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# The Growth of Telehealth Services in Child and Youth Behavioral Health Care During the COVID-19 Pandemic

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**T**HE CORONAVIRUS DISEASE 2019 (COVID-19) pandemic has had major impacts on the health and well-being of many persons and communities, and resulted in significant shifts in the health care system. One of these shifts has been the rapid expansion of telehealth services during COVID-19. Telehealth, described by the Washington State Health Care Authority (HCA, 2020a, p. 2), is “the use of electronic information and telecommunications technologies to support distant primary health and behavioral health care; patient and professional health-related education; public health, and health administration.” This report documents the increased use of telehealth services to deliver behavioral health services in Washington State during the COVID-19 pandemic and the extent to which providers had begun transitioning back to in-person services as of December 2021. Use of telehealth for delivery of behavioral health services to children and youth (ages 0 to 20) is examined by service type and by different population demographics. Information provided in this report can help program and policy leaders to understand the role of telehealth in behavioral health service delivery in Washington State’s system of care for children and youth.

## Key Findings

- 1. Telehealth services were rapidly implemented early in the pandemic and utilization of telehealth for service delivery varied by service modality.** The percent of mental health outpatient (MH OP) and substance use disorder (SUD) services delivered by telehealth to children and youth ages 0-20 (“telehealth rates”) rose from negligible levels in early 2020 to averages of 58 and 38 percent over the first complete year of the pandemic (April 2020-March 2021), respectively. Telehealth rates fell slowly beginning in early 2021, associated with Washington’s phased reopening, reaching 35 and 16 percent, respectively, by December 2021. Rates in 2021 varied substantially by service modality for both MH OP and SUD services (e.g., telehealth was used twice as often for MH child and family team meetings as for MH crisis services) and were generally higher in urban and suburban areas.
- 2. By the end of 2021, the majority of telehealth services for children’s behavioral health were provided using HIPAA-compliant telemedicine** (75 percent of MH OP telehealth; 86 percent SUD) up from roughly half (53 percent MH OP; 50 percent SUD) in March 2020, perhaps reflecting the time needed for providers to set up such systems. At the outset of the pandemic, HIPAA-compliant telemedicine was already allowable for many Medicaid-paid behavioral health services, and non-HIPAA compliant telehealth such as telephone calls and emails received emergency authorization. Both ramped up quickly in early 2020. Declines in overall telehealth rates after the initial pandemic spike were driven by steep declines in non-HIPAA compliant telehealth (labeled in report figures as

“other telehealth”) rather than the more gradual declines HIPAA-compliant audio-visual telemedicine, resulting in an increasing proportion of telehealth in the HIPAA-compliant category.

- 3. Telehealth utilization for both MH OP and SUD services was highest for transition-age youth 18 to 20 as of December 2021.** Transition-age youth also generally had the highest SUD telehealth rates earlier in the pandemic. For MH OP telehealth, rates were higher for children ages 5 to 17 during the first year of the pandemic. Young children ages 0 to 4 had the lowest MH OP telehealth rates across the pandemic. Small differences were observed across race/ethnic groups for MH OP, and somewhat larger differences were observed for SUD, with group patterns inconsistent across the two service types.

## Literature Review

### Impact of the COVID-19 Pandemic on Youth Mental Health

The COVID-19 pandemic brought unprecedented challenges for population well-being, especially for youth in a formative stage of social development (HHS, 2018). Even prior to the pandemic, youth mental health was a public health concern, with suicide being the second leading cause of death among those ages 5-19 years old between 1999 and 2019 (CDC, 2022). The COVID-19 pandemic and associated “lockdowns, social isolation, educational adaptations, and loss of moderating community supports” (Benton et al., 2022, p. 1) contributed to increases in anxiety, depression (Racine et al., 2021; Samji et al., 2022; Patton et al., 2023), and suicidal behaviors (Yard et al., 2021; Patton et al., 2023). There also has been a notable increase in the proportion of children’s emergency department (ED) visits that are mental health related, likely driven by both a rise in unmet mental health needs and a decline in overall ED visits (Leeb et al., 2020; DOH, 2021).

In swift response to these growing concerns, an emergency proclamation to support the behavioral health needs of children and youth was issued in Washington State (Emergency Proclamation 21-05; OOG, 2021b) followed by a U.S. Surgeon General advisory addressing the youth mental health crisis (OSG, 2021). In addition to government responses to youth behavioral and mental health needs, researchers and educators published various guides and resources on how providers can better support youth during COVID-19 using telehealth (e.g., Seager van Dyk et al., 2020; Myers, 2021; Martinez et al., 2022).

### The COVID-19 Pandemic and the Growth of Telehealth

The onset of the COVID-19 pandemic in early 2020 drove many healthcare providers to quickly adopt or expand telehealth services. For example, a recent Government Accountability Office (GAO) analysis of Medicaid data from five states (Arizona, California, Maine, Mississippi, and Missouri) showed an exponential growth in telehealth utilization over the first year of the pandemic: 32.5 million telehealth services were delivered to roughly 4.9 million Medicaid beneficiaries from March 2020 through February 2021, compared to 2.1 million telehealth services delivered to roughly 0.5 million beneficiaries in the prior year (GAO, 2022). Behavioral health services were among the most common services delivered via telehealth early in the pandemic, both among Medicaid and Medicare clients (GAO, 2022; Samson et al., 2021). The increase in behavioral health telehealth during the COVID-19 pandemic was also documented in a Washington State-specific report on youth behavioral health trends, which showed a dramatic increase in behavioral health telehealth claims for Medicaid clients under age 18 in early 2020 (DOH, 2021), consistent with more detailed findings presented in this report.

