United States Government Accountability Office

Report to Congressional Committees

March 2022

MEDICAID

CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care

MEDICAID

CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care

Why GAO Did This Study

To respond to the COVID-19 pandemic, states have expanded their coverage of telehealth in Medicaid, a jointly financed federal-state health care program for low-income and medically needy individuals.

The CARES Act includes a provision for GAO to report on the federal response to the pandemic. In addition, GAO was asked to examine the use of Medicaid flexibilities in response to COVID-19. This report describes selected states' telehealth use before and during the pandemic, and experiences with and plans for telehealth. It also evaluates, among other things, CMS's telehealth oversight of quality of services.

GAO analyzed state-reported data on telehealth use in six states selected, in part, based on variation in geography, Medicaid program size, and percentage of population living in rural areas. GAO reviewed federal oversight documents, interviewed state and federal Medicaid officials, and assessed CMS oversight against CMS guidance on using data to identify disparities in health care and target improvements.

What GAO Recommends

GAO is making two recommendations to CMS to (1) collect and analyze information about the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive, and (2) determine any next steps based on the results of the analysis.

View GAO-22-104700. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found
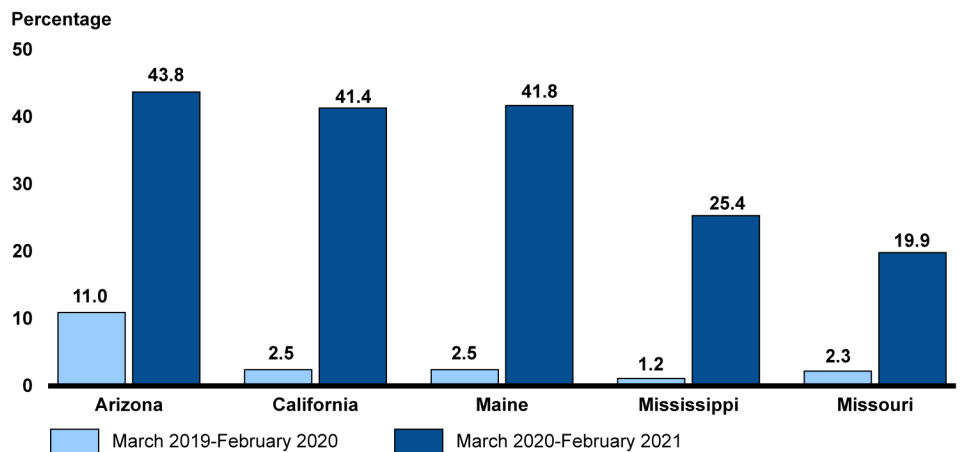
GAO's analysis of Centers for Medicare & Medicaid Services (CMS) data in five selected states shows that the number and percentage of services delivered via telehealth and Medicaid beneficiaries receiving them increased exponentially at the beginning of the COVID-19 pandemic in March 2020. From March 2020 through February 2021, 32.5 million services were delivered via telehealth to about 4.9 million beneficiaries in the five states, compared with 2.1 million services to about 455,000 beneficiaries in the 12 months prior to the pandemic.

Percentage of Medicaid Beneficiaries Receiving at Least One of Their Services via Telehealth, March 2019 through February 2020 and March 2020 through February 2021

Percentage

	March 2019-February 2020	March 2020-February 2021
Arizona	11.0	43.8
California	2.5	41.4
Maine	2.5	41.8
Mississippi	1.2	25.4
Missouri	2.3	19.9

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Note: GAO determined Tennessee's data were not sufficiently reliable for purposes of this analysis.

Medicaid officials from all six selected states said expanding telehealth supported beneficiaries' access to care, but also identified some limitations. Officials reported making or considering post-pandemic telehealth modifications.

CMS does not collect, assess, or report information about any effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive and has no plans to do so. Doing so is important, given concerns GAO has raised about the quality of care provided via telehealth. It would also be consistent with how CMS has encouraged states to use data on quality of care to identify disparities in health care and target opportunities for improvement to advance health equity. These efforts could begin with data for quality measures CMS already collects or through other means.

CMS neither agreed nor disagreed with GAO's recommendations. GAO maintains it is crucial for CMS to collect and analyze information to assess telehealth's effect on the quality of care Medicaid beneficiaries receive.

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The COVID-19 pandemic has resulted in catastrophic loss of life and disruption to the health care system, including in-person delivery of care. Telehealth can provide certain clinical services that are typically provided in person, but are instead conducted remotely via audio-only, audio-video, or other telecommunication technologies. Since the COVID-19 pandemic was declared a national emergency in March 2020, telehealth services have been used as a means of ensuring necessary health care, while reducing patients' risk of exposure to COVID-19.[1] Beneficiaries enrolled in Medicaid, a federal-state health care financing program for certain low-income and medically needy individuals, also had increased access to telehealth services.

To assist states' response to the pandemic, the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, issued guidance to states on implementing various flexibilities to expand their use of telehealth in Medicaid.[2] CMS and states share responsibility for Medicaid program integrity oversight activities that seek to protect Medicaid from

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[1]On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency for the United States, retroactive to January 27. Subsequently, on March 13, 2020, the President declared COVID-19 a national emergency under the National Emergencies Act and a nationwide emergency under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). See 50 U.S.C. § 1601 et seq. and 42 U.S.C. § 5121 et seq. The President has also approved major disaster declarations under the Stafford Act for all 50 states, the District of Columbia, and five territories.

[2]Medicaid covered an estimated 77 million people and spending totaled an estimated $673 billion (total federal and state) in fiscal year 2020. These enrollments and expenditures reflect increased federal spending for which all states and territories could qualify by meeting certain conditions, such as ensuring that certain Medicaid enrollees are treated as eligible for benefits through the end of the month in which the public health emergency ends. Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6008, 134 Stat. 178, 208-09 (2020).

fraud, waste, and abuse, and for ensuring the quality of services delivered to Medicaid beneficiaries.[3]

The CARES Act includes a provision for us to conduct monitoring and oversight of the federal government's efforts to prepare for, respond to, and recover from the COVID-19 pandemic.[4] We also received a request to review the temporary changes HHS used to respond to the COVID-19 pandemic and the effects of these changes. In this report, we

1. describe the extent to which the provision of services delivered via telehealth in Medicaid has changed in selected states from pre-pandemic to during the pandemic;

2. describe selected states' experiences with using telehealth in Medicaid during the pandemic, and what their telehealth plans are after the end of the pandemic;

3. examine efforts by selected states and CMS to oversee program integrity risks in services delivered via telehealth in Medicaid; and

4. examine any efforts by CMS and selected states to oversee the quality of care provided via telehealth in Medicaid.

For all four objectives, we focused on six states—Arizona, California, Maine, Mississippi, Missouri, and Tennessee—selected for variation in total Medicaid beneficiaries, total Medicaid beneficiaries living in rural areas, the percentage of the state's population without broadband internet, and geography. We conducted open-ended interviews with Medicaid officials in these states and reviewed state Medicaid documents.

To describe the extent to which the provision of services delivered via telehealth in Medicaid has changed in selected states from pre-pandemic to during the pandemic, we analyzed data from the Transformed Medicaid

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[3]The Medicaid program is on GAO's High-Risk List, in part, due to concerns about fraud, waste, and abuse. See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021).

[4]Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). We have regularly issued government-wide reports on the federal response to COVID-19. For the latest report, see GAO, *COVID-19: Significant Improvements Are Needed for Overseeing Relief Funds and Leading Responses to Public Health Emergencies*, GAO-22-105291 (Washington, D.C.: Jan. 27, 2022). Our next government-wide report will be issued in April 2022 and will be available on GAO's website at https://www.gao.gov/coronavirus.

Statistical Information System (T-MSIS), CMS's initiative to improve state-reported data available for overseeing Medicaid.[5] We analyzed T-MSIS data for services, such as physician services and outpatient hospital services, which are not provided by an inpatient hospital, long-term care facility, or pharmacy. We included fee-for-service claims and managed care encounters for Medicaid beneficiaries.[6] We accessed T-MSIS data on October 18, 2021, for the 12 months prior to the start of the pandemic (March 2019 through February 2020) and the first 12 months of the pandemic (March 2020 through February 2021). We categorized services as being delivered either via telehealth or not via telehealth; for example, through in-person visits, based on states' telehealth definitions, which varied.

We did not independently verify the accuracy of the T-MSIS data; however, we took steps to assess the reliability of the data. On the basis of this review, we determined that the T-MSIS data in Arizona, California, Maine, Mississippi, and Missouri were sufficiently reliable for our purposes. We accounted for any limitation or discrepancy in these data during our analyses. We also determined the T-MSIS data in Tennessee were not sufficiently reliable for our purposes and excluded the state's data from our analysis. (See app. I and app. II for more detail on the scope and methodology, and additional details about the T-MSIS data limitations we identified.) After taking these steps, we determined (1) the number and percentage of services delivered via telehealth; (2) the types of services delivered via telehealth; (3) the number and percentage of beneficiaries receiving services via telehealth, and (4) selected demographic characteristics of those beneficiaries—age, gender, race/ethnicity, and whether the beneficiary lived in an urban or rural area of the state.

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[5]Specifically, we reviewed data in CMS's T-MSIS Analytic Files, a series of analytic-optimized data sets, including those related to claims and demographic information about Medicaid beneficiaries. For the purposes of our report, we refer to the T-MSIS Analytic Files as T-MSIS data.

[6]We excluded other types of claims that cannot be directly tied to a service, such as Medicaid supplemental payments, which are lump-sum payments that are not directly tied to care for individual Medicaid beneficiaries, but may help offset costs of care for beneficiaries. We also excluded beneficiaries enrolled in the Children's Health Insurance Program, a joint federal-state program that provides health coverage to low-income children with family incomes that are too high to qualify for Medicaid, but may be too low to afford private insurance.

To describe all six selected states' experiences with using telehealth during the pandemic, and what their telehealth plans are after the end of the pandemic, we reviewed state Medicaid documents and interviewed state Medicaid officials.

To examine efforts by the six selected states and CMS to oversee program integrity risks in services delivered via telehealth in Medicaid, we interviewed CMS officials about how the agency is overseeing program integrity risks and reviewed supporting documentation provided by CMS officials. We compared CMS's oversight efforts to the fraud risk assessment process outlined in *A Framework for Managing Fraud Risks in Federal Programs*.[7] Fraud risk exists when individuals have an opportunity to engage in fraudulent activity, have an incentive or are under pressure to commit fraud, or are able to rationalize committing fraud. When fraud risks can be identified and mitigated, fraud may be less likely to occur.[8] Assessing fraud risks generally involves the following five actions: (1) identify inherent fraud risks affecting the program; (2) assess the likelihood and impact of inherent fraud risks; (3) determine fraud risk tolerance; (4) examine the suitability of existing fraud controls and prioritize residual fraud risks; and (5) document the program's fraud risk profile.

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[7]See GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.; July 28, 2015). The Fraud Risk Framework helps managers meet their responsibilities to assess and manage fraud risks, as required by federal internal control standards. See GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014). The leading practices of the Fraud Risk Framework are also required to have been incorporated into Office of Management and Budget guidelines and agency controls under the Fraud Reduction and Data Analytics Act of 2015 and its successor provisions in the Payment Integrity Information Act of 2019. The Fraud Reduction and Data Analytics Act of 2015, enacted in June 2016, required the Office of Management and Budget to establish guidelines for federal agencies to create controls to identify and assess fraud risks and to design and implement antifraud control activities. Pub. L. No. 114-186, 130 Stat. 546 (2016). The act further required the Office of Management and Budget to incorporate the leading practices from the Fraud Risk Framework in the guidelines. The Payment Integrity Information Act of 2019, which repealed the Fraud Reduction and Data Analytics Act, requires these guidelines to remain in effect, subject to modification by the Office of Management and Budget as necessary and in consultation with GAO. Pub. L. No. 116-117, 134 Stat. 113 (2020); see also Office of Management and Budget, *OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control*, M-16-17 (July 2016).

[8]Fraud and "fraud risk" are distinct concepts. Fraud is challenging to detect because of its deceptive nature.

To examine any efforts by CMS and the six selected states to oversee the quality of care provided via telehealth in Medicaid, we reviewed CMS documents and interviewed CMS officials. We compared CMS's oversight efforts with its responsibility for ensuring the quality of services delivered to Medicaid beneficiaries, and with CMS guidance on using data to identify disparities in health care and target opportunities for improvement to advance health equity.[9] In addition, we interviewed a non-generalizable sample of stakeholders, including provider groups knowledgeable about delivering services via telehealth, and a beneficiary advocacy group, as well as an organization that endorses quality measures. We also reviewed work conducted by the Department of Health and Human Services Office of Inspector General.[10]

We conducted this performance audit from January 2021 to March 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background
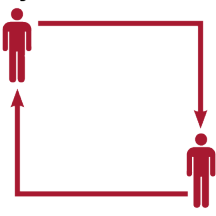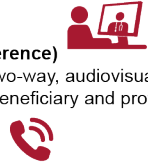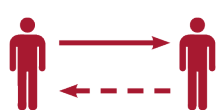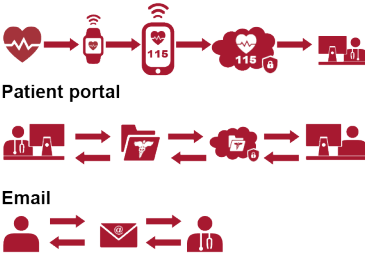
Delivery of Services via Telehealth

A variety of modalities exist for delivering health care services via telehealth, as shown in figure 1.

[9]See Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, *2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets*, Informational Bulletin (Baltimore, Md.: Dec. 10, 2021).

[10]Department of Health and Human Services, Office of Inspector General, *Opportunities Exist To Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid*, OEI-02-19-00401 (Washington, D.C.: September 2021).

