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Maintaining Telehealth Access to Medicaid-Covered Pediatric Services After the End of the COVID-19 Public Health Emergency

Introduction

The COVID-19 public health emergency (PHE) spurred a seismic shift in the delivery of health care, including services provided to children and adolescents. Pediatric providers rapidly scaled up their telehealth¹ capabilities in response to the PHE to reduce disease transmission and ensure continuity of care for children and adolescents, including those with special health care needs. Temporary Medicaid policies enacted at the state level facilitated the widespread use of telehealth during the PHE. State Medicaid agencies recognize that telehealth is now a more accepted, and in some cases preferred, method of care delivery and are focused on developing their post-PHE Medicaid telehealth policies.

As states look to the future of their Medicaid telehealth policies, there are opportunities to maintain access to certain pediatric services delivered through telehealth for children and adolescents, including those with special health care needs. This issue brief, one of a three-part series focused on improving access to Medicaid and CHIP services for children at the end of the PHE, provides a brief overview of the pediatric telehealth response to COVID-19, outlines temporary state policy flexibilities that improved access to pediatric telehealth services during the PHE, and highlights opportunities for permanent state policy expansions to maintain access to pediatric telehealth services within Medicaid after the PHE ends.

¹ Telehealth refers to health care delivered remotely via video or audio-only visits.

Rapid Adoption of Pediatric Telehealth Across All Payors in Response to the COVID-19 PHE

Prior to the PHE, telehealth utilization among pediatric and other providers was limited. A study conducted by the American Academy of Pediatrics found that, prior to the pandemic, only 15% of pediatricians offered services via telehealth,² with greatest usage among the following pediatric subspecialties: genetics, behavioral health, pulmonology, endocrinology, gastroenterology and neurology.³

After the onset of the PHE, telehealth utilization across all payors, including Medicaid, soared as social distancing measures were implemented, preventing patients from attending in-person appointments. Telehealth, as a percentage of overall outpatient utilization for all patients (adults and children), spiked across all specialties, accounting for ~14% of visits during late March–April 2020, then plateaued at ~5%–7% above the pre-PHE baseline of less than 1% by the end of 2020.⁴ Multi-payor data from December 2020 demonstrated notable variation in telehealth utilization across specialties. Behavioral health accounted for the highest percentage of telehealth visits (56%), with all other specialties utilizing telehealth at rates of 25% or less; only 12% of adult primary care and 8% of pediatric visits were conducted via telehealth during that month.⁵

While access to telehealth helped some children to continue to receive care during the pandemic, many children and adolescents, including those with special health care needs, missed appointments. A Kaiser Family Foundation analysis of household survey data from June and July 2021 found that 25% of households with children reportedly missed, delayed or skipped preventive pediatric appointments in the 12 months prior.⁶

There are unique challenges to delivering pediatric services via telehealth, which may have resulted in lower rates of telehealth utilization relative to other specialties. Most notably, there are important components of pediatric care that cannot be delivered via telehealth, such as comprehensive physical exams and immunizations. In addition, some families may not have experience with telehealth or may perceive it as lower-quality care, which may make it more difficult to engage remotely. Moreover, privacy may be a concern, particularly for adolescents who may not have access to private spaces where they can receive sensitive services (e.g., behavioral health treatment or sexual and reproductive health services) via telehealth.

There are also significant inequities in access to telehealth for low-income families that are exacerbated for those in rural areas, racial/ethnic minorities, and those with limited health or English literacy. For example, 43% of low-income Americans have access to broadband internet at home, which is necessary to participate

² Blake Sisk et al., [Pediatrician Attitudes Toward and Experiences With Telehealth Use: Results from a National Survey](#) (Academic Pediatrics, July 2020).

³ Lori Uscher-Pines et al., [Use of Telehealth Across Pediatric Subspecialties Before and During the COVID-19 Pandemic](#). JAMA Netw Open. 2022;5(3):e224759 (March 2022).

⁴ Ateev Mehrotra et al., [The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases](#) (Commonwealth Fund, February 2021).

⁵ Ateev Mehrotra et al., [The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases](#) (Commonwealth Fund, February 2021).

⁶ Elizabeth Williams, [Back to School amidst the New Normal: Ongoing Effects of the Coronavirus Pandemic on Children's Health and Well-Being](#) (Kaiser Family Foundation, 2022).

in a video visit; by comparison, more than 90% of high-income households have reliable internet access at home.⁷ These telehealth-specific inequities, often referred to as the “digital divide,” create significant barriers to increasing access to telehealth services for children and adults.

Despite these challenges, there are several benefits to offering telehealth as an option to deliver some pediatric services. Telehealth can improve access to primary, behavioral and specialty care for children while simultaneously reducing barriers facing families such as travel and the need to take time off work or miss school. Telehealth can also help children and adolescents in geographically distant or rural areas connect with specialists and providers they may not otherwise be able to reach. Telehealth allows families to opt for telehealth or in-person care based on their preference, and enables pediatric providers to observe and interact with children and families in their homes and ensures patient safety during a PHE.