### Telehealth Outcomes for Youth

Pre-pandemic research showed promising results on use of technology to deliver healthcare services to youth (e.g., Myers et al., 2008). Studies on children and adolescents have revealed that use of

various telehealth modalities have been effective in reducing symptoms of depression (Topooco et al., 2018; Topooco et al., 2019), obsessive-compulsive disorder (Storch et al., 2011), posttraumatic stress disorder (Stewart et al., 2020), and attention-deficit/hyperactivity (Myers et al., 2015). These positive outcomes may be partially attributed to young people's familiarity and comfort with using technology. Considered "digital natives," or those born and raised in the digital age, youth have demonstrated ability "to build rapport and therapeutic relationships with health care providers using technology" (Evans et al., 2020, p. 470). During the pandemic, youth were found to be highly accepting of telehealth for healthcare services broadly. Benefits identified by both youth and their caregivers included improved access to and continuity of care as well as improved convenience and safety (Wood et al., 2021). On the other hand, some adolescents and young adults have expressed privacy or quality concerns or experienced technical issues (Wood et al., 2021).

## Advantages of and Disparities in Telehealth

The collective pivot to telehealth services promoted continuity of care as both patients and providers adapted to stay-at-home orders and social-distancing mandates, allowing providers to maintain critical access to care while prioritizing community safety. Telehealth may also have helped to improve care access and quality for vulnerable populations by eliminating transportation obstacles, reducing work missed, saving time and money, and improving gender-affirming care (D'Angelo et al., 2021; Wood et al., 2021; GAO, 2022). Despite the many advantages of telehealth, its surge also exposed inequities stemming from the so-called "digital divide" (Lai & Widmar, 2020; Ramsetty & Adams, 2020; Vogels et al., 2020). The digital divide is the gap in access to technology across different populations. For example, Hispanic and lower-income Americans have more concerns with paying for broadband internet and cellphone bills (Vogels et al., 2020), Black and Latino households have less stable internet access (SAMHSA, 2020), and rural communities have limited access to broadband internet and digital technologies (Hirko et al., 2020; Lai & Widmar, 2020).<sup>1</sup> In addition to differences in internet and device access, patients with lower socioeconomic status may also face greater challenges with privacy due to more crowded living arrangements (Wood et al., 2021). Thus, in some respects telehealth may widen the equity gap in health care delivery. In this report, we begin to examine potential disparities in telehealth service delivery in Washington State by studying service use across different demographics.

## Current Study

To contribute to our understanding of the impact of telehealth services on behavioral health systems of care for children and youth (ages 0-20) with medical assistance in Washington State, this study examines the growth of telehealth utilization for publicly funded mental health outpatient (MH OP) and substance use disorder (SUD) services during the COVID-19 pandemic. Trends in HIPAA compliance and utilization by geography and demographics are examined from January 2020 through December 2021.

For this study, behavioral health services delivered via telehealth were identified based on details (procedure codes, modifier codes, place of service codes) contained in claims and encounters in ProviderOne; see the technical notes at the end of this report for additional information. An important caveat in the report findings is that because behavioral health providers pivoted so rapidly to telehealth at the onset of the pandemic, rates of telehealth use at the outset of the pandemic may be underestimated because transitions in data systems and billing/documentation practices may have lagged behind utilization during this crisis period.

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<sup>1</sup> To address these digital inequities, Washington State passed House Bill 1723 in March 2022, which aimed to "clos[e] the digital equity divide by increasing the accessibility and affordability of telecommunications services, devices, and training" (E2SHB 1723, Washington State Legislature, 2022). One of the bills' objectives is to ensure funding to community-led programs that support ongoing work on advancing digital equity and inclusion (Upgrade King County, 2022).

## KEY TERMS

**Mental Health Outpatient Services (MH OP)** – Includes claims or encounters from the ProviderOne data system classified as mental health outpatient services for children and youth (ages 0-20) enrolled in medical assistance.

**Substance Use Disorder Services (SUD)** – Includes claims or encounters from the ProviderOne data system classified as substance use disorder services (outpatient and other types) for youth (ages 12-20) enrolled in medical assistance.

**Telehealth** – For the period covered by this report (2020-2021), includes both:

- HIPAA-Compliant Telemedicine:** Services provided using real-time interactive audio and video technology that meets HIPAA security standards.
- Other Telehealth:** Services provided via audio and/or video technologies that are non-HIPAA compliant, such as Skype or FaceTime; telephone calls (audio only); emails; text messages.