Figure 1: Types of Medicaid Telehealth Modalities Used to Deliver Services

Telehealth type	Definition	Examples
Synchronous	Live, two-way interaction between the beneficiary and the provider in real time.	May include: • **Live video (videoconference)** Real-time, two-way, audiovisual connection between a beneficiary and provider • **Audio-only (telephone)** Real-time, two-way, audio-only connection between a beneficiary and provider
Asynchronous	Not live or real-time but still requires two-way interaction between the beneficiary and the provider.	May include: • **Remote patient monitoring** • **Patient portal** • **Email**

Source: GAO analysis of Centers for Medicare & Medicaid Services documents. | GAO-22-104700

Each telehealth modality has different attributes to consider in delivering services to beneficiaries. For example, according to CMS:

- Live video telehealth is the most widely available modality for providers, but requires internet bandwidth and a smartphone, tablet, or computer.

- Audio-only telehealth may be more feasible for beneficiaries who do not have access to the necessary internet bandwidth or technology, but limitations exist regarding the types of services that can be delivered via audio-only telehealth.[11]

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[11]See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *State Medicaid & CHIP Telehealth Toolkit, Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1* (Baltimore, Md.: October 2020).

Telehealth in Medicaid and Flexibilities during Emergencies

States have significant flexibility to determine any restrictions and limitations for the delivery of Medicaid services via telehealth, including the services covered and how much providers are paid for delivering telehealth services. These are documented in a state Medicaid plan and amendments to that plan, which must be approved by CMS.

In certain emergency circumstances, the Secretary of HHS has the authority to waive or modify application of certain federal health care program requirements, including Medicaid requirements, to help ensure the availability of care.[12] Since the beginning of the pandemic, CMS has issued guidance to states on implementing various flexibilities—including those related to the delivery of services via telehealth—and on resuming normal activities once the public health emergency has ended. For example, CMS issued

- a toolkit in April 2020 with policy considerations for states to accelerate adoption of broader coverage of telehealth;[13]

- a list of COVID-19 frequently asked questions for state Medicaid agencies, including questions about delivering services via telehealth; and

- a toolkit supplement in October 2020, which was updated in December 2021, with additional information for states about expanding coverage of telehealth and considerations for the use of telehealth after the end of the pandemic.[14]

Using existing authorities, our six selected states changed Medicaid telehealth policies during the pandemic, such as expanding allowable services and modalities, as shown in table 1.

[12]See 42 U.S.C. § 1320b-5 (authority to waive requirements during national emergencies).

[13]See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *State Medicaid & CHIP Telehealth Toolkit, Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version* (Baltimore, Md.: April 2020).

[14]See Department of Health and Human Services, Centers for Medicare & Medicaid Services, State Medicaid & CHIP Telehealth Toolkit, Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1 (Baltimore, Md.: October 2020).

Table 1: Examples of State Telehealth Policies before and during the COVID-19 Pandemic

Domains of telehealth policies		Arizona	California	Maine	Mississippi	Missouri	Tennessee
Services and payments	Primary care	●	●	●	●	●	◑
	Behavioral health	●	●[a]	●	●	●	●
	Physical, occupational, and speech therapies	●[a]	●	●	◑[b]	◑	◑
	Payment parity between telehealth and in-person services	●	●	●[a]	●	●	●
Modalities	Live video	●	●	●	●	●	●
	Asynchronous	●	●	◑	●	●	●
	Remote patient monitoring	●	◑	●	●	●	●
	Audio-only	●[a]	●[a]	●	◑	◑	◑[c]
Providers	Services provided to beneficiaries in their homes	●	●	●[a]	◑	●	◑
	Out-of-state providers allowed	●[a]	●	●[a]	●	◑	●

Key:
◑ Permitted during the pandemic
● Permitted prior to and during the pandemic

Source: GAO analysis of interviews and documents from selected states, Centers for Medicare & Medicaid Services (CMS) documents, and Medicaid and CHIP Payment and Access Commission documents. | GAO-22-104700

[a]Available prior to the pandemic, but with more restrictions.

[b]When permitted, this service was only available to established patients.

[c]When permitted, this modality was only available for certain types of services.

Telehealth Program Integrity and Quality Oversight

States and CMS are responsible for managing program integrity risks in Medicaid, including services delivered via telehealth. States are responsible for day-to-day Medicaid program oversight, such as actions aimed at preventing improper payments, including those that are a result

of fraud.[15] CMS is responsible for managing fraud risks and implementing practices for combating those risks, according to federal standards and guidance.

As part of its responsibility to oversee states' efforts to ensure the quality of services provided to Medicaid beneficiaries, CMS also collects, assesses, and reports on standardized measures of quality of care provided to Medicaid beneficiaries. CMS does this primarily through the Child and Adult Core Sets. These Core Sets include health care quality measures related to primary and preventive care, behavioral health care, and patients' experiences of care. In 2021, there were 32 measures in the Adult Core Set and 23 in the Child Core Set. States report Core Sets measure results to CMS annually, and while state reporting is currently voluntary, certain Core Sets measures are scheduled to become mandatory in 2024.[16]

Quality measures are composed of a number of clinical data elements, or pieces of data, that are needed to calculate providers' performance on any given measure. The measure steward, the entity that typically has developed the measure and is responsible for maintaining it, sets these specifications. CMS is itself a steward for measures for which it has sponsored their development, and it also draws on measures developed and maintained by other agencies and organizations. For example:

- CMS is the measure steward for a Core Set quality measure about the percentage of beneficiaries screened for depression when there is

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[15]An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper payments include payments made as a result of fraud, which involves obtaining something of value through willful misrepresentation, though not all improper payments are the result of fraud.

[16]Beginning with the state reports for 2024, states generally must report all measures included in the Child Core Set and all behavioral health measures included in the Adult Core Set. See 42 U.S.C. §§ 1320b-9a(a)(4)(B) (mandatory reporting of child health quality measures), 1320b-9b(b)(3)(B) (mandatory reporting of adult behavioral health quality measures).

a medical reason, and if positive, for whom a follow-up plan is documented.[17]

- The Agency for Healthcare Research and Quality is the measure steward for The Consumer Assessment of Health Care Providers and Systems, a set of surveys that assess patients' experiences of care that are included in CMS's Core Sets. States may supplement these surveys by adding questions.

According to CMS, the Core Sets are a foundational tool for understanding the quality of health care provided to, and the extent of health disparities experienced by, Medicaid beneficiaries and for targeting opportunities for improving health equity.[18] CMS assesses and publishes state-specific performance on certain Core Set measures, which serves to guide improvement in the quality of care provided to Medicaid beneficiaries and advance health equity.[19] For example, CMS can work with state Medicaid programs to use the Core Sets' measures to identify areas with potential for improvement, and to provide tools and technical assistance for states' quality improvement efforts.

During the pandemic, CMS provided states with updated information from the Core Sets' measure stewards, which clarified how to incorporate services delivered via telehealth into existing quality measures—such as the Adult Core Set and the Child Core Set—that previously were limited to services provided in person. Specifically, in May 2021, CMS issued technical assistance explaining the circumstances under which states

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[17]This measure is in both the Adult Core Set and Child Core Set.

[18]See Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, *2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets*, Informational Bulletin (Baltimore, Md.: Dec. 10, 2021).

[19]CMS assesses state-specific performance for measures that are reported by at least 25 states and that met CMS standards for data quality.

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could include services received via telehealth together with services provided in person when reporting measure results.[20] For example:

- For a measure related to follow-up when a beneficiary visits the emergency department for alcohol or drug abuse, states are permitted to include instances where the follow-up visit was conducted either via telehealth or in-person when reporting results on this measure.

- For certain other measures, such as those assessing the proportion of patients receiving influenza vaccinations, there were no services available through telehealth that were relevant to performance on those measures.

In 2017, the National Quality Forum—an organization that endorses quality measures—issued a report that outlined a framework that identifies measures and serves as a conceptual foundation for new measures, where needed, to assess the quality of care provided using telehealth modalities.[21] The framework included an initial list of existing quality measures to assess the use of telehealth as a means of care delivery and its effect on quality of care. Within that list were some measures that are already included in the Core Sets, such as controlling high blood pressure among those with a hypertension diagnosis and conducting follow-up visits after an individual has an emergency department visit due to a mental illness. The report noted that continual assessment of access to clinical services and the overall experience of receiving care through telehealth, among other things, can help ensure that various modalities of telehealth provide quality care.

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[20]The technical assistance noted 21 measures in the Adult Core Set and 14 measures in the Child Core Set where states could include services received via telehealth together with services provided in person when reporting measure results. See CMS, *Allowance of Telehealth in the 2021 Child, Adult, and Health Home Core Set Measure Specifications* (Baltimore, Md.: May 2021). The National Committee for Quality Assurance is the measure steward for many of the measures used in the Child and Adult Core Sets. The committee noted that it updated certain measures to include services delivered via telehealth, in response to the increase in telehealth utilization during the pandemic and to align with the changes CMS and other stakeholders made to telehealth policies during the pandemic.

[21]See National Quality Forum, *Creating a Framework to Support Measure Development for Telehealth* (Washington, D.C.: Aug. 31, 2017).

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Selected States' Provision of Medicaid Services Delivered via Telehealth Increased Exponentially at the Pandemic's Onset

Medicaid Services Delivered via Telehealth in Selected States Increased from about 2.1 Million to about 32.5 Million in First Year of Pandemic

According to our analysis of T-MSIS data, providers in five of our selected states delivered about 32.5 million total health care services via telehealth from March 2020 through February 2021, the first 12 months of the pandemic.[22] This is an increase from 2.1 million in the year prior.[23] The number of services delivered via telehealth from March 2020 through February 2021 ranged from less than 1 million services in Mississippi and Missouri to 21.3 million services in California. The services most-commonly delivered via telehealth were evaluation and management services, and mental and behavioral health services.[24]

Despite the increase in services delivered via telehealth, the number of services delivered overall for our five selected states (telehealth and non-telehealth) decreased by nearly 64 million during the first 12 months of the pandemic, as compared to the year prior. This suggests that despite

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[22]The selected states were Arizona, California, Maine, Missouri, and Mississippi. We determined that the T-MSIS data in Tennessee were not sufficiently reliable for the purposes of our reporting and excluded the state's data from our analysis. We analyzed T-MSIS data for services, such as physician services and outpatient hospital services, which are not provided by an inpatient hospital, long-term care facility, or pharmacy.

[23]The increase in the number of services delivered via telehealth during the first 12 months of the pandemic is similar to results found by FAIR Health in their National Private Insurance Claims database of more than 32 billion privately billed medical and dental claim records from more than 60 contributors nationwide. FAIR Health is an independent, nonprofit organization that collects data for and manages a database of private health insurance claims data. See FAIR Health, Monthly Telehealth Regional Tracker, accessed Sept. 7, 2021, https://www.fairhealth.org/states-by-the-numbers/telehealth.

[24]Evaluation and management includes office visits, hospital visits, and consultations. Due to limitations in categorizing services delivered via telehealth, we are unable to distinguish between services delivered via live audio-visual telehealth and live audio-only telehealth.

receiving more services delivered via telehealth, beneficiaries in our five selected states likely forewent services during this time.

The percentage of Medicaid services delivered via telehealth in the selected states was also higher during the pandemic than it was before the pandemic, reaching a peak in April 2020 and leveling off at a rate higher than before the pandemic. For example, in California, the percentage of services delivered via telehealth each month during the 12 months prior to the pandemic was never higher than 0.2 percent. In April 2020, this percentage increased to 9.1 percent and has been between 5.7 percent and 7.3 percent since September 2020.

The increase in the percentage of services delivered via telehealth, particularly at the beginning of the pandemic, coincided with state efforts to promote physical distancing and limit time spent away from the home that four of our five selected states had undertaken during most or all of April 2020.[25] In addition, the inventory of personal protective equipment and supplies (such as face masks and gloves) to protect responders and to treat Americans sickened with COVID-19 was largely exhausted in spring 2020, which meant health care providers may not have had the necessary resources to provide care in-person in a safe manner.[26] (See fig. 2 for the number and percentage of services delivered via telehealth in our selected states prior to and during the pandemic.)

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[25]For example, Arizona issued an executive order on March 30, 2020, to promote physical distancing, while also encouraging social connectedness. Similar efforts were not undertaken in Missouri, according to state Medicaid officials.

[26]See GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, GAO-20-625 (Washington, D.C.: June 25, 2020).

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Figure 2: Number and Percentage of Medicaid Services Delivered via Telehealth in Selected States, March 2019 through February 2021

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Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the selected states' telehealth definitions. We analyzed T-MSIS

data for health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary. Services delivered via telehealth are potentially underreported in California due to limitations in how the place of service (either via telehealth or not via telehealth) was documented for services delivered via telehealth in certain settings at the time of our report.

About 4.9 Million Beneficiaries in Selected States Received Services via Telehealth during the First 12 Months of the Pandemic

According to our analysis of T-MSIS data, about 4.9 million unique Medicaid beneficiaries in our five selected states received at least one service via telehealth from March 2020 through February 2021.[27] This is a more than tenfold increase from the approximately 455,000 unique beneficiaries receiving at least one service via telehealth in the 12 months prior to the pandemic (March 2019 through February 2020).

The percentage of unique beneficiaries receiving at least one service via telehealth increased in all five selected states during the pandemic. For example, in Arizona, 11 percent of unique beneficiaries received at least one of their services via telehealth in the 12 months prior to the pandemic, a percentage that increased to 43.8 percent during the first 12 months of the pandemic. Arizona officials said the state had been active in delivering services via telehealth prior to the pandemic and had updated their telehealth policy in October 2019, months prior to the beginning of the pandemic. (See fig. 3 for the percentage of unique beneficiaries receiving at least one of their services via telehealth in each of the selected states in the year prior to and during the first year of the pandemic.)

