MEDICAID EVIDENCE-BASED DECISIONS PROJECT

Telehealth for Pediatric Preventive Screenings Post-COVID-19

A question facing state Medicaid officials in the post-pandemic landscape is whether care models that blend telehealth and in-person visits can effectively deliver pediatric preventive care without sacrificing quality. During the COVID-19 public health emergency, telehealth claims for children in Medicaid rose dramatically. One driver of this increase was that Medicaid programs began allowing telehealth for preventive care components that did not uniformly require physical examination, such as counseling, developmental screenings, and behavioral health assessments. Now, with temporary emergency measures expired, Medicaid programs are navigating which telehealth expansions to keep, which to discard, and whether hybrid care should remain a viable strategy for keeping children current on preventive screenings.

BACKGROUND

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive preventive services for children and adolescents. At a minimum, EPSDT requires a health and developmental history, an unclothed physical examination, age-appropriate immunizations, laboratory tests (such as lead screening), and anticipatory health education.[1,2] Because many EPSDT components require physical assessment or procedures, hybrid strategies are most relevant when they connect virtual counseling and assessment to in-person completion of required in-person elements.[2]

Telehealth use expanded rapidly during the pandemic.[3,4] National analyses of Medicaid and CHIP claims show that telehealth represented about 0.3 percent of pediatric services before the emergency and rose sharply during 2020, reflecting broad state adoption of emergency-era flexibilities and new modalities.[3,4]

Federal guidance has encouraged states to use telehealth to strengthen access to EPSDT services, particularly where workforce shortages and geographic barriers limit in-person capacity.[5,6] At the same time, post-pandemic policymaking has focused on determining which pediatric preventive services can be safely delivered virtually, how to maintain quality, and how to ensure that telehealth contacts do not substitute for required in-person screening components.[5-7]

METHODS

This brief summarizes a review of publicly available Medicaid telehealth policy documents and pediatric preventive care outcomes across 8 Medicaid programs (Arizona, California, Kentucky, Maryland, Minnesota, New York, South Carolina, and Vermont).[1,8-16] To identify potential associations between hybrid care policies and preventive screening outcomes, staff from the Center for Evidence-based Policy (Center) reviewed the Centers for Medicare & Medicaid Services (CMS) Child Core Set well-child visit reports and CMS-416 EPSDT screening ratio reports for FY 2019 (pre-pandemic baseline) through FY 2023 (the first full year following the end of the public health emergency).[1,16] Pediatric telehealth utilization data were available through public dashboards or state reports for 6 programs.[17-22]