## Adopting Telehealth Services during the COVID-19 Pandemic

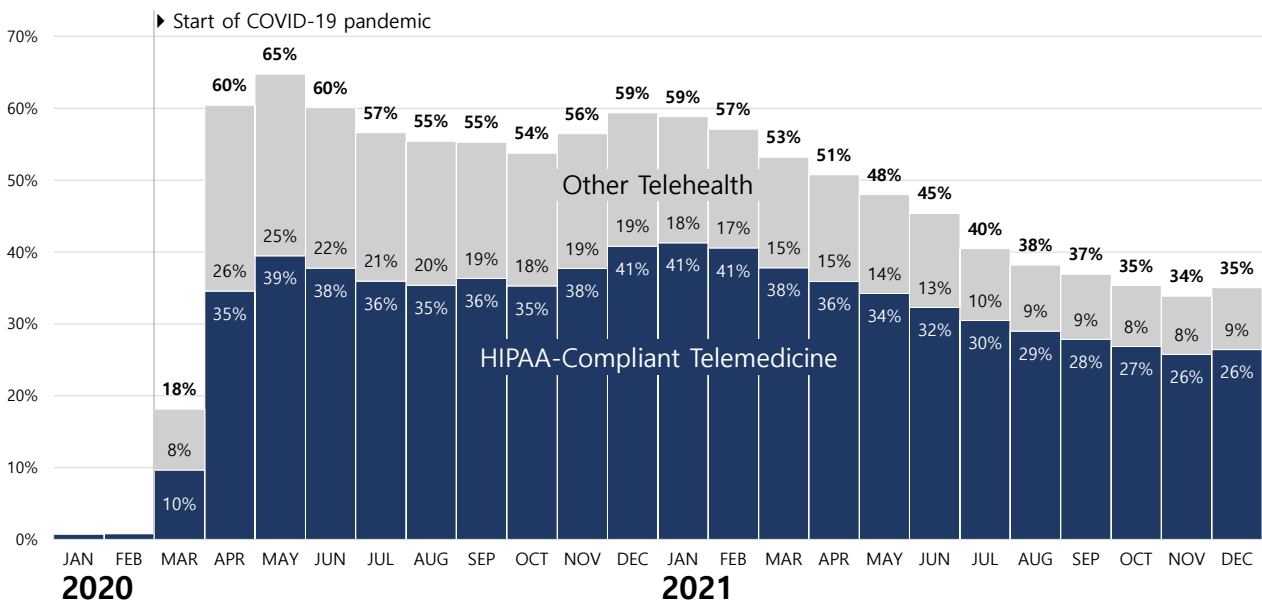
### Mental Health Outpatient Services

The proportion of MH OP services for children and youth (ages 0-20) delivered by telehealth rose from negligible levels at the beginning of 2020 to an average of 58 percent between April 2020 and March 2021, the first complete 12-month period of the pandemic. MH OP telehealth services peaked in May 2020 at 65 percent but remained high throughout the first year of the pandemic (Figure 1). Telehealth rates began to fall slowly in early 2021, reaching 35 percent by December 2021. The gradual decline in MH OP telehealth rates in 2021 may have been due to Washington State’s relaxing of COVID-19 restrictions, beginning in March 2021 and transitioning to a statewide reopening in June 2021, including a return to in-person learning for K-12 schools (OOG, 2021a, 2021b, 2021c).

FIGURE 1

### Children’s MH OP Services Delivered via Telehealth

PROPORTIONS OF TOTAL MH OP SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



NOTE: Telehealth subcategory rates may not sum to total rates due to rounding. Percentage labels are not shown for values below one percent.

## Youth Substance Use Disorder Services

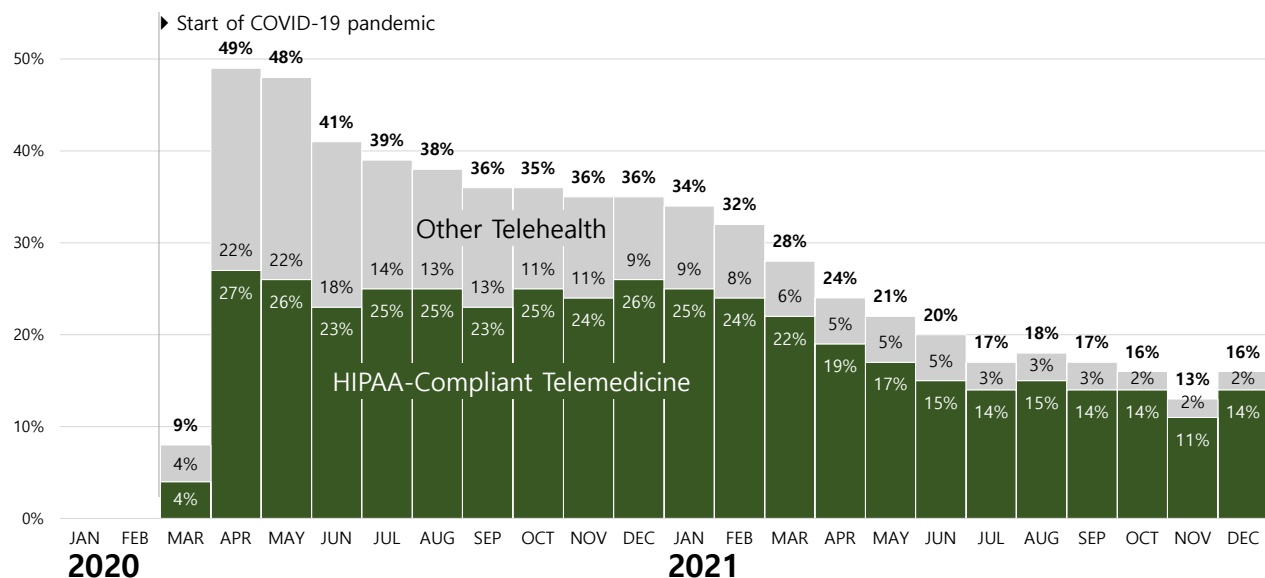
The proportion of SUD services for youth (ages 12-20) delivered by telehealth increased from 0 percent at the beginning of calendar year (CY) 2020 to an average of 38 percent between April 2020 and March 2021. Proportions of services delivered via telehealth in April and May 2020 were notably higher than the following months, with nearly half (48 to 49 percent) of all youth SUD service encounters delivered via telehealth in this timeframe. Rates remained high, accounting for about one-third or higher of all SUD services, through February 2021, and then fell quickly throughout the year, reaching 16 percent by December 2021 (see Figure 2). Note that rates cited in this section include all types of SUD services; see section “Telehealth Utilization by Service Modality” to see how rates differ across service types.