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[27]A beneficiary receiving at least one service via telehealth in multiple months from March 2020 through February 2021 would count once toward this total.

Figure 3: Percentage of Medicaid Beneficiaries in Selected States Receiving at Least One of Their Services via Telehealth, March 2019 through February 2020 and March 2020 through February 2021

Percentage

State	March 2019-February 2020	March 2020-February 2021
Arizona	11.0	43.8
California	2.5	41.4
Maine	2.5	41.8
Mississippi	1.2	25.4
Missouri	2.3	19.9

■ March 2019-February 2020
■ March 2020-February 2021

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the selected states' telehealth definitions. For each 12-month period, the percentage is the number of beneficiaries who received at least one service delivered via telehealth divided by the number of beneficiaries receiving services by any means (for example, in-person or via telehealth). A beneficiary receiving services in multiple months from March 2020 through February 2021 counts once toward this total. We analyzed T-MSIS data for health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary. The percentage of beneficiaries receiving services delivered via telehealth are potentially underreported in California due to limitations in how the place of service (either via telehealth or not via telehealth) was documented for services delivered via telehealth in certain settings at the time of our report.
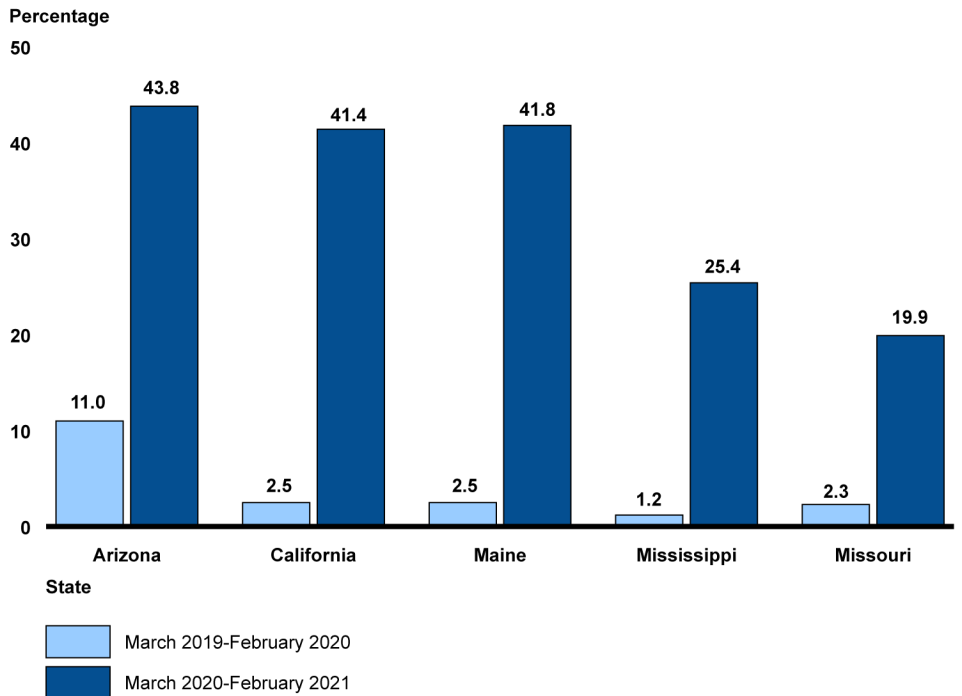
In the four states with sufficiently complete data on the race and ethnicity of beneficiaries (California, Maine, Mississippi, and Missouri), we found that each race and ethnicity group experienced the same general pattern of increases in telehealth use described previously—namely, that telehealth use spiked in April 2020 and has decreased somewhat since

then.[28] However, the percentage of eligible beneficiaries with unknown race and ethnicity in the first 12 months of the pandemic in these four states was between 8.1 percent and 13.3 percent each month, which can obscure trends that may be occurring between different race or ethnicity groups.[29]

Our analysis found that in one state with generally reliable data, state T-MSIS race and ethnicity data could not be used. According to our T-MSIS analysis, race and ethnicity data in Arizona was reported as unknown for over 30 percent of Medicaid beneficiaries in each of the first 12 months of the pandemic. In January 2021, we reported that CMS asked states to focus on improving the accuracy and completeness of beneficiary eligibility data in T-MSIS, which includes beneficiaries' race and ethnicity.[30] We reported that 21 of 50 states had acceptable race and ethnicity data for 2016.[31] We also noted in that report that we have made at least 13 recommendations between July 2014 and September 2020 related to improving T-MSIS data and expediting their use for program oversight. As of September 2020, CMS had taken action to address five of these recommendations, and had not yet fully addressed eight. Implementing these recommendations would help CMS strengthen program oversight through improved T-MSIS data.

Accurate and complete race and ethnicity data are particularly important in light of our recent work on health disparities experienced by racial and ethnic groups. As we noted, complete reporting of race and ethnicity information by states, and the routine analysis of health outcomes using these data, can, in the case of Medicaid, help states and the federal government better understand existing health disparities and take actions

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[28]In these four states, the percentage of eligible beneficiaries with unknown race and ethnicity in the first 12 months of the pandemic was below 15 percent each month.

[29]The percentage of unknown values for other demographic categories (age, gender, and rural or urban area) was lower than for race and ethnicity. It was never higher than 6.2 percent in any state in any month.

[30]See GAO, *Medicaid: Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met*, GAO-21-196 (Washington, D.C.: Jan. 14, 2021).

[31]We referred to states' data that CMS determined as having low data quality concern as acceptable data. The 2016 T-MSIS files we reviewed at that time included data from 49 states and the District of Columbia (collectively referred to as states). CMS excluded Arkansas from the 2016 files due to significant data quality issues.

to promote health equity.[32] In addition, in November 2021, the CMS Administrator noted the need for accurate race and ethnicity data and a commitment to work with states to improve measurement of health disparities in describing the agency's strategic vision for Medicaid.[33]

Our T-MSIS analysis of other demographic data in the five selected states showed variation in the percentage of beneficiaries who received at least one of their services via telehealth in a given month. Specifically:

- **Age.** In each state, the percentage of beneficiaries in the 65 years old and older age group receiving at least one of their services via telehealth in a given month was the lowest, and therefore, the percentage receiving all of their services through other means—for example, through in-person visits—was the highest.[34] T-MSIS data do not include claims paid by Medicare for beneficiaries who are enrolled in both Medicaid and Medicare.

- **Gender.** In three states, a larger percentage of male beneficiaries received at least one of their services via telehealth in a given month than female beneficiaries.[35]

- **Rural or urban area.** In each selected state, a larger percentage of beneficiaries living in urban areas received at least one of their services via telehealth in a given month than beneficiaries living in rural areas.[36]

See figures 4 through 8 for more demographic information about the use of health care services delivered via telehealth from each of our five selected states during the first 12 months of the COVID-19 pandemic.

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[32]See GAO, *Health Care Capsule: Racial and Ethnic Health Disparities*, GAO-21-105354 (Washington, D.C.: Sept. 23, 2021).

[33]See Health Affairs Blog, *A Strategic Vision for Medicaid and The Children's Health Insurance Program (CHIP)* (Nov. 16, 2021).

[34]We analyzed three age groups: under 19 years of age, 19 to 64, and 65 years of age and older. How often these beneficiaries received services paid by Medicare via telehealth was beyond the scope of our work.

[35]T-MSIS data include the following genders: male and female.

[36]To determine whether beneficiaries lived in a rural or urban area of their states, we compared the county each beneficiary lives in, as reported in T-MSIS, to the CMS Core Based Statistical Area state and county code, which we used to define rural and urban areas.

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Figure 4: Arizona: Number and Percentage of Medicaid Beneficiaries Receiving Services via Telehealth, Overall and by Selected Demographic Categories, March 2020 through February 2021

NUMBER OF BENEFICIARIES, BY TYPE OF SERVICES

Number receiving services (in thousands)

Telehealth services   Non-telehealth services

PERCENTAGE OF BENEFICIARIES, BY AGE

Percentage receiving telehealth services

Under 19 years old   19 to 64 years old   65 years old and above

PERCENTAGE OF BENEFICIARIES, BY GENDER

Percentage receiving telehealth services

Female   Male

PERCENTAGE OF BENEFICIARIES, BY GEOGRAPHY

Percentage receiving telehealth services

Rural   Urban

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the state's telehealth definitions. We analyzed T-MSIS data for health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary.
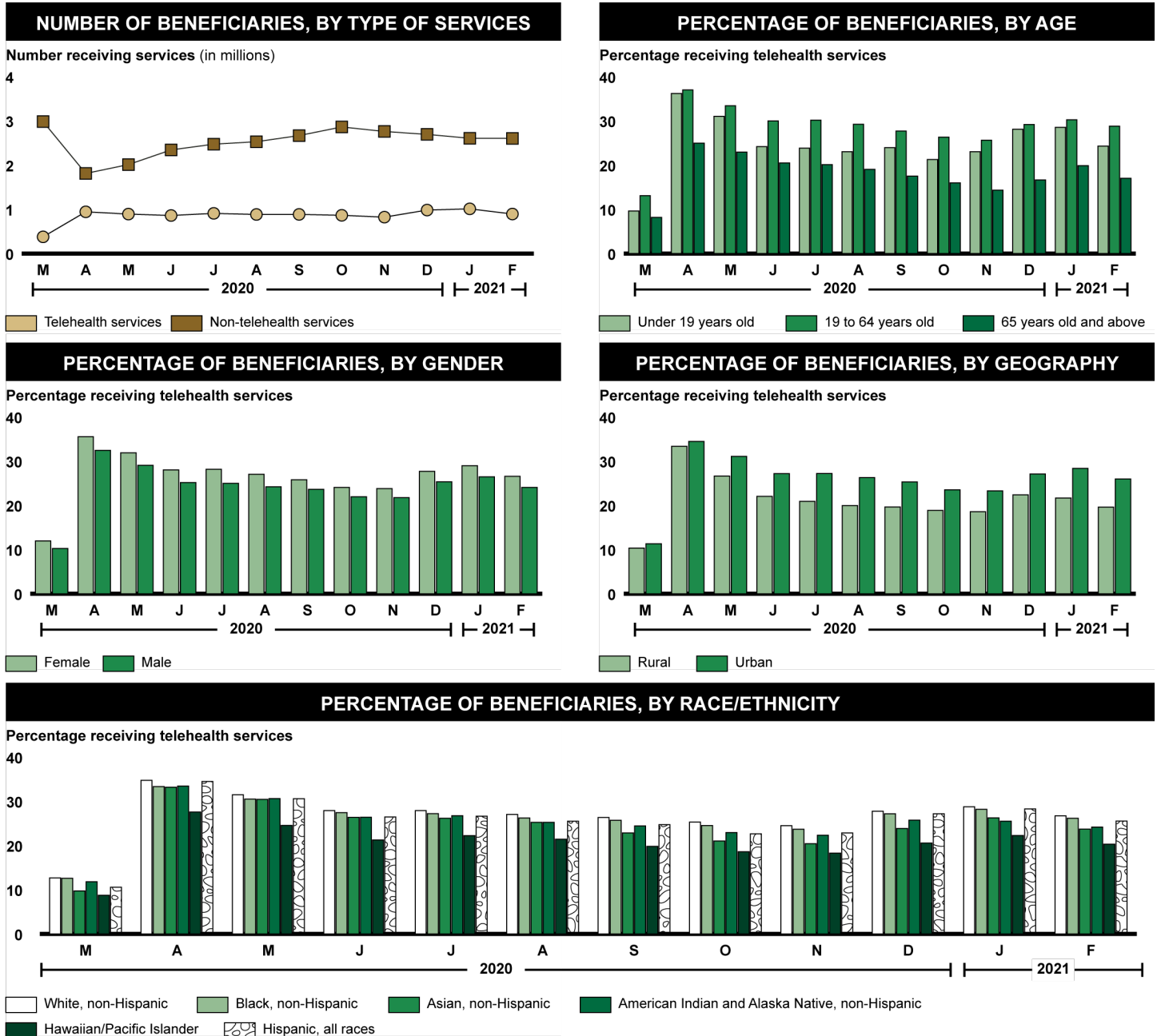
Figure 5: California: Number and Percentage of Medicaid Beneficiaries Receiving Services via Telehealth, Overall and by Selected Demographic Categories, March 2020 through February 2021

NUMBER OF BENEFICIARIES, BY TYPE OF SERVICES

Number receiving services (in millions)