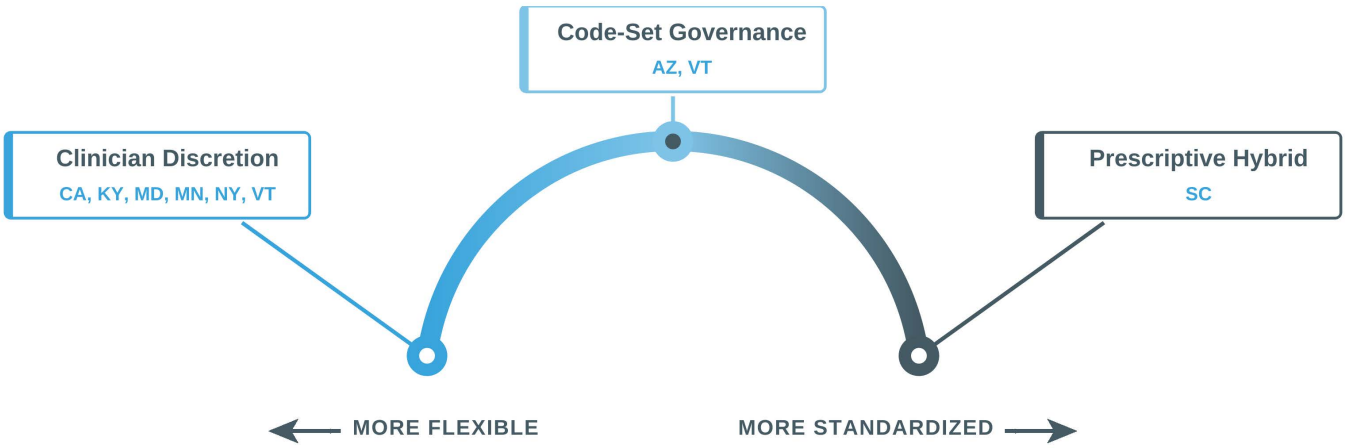
FINDINGS

Program Structure: 3 Hybrid Policy Models

Across reviewed programs, hybrid telehealth policy approaches clustered into 3 models, reflecting a continuum between flexibility and standardization: **clinician discretion**, **code set governance**, and **prescriptive hybrid rules**.[8,9,14,23,24] Although the reviewed Medicaid programs may blend elements across approaches, the dominant governance model used in each state shapes how clinicians, plans, and beneficiaries understand what may be delivered virtually and how virtual care should be linked to in-person components.[8,9,14,23,24] We outline each approach in Figure 1.

FIGURE 1.

Continuum of hybrid telehealth governance approaches[8-15,23,24, 27-29]



Clinician Discretion
CA, KY, MD, MN, NY, VT
Clinician judgment decides what stays virtual. CPT/HCPCS codes delineate hands-on services; modifiers and place-of-service codes support oversight.

Code-Set Governance
AZ, VT
Public code lists map each service to allowable telehealth modalities.

Prescriptive Hybrid
SC
Payment rules by facility type determine which services can be delivered virtually.

South Carolina's Prescriptive Tiers: Flexibility Varies by Facility Type

MOST FLEXIBLE
Physicians (EPSDT)
Split billing allowed; telehealth and in-person components can be billed for the same visit.

MODERATE
RHCs
Encounter rate plus carve-outs enable hybrid delivery within payment constraints.

MOST RESTRICTIVE
FQHCs
Bundled rate with no split billing; the encounter payment structure limits hybrid options.

Abbreviations. AZ: Arizona; CA: California; CPT: Current Procedural Terminology; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; FQHCs: Federally Qualified Health Centers; HCPCS: Healthcare Common Procedure Coding System; KY: Kentucky; MD: Maryland; MN: Minnesota; NY: New York; RHCs: Rural Health Clinics; SC: South Carolina; VT: Vermont.

Clinician discretion models generally establish modality-agnostic standards rooted in clinical appropriateness.[9-13,15] In these approaches, telehealth can be used when it is clinically appropriate for a given service and patient, while state policy documents and standard coding definitions help delineate which services inherently require hands-on delivery.[9-13,15,25] Effective clinician discretion models still depend on clear program guardrails, including consistent use of telehealth modifiers and place-of-service codes to track modality and support oversight.[8-10,12-14]

In Arizona's code set governance approach, a publicly available telehealth code set links each covered service code to allowable delivery methods and corresponding modifiers.[8,23] This structure offers billing clarity and standardized modality rules that can support tracking and policy refinement over time.[8,23]

South Carolina's prescriptive hybrid approach relies on explicit rules that vary by facility and payment type.[14,24,26-28] Provider manuals and encounter payment structures specify how virtual and in-person components can be combined and reimbursed, shaping whether preventive services can be split across modalities or must be delivered in person.[14,24,26-28] This approach provides clearer guardrails but may limit flexibility for providers to tailor modality to patient circumstances.[14,24,26-28]

Age-Based Limits

In-person requirements illustrate how states can draw clear lines for early childhood preventive care.[29,30] Maryland has effectively prohibited telehealth for preventive medicine CPT codes that apply to children aged 24 months and younger.[30] South Carolina discontinued telehealth coverage for most well-child visits for children aged 2 years and younger beginning in January 2025, with limited exceptions in specific clinical settings that are subject to documentation requirements.[29]

Implementation Levers: Modality, Site of Care, and Managed Care

Four categories of policy decisions shape whether and how hybrid telehealth and in-person preventive care can be operationalized within Medicaid programs (Figure 2). These levers operate across 2 dimensions: modality decisions that govern how care is delivered (audio-only rules and managed care contract specifications) and structural decisions that govern where care can occur and who delivers it (site-of-service rules and school-based platforms). Each lever involves distinct trade-offs between flexibility and standardization, and together they define the practical boundaries of hybrid feasibility for pediatric preventive services.

FIGURE 2.