Similar to trends observed for MH OP services, the decline in SUD telehealth rates may have been impacted by Washington’s phased reopening in 2021 (OOG, 2021d) and by service delivery recommendations from the State Emergency Proclamation on Children and Youth Mental Health Crisis (OOG, 2021b).<sup>2</sup>

FIGURE 2

### Youth SUD Services Delivered via Telehealth

PROPORTIONS OF TOTAL SUD SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



NOTE: Telehealth subcategory rates may not sum to total rates due to rounding. Percentage labels are not shown for values below one percent.

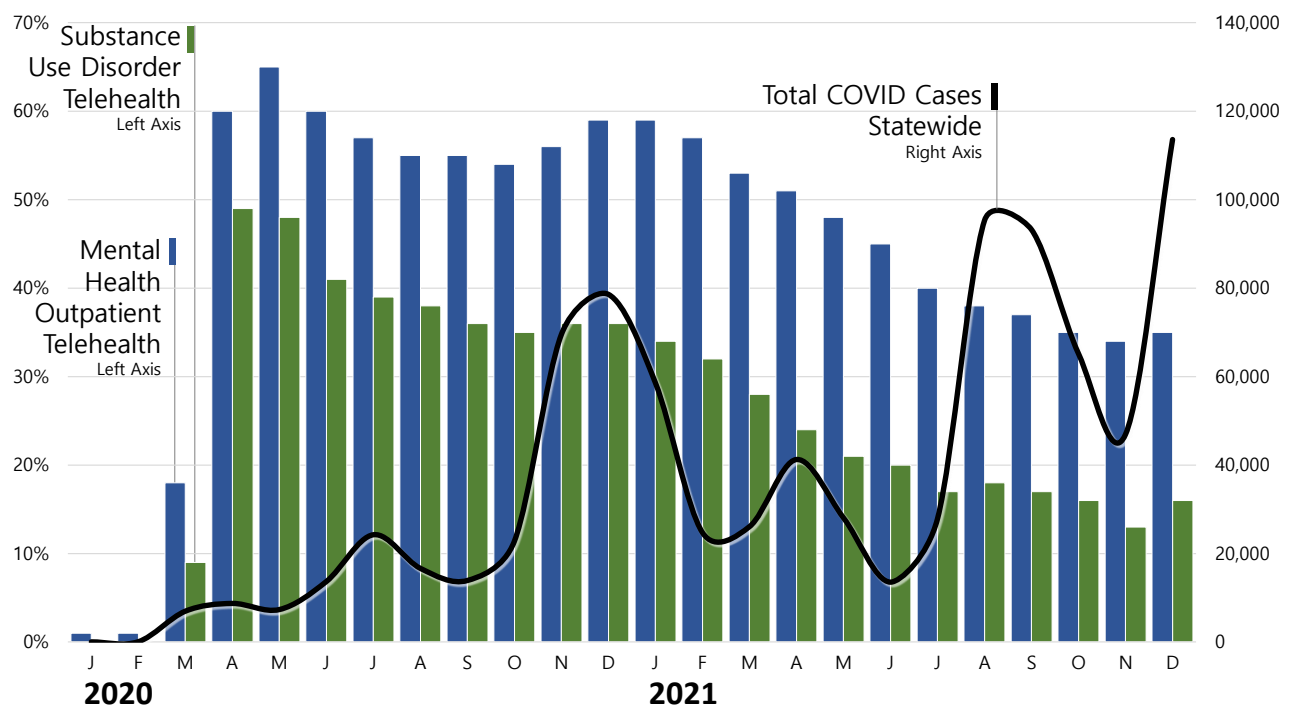
## COVID-19 Case Rates and Telehealth Trends

Although the first significant surge in COVID-19 cases in November 2020 to January 2021 corresponded to minor upticks in telehealth rates for both children’s MH OP and SUD services, telehealth rates appeared, for the most part, decoupled from later COVID-19 surges. Significant surges in COVID-19 case rates in August 2021 and December 2021 did not appear to prompt notable increases in telehealth utilization (see Figure 3).