Legend: Telehealth services, Non-telehealth services

PERCENTAGE OF BENEFICIARIES, BY AGE

Percentage receiving telehealth services

Legend: Under 19 years old, 19 to 64 years old, 65 years old and above

PERCENTAGE OF BENEFICIARIES, BY GENDER

Percentage receiving telehealth services

Legend: Female, Male

PERCENTAGE OF BENEFICIARIES, BY GEOGRAPHY

Percentage receiving telehealth services

Legend: Rural, Urban

PERCENTAGE OF BENEFICIARIES, BY RACE/ETHNICITY

Percentage receiving telehealth services

Legend: White, non-Hispanic; Black, non-Hispanic; Asian, non-Hispanic; American Indian and Alaska Native, non-Hispanic; Hawaiian/Pacific Islander; Hispanic, all races
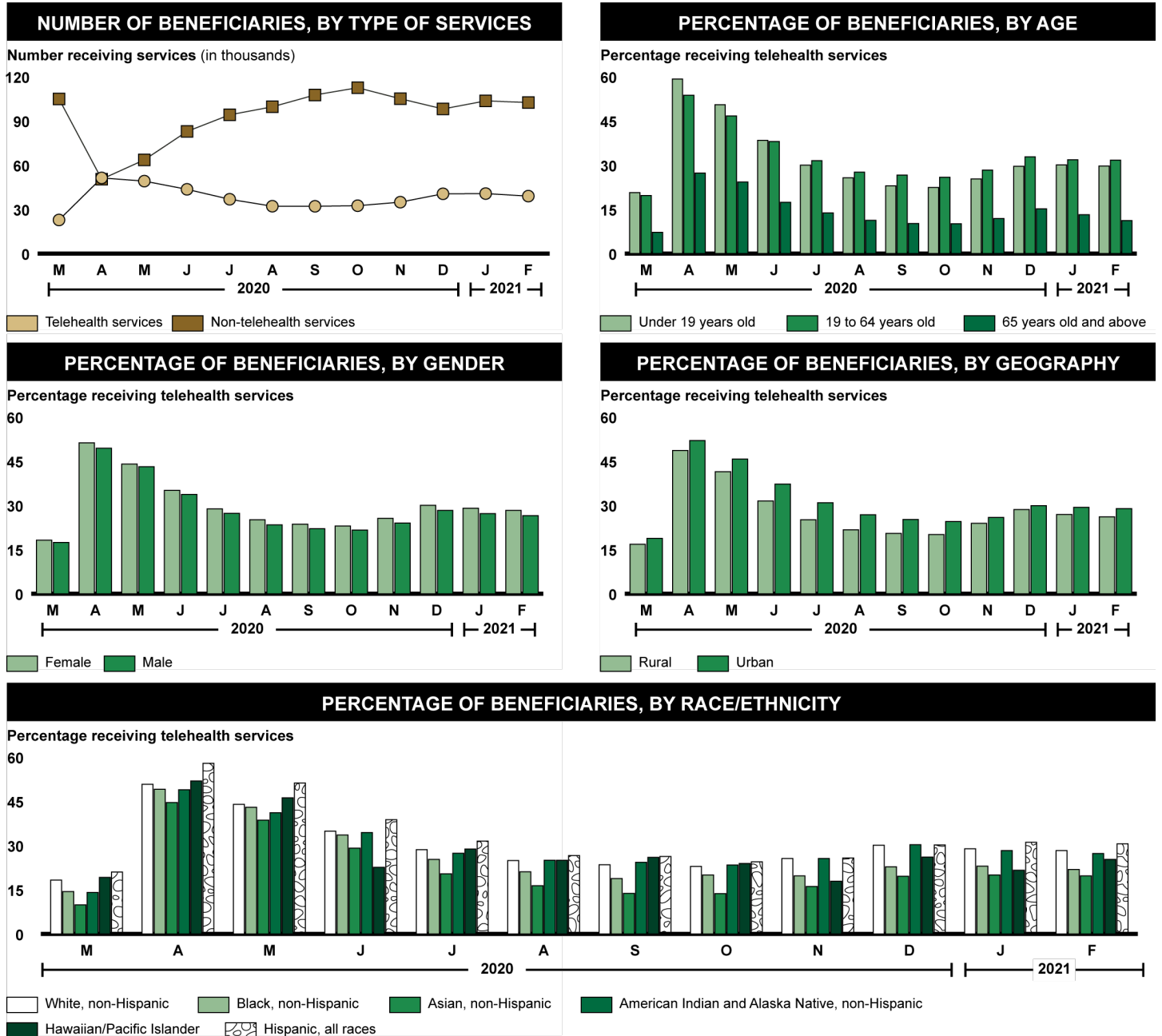
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the state's telehealth definitions. We analyzed T-MSIS data for

health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary. The percentage of eligible beneficiaries with unknown race/ ethnicity in the first 12 months of the pandemic was between 8.1 percent and 9.6 percent each month. Services delivered via telehealth are potentially underreported in California due to limitations in how the place of service (either via telehealth or not via telehealth) was documented for services delivered via telehealth in certain settings at the time of our report.

Figure 6: Maine: Number and Percentage of Medicaid Beneficiaries Receiving Services via Telehealth, Overall and by Selected Demographic Categories, March 2020 through February 2021

NUMBER OF BENEFICIARIES, BY TYPE OF SERVICES

Number receiving services (in thousands)

Legend:
- Telehealth services
- Non-telehealth services

PERCENTAGE OF BENEFICIARIES, BY AGE

Percentage receiving telehealth services

Legend:
- Under 19 years old
- 19 to 64 years old
- 65 years old and above

PERCENTAGE OF BENEFICIARIES, BY GENDER

Percentage receiving telehealth services

Legend:
- Female
- Male

PERCENTAGE OF BENEFICIARIES, BY GEOGRAPHY

Percentage receiving telehealth services

Legend:
- Rural
- Urban

PERCENTAGE OF BENEFICIARIES, BY RACE/ETHNICITY

Percentage receiving telehealth services

Legend:
- White, non-Hispanic
- Black, non-Hispanic
- Asian, non-Hispanic
- American Indian and Alaska Native, non-Hispanic
- Hawaiian/Pacific Islander
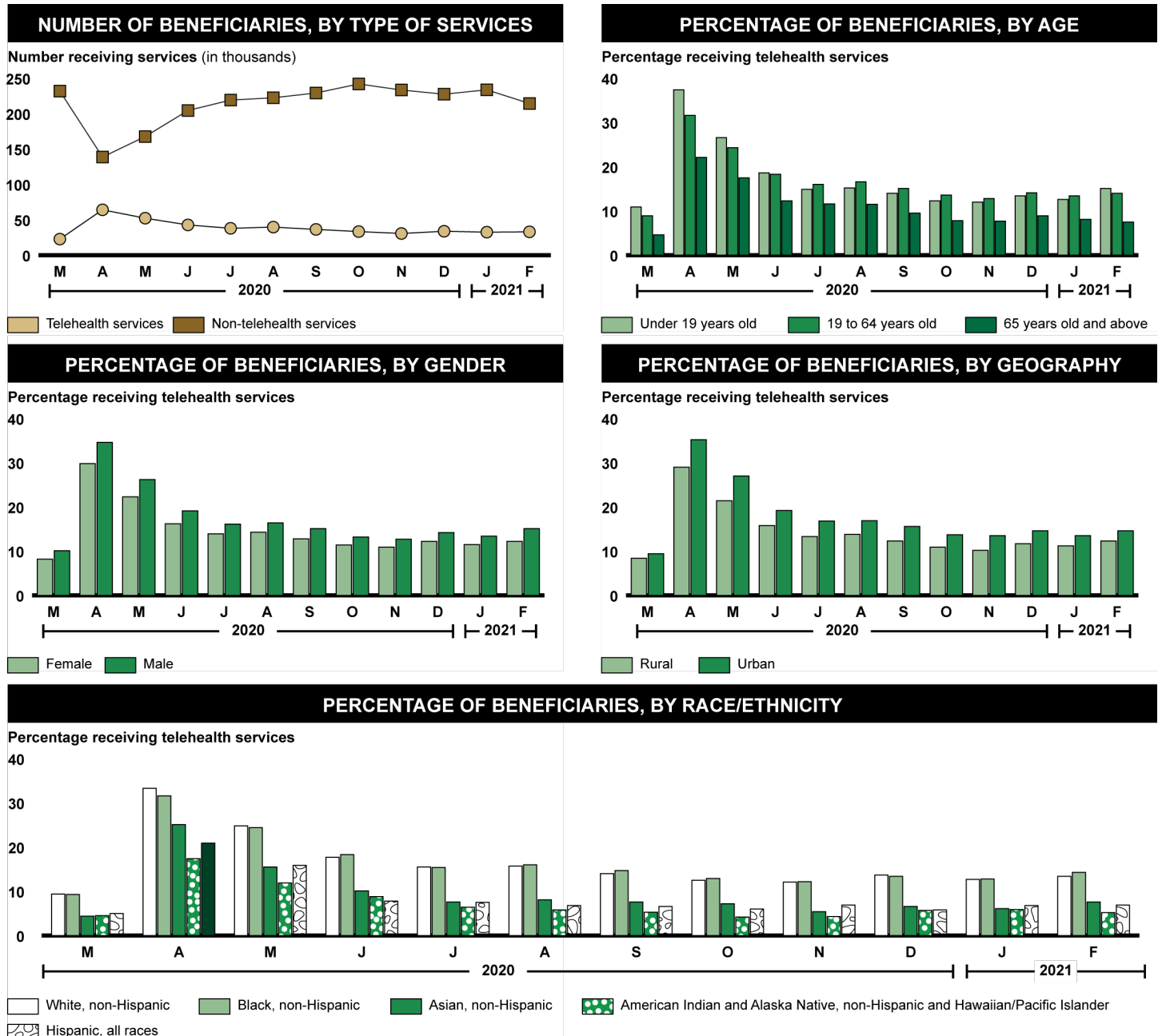- Hispanic, all races

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the state's telehealth definitions. We analyzed T-MSIS data for

health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary. The percentage of eligible beneficiaries with unknown race/ ethnicity in the first 12 months of the pandemic was between 9.3 percent and 11.1 percent each month.

Figure 7: Mississippi: Number and Percentage of Medicaid Beneficiaries Receiving Services via Telehealth, Overall and by Selected Demographic Categories, March 2020 through February 2021

NUMBER OF BENEFICIARIES, BY TYPE OF SERVICES

Number receiving services (in thousands)

Telehealth services   Non-telehealth services

PERCENTAGE OF BENEFICIARIES, BY AGE

Percentage receiving telehealth services

Under 19 years old   19 to 64 years old   65 years old and above

PERCENTAGE OF BENEFICIARIES, BY GENDER

Percentage receiving telehealth services

Female   Male

PERCENTAGE OF BENEFICIARIES, BY GEOGRAPHY

Percentage receiving telehealth services

Rural   Urban

PERCENTAGE OF BENEFICIARIES, BY RACE/ETHNICITY

Percentage receiving telehealth services

White, non-Hispanic   Black, non-Hispanic   Asian, non-Hispanic   American Indian and Alaska Native, non-Hispanic and Hawaiian/Pacific Islander
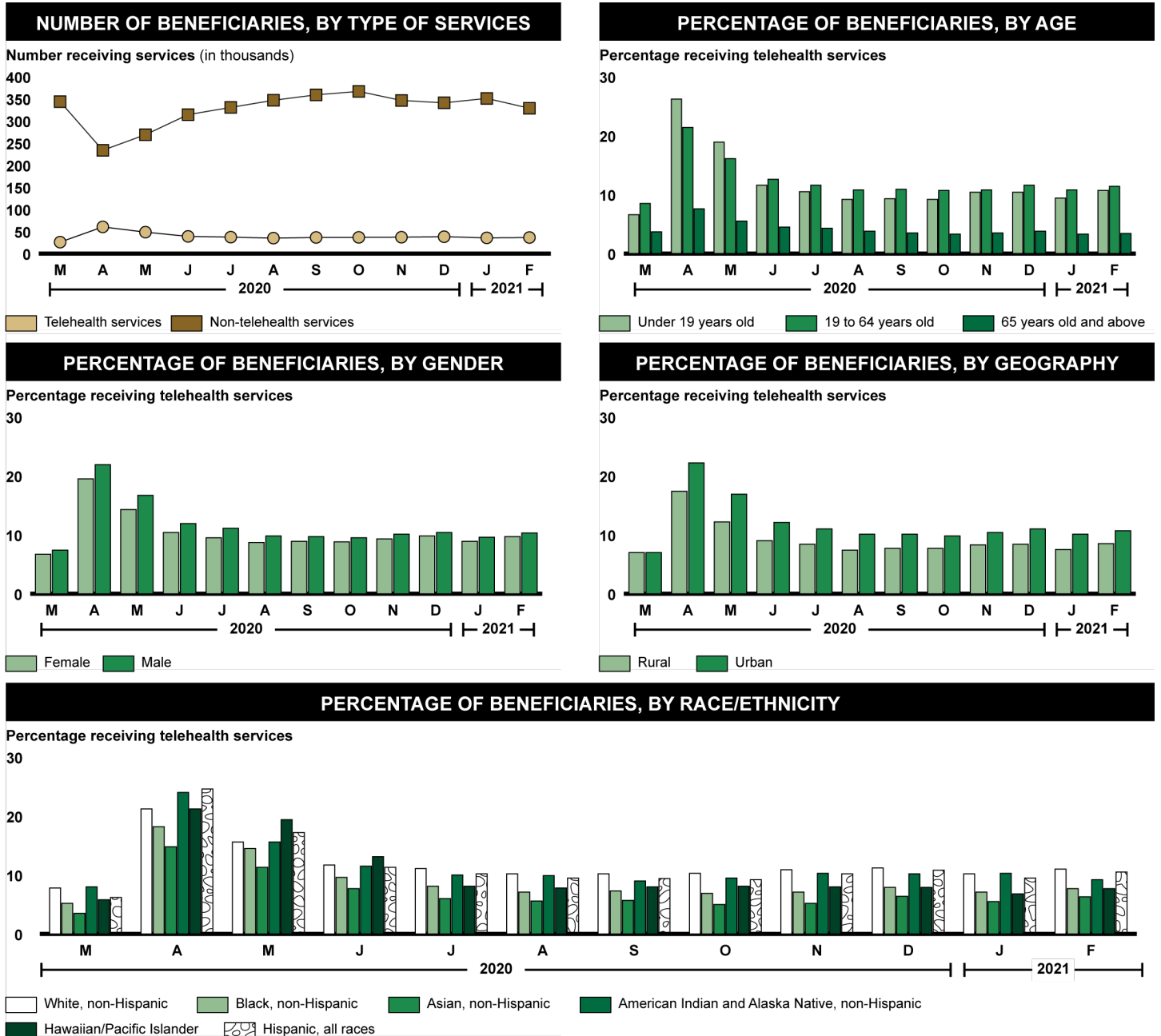Hispanic, all races

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the state's telehealth definitions. We analyzed T-MSIS data for

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health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary. The percentage of eligible beneficiaries with unknown race/ ethnicity in the first 12 months of the pandemic was between 12.1 percent and 12.5 percent each month.

