. A trusted broker of information, AcademyHealth brings stakeholders together to address the current and future needs of an evolving health system, inform health policy, and translate evidence into action. Learn more at **www.academyhealth.org** and follow us on Twitter @AcademyHealth.

Appendix

Summary of MMDN Environmental Scan Results Regarding Telehealth Policies

The MMDN participated in an AcademyHealth-led environmental scan with the goal of understanding the myriad COVID-related policy challenges and successes for state Medicaid programs, including telehealth. The scan was disseminated to 40 lead clinicians in 40 states. With a 47.5% response rate, the survey informed the Medicaid Medical Directors (MMDs) of their peer state Medicaid programs' COVID-19-related policy responses, challenges encountered and analyses (proposed and planned), to meet beneficiaries needs. The following results pertain to telehealth policies.

Increase in Telehealth Coverage

Responding states shared that there has been an increase in telehealth coverage across many services for Medicaid beneficiaries. Services with the biggest increase (in percentage points) are:

- Ancillary services (ST/PT/OT, etc.) (+71.4)
- Peer support services (+70)
- Post-surgical follow-up (+64.29)
- Well child visits (+58.34)
- Dental (+54.55)
- Responding states shared they are very likely to continue covering telehealth services after the pandemic.

Audio Only Coverage Policies

Of those states responding, several states are discussing whether to continue covering audio only and others do not know.

- Some reported they will terminate or believe it is unlikely to be continued.
- Others will continue covering it but at a discount rate.
- One state mentioned the advantage of audio only as clients have broadband issues.

Barriers to Accessing Teleservices

Beneficiaries main barriers to accessing teleservices are connectivity and technology. Responding states noted that beneficiaries have the following challenges to utilizing telehealth services:

- Lack of access to broadband/internet
- Lack of access to technology (e.g. tablet, smart phone, computer)
- Technology illiteracy
- Rural vs. urban vs. suburban divide

Challenges to Providing Telehealth

Responding states expressed facing technological and administrative challenges to provide telehealth. The main barriers are:

- Issues of quality or to measure quality
- Fraud prevention
- IT and broadband access
- Reimbursement and billing
- Primary needs to enable telehealth provision are:
  - IT infrastructure (including funding)
  - Broadband access
  - Other: billing support, guidance on appropriateness, and evidence to answer questions about quality and equitable access.

Other Telehealth Needs

Responding states also reported financing and education needs related to telehealth services. Other needs reported include:

- Teach physicians to diagnose and treat without a physical exam
- Protocols for accountability and quality measurement
- Population level financing to provide high-quality care within the constraints of a limited resource system (beyond FFS)
- Broader access to SUD treatment via telehealth
- The funding structure to maintain a telehealth network in the times of budget cuts

Gaps in Telehealth Research

Responding states noted the following categories of telehealth research gaps:

- Quality
- Impact on equity and on the delivery system/payment reform
- Effectiveness
- Specific studies with Medicaid population
- Access for minorities

Endnotes

1   Modern Healthcare. Medicaid, CHIP enrollment grew by 4 million during COVID-19. Accessible online: https://www.modernhealthcare.com/medicaid/medicaid-chip-enrollment-grew-4-million-during-covid-19

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4   "Early Impact of CMS Expansion of Medicare Telehealth During COVID-19, " Health Affairs Blog, July 15, 2020. DOI: 10.1377/hblog20200715.454789

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