<sup>2</sup> This proclamation directed the Health Care Authority and Department of Health to “immediately begin work on recommendations on how to support the behavioral health needs of our children and youth over the next 6 to 12 months and to address and triage the full spectrum of rising pediatric behavioral health needs” (OOG, 2021b, p. 6).

FIGURE 3

### Telehealth Rates for Children’s Behavioral Health and Washington’s COVID-19 Cases



SOURCE: Overall COVID-19 trend data is from the Washington State Department of Health.

## Telehealth Utilization by Service Modality

### Mental Health Outpatient Services

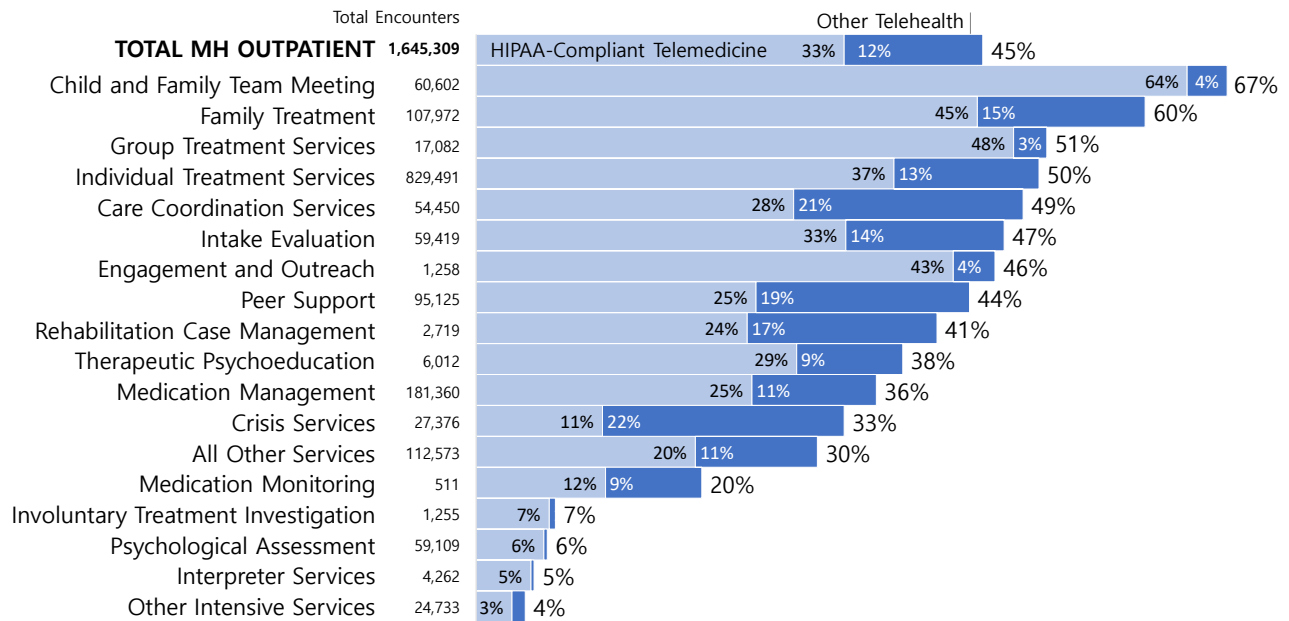
Telehealth rates differed by MH OP service modality.<sup>3</sup> In calendar year (CY) 2021, rates were highest for child and family team meetings, two-thirds of which were conducted via telehealth (67 percent), compared to the average of 45 percent for all MH OP services for that year. Other modalities where telehealth was frequently used were family treatment (60 percent), group treatment (51 percent), and individual treatment services (50 percent). Service modalities where telehealth services were least frequent included intensive services (4 percent), interpreter services (5 percent), psychological assessment (6 percent) and involuntary treatment investigation (7 percent). Crisis services (33 percent) and medication monitoring (20 percent) were also relatively infrequently delivered via telehealth technologies. See Figure 4 below for complete findings.

<sup>3</sup> Service modalities were determined based on guidelines in Washington’s Service Encounter Reporting Instructions (SERI), with minor exceptions as described in the Technical Notes section.

FIGURE 4

### Telehealth Rates for Children’s MH OP Services, by Service Modality

PROPORTIONS OF MH OP SERVICES THAT WERE DELIVERED VIA TELEHEALTH, CY 2021



NOTE: Telehealth subcategory rates may not sum to total rates due to rounding. Percentage labels are not shown for values below one percent.

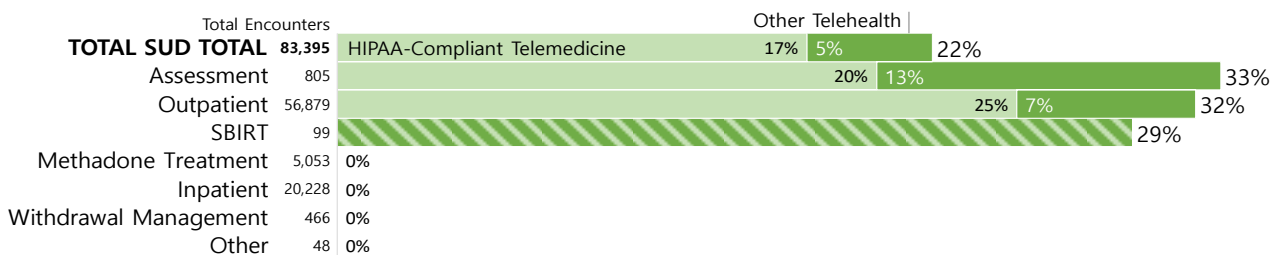
### Youth Substance Use Disorder Services