Figure 8: Missouri: Number and Percentage of Medicaid Beneficiaries Receiving Services via Telehealth, Overall and by Selected Demographic Categories, March 2020 through February 2021

NUMBER OF BENEFICIARIES, BY TYPE OF SERVICES

Number receiving services (in thousands)

Legend:
- Telehealth services
- Non-telehealth services

PERCENTAGE OF BENEFICIARIES, BY AGE

Percentage receiving telehealth services

Legend:
- Under 19 years old
- 19 to 64 years old
- 65 years old and above

PERCENTAGE OF BENEFICIARIES, BY GENDER

Percentage receiving telehealth services

Legend:
- Female
- Male

PERCENTAGE OF BENEFICIARIES, BY GEOGRAPHY

Percentage receiving telehealth services

Legend:
- Rural
- Urban

PERCENTAGE OF BENEFICIARIES, BY RACE/ETHNICITY

Percentage receiving telehealth services

Legend:
- White, non-Hispanic
- Black, non-Hispanic
- Asian, non-Hispanic
- American Indian and Alaska Native, non-Hispanic
- Hawaiian/Pacific Islander
- Hispanic, all races

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104700

Notes: We categorized services as being delivered either via telehealth or not via telehealth (such as through in-person visits) based on the state's telehealth definitions. We analyzed T-MSIS data for

health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, specifically those that can be directly tied to a service for a specific beneficiary. The percentage of eligible beneficiaries with unknown race/ ethnicity in the first 12 months of the pandemic was between 8.1 percent and 13.3 percent each month.

Selected State Medicaid Officials Reported Positive Effects from Pandemic Expansions of Telehealth, and Some States Have Begun Adjusting Telehealth Policies

Selected State Medicaid Officials Reported Supporting Beneficiaries' Access to Care among Telehealth's Benefits, but Identified Some Limitations

Medicaid officials from all six selected states we interviewed said the increased use of telehealth during the pandemic supported their primary goal of maintaining beneficiary access to health care services. Officials noted that expanding the use of telehealth during the pandemic often mitigated pandemic-specific obstacles to receiving care. For example:

- **Reducing COVID-19 exposures.** Officials from all six selected states said providing services via telehealth during the pandemic allowed people to receive those services remotely, lowering their risk of being exposed to COVID-19.

- **Providing alternative care sites.** Officials in Arizona, California, Mississippi, and Tennessee said telehealth helped maintain access to services when in-person visits were not recommended or available, such as continuing school-based therapies while schools were closed.[37] Officials from Arizona and Mississippi noted that telehealth

[37]States may use their Medicaid programs to pay for certain health services provided to eligible children by schools, including diagnostic screening, and ongoing treatment, such as physical therapy.

was particularly helpful for delivering services during stay-at-home orders.

State Medicaid officials also provided the following examples of other obstacles to accessing care that were mitigated by delivering services via telehealth:

- **Privacy.** Officials from Maine and Mississippi said beneficiaries reported feeling more comfortable receiving behavioral health services at home than in-person. Maine officials said it was because telehealth gave beneficiaries more privacy, and Mississippi officials said it addressed beneficiaries' concerns about visiting a mental health center. According to officials from California, Maine, and Mississippi, more beneficiaries sought behavioral health services via telehealth during the pandemic than before the pandemic.[38] Maine officials said more beneficiaries may have used behavioral health services via telehealth either because of the psychological effects of the pandemic or because telehealth increased access to behavioral health services. As noted earlier, we found that behavioral health services were among the services most-commonly delivered via telehealth during the first 12 months of the pandemic.[39]

- **Child care and transportation issues.** Officials from California and Tennessee said beneficiaries could attend their medical appointments more easily through various telehealth modalities, eliminating obstacles for beneficiaries to in-person appointments, such as arranging child care and transportation. Studies from the National Committee for Quality Assurance, the American Psychiatry Association, and the health care journal *Telemedicine and e-Health* also found that delivering services via telehealth reduced no-show

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[38]A recent CMS data snapshot noted that overall use of behavioral health services declined during the pandemic, but did not discuss the use of behavioral health services delivered via telehealth during the pandemic. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid & CHIP and the COVID-19 Public Health Emergency* (Baltimore, Md.: May 2021). As we noted previously, while the number of services delivered via telehealth has increased during the first 12 months of the pandemic, the number of services delivered overall has decreased during this time.

[39]A recent report from the HHS Office of Inspector General found that telehealth, particularly live video telehealth, can be used to provide behavioral health services, including mental health assessments, individual therapy, and medication management. The report noted that telehealth could improve beneficiaries' access to behavioral health services, based on available state evaluations of telehealth during the pandemic. See Department of Health and Human Services, Office of Inspector General, OEI-02-19-00401.

rates.[40] Officials from America's Health Insurance Plans similarly told us that telehealth saves patients time and money by reducing the need to travel to appointments or find child care before seeing a doctor.

Medicaid officials from all six selected states also cited limitations of delivering services via telehealth. Examples cited by the officials included the following:

- **Less-comprehensive well-child visits.** Officials in Arizona, California, Maine, Missouri, and Tennessee raised concerns about conducting well-child visits via telehealth.[41] For example, officials in Arizona and California noted that a provider could not conduct a comprehensive assessment of a child's physical symptoms via telephone, and it may be more difficult to hold a child's attention during a telehealth visit, particularly if the child has behavioral health needs. Officials from Maine said well-child visits generally involve services that providers can only deliver in person, such as vaccine administration and physical examination. Maine officials said they expected providers to follow-up each virtual well-child visit with an in-person visit, to ensure that the child received all the services included in a well-child visit. An official in Missouri said telehealth could not provide children with the same level of care as a well-child visit delivered in-person, so the state did not cover well-child visits provided via telehealth.

- **Limited effectiveness for physical therapy.** Officials in Mississippi and Tennessee said they had concerns about whether delivering physical therapy services via telehealth was as effective as delivering them in-person. Officials from Mississippi said they addressed this limitation by only permitting established patients to receive physical therapy via telehealth.

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[40]See Taskforce on Telehealth Policy, National Committee for Quality Assurance, *Findings and Recommendations* (September 2020); American Psychiatric Institute, *Psychiatrists Use of Telepsychiatry During COVID-19 Public Health Emergency Survey Results* (July 2021); and Brenden Drerup et al., "Reduced No-Show Rates and Sustained Patient Satisfaction of Telehealth during the COVID-19 Pandemic," *Telemedicine and e-Health*, vol. 27, no. 12 (2021): 1409-1415.

[41]According to the American Academy of Pediatrics, where community circumstances require pediatricians to limit in-person well-child visits, the visits may be conducted through telehealth, recognizing that some elements of the well-child exam should be completed in-person once community circumstances allow.

- **Provider technological barriers.** Officials from California and Maine said providers initially struggled to acquire the proper equipment and develop an infrastructure to deliver services via telehealth. In response, officials from California said they gave providers additional supports through new grant opportunities and reimbursement of telehealth equipment, and officials from Maine reported providing technical assistance support. In the December 2021 telehealth toolkit supplement CMS made available to states, CMS noted that states used a variety of methods to reach out and support providers, including written guidance, webinars, and phone calls.[42]

- **Beneficiary technological barriers.** Officials in Arizona, California, Maine, Mississippi, and Tennessee said beneficiaries may lack the equipment necessary for live video, such as smartphones, computers, or broadband internet. The HHS Office of Inspector General also identified technological barriers to telehealth in its review of the use of telehealth to deliver behavioral health services, including the cost of telehealth infrastructure and limited internet connectivity for both providers and beneficiaries.[43] Officials from Arizona, California, Mississippi, and Missouri said delivering services via audio-only telehealth helped ensure access to care for beneficiaries lacking access to broadband internet. Officials from Maine and Tennessee said they preferred interactive telehealth provided via live video, but allowed services to be delivered via audio-only telehealth when interactive telehealth was not available.

Medicaid officials from our selected states provided examples of how CMS actions, existing state policies, and Medicare and private health insurers' coverage of telehealth services helped them respond to the pandemic.

- **CMS and HHS actions and guidance.** Officials highlighted several CMS and HHS actions they found particularly helpful during the pandemic, including CMS's guidance on state plan amendments; CMS's prompt approval of emergency state plan amendments; and HHS's decision to exercise enforcement discretion to waive potential

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[42]See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *State Medicaid & CHIP Telehealth Toolkit, Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1* (Washington, D.C.: December 2021).

[43]See Department of Health and Human Services, Office of Inspector General, *States Reported Multiple Challenges With Using Telehealth To Provide Behavioral Health Services to Medicaid Enrollees*, OEI-02-19-00400 (Washington, D.C.: September 2021).

penalties for violations of Health Insurance Portability and Accountability Act requirements against providers in certain circumstances in connection with their provision of telehealth during the COVID-19 public health emergency.[44]

- **Pre-pandemic state telehealth policies.** Officials from Arizona, California, and Maine said having established telehealth policies before the pandemic made it easier for them to support providers' use of telehealth during the pandemic. For example, California officials said pre-existing telehealth policies made them more prepared for the pandemic and helped them expand the state's telehealth infrastructure during the pandemic.

- **Medicare and private health insurance telehealth coverage.** Officials from Maine and Tennessee said Medicare and private insurance coverage of telehealth services during the pandemic gave providers more incentive to deliver services via telehealth to Medicaid beneficiaries.[45] For example, officials from Tennessee said having telehealth services covered by all insurers made it easier and more cost-effective for providers to develop the processes to deliver services via telehealth during the pandemic.

Selected State Medicaid Officials Have Made or Considered Post-Pandemic Telehealth Modifications, Including Changes for Audio-Only Telehealth

Medicaid officials in our selected states reported that as of November 2021 they had implemented or were considering various modifications to how health care services delivered via telehealth will be covered and paid for when the pandemic ends. Officials said access to care; quality of care; patient privacy; and risks of fraud, waste, and abuse for services delivered via telehealth were among the factors they were taking into account when considering post-pandemic modifications.

- **Audio-only telehealth.** Officials from our selected states said they had modified or were considering modifying coverage of audio-only

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[44]The Health Insurance Portability and Accountability Act of 1996, as amended, provides protections for the privacy and security of certain health information, including through standards governing remote communications technologies. See Pub. L. No. 104-191, tit. II, sub. F, 110 Stat. 1936, 2021. See also Department of Health and Human Services, Office for Civil Rights, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Washington, D.C.: March 2020).

[45]Typically in Medicare, telehealth services may only be furnished under limited circumstances; for example, in certain (largely rural) areas, to patients located in certain medical facilities. In response to COVID-19, the Secretary of HHS has waived or modified certain Medicare telehealth requirements, such as allowing Medicare telehealth services to be furnished to patients nationwide (including nonrural areas) and at any location, including patient homes. See GAO-20-625.

telehealth after the pandemic. Arizona officials said the state limited which services could receive reimbursement when delivered via audio-only telehealth starting in January 2022. Mississippi officials said the state stopped permitting any services to be delivered via audio-only telehealth in November 2021. Examples of audio-only telehealth changes the states were considering included the following:

- California officials said they were considering audio-only telehealth limitations, because while audio-only telehealth increased access to care, it could become vulnerable to fraud, waste, and abuse.

- Maine officials said they expected to permit services to be delivered via audio-only telehealth after the pandemic when live video telehealth was unavailable, but said that their state legislature would ultimately determine its post-pandemic policies for audio-only telehealth.

- Some state officials also noted that any modifications to coverage of audio-only telehealth would affect beneficiaries' access to care, because many beneficiaries lack access to a smartphone, computer, or internet connection.

- **Site and type of services.** Some state officials told us they would continue or were considering continuing modifications to the sites of service and the types of services permitted to be delivered via telehealth after the pandemic.

  - Officials from Mississippi said they would continue allowing Medicaid beneficiaries to receive telehealth services from their homes after the pandemic.

  - Maine officials said that while they allowed Medicaid beneficiaries to receive telehealth services from their home before the pandemic, they greatly loosened restrictions on receiving services from their homes during the pandemic and would continue those loosened restrictions after the pandemic.[46]

  - Tennessee officials said they were considering continuing to allow telehealth services from beneficiaries' homes after the pandemic.

  - Officials from Maine and Mississippi said they planned to continue allowing certain services to be delivered via telehealth after the pandemic that had not previously been covered, such as physical

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[46]Arizona, California, Maine, and Missouri permitted Medicaid beneficiaries to receive telehealth services from their homes before the pandemic.

therapy for established patients, virtual check-ins, and remote consultations.

Selected States Used Various Activities to Oversee Medicaid Telehealth; CMS Took Certain Fraud Risk Assessment Actions

Officials from Selected States Described Activities to Oversee Medicaid Program Integrity Risks Related to Telehealth

State Medicaid officials from all six selected states described conducting program integrity activities related to risks of fraud, waste, and abuse that may result from services delivered via telehealth. For example:

- **Written guidance.** Medicaid officials from the six selected states discussed providing written guidance on telehealth. For example, Arizona officials said they provide updates on telehealth policies on a telehealth web page and through frequently asked questions. California officials said they have a COVID-19 website with telehealth information for providers and beneficiaries.

- **Technical assistance.** Medicaid officials from all six states discussed how they offered technical assistance to providers on telehealth. Maine officials said they conducted webinars to update providers on telehealth billing and coding guidance. Mississippi officials said they respond to provider questions about providing specific services via telehealth, such as well-child visits.

- **Data analysis.** Medicaid officials from all six selected states mentioned conducting data analysis related to ensuring program integrity for services delivered via telehealth. Missouri officials said they are reviewing data to ensure providers did not bill for services delivered via telehealth when telehealth was not permitted. Tennessee officials said they are reviewing data for outliers, such as providers who billed for an excessive number of claims in a single day.