Temporary Policies That State Medicaid Agencies Utilized in Response to the PHE

States adopted a myriad of temporary state Medicaid policies that made it possible for patients to receive care via telehealth during the PHE, many of which could be extended beyond the end of the PHE. The following are key temporary state policy flexibilities that states have legal authority to extend without a waiver (see details on page 4) and that most significantly improved access to care via telehealth for **children and adults**:

- **Payment Parity:** Several states (e.g., Idaho, Montana) enacted laws or issued guidance requiring all payors, including Medicaid fee-for-service programs and managed care plans, to reimburse video visits, and in some cases audio-only visits, at the same rate as in-person services, which encouraged provider adoption and utilization of telehealth.
- **Audio-Only Visits (e.g., telephone calls):** Several states (e.g., Arizona, California) amended their Medicaid telehealth policies to cover services delivered via audio-only modalities, which enabled patients who may not have access to broadband internet or were otherwise unable to connect via video to receive care via telehealth.
- **Originating Sites:** Almost all states allowed the originating site (i.e., where the patient is located at the time of a telehealth visit) to include a patient’s home or wherever they may be located, which made it easier for patients to access telehealth services regardless of their location.
- **Telehealth-Eligible Provider Types and Services:** Many states (e.g., Massachusetts, North Carolina) improved access to telehealth by expanding the types of services that could be delivered via telehealth and the list of telehealth-eligible providers, which significantly expanded the types of telehealth services that patients could receive.
- **Initial In-Person Visits:** Most states allowed providers to deliver telehealth services to new patients without requiring an initial in-person visit, which enabled patients to receive care in a timely manner regardless of whether they had previously been seen by a provider in person.

⁷ Emily Vogels, [Digital divide persists even as Americans with lower incomes make gains in tech adoption](#) (Pew Research Center, June 2021).

State Medicaid programs also implemented temporary telehealth policy flexibilities aimed at expanding access to telehealth services for children and adolescents, all of which could be extended beyond the PHE:

- **Children’s Behavioral Health:** Almost all state Medicaid agencies enabled coverage for a broad set of behavioral health services that could be delivered in a clinically appropriate manner via video or audio-only visit, such as therapy for adolescents, applied behavioral analysis, and research-based autism spectrum disorder services, among others. These coverage expansions increased access to necessary services during a time when rates of behavioral health conditions among children rose dramatically due to the impact of the pandemic.
- **Well-Child Services:** Several states (e.g., Maryland, Tennessee) allowed select well-child visit services that do not require physical touch (e.g., developmental and emotional/behavioral screenings, preventive medicine/individual counseling, vaccine counseling) to be delivered via video visit for children over 24 months of age, which avoided disruption of some preventive well-child care. Most states required a follow-up in-person visit within a certain time frame to deliver remaining well-child services and continued to recommend in-person well-child visits for children under 24 months of age.
- **Specialized Therapies:** Many states (e.g., Missouri, Ohio) enabled the delivery of some physical, occupational and speech language therapy services via video visit, which proved to be a critical tool in maintaining access to specialized therapy services for children with special health care needs during the PHE.
- **Early Childhood Intervention Services:** Some states (e.g., Minnesota, New York) issued guidance allowing for a limited set of early childhood intervention services that could be delivered in a clinically appropriate manner (e.g., case management, patient/family training and counseling) to be delivered via video visit, which enabled coordination and continuity of care for these critical services.

Looking Ahead: Opportunities for Permanent State Policy Expansions to Maintain Access to Medicaid Pediatric Telehealth Services

Some of the temporary policies implemented by states have expired, as they may have been tied to each state’s public health emergency or other executive orders. Some of the services that are of particular interest for children and adolescents, such as early childhood intervention and well-child services, will likely revert to being delivered in person on a permanent basis; however, there are opportunities for states to strengthen access to care by making permanent some PHE-era Medicaid telehealth policy flexibilities including:

- Implementing payment parity for video visits;
- Enabling coverage of audio-only visits for select services (e.g., behavioral health);
- Including the patient’s home or any location as an eligible originating site for telehealth visits; and

States Have Authority to Make Medicaid Telehealth Policy Changes

State Medicaid agencies have broad flexibility in designing their telehealth reimbursement and coverage policies. States are only required to submit a State Plan Amendment to CMS if they seek to reimburse for telehealth services at a rate that is different from in-person care.

- Expanding the list of telehealth-eligible providers and services to include specialized therapies, applied behavioral analysis, and research-based autism spectrum disorder services, among others.

In addition to making permanent telehealth policies that help to maintain access for children and youth, states may also consider developing infrastructure and processes to enable data collection and reporting related to quality of care delivered via telehealth to all individuals. The adoption of telehealth has outpaced states' existing telehealth-related data capabilities, and it will be important for states to be able to measure and report on the quality of care delivered via telehealth going forward. Widespread broadband availability is another key issue that states will likely focus on going forward, as poor access to reliable internet (e.g., in rural and low-income communities) prevents many children and youth from receiving telehealth services.

Conclusion

With the end of the PHE looming, now is the time for families, pediatric providers, managed care plans, children's advocates, and state Medicaid and CHIP agencies to come together to identify which temporary telehealth policies that were used during the PHE should be made permanent in order to increase access to physical and behavioral health services for children and adolescents.

About Manatt Health

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