Overall telehealth rates for SUD services were less than half of rates for MH OP services (22 percent vs. 45 percent in CY 2021), but this difference narrowed substantially once SUD services that must be delivered in-person (inpatient, methadone treatment<sup>4</sup>, withdrawal management) were excluded. Of SUD service types that could be delivered via telehealth, rates in CY 2021 were 33 percent for assessment services; 32 percent for outpatient (OP), which is the largest service category by volume; and 29 percent for Screening, Brief Intervention and Referral to Treatment (SBIRT). See Figure 5 below for complete findings.

FIGURE 5

### Telehealth Rates for Youth SUD Services, by Service Modality

PROPORTIONS OF SUD SERVICES THAT WERE DELIVERED VIA TELEHEALTH, CY 2021



NOTE: A small number of encounters (<1 percent) meet criteria for multiple SUD service modalities; modalities are not mutually exclusive. Telehealth subcategory rates may not sum to total rates due to rounding. Telehealth subcategory rates for SBIRT are not shown due to small numbers.

<sup>4</sup> Methadone treatment as measured here does not include buprenorphine treatment, which may utilize telehealth.

## Trends in HIPAA-Compliant Telemedicine Services

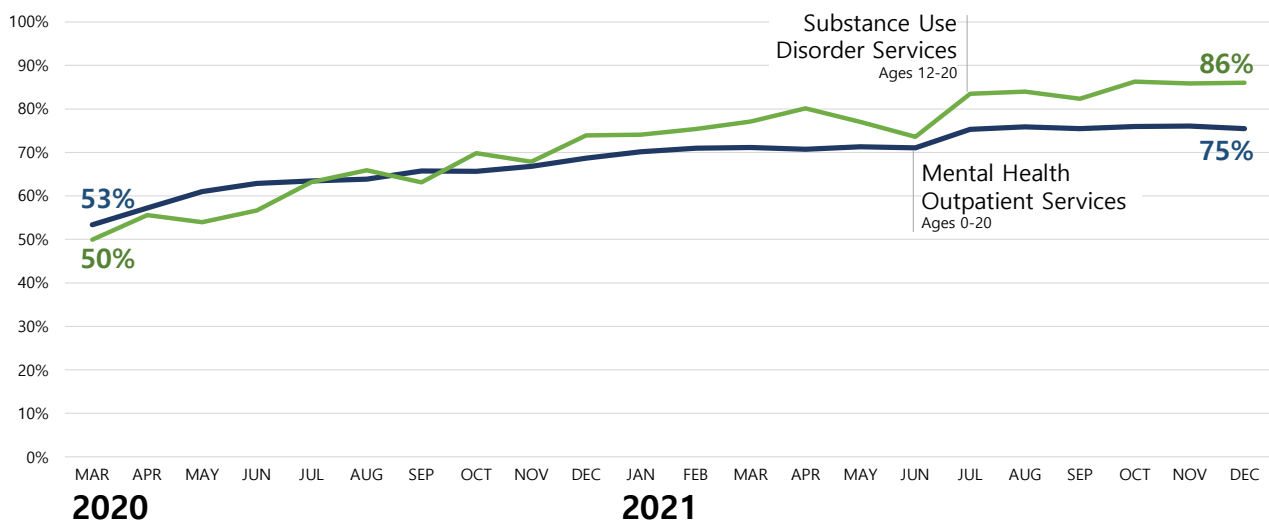
HIPAA-compliant telemedicine services are provided using real-time interactive audio and video technology that “meet[s] the standards required by state and federal laws governing the privacy and security of protected health information” (HCA, 2020a, p.1). For example, a Zoom video call with a mental health counselor would be considered HIPAA-compliant telemedicine. At the outset of the COVID-19 pandemic, Washington’s Health Care Authority authorized billers and providers to also use other non-HIPAA-compliant technologies to help maintain client access to services as well as client and provider safety. As labeled in this report (see Technical Notes), “other telehealth” refers to a variety of non-HIPAA compliant audio and/or video technologies, such as Skype or FaceTime; telephone calls (audio only); emails; and text messages.

The proportion of total children’s MH OP telehealth services that were HIPAA-compliant rose across the pandemic; 53 percent were HIPAA-compliant in March 2020, rising steadily to 75 percent by December 2021 (see Figure 6). This increase is partially explained by the overall decline in total telehealth services in CY 2021 (see Figure 1), with the decline for HIPAA-compliant telemedicine beginning later and being smaller and more gradual relative to other telehealth (analyses not shown). The trend was similar for youth (ages 12-20) SUD services, with HIPAA-compliant telemedicine increasing from 50 percent of total telehealth in March 2020 to 86 percent by December 2021 (see Figure 6).