Medicaid officials from some selected states discussed investigations of services delivered via telehealth for possible fraud, waste, and abuse. For example, officials from one state discussed investigating a provider who billed the state Medicaid program for an unusually large number of services delivered via telehealth. Officials from some of these states said

the investigations so far determined no fraud occurred, but as of November 2021, some states had ongoing investigations.

CMS Evaluated Certain Fraud Risk Elements and Implemented Mitigation Strategies

CMS officials said evaluating and mitigating the fraud risks of telehealth became a primary focus for the agency once the pandemic began and telehealth utilization increased. As noted earlier, fraud risk exists when individuals have an opportunity to engage in fraudulent activity, have an incentive or are under pressure to commit fraud, or are able to rationalize committing fraud. In December 2020 and April 2021, CMS identified fraud risks due to expanded telehealth use during the pandemic and documented the agency's findings. In taking this step, CMS incorporated into its oversight some elements of the fraud risk assessment process from *A Framework for Managing Fraud Risks in Federal Programs*.[47]

CMS identified the following potential types of risk due to the expansion of telehealth:

- Providers could bill states for services that are not medically necessary or not provided.

- Providers could collect beneficiary information and use that information for fraudulent billing.

- Providers could bill states incorrectly due to confusion about new telehealth policies.

- States could pay for services that are not eligible for payment.

The types of risk CMS identified are not unique to telehealth. However, we have previously reported that the delivery of services via telehealth may pose increased fraud risks related to the potential for increased spending and lack of complete data, even if the types of risk are not unique to telehealth.[48] CMS also evaluated the risk level of each type of fraud risk by identifying the effect and likelihood of financial harm and patient harm and ranking them as low, medium, or high. CMS officials

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[47]See GAO-15-593SP. Assessing fraud risks generally involves the following five actions: (1) identify inherent fraud risks affecting the program; (2) assess the likelihood and impact of inherent fraud risks; (3) determine fraud risk tolerance; (4) examine the suitability of existing fraud controls and prioritize residual fraud risks; and (5) document the program's fraud risk profile.

[48]See GAO, *Medicare and Medicaid: COVID-19 Program Flexibilities and Considerations for Their Continuation*, GAO-21-575T (Washington, D.C.: May 19, 2021).

said agency officials and senior leadership determined these rankings based on their knowledge of program integrity issues.

According to agency officials, CMS implemented activities to mitigate each of the identified risks. The activities CMS implemented include some identified as leading practices in *A Framework for Managing Fraud Risks in Federal Programs*; specifically, data analytics and fraud-awareness initiatives. (See table 2.)

Table 2: Examples of CMS Activities to Mitigate Identified Risks in Delivering Services via Telehealth

Type of leading practice	Description of mitigation activity
Fraud-awareness initiatives	• In July 2021, CMS provided states with an optional tool to evaluate fraud risks created by COVID-19 flexibilities and waivers, including telehealth. CMS presented a suggested set of questions states may consider when assessing fraud risks related to services delivered via telehealth during a webinar about the tool.
	• CMS hosted technical assistance calls that provided opportunities for states to share their experiences regarding oversight of services. Several of these calls included discussion of services provided via telehealth, such as strategies for conducting analysis.
	• CMS conducted a training for states that explained how states could conduct their own fraud risk assessment to identify the potential for fraud resulting from COVID-19 flexibilities, including telehealth.
Data analytics	• Unified Program Integrity Contractors analyzed claims data for indications of potentially fraudulent activities, such as an unusually large number of claims for services delivered via telehealth.[a]
	• CMS used National Correct Coding Initiative edits—algorithms that identify service claims that do not meet certain criteria—to prevent payment for services that are not covered, such as services that should not be billed at the same time.[b]

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documents. | GAO-22-104700

[a]The Unified Program Integrity Contractors perform activities to identify and prevent fraud, waste, and abuse in Medicaid and Medicare. CMS instructed Unified Program Integrity Contractors to conduct analyses of Medicaid claims using data from the Transformed Medicaid Statistical Information System to the maximum extent possible as of August 2021.

[b]CMS temporarily suspended National Correct Coding Initiative edits, but finished re-implementing these processes as of January 2021.

As a result of these mitigation activities, CMS has opened investigations into potential fraud related to services delivered via telehealth across multiple states. CMS officials said they will continue to update their processes for data analysis to identify new and emerging fraud trends related to telehealth.

While CMS has implemented some elements of the fraud risk framework, agency officials said they had not determined fraud risk tolerance—the amount of fraud risk an agency is willing to accept, since fraud risk cannot be completely eliminated—for services delivered via telehealth. As of

September 2021, CMS had not determined fraud risk tolerance and had no plans to do so.[49] CMS officials said they considered the risk of fraud due to the use of services delivered via telehealth during the pandemic to be minimal in comparison to the health risks of in-person services or foregone care.

In December 2021 and February 2022—after CMS had identified fraud risks due to expanded telehealth use during the pandemic and documented the agency's findings—CMS provided us with documentation of a Medicaid risk assessment framework. This was in response to a December 2017 recommendation that CMS conduct a fraud risk assessment for the Medicaid program as a whole, to include fraud risk profiles and plans for regularly updating the assessments and profiles.[50] Doing so would include determining the agency's risk tolerance. The framework CMS provided outlines the agency's approach and prioritization factors for conducting fraud risk assessments for specific program areas within Medicaid using a standard format to document vulnerabilities, risks levels, residual risks, and mitigation strategies, among other topics. These actions meet the intent of our recommendation. Therefore, we considered the recommendation implemented as of March 2022.[51] We will continue to monitor how CMS applies the framework, including determining a fraud risk tolerance, going forward to other aspects of Medicaid.

[49]*A Framework for Managing Fraud Risks in Federal Programs* describes risk tolerance as the acceptable level of variation in performance relative to the achievement of objectives. Fraud risk tolerance does not mean that managers tolerate fraud. Rather, it means that managers accept a certain degree of risk, based on an assessment of the likelihood and effect of fraud. For example, an agency might have a high tolerance for fraud risk to ensure access to the agency's services in an emergency, such as the pandemic, but a low tolerance for fraud risk once the emergency ends. See GAO-15-593SP.

[50]See GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017). HHS concurred with our recommendation.

[51]As of March 2022, CMS is continuing to work on another recommendation we made in December 2017 that CMS use the results of the fraud risk assessment to develop an antifraud strategy that includes an approach for monitoring and evaluation. See GAO-18-88. HHS concurred with our recommendation. We will continue monitoring CMS's progress in this area.

CMS Has No Plans to Assess the Quality of Care for Services Delivered via Telehealth and Selected States' Plans to Do So Varied

CMS Does Not Collect, Assess, or Report on How Telehealth Affects the Quality of Care Medicaid Beneficiaries Receive and Has No Plans to Do So

Based on our interviews with agency officials and reviews of agency documentation, we found CMS does not collect, assess, or report information about any effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive. As noted earlier, CMS issued technical assistance in May 2021 explaining in which existing Core Sets' measures states could include services received via telehealth, as well as in person, when reporting measure results. However, states do not separately report on existing Core Sets' measure results by the way the service was delivered (for example, in-person or via telehealth).

CMS officials said they do not plan to update existing state reporting requirements on quality measures, such as those in the Core Sets, to differentiate between the quality measure results obtained by beneficiaries provided services via telehealth versus those receiving the comparable service in person. Nor did they provide states with any guidance about how to ensure the quality of care provided via telehealth. Therefore, CMS lacks information on any effect the delivery of services via telehealth has on quality compared with the quality of services delivered in-person, or on any potential disparities in terms of those who receive services via telehealth.

Assessing the effect that delivering services via telehealth has on the quality of care Medicaid beneficiaries receive is important, given concerns raised about the quality of care provided via telehealth. Telehealth services have been used as a means of ensuring access to necessary health care while reducing patients' risk of exposure to COVID-19; however, Medicaid officials in our six selected states also identified possible limitations to providing certain services via telehealth, such as circumstances in which telehealth services might be less comprehensive or effective. Representatives from two provider associations told us delivery of care via telehealth would not always provide the same quality

as delivery of care in-person, concerns that we and others have previously reported. For example:

- The HHS Office of Inspector General reported that state Medicaid directors from 10 of 37 states expressed concerns about the quality of behavioral health services delivered via telehealth, particularly visits that include prescribing medications or are conducted via audio-only.[52] Two of the 10 state Medicaid directors said training providers—for example, on best telehealth practices—could improve the quality of care provided via telehealth.

- In September 2021, we reported that some state Medicaid officials expressed concerns about the quality of home- and community-based service assessments conducted via telehealth during the pandemic.[53] State Medicaid officials provided examples where assessing beneficiaries' needs for equipment or care over the phone or video rather than in person hindered the ability of providers or case managers to observe beneficiaries' living conditions and capabilities.[54] As a result, officials in one state said case managers identified problems with beneficiaries' quality of life or living conditions after resuming in-person visits that could have been caught earlier through in-person assessments; for example, unmet beneficiary needs for additional durable medical equipment, home modifications, and assistive technology.

Obtaining the information necessary to begin assessing the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive would be consistent with CMS's responsibility to oversee states' efforts to ensure the quality of services delivered to Medicaid beneficiaries. It would also be consistent with how CMS has

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[52]See Department of Health and Human Services, Office of Inspector General, OEI-02-19-00401.

[53]Medicaid home- and community-based services provide Medicaid beneficiaries who are aged or have disabilities with long-term services and supports, including assistance with daily activities, such as eating, dressing, and bathing.

[54]See GAO, *Medicaid Home- and Community-Based Services: Evaluating COVID-19 Response Could Help CMS Prepare for Future Emergencies*, GAO-21-104401 (Washington, D.C.: Sept. 8, 2021).

encouraged states to use Core Set data to identify disparities in health care and target opportunities for improvement to advance health equity.[55]

There are approaches CMS could use to begin assessing any effect that delivering services via telehealth has on the quality of care Medicaid beneficiaries receive, understanding that assessing telehealth's effects will take time and effort. For example, CMS is the measure steward for a Core Set quality measure about the percentage of beneficiaries screened for depression when there is a medical reason, and if positive, for whom a follow-up plan is documented. The agency could develop a plan for reporting this measure in a way that would promote assessing telehealth's effect on it.

Based on the results of initial assessments of any effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive, CMS could assess the value—relative to its other quality reporting priorities—of conducting more-detailed assessments. These assessments could take into consideration the results of the National Quality Forum's framework to support measure development for telehealth.[56] As noted earlier, the framework included an initial list of existing quality measures—some of which are in the Core Sets—to assess the use of telehealth as a means of care delivery and its effect on quality of care. While the forum's report was not focused on delivering services via telehealth to Medicaid beneficiaries, in July 2021, National Quality Forum officials confirmed that the measures are applicable across insurance programs, including Medicaid. The results of more-detailed assessments could be used to develop guidance to assist states in making decisions regarding which health care services they will cover and pay for when those services are delivered via telehealth, among other things.

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[55]See Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services, 2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets, Informational Bulletin (Baltimore, Md.: Dec. 10, 2021).

[56]See National Quality Forum, *Creating a Framework to Support Measure Development for Telehealth* (Washington, D.C.: Aug. 31, 2017).

Selected State Medicaid Officials Varied in Their Assessments of the Quality of Care Provided via Telehealth

Officials in four of the six selected states discussed various activities to assess the quality of care provided via telehealth. For example:

- **Surveys.** Arizona added supplemental questions to its Consumer Assessment of Healthcare Providers and Systems survey to obtain information about the patient experience of services delivered via telehealth. The initial results of the survey found that the majority of beneficiaries considered the quality of care provided via telehealth to be about the same as the quality of care provided in-person. Maine officials said they integrated a subset of questions related to telehealth into a survey sent to beneficiaries, but had not received the results as of November 2021. (See app. III for sample questions on patient experience with telehealth provided by Arizona and Maine.)

- **Service use analysis.** Tennessee officials said their own state analysis of services found that beneficiaries who received services via telehealth increased their adherence to medication prescriptions. However, they could not determine through their analysis whether increased adherence to prescribed medications was due to telehealth.

- **External studies.** California officials said the state is reviewing external studies to assess the quality of care delivered via telehealth.

California and Missouri officials both said they plan to assess the quality of care provided via telehealth in the future, but did not have details about what those assessments will include. Mississippi officials said services provided via telehealth are included in the state's existing quality of care assessments and they do not plan to assess the quality of care provided via telehealth specifically.

Conclusions

The onset of the COVID-19 pandemic spurred sizable increases in the use of telehealth services as a means to maintain Medicaid beneficiaries' access to care. Trends show sustained telehealth use that is significantly higher than prior to the pandemic. Growing telehealth use requires assessing the quality of care provided to beneficiaries beyond the pandemic.

CMS regularly collects, assesses, and reports information about quality of care provided to Medicaid beneficiaries. However, it lacks information about the quality of care provided by the way health care services are delivered (in-person or via telehealth), because states do not separately report on existing Core Sets' measure results by the way the service was delivered, and CMS has no plans to update reporting requirements to do so. This inhibits CMS's ability to assess any effect that delivering services via telehealth has on the quality of care Medicaid beneficiaries receive

compared with the service delivered in-person. It also prevents the agency from determining whether further quality assessments of telehealth are warranted. Information about the effect of telehealth services on quality care could then be shared with states making coverage and payment decisions. Given that states are scheduled to begin mandatory reporting of the Child Core Set and certain Adult Core Set measures in 2024, this is an opportune time for CMS to ensure these measures are reported with enough detail to assess the quality of health care services delivered via telehealth.

Likewise, if CMS decides that the Core Sets are not appropriate for measuring the effect that delivering services via telehealth has on the quality of care Medicaid beneficiaries receive, now would be the time for the agency to begin making other plans to do so. Given that telehealth use has grown to represent a larger amount of services delivered, CMS can take the opportunity to identify and plan for the data it will need in the future to make assessments about the quality of telehealth care.