Four policy levers shaping hybrid preventive care delivery[8-13,23,26-28,31-63]

	Clinician-Facing Decisions	System-Facing Decisions
Modality Decisions	**Lever 1** **Audio-Only Telehealth** • Some states allow audio-only when the patient prefers it; others require that video is unavailable • Reimbursement may match video telehealth rates or be lower, depending on the state • Some states allow new patient relationships to begin via audio-only; others require an initial video or in-person visit	**Lever 3** **Managed Care Contracts** • Plans must ensure EPSDT access and may be required to support telehealth, but contracts rarely define what a hybrid preventive visit looks like • Most contracts lack specific billing codes, timelines, or tracking requirements for split-modality encounters • Without these definitions, hybrid care can fragment across multiple vendors, clinicians, and settings
Structural Decisions	**Lever 2** **Site-of-Service Rules** • Federal "4 walls" rules historically required clinicians and patients to be inside a licensed clinic for payment • Maryland and Arizona created permanent pathways in 2025 allowing clinic services outside clinic walls • States are using waivers and plan amendments to extend reimbursement to schools, mobile units, and Tribal communities	**Lever 4** **School-Based Platforms** • School-based services reduce transportation and scheduling barriers, making them practical sites for adolescent preventive care • States are expanding Medicaid billing pathways so school-based services can be reimbursed • On-site school staff can conduct in-person screenings and connect students to virtual clinicians for follow-up

Abbreviations. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment.

Audio-only telehealth has been maintained across states as a strategy to address limited broadband, transportation constraints, and accessibility needs.[8-12,23,26-28,32-41,59] However, state policies diverge on critical design choices, such as whether audio-only is permitted based on patient preference or only when video is unavailable; whether reimbursement is at parity with video telehealth; and whether new patient relationships may be established through audio-only encounters.[8,9,27,35,40,41] These choices carry direct implications for equity and program integrity, particularly for families seeking remote

access to preventive counseling and behavioral health services.[8-12,23,26-28,32-41,59] A March 2026 MED report addresses Medicaid coverage policies and billing guidance for audio-only telehealth.[64]

Site-of-service rules present a second constraint on hybrid feasibility.[26,31,39] The federal "4 walls" policy for clinic services historically limited reimbursement when clinicians or patients were outside licensed clinic sites, restricting payment for services delivered in homes, schools, or other community settings.[26,31,39] During the pandemic, CMS temporarily waived certain location-based restrictions, and some states have pursued longer-term pathways to maintain site flexibility.[58,60,61] Maryland and Arizona implemented permanent mechanisms beginning in January 2025: Maryland received section 1115 demonstration approval associated with its HealthChoice program, and Arizona implemented a state plan amendment pathway aligned with federal exceptions affecting specific clinic types and geographies.[58,60,62] These approaches illustrate how waivers and plan amendments can support school-based health, mobile and outreach models, and improve access in rural and Tribal communities.[26-28,31,39]

Managed care contracts represent a third lever in states where Medicaid is primarily delivered through managed care.[13,42-47] Contract reviews show that plans are typically held accountable for EPSDT-related responsibilities and may be required to support telehealth access, but contracts often do not define how telehealth and in-person components should be operationalized as a unified hybrid preventive encounter.[13,42-47] The absence of clear definitions, timelines, and billing and tracking expectations creates conditions under which hybrid care can fragment across vendors, clinicians, and settings.[13,42-47]

Finally, schools offer a practical access platform for adolescent preventive services by reducing transportation and scheduling friction, and serving as settings for both in-person screenings and telehealth-enabled connections.[48-58] States have undertaken substantial steps to expand school-based health delivery and clarify Medicaid billing pathways for school-based services.[48-55] Policy changes that expand Medicaid billing in schools are associated with increased school-based encounters and can be paired with hybrid strategies that link on-site staff to virtual clinicians.[57,58,63]

Utilization and Preventive Screening Outcomes

Evaluation of pediatric telehealth use is constrained by uneven data availability.[17-22] Arizona and California maintain public dashboards that report pediatric telehealth utilization and spending over time, while several other states published time-limited telehealth reports during the pandemic.[17-22] Preventive screening outcomes are reported consistently through CMS Child Core Set well-child visit measures and CMS-416 EPSDT screening ratio reporting, and survey-based adolescent preventive visit trends are available through National Performance Measure (NPM) 10 in most reviewed states.[1,16,48-55]