FIGURE 6

### Trends in HIPAA-Compliant Telemedicine, of All Children’s MH OP and Youth SUD Services Delivered via Telehealth

PROPORTIONS OF TELEHEALTH BEHAVIORAL HEALTH SERVICES THAT WERE DELIVERED VIA HIPAA-COMPLIANT TECHNOLOGIES, MARCH 2020 – DECEMBER 2021



## Telehealth Utilization by Geography

Telehealth rates varied across locations within Washington State, with rates generally highest for youth residing in urban core census tracts, second highest in suburban census tracts, and lowest in towns and rural areas. This geographic pattern is consistent with higher telehealth rates reported in urban areas compared to rural areas in a national study of telehealth utilization among Medicaid beneficiaries in five states in the first year of the pandemic (GAO, 2022).



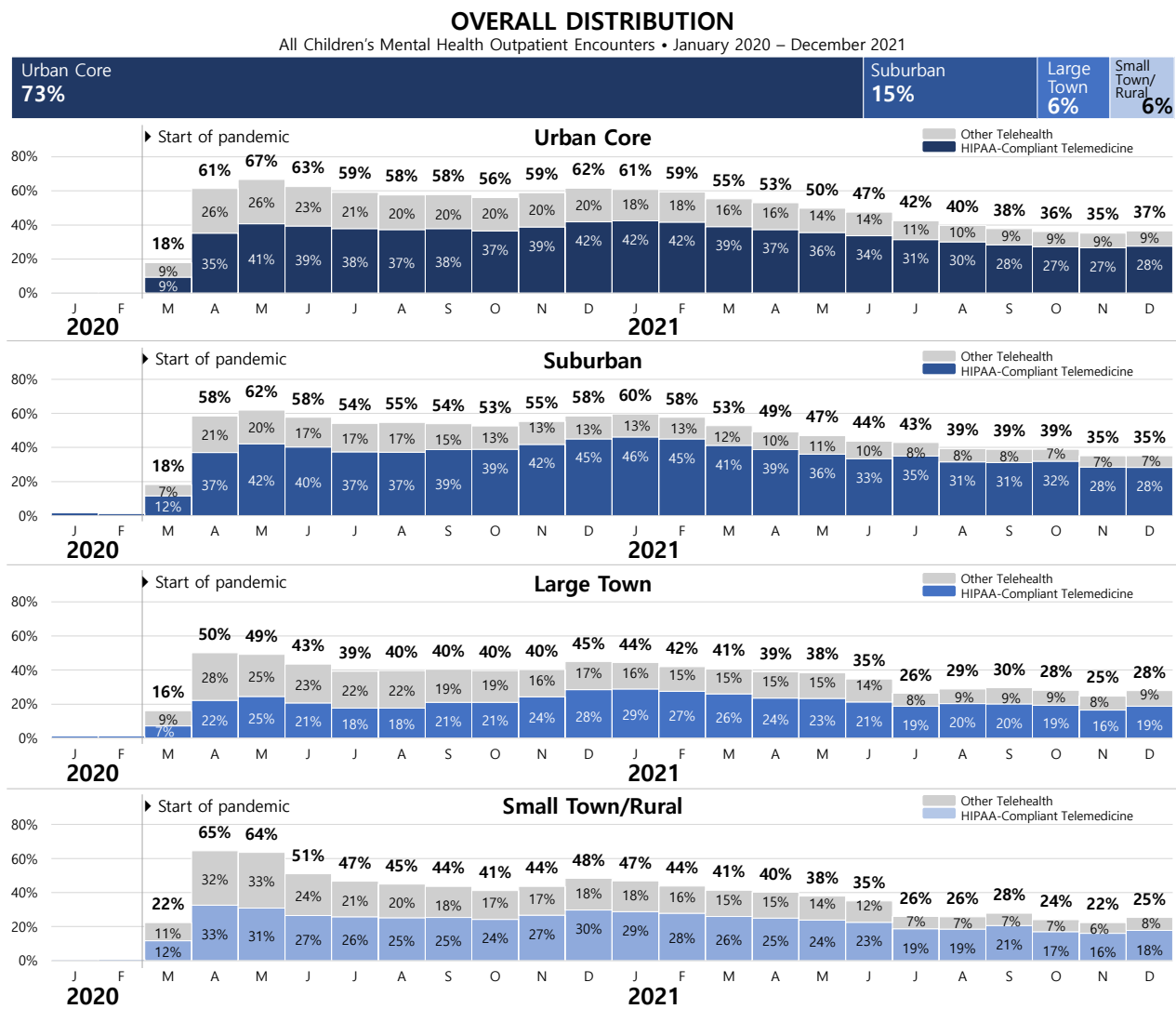
## Mental Health Outpatient Services

More than half of all MH OP services delivered to children residing in urban core and suburban census tracts in the first complete 12-month period of the pandemic (April 2020-March 2021) were delivered via telehealth. In CY 2021, nearly half of such services were delivered via telehealth. Eighty-eight percent of all children's MH OP services in CY 2021 to 2022 were delivered to children living in urban core or suburban areas (see horizontal bar chart within Figure 7). Thus, statewide telehealth rates shown in Figure 1 more closely resemble urban core and suburban telehealth rates than they do large town or small town/rural rates. In contrast, telehealth rates for MH OP services over the first two years of the pandemic were lowest for those in large town and small town/rural census tracts. Fewer than half of all MH OP services delivered between April 2020 to March 2021 to children residing in large town and small town/rural census tracts were delivered via telehealth, and in CY 2021, approximately one-third of all MH OP services in these areas were delivered via telehealth.