Recommendations for Executive Action

We are making the following two recommendations to CMS:

The Administrator of CMS should collect and analyze the information needed to assess the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive. (Recommendation 1)

The Administrator of CMS should determine, based on the results of its initial assessment, whether further assessments of the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive are warranted, for the purposes of developing guidance to assist states in making telehealth coverage and payment decisions. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment, and its comments are reprinted in appendix IV. HHS also provided technical comments, which we incorporated as appropriate.

HHS neither agreed nor disagreed with the recommendations. In its comments, HHS recognized the gaps in measures on the quality of care Medicaid beneficiaries receive via telehealth, including measures on the Child and Adult Core Sets. According to HHS, CMS does not have the authority to modify the specifications of measures in the Core Sets' measures for which it is not the measure steward.

However, CMS is the measure steward for a Core Set quality measure about the percentage of beneficiaries screened for depression when there is a medical reason, and if positive, for whom a follow-up plan is documented. The agency could develop a plan for reporting this measure in a way that would provide information on any effect the way the service is delivered (for example, in-person or via telehealth) has on the quality of care Medicaid beneficiaries receive. For the measures for which CMS is not the measure steward, CMS could assess the feasibility of alternatives to current reporting. For example, CMS could work with other measure stewards to determine the appropriateness of separately reporting results for beneficiaries receiving services delivered via telehealth and in-person when services delivered via telehealth are permitted to be included when reporting a measure.

As HHS noted in its comments, telehealth has been a way to provide certain services while maintaining social distance during the pandemic and has potential to serve as an additional way for beneficiaries to receive services when social distancing is no longer required. While HHS said it was not aware of any existing stand-alone measures that focus solely on the delivery of services through telehealth, we identified efforts in four of the six selected states to assess the quality of care provided via telehealth. These may merit further agency investigation. HHS also noted it was premature to determine whether additional assessments of the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive were warranted. The agency specifically noted the rapidly evolving telehealth landscape due to the ongoing COVID-19 pandemic and telehealth's role in closing gaps in service delivery during the pandemic. The pandemic is entering its third year. We maintain it is crucial for CMS to collect and analyze information to assess the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive, through the Core Sets or through other means. Further, the results of these initial assessments should inform whether further assessments are warranted to develop guidance to assist states in making telehealth coverage and payment decisions.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Carolyn L. Yocom
Director, Health Care

List of Committees

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The Honorable Richard Shelby
Vice Chairman
Committee on Appropriations
United States Senate

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Chairman
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Ranking Member
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The Honorable Kevin Brady
Republican Leader
Committee on Ways and Means
House of Representatives

Appendix I: Scope and Methodology for the Transformed Medicaid Statistical Information System Data Analysis

To describe the extent to which utilization of health care services delivered via telehealth in Medicaid has changed in six selected states from pre-COVID-19 pandemic to during the pandemic, we analyzed data from the Transformed Medicaid Statistical Information System (T-MSIS), the Centers for Medicare & Medicaid Services' (CMS) initiative to improve state-reported data available for overseeing Medicaid. Specifically, we reviewed claims and demographic data about Medicaid beneficiaries in the Other Services and Annual Demographic and Eligibility T-MSIS Analytic Files. These are a series of research-ready analytic files CMS created to support analysis, research, and data-driven decisions on key Medicaid topics, as well as program oversight. For the purposes of our report, we refer to the data in the T-MSIS Analytic Files as T-MSIS data. Prior to conducting our analysis, we selected the states, services, beneficiaries, and time frame to include in our analysis, and developed our definition of services delivered via telehealth.

- **State selection.** We selected six states—Arizona, California, Maine, Mississippi, Missouri, and Tennessee—to achieve a range of characteristics based on total population, total rural population, the percentage of the state's population without broadband internet, and geographic variation.[1]

- **Services.** We analyzed T-MSIS data for health care services including, but not limited to, physician services; outpatient hospital services; other physician services, such as chiropractors, podiatrists, psychologists, and optometrists; clinic services; laboratory services; X-ray services; home health services; and personal support services. We excluded health care services provided by an inpatient hospital, long-term care facility, or pharmacy, as well as dental services. We analyzed fee-for-service claims and managed care encounters for Medicaid beneficiaries, excluding other types of claims. For example, we excluded other types of claims that cannot be directly tied to a service, such as Medicaid supplemental payments, which are lump-sum payments that are not directly tied to care for individual Medicaid beneficiaries, but may help offset costs of care for beneficiaries.

- **Beneficiaries.** We analyzed T-MSIS data for beneficiaries enrolled in Medicaid. For the purposes of our report, we excluded other beneficiaries who also appear in the T-MSIS data. For example, we excluded beneficiaries enrolled in the Children's Health Insurance

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[1]Percentage of the state's population without wired broadband internet was determined based on a 2021 Federal Communication Commission Broadband Deployment report. See Federal Communications Commission, *Fourteenth Broadband Redeployment Report* (Washington, D.C.: Jan. 19, 2021).

Program, a joint federal-state program that provides health coverage to low-income children with family incomes that are too high to qualify for Medicaid, but may be too low to afford private insurance.

- **Time frame.** We accessed T-MSIS data on October 18, 2021. This provided for at least 6 months for states to submit data for the period of our analysis—the 12 months prior to the start of the pandemic (March 2019 through February 2020) and the first 12 months of the pandemic (March 2020 through February 2021). However, data for recent months are likely to be adjusted upward due to delays between when a service occurs and when the claim or encounter for that service is reflected in the data; thus, states' data may have different levels of completeness.[2]

- **Telehealth.** We analyzed procedure codes, modifier codes, and place of service codes in the T-MSIS data.[3] We then categorized services as having been delivered either via telehealth or not via telehealth; for example, through in-person visits. To do so, we compared these codes to CMS and state documentation on identifying all health care services delivered via telehealth, and interviewed CMS and state officials to confirm our categorization. We determined that each state identified services delivered via telehealth differently and adjusted the codes used in our analysis accordingly.

We did not independently verify the accuracy of the T-MSIS data; however, we reviewed how CMS assesses the quality of T-MSIS data and develops T-MSIS files for research. We also checked the T-MSIS data for obvious errors and omissions, compared analysis results to reported information on utilization of services delivered via telehealth in Medicaid, and interviewed CMS and state officials to resolve any

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[2]According to CMS, there will always be a delay, or claims lag, between when a service occurs and when the claim or encounter for that service is reflected in its database. The length of the lag depends on the submitting state, claim type, and the delivery system. Historically, at least 90 percent of both fee-for-service claims and managed care encounters in the Other Services claim file (the name of the T-MSIS Analytic File in the T-MSIS data we analyzed appears in) are submitted within 6 months, based on claims with a March 2018 service date. There is significant variation across states in terms of claims submissions. Some states submit 90 percent of all other services claims within only 4 months, while other states take nearly a year. It is possible that there is a longer claims lag due to the pandemic.

[3]Health care providers use a series of codes to describe the services they provided when they bill for a service. The procedure code captures the Current Procedural Terminology or Health Care Procedural Coding System code that describes a service or good rendered by the provider to a Medicaid beneficiary on the specified date of service. The modifier code is used to add information or change a description of a service to improve accuracy or specificity. The place of service code indicates where a service took place.

identified discrepancies. On the basis of this review, we determined the T-MSIS data in Arizona, California, Maine, Mississippi, and Missouri were sufficiently reliable for the purposes of this report, and we accounted for any limitation or discrepancy in these data during our analyses. We also determined that the T-MSIS data in Tennessee were not sufficiently reliable for the purposes of our reporting and excluded the state's data from our analysis. At the time we conducted our analysis, the T-MSIS data for Tennessee did not allow for reported services to be fully linked to individual beneficiaries for claims from January 2020 through February 2021. See appendix II for additional details about the T-MSIS data limitations we identified.

After taking these steps, we determined (1) the number and percentage of services delivered via telehealth; (2) the types of services delivered via telehealth; and (3) the number and percentage of beneficiaries receiving services via telehealth, and selected demographic characteristics of those beneficiaries.

To determine the number and percentage of services delivered via telehealth, we analyzed T-MSIS data to identify whether each service was delivered via telehealth. We then calculated the number and percentage of services delivered via telehealth.

To determine the types of services delivered via telehealth, we analyzed T-MSIS data on the procedure codes for each service delivered via telehealth.

To determine the number and percentage of beneficiaries receiving services via telehealth, and selected demographic characteristics of those beneficiaries, we analyzed T-MSIS data, as well as the CMS Core Based Statistical Area state and county code crosswalk to determine whether a beneficiary lived in an urban or rural area. Overall and within each of our demographic categories—age, gender, race/ ethnicity, and whether the beneficiary lived in an urban or rural area of the state—we took the following steps:

- Determined the number of enrolled Medicaid beneficiaries each month.

- Determined how many of the enrolled Medicaid beneficiaries during a particular month received a service.

- Determined the group to which each beneficiary who received a service belonged: (1) beneficiaries who received at least one service

via telehealth, and (2) beneficiaries who received no services via telehealth.

- Calculated for each month the number of beneficiaries who received at least one service via telehealth as a percentage of (1) beneficiaries who received a service, and (2) enrolled Medicaid beneficiaries.

In addition, we identified and organized demographic characteristics as follows:

- **Age.** Beneficiary age in years as of the last day of the last month of enrollment in the calendar year.[4] For purposes of our report, we organized beneficiary ages into three age groups: under 19 years of age, 19 to 64 years of age, and 65 years of age and older.

- **Gender.** Beneficiary's biological sex or their self-identified sex. T-MSIS data include the following values for gender: male and female.

- **Race/ ethnicity.** T-MSIS data includes the following values for race/ ethnicity that we identified in our analysis: American Indian and Alaska Native, non-Hispanic; Asian, non-Hispanic; Black, non-Hispanic; Hawaiian/ Pacific Islander; Hispanic, all races; White, non-Hispanic; and null, which may occur, for example, if the beneficiary's race/ ethnicity was not reported.

- **Rural/ urban area.** To determine whether beneficiaries lived in a rural or urban area, we compared the county each beneficiary lives in, as reported in T-MSIS, to the CMS Core Based Statistical Area state and county code crosswalk, which we used to define rural and urban areas.[5]

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[4]According to CMS, if age is missing for all months of the calendar year, the most recent non-missing age from the previous two Annual Demographic and Eligibility T-MSIS Analytic Files is used.

[5]The Office of Management and Budget designates counties as Metropolitan, Micropolitan, or Neither. A Metropolitan area contains a core urban area of 50,000 or more population, and a Micropolitan area contains an urban core of at least 10,000 (but less than 50,000) population. All counties that are not part of a Metropolitan Statistical Area are considered rural. Micropolitan counties are considered non-Metropolitan or rural along with all counties that are not classified as either Metropolitan or Micropolitan.

Appendix II: Transformed Medicaid Statistical Information System Data Differences and Limitations

To describe the extent to which utilization of health care services delivered via telehealth in Medicaid has changed in our six selected states from pre-pandemic to during the COVID-19 pandemic, we analyzed data from the Transformed Medicaid Statistical Information System (T-MSIS), the Centers for Medicare & Medicaid Services' (CMS) initiative to improve state-reported data available for overseeing Medicaid.[1] The six states—Arizona, California, Maine, Mississippi, Missouri, and Tennessee—were selected to achieve a range of characteristics based on total population, total rural population, the percentage of the state's population without broadband internet, and geographic variation.

To assess the reliability of the T-MSIS data in these states, we reviewed how CMS assesses the quality of T-MSIS data and develops T-MSIS files for research, checked the T-MSIS data for obvious errors and omissions, compared analysis results to reported information on utilization of services delivered via telehealth in Medicaid, and interviewed CMS and state officials. Based on this review, we determined that each state identified services delivered via telehealth differently and adjusted the codes used in our analysis accordingly. We also identified limitations in the data and accounted for them during our analyses. For example, we did not analyze data on beneficiary income based on CMS's assessment of the quality of these data. See table 3 for additional limitations we identified in our six selected states.

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[1]For additional recent information about our work on T-MSIS, see GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, GAO-18-70 (Washington, D.C.: Dec. 8, 2017); and GAO-21-196.

Table 3: Limitations Identified in Selected States' T-MSIS Data

State	Limitation	Resolution
Arizona	Race/ ethnicity information was reported as unknown for over 30 percent of Medicaid beneficiaries in each of the first 12 months of the pandemic.	Did not report race/ ethnicity information.
California	Potential underreporting of services delivered via telehealth for Federally Qualified Health Centers, Rural Health Centers, Tribal 638 Clinics, and the Local Educational Agency Medi-Cal Billing Option Program services delivered via telehealth.	Noted limitation in our report.
	Race/ ethnicity information was reported as unknown for over 8 percent of Medicaid beneficiaries in each of the first 12 months of the pandemic.	Reported the percentage of beneficiaries with unknown race/ ethnicity.
Maine	Race/ ethnicity information was reported as unknown for over 9 percent of Medicaid beneficiaries in each of the first 12 months of the pandemic.	Reported the percentage of beneficiaries with unknown race/ ethnicity.
Mississippi	Race/ ethnicity information was reported as unknown for over 12 percent of Medicaid beneficiaries in each of the first 12 months of the pandemic.	Reported the percentage of beneficiaries with unknown race/ ethnicity.
Missouri	Race/ ethnicity information was reported as unknown for over 8 percent of Medicaid beneficiaries in each of the first 12 months of the pandemic.	Reported the percentage of beneficiaries with unknown race/ ethnicity.
Tennessee	Unable to fully link reported services to individual beneficiaries for claims from January 2020 through February 2021.	Did not report T-MSIS data.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) data. | GAO-22-104700

Appendix III: Examples of Questions Selected State Medicaid Officials Asked Beneficiaries to Gauge Satisfaction with Telehealth

Table 4 presents examples of questions that Medicaid officials from two of our six selected states, Arizona and Maine, said they asked beneficiaries about delivering health care services via telehealth for children.