Where diagnosis-level or procedure-level detail is available, pediatric telehealth utilization is dominated by mental, behavioral, and neurodevelopmental conditions and related services.[17,19,20,22] These utilization patterns indicate that telehealth has become a durable access modality for talk-based pediatric care, while comprehensive preventive screening continues to rely heavily on in-person delivery.[17,19,20,22] Across states with age-stratified reporting, telehealth use tends to increase with age and is often highest among adolescents.[17,19,20,22,65]

Pandemic-era utilization included high-frequency use patterns that later normalized.[17,22,65] For example, California reported 7.2 million pediatric telehealth visits in 2021 and 5.4 million in 2022, and Arizona reported pediatric telehealth payments of $146,831,379 in July 2022 through June 2023 and $128,738,063 in July 2023 through June 2024.[17,22,65]

Preventive Screening Outcomes and Measurement Considerations

Several measurement and policy changes affect interpretation of preventive screening trends.[66-68] During the pandemic, the National Committee for Quality Assurance modified certain Healthcare Effectiveness and Information Set (HEDIS) well-child measures to allow some synchronous audiovisual telehealth encounters to count when full well-care requirements were met.[66,67,69] CMS guidance also described how telehealth could be used for portions of EPSDT visits and how telehealth-delivered screenings could be counted in CMS-416 reporting when performed according to state periodicity schedules and documented appropriately.[68]

Claims-based well-child visit rates improved modestly across reviewed programs during the period captured in the CMS Child Core Set reports.[16] From FY 2021 to FY 2023, 7 of 8 programs reviewed for this policy brief showed increases in the Child and Adolescent Well-Child Visits measure, with a mean improvement of 2.5 percentage points.[16] These modest gains are consistent with recovery of missed preventive visits after the acute pandemic period, but they do not establish that telehealth policy alone improved comprehensive screening completion.[16]

In contrast, CMS-416 EPSDT screening ratios declined across all 8 reviewed Medicaid programs from FY 2019 to FY 2023.1 Across the 8 programs, the eligible population increased from 12,258,100 to 13,014,269 individuals, while reported screening service delivery decreased from 10,559,187 to 8,558,416 screens.[1] This is likely because the majority of EPSDT screenings primarily take place in-person, as outlined in Box 1

BOX 1.

EPSDT screening breakdown[1]

Understanding the EPSDT Screening Ratio

What This Measure Captures

The EPSDT screening ratio measures whether age-appropriate screenings were completed for each eligible child according to the state periodicity schedule. Unlike well-child visit measures, which count whether at least 1 preventive visit occurred, this ratio reflects whether recommended screening components were actually delivered.

Required Screening Components

- **Physical examinations** in-person
- **Immunizations** in-person
- **Laboratory tests** in-person
- **Developmental screenings**: may use validated tools
- **Vision and hearing screenings**: often require specialized equipment

⚠ Most core screening components require hands-on, in-person delivery. Telehealth policy flexibilities did not address the primary barrier to screening completion.

This pattern indicates that, although more children were eligible for screenings, fewer screenings were delivered, underscoring the challenge of translating policy flexibility into completed age-appropriate screening components.[1] The divergence between well-child visit rates and EPSDT screening ratios reflects that the measures capture different concepts (Figure 3).[1,16] Another explanation for the divergence is that, in aggregate, well-child rates can appear higher than EPSDT rates—primarily because EPSDT's denominator spans all children under 21, including adolescents and young adults, who tend to have lower participation rates.[1,16] Center staff noted that EPSDT outperforms well-child screening rates in infancy and early toddlerhood, where vaccine-driven visit requirements and high parental engagement produce notably higher participation; well-child screening rates pull ahead in the school-age range of 3 and older, where HEDIS-based managed care accountability creates stronger incentive structures to ensure these screenings take place.[1,16]

FIGURE 3.

EPSDT screening ratios declined as the eligible child population grew, FY 2019–2023[1]

Eligible Children vs. Screenings Delivered, FY 2019–2023

Across 8 Medicaid managed care programs (CMS-416 Annual EPSDT Participation Reports)

Measure	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
■ Eligible children	12.26M	12.50M	12.70M	12.85M	13.01M
● Screenings delivered	10.56M	8.80M	8.50M	8.60M	8.56M
Screening gap	1.70M	3.70M	4.20M	4.25M	4.45M

▲ **+756,169 eligible children** from FY 2019 to FY 2023. More children enrolled in Medicaid were due for screenings.

▼ **−2,000,771 screenings delivered** from FY 2019 to FY 2023. Fewer age-appropriate screenings were completed despite policy flexibilities.

Source: Form CMS-416 annual report data from Medicaid programs.

Abbreviations. CMS: Centers for Medicare & Medicaid Services; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; FY: fiscal year; M: million.

Well-child visit measures indicate whether at least 1 preventive visit occurred in a year, while EPSDT ratios reflect whether recommended screenings were completed for a child's age, including components that often require in-person delivery, such as physical examinations, immunizations, and laboratory tests.[1,2,16] Interpreting hybrid policy impact requires attention to which measure is being used and whether policies and payment structures support completion of hands-on components within clinically appropriate timeframes.[1,2,16]

Survey-based adolescent preventive visit reporting (NPM 10) also declined consistently across all reporting states from 2019 to 2023.[48-55] Because NPM 10 is self-reported and does not identify visit modality or verify comprehensiveness, it should be interpreted cautiously.[48-55] However, the consistent decline across states reinforces concerns about adolescent preventive engagement, even during a period when telehealth access expanded for many pediatric services.[17,19,20,22,48-55]

STATE CONSIDERATIONS

Policy domain	If the state wants to …	Then the state can …
Hybrid Encounter Design	Integrate telehealth into required preventive care while ensuring completion of hands-on components	• Define what constitutes a split-modality preventive encounter and set clinically appropriate completion windows for in-person components • Adopt a bundled payment for the combined hybrid encounter, or establish billing rules for separate components that together satisfy EPSDT periodicity requirements
Managed Care Operationalization	Ensure managed care plans and providers deliver hybrid preventive care consistently and accountably	• Require consistent use of telehealth modifiers and place-of-service codes across plans and network providers • Mandate encounter data-sharing with primary care and reporting on completion of key preventive components • Clarify how hybrid encounters will be credited in quality measurement and performance incentives
Equitable Modality Access	Ensure that telehealth access does not depend on broadband availability and that early childhood screenings include necessary physical assessment	• Preserve audio-only coverage for defined services and populations with specified documentation, consent, and reimbursement standards • Establish minimum in-person age thresholds for selected preventive services to ensure clinically necessary physical assessment in early childhood
Expanded Delivery Sites	Support completion of in-person preventive components by expanding where care can be delivered and billed	• Use waivers or state plan amendments to address location-based billing constraints for school-based health centers, home-based follow-up, and mobile or outreach models • Standardize school-linked billing pathways, consent workflows, and data-sharing processes, particularly for adolescent preventive services
Behavioral Health Linkage	Leverage the concentration of pediatric telehealth in behavioral health to support broader preventive care completion	• Encourage or require workflows that use behavioral health encounters to identify gaps in preventive service status • Facilitate scheduling or referral for in-person screening components when gaps are identified during virtual behavioral health contacts

Abbreviation. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment. Superscript numbers correspond to references cited in the text.

DISCUSSION

Across reviewed programs, telehealth appears best suited for talk-based pediatric care, particularly mental and behavioral health, while comprehensive preventive screening completion remains dependent on in-person care.[1,17,19,20,22] The persistent decline in EPSDT screening ratios alongside modest gains in claims-based well-child visit rates suggests that hybrid policy success should be evaluated not only by whether visits occur, but also by whether systems and incentives support completion of age-appropriate screening components.[1,16]

A shifting measurement environment adds complexity for Medicaid agencies and managed care plans.[70,71] NCQA has announced changes that remove certain telehealth allowances in well-child measures beginning in 2025, while CMS has indicated that telehealth can continue to be recognized in Medicaid and Children's Health Insurance Program Core Set measure specifications.[70,71] For programs that rely on managed care and HEDIS reporting, these differing standards can create conflicting expectations and may influence how plans prioritize hybrid preventive care strategies.[70,71]

Broader coverage and financing dynamics may also affect preventive screening trends, including eligibility churn and other post-emergency enrollment changes.[72,73] State Medicaid programs should interpret screening outcomes in the context of these system factors and prioritize hybrid strategies that improve follow-through on in-person components and reduce missed opportunities for preventive screening,[1] particularly for adolescents and populations facing access barriers.[72,73]

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centerforevidencebasedpolicy.org

Center for Evidence-based Policy

3030 S Moody Avenue, Suite 250
Portland, OR 97201

Phone: (503) 494-2182
Fax: (503) 494-3807

centerforevidencebasedpolicy.org