Table 4: Examples of Questions Arizona and Maine Medicaid Officials Asked Beneficiaries to Gauge Satisfaction with Health Care Services Delivered via Telehealth to Children

Question topic	Arizona	Maine
General/ telehealth usage	• In the last 6 months, did your child have a healthcare visit by phone or video?	• In the last 6 months, was a telehealth appointment offered for your child instead of an in-person appointment? • In the last 6 months, how often did you choose to use telehealth for your child's health care when it was offered by a doctor or other health provider? • Which of the following describes why you chose NOT to use telehealth for your child's health care? • In the last 6 months, how many times did you have a telehealth visit to get care, tests, or treatment for your child?
Services	*Arizona did not ask questions related to services delivered via telehealth.*	• In the last 6 months, which of the following types of telehealth services did your child receive?
Technology	• What type of device was used for your child's healthcare visit by phone or video? • How easy or difficult has it been to use technology during your child's healthcare visit by phone or video?	• Which of the following devices did you use for your telehealth appointment(s)? • What technical problems did you have?
Privacy	• In the last 6 months, how often were you concerned about privacy during your child's healthcare visit by phone or video?	*Maine did not ask questions related to telehealth privacy.*
Quality	• In the last 6 months, was the quality of care your child received during phone or video visits better or worse than the care your child received during in-person visits?	• Compared to in-person healthcare visits, how satisfied are you with the care your child received through telehealth? • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your child's telehealth care in the last 6 months?
Future telehealth use	*Arizona did not ask questions related to future use of telehealth.*	• How likely are you to continue using telehealth during the COVID-19 pandemic? • How likely are you to continue using telehealth when the COVID-19 pandemic is over?

Source: GAO analysis of questionnaire documents in Arizona and Maine. | GAO-22-104700.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

March 7, 2022

Carolyn L. Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled,
"MEDICAID: CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries'
Quality of Care" (GAO-22-104700).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID: CMS SHOULD ASSESS EFFECT OF INCREASED
TELEHEALTH USE ON BENEFICIARIES' QUALITY OF CARE (GAO-22-104700)**

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the
Government Accountability Office (GAO) to review and comment on the GAO's draft report
examining state utilization and HHS oversight of Medicaid services delivered via telehealth
during the first year of the COVID-19 Public Health Emergency (PHE). HHS continues to
monitor the impact of the COVID-19 PHE on telehealth utilization to determine whether changes
to current oversight are needed.

The telehealth landscape has vastly changed, and is continuing to rapidly evolve, during the
COVID-19 PHE. Although telehealth has been utilized by many states for decades, the recent
COVID-19 PHE has accelerated state interest in this model of service delivery. HHS has been
regularly analyzing the impact of COVID-19 on Medicaid and CHIP enrollment and
expenditures, including reporting on the use of telehealth during COVID-19. HHS has published
several preliminary data snapshots to share impact and outcomes of these analyses, with the most
recent publication analyzing services delivered through May 31, 2021.[1] HHS saw the number of
services delivered via telehealth surge at the onset of the PHE, with 46,897,937 services being
delivered through telehealth from March through July 2020, an increase of 2,846% compared to
March through July 2019.[2]

HHS recognizes the important role that telehealth has played in closing gaps in service delivery
and bolstering the fiscal sustainability of the provider workforce. While telehealth has become a
resourceful way to provide select services while maintaining social distance during the COVID-
19 PHE, it also has potential as an additional access pathway for services when social distancing
is no longer required. As such, many states are considering implementing policies for continued
telehealth flexibilities on a more permanent basis following the end of the COVID-19 PHE.
States have a great deal of flexibility with respect to covering Medicaid services provided via
telehealth, which has been the case prior to the COVID-19 PHE and will continue to be after the
end of the COVID-19 PHE. For example, states have the option to determine whether or not to
utilize telehealth, what types of services to cover, where in the state it can be utilized, what types
of practitioners or providers may deliver services via telehealth, as well as reimbursement rates.

HHS has taken a number of actions to support states in their efforts to continue providing care to
Medicaid beneficiaries during the ongoing COVID-19 PHE. In 2020, HHS created a dedicated
website for Medicaid-related COVID-19 information.[3] As described in the GAO's report, in
April 2020, HHS also released the State Medicaid & CHIP Telehealth Toolkit that provides
states with information to consider as they evaluate the need to expand their telehealth

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[1] Preliminary Medicaid and CHIP Data Snapshot, Services through May 31, 2021, https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot-11122021.pdf
[2] Medicaid & CHIP COVID-19 Summaries: Preliminary Medicaid & CHIP Data Snapshot,
https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf
[3] COVID-19 Medicaid and CHIP Resources, https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html

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capabilities and coverage policies.[4] The Telehealth Toolkit discusses topics such as coverage and
reimbursement policies, providers and practitioners eligible to provide telehealth, technology
requirements, and pediatric considerations. Furthermore, in October 2020, HHS released the
COVID-19 Version: Supplement #1 to the State Medicaid & CHIP Telehealth Toolkit in order to
provide additional support to states in their adoption and implementation of telehealth as they
begin to plan beyond COVID-19 PHE flexibilities.[5] The Supplement covers communication
strategies, telehealth operations and implementation tools, as well as shared experiences and
examples from states and territories across the nation. HHS later updated the COVID-19
Version: Supplement #1 in December 2021.

HHS also discusses telehealth with states on regularly scheduled all-state calls, and provides one-
on-one technical assistance support to states, often through review of the states' submitted State
Plan Amendments (SPAs). It is important to note that no federal approval is needed for state
Medicaid programs to reimburse providers for services delivered via telehealth in the same
manner or at the same rate that states pay for face-to-face services. However, a SPA is necessary
if states want to cover or pay for services delivered via telehealth differently than they do for
services delivered face-to-face. States may elect to submit SPAs to more comprehensively
document coverage and payment for services delivered via telehealth, but are not required to do
so.

HHS has built a suite of analyses to detect and address vulnerabilities that may arise from the
time-limited waivers and flexibilities granted to states during the COVID-19 PHE, including
those in the rapidly-changing telehealth landscape. As part of this effort, HHS' Vulnerability
Collaboration Council used the GAO's Fraud Risk Framework to develop a process to evaluate
waivers and flexibilities issued to states during the COVID-19 PHE, including telehealth waivers
and flexibilities. The evaluation enabled HHS to identify and quantify associated program
integrity risks and determine appropriate mitigation activities. Using the experience gained from
this process, and the GAO's Fraud Risk Framework, HHS developed a Risk Assessment
Template to support state Medicaid agencies' efforts to identify and address program integrity
risks.[6] The Risk Assessment Template is not limited solely to COVID-19 PHE waivers,
flexibilities, and other requirements, but can also be used to conduct a risk assessment on any
aspect of a state's Medicaid program, including the continued expansion of telehealth services
after the COVID-19 PHE, should the state choose to make certain flexibilities permanent.

As the direct administrators of their programs, states are primarily responsible for monitoring
and overseeing the quality of care provided to Medicaid beneficiaries. As noted in the GAO's

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[4] State Medicaid & CHIP Telehealth Toolkit, https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf
[5] COVID-19 Version: Supplement #1, https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf
[6] COVID-19 Risk Assessment Template, https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx

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report, several states have already undertaken activities, such as surveys and service use
analyses, to assess the quality of services provided via telehealth. At the federal level, HHS
utilizes the Medicaid and Children's Health Insurance Program (CHIP) Child and Adult Core
Sets to monitor the overall quality of care Medicaid and CHIP beneficiaries receive and their
access to care. State reporting on the Core Sets measures is currently voluntary, and reporting on
the full Child Core Set and the behavioral health measures in the Adult Core Set will become
mandatory in 2024. HHS annually reports information on state performance on the Child and
Adult Core Sets measures that are reported by at least 25 states and that met CMS standards for
data quality. Notably, for Federal Fiscal Year 2020, which generally covers care delivered in
calendar year 2019, HHS publicly reported performance on 21 of the 24 Child Core Set measures
and 28 of the 33 Adult Core Set measures.[7]

Measure stewards, which are typically external stakeholders and/or other divisions of HHS, are
responsible for maintaining the measure specifications for quality measures, including
determining the extent to which services delivered via telehealth can be included in a given
measure. During the COVID-19 PHE, HHS published guidance to provide states with
information on the telehealth allowances that had already been specified by the measure
stewards.[8] Through the form of FAQs, HHS acknowledged that services offered through
telehealth may not be captured in certain Core Sets measures if the measure steward has not
modified the specifications to allow for telehealth.[9] It is important to note that while current
reporting on all of the Core Sets measures does not allow HHS to differentiate between services
delivered in-person versus those delivered via telehealth, reporting on certain Core Sets measures
will still account for services delivered via telehealth. To the extent that the measure steward for
a given measure determined that services delivered via telehealth can be included, the data that
states report to HHS will reflect the quality of services delivered via telehealth as well as in-
person. However, HHS does not have the authority to modify the specifications of measures for
which it is not the measure steward, including requesting stratification of services delivered via
telehealth versus in-person if this is not already included in the technical specifications.

Finally, the Child and Adult Core Sets Annual Review process is designed to identify ways to
strengthen and improve the Child and Adult Core Sets each year. The Annual Review
Workgroup is comprised of Medicaid and CHIP stakeholders, measurement experts, and Federal
liaisons. While the Workgroup has already identified the impact of telehealth on access,
utilization, disparities, and identification of social risks as a gap area in the Core Sets, they have
not to date identified, nor proposed, any telehealth specific measures for consideration.

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[7] Quality of Care for Children and Adults in Medicaid and CHIP: Overview of Findings from the 2020 Child and
Adult Core Sets, https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2020-core-set-reporting.pdf
[8] Allowance of Telehealth in the 2021 Child, Adult, and Health Home Core Set Measure Specifications,
https://www.medicaid.gov/medicaid/quality-of-care/downloads/telehealth-ta-resource.pdf
[9] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program
(CHIP) Agencies, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

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Currently, HHS is not aware of any existing stand-alone measures that focus solely on the
delivery of services through telehealth. In the future, if such a measure is developed and the
Workgroup recommends it, HHS will consider it for addition to the Core Sets.

GAO's recommendations and HHS' responses are below.

Recommendation 1

The Administrator of CMS should collect and analyze the information needed to assess the effect
delivering services via telehealth has on the quality of care Medicaid beneficiaries receive.

HHS Response

HHS greatly appreciates the GAO's insight into the changes in telehealth utilization during the
first year of the COVID-19 PHE, and will continue to monitor the impact of the COVID-19 PHE
on telehealth utilization to determine whether changes to current oversight are needed.[10]
Telehealth has become a resourceful way to provide select services while maintaining social
distance and reducing the risk of in-person COVID-19 transmission. As the direct administrators
of their programs, states are primarily responsible for monitoring and overseeing the quality of
care provided to Medicaid beneficiaries. As noted in the GAO's report, several states have
already undertaken activities, such as surveys and service use analyses, to assess the quality of
care provided via telehealth. Throughout the COVID-19 PHE, HHS has supported state
utilization of telehealth by providing written guidance, holding regularly scheduled all-state
calls, and providing one-on-one technical assistance as needed. HHS will continue to support
states as they consider implementing policies for continued telehealth flexibilities on a more
permanent basis following an end to the COVID-19 PHE.

It is also important to note that for the 2022 Adult Core Set, the Centers for Medicare &
Medicaid Services (CMS) is the measure steward for only two out of the 33 measures, and for
one of the 25 measures in the 2022 Child Core Set. The measure stewards are responsible for
maintaining the specifications for quality measures and CMS does not have the authority to
modify the specifications of measures for which it is not the measure steward. In addition, while
the Annual Review Workgroup has identified telehealth as a gap area in the Core Sets, they have
not to date identified nor proposed any telehealth specific measures for consideration. In the
future, if such a measure is recommended by the Workgroup, HHS will consider it for addition to
the Core Sets. Finally, while HHS understands that the GAO has not specified that the Core Sets
are the only way to collect and analyze the information needed to assess the effect delivering
services via telehealth has on the quality of care Medicaid beneficiaries receive, there are no
other viable avenues to collect this type of quality data at this time.

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[10] Medicaid & CHIP COVID-19 Summaries: Preliminary Medicaid & CHIP Data Snapshot,
https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf

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<u>Recommendation 2</u>

The Administrator of CMS should determine, based on the results of its initial assessment,
whether further assessments of the effect delivering services via telehealth have on the quality of
care Medicaid beneficiaries receive are warranted, for the purposes of developing guidance to
assist states in making telehealth coverage and payment decisions.

<u>HHS Response</u>

HHS appreciates the intent behind the GAO's recommendation. As previously stated, HHS has
supported state utilization of telehealth by providing written guidance, holding regularly
scheduled all-state calls, and providing one-on-one technical assistance as needed. HHS will
continue to support states as they consider implementing policies for continued telehealth
flexibilities on a more permanent basis following an end to the COVID-19 PHE. Additionally,
while HHS understands that the GAO has not specified that the Core Sets are the only way to
collect and analyze the information needed to assess the effect delivering services via telehealth
has on the quality of care Medicaid beneficiaries receive, there are no other viable avenues to
collect this type of quality data at this time. As such, it is premature for HHS to determine
whether additional assessments of the effect delivering services via telehealth have on the quality
of care of Medicaid beneficiaries receive are warranted, especially given the rapidly evolving
telehealth landscape due to the ongoing COVID-19 PHE and telehealth's role in closing gaps in
service delivery during the PHE.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Lori Achman (Assistant Director), Peter Mangano (Analyst-in-Charge), Zhi Boon, Kerry Casey, Sonia Chakrabarty, Lauren Gomez, Drew Long, Eric Peterson, Vikki Porter, and Jennifer Rudisill made key contributions to this report.