FIGURE 7

### Telehealth Rates for Children's MH OP Services, by Urban/Rural Geography

PROPORTIONS OF MH OP SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



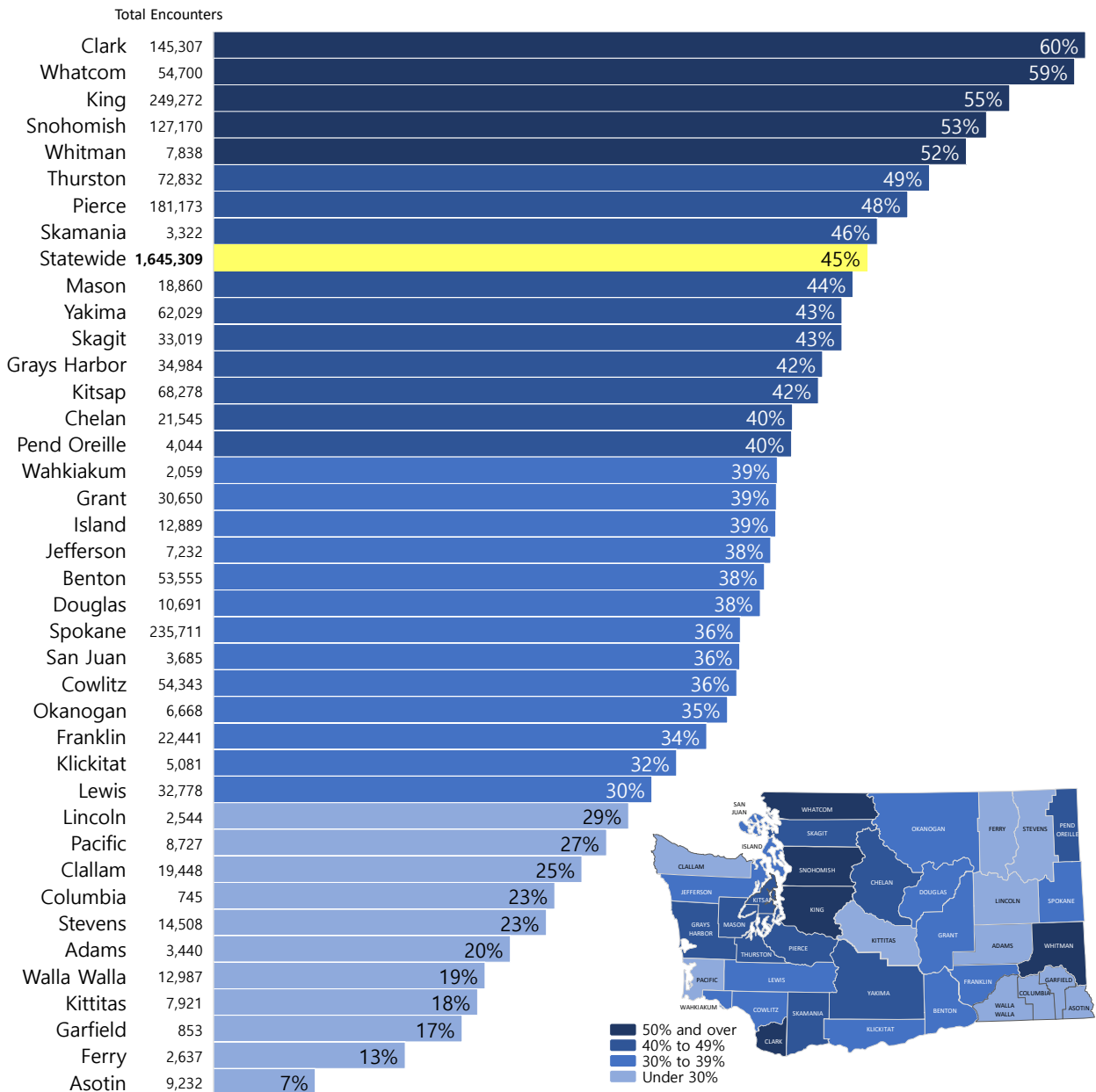
NOTES: Urban/rural classification is based on the census tract of the client's residence on the date of encounter. Telehealth subcategory rates may not sum to total rates due to rounding. Percentage labels are not shown for values below five percent.

At the county level, the proportion of children’s MH OP services delivered via telehealth in CY 2021 varied from a low of 7 percent to a high of 60 percent. MH OP telehealth rates were highest for Clark (60 percent; contains the Vancouver urban area), Whatcom (59 percent; contains the Bellingham urban area), and King (55 percent; contains the Seattle urban area) counties and lowest for Asotin (7 percent; largely rural), Ferry (13 percent; largely rural), and Garfield (17 percent; largely rural) counties. See Figure 8 below for complete details.

FIGURE 8

### Telehealth Rates for Children’s MH OP Services, by County

PROPORTIONS OF MH OP SERVICES THAT WERE DELIVERED VIA TELEHEALTH, CY 2021



NOTE: County is based on the client’s residence on the date of encounter. Excludes a small number of encounters (<0.1 percent) for which the child/youth’s county of residence is unknown.

## Youth Substance Use Disorder (SUD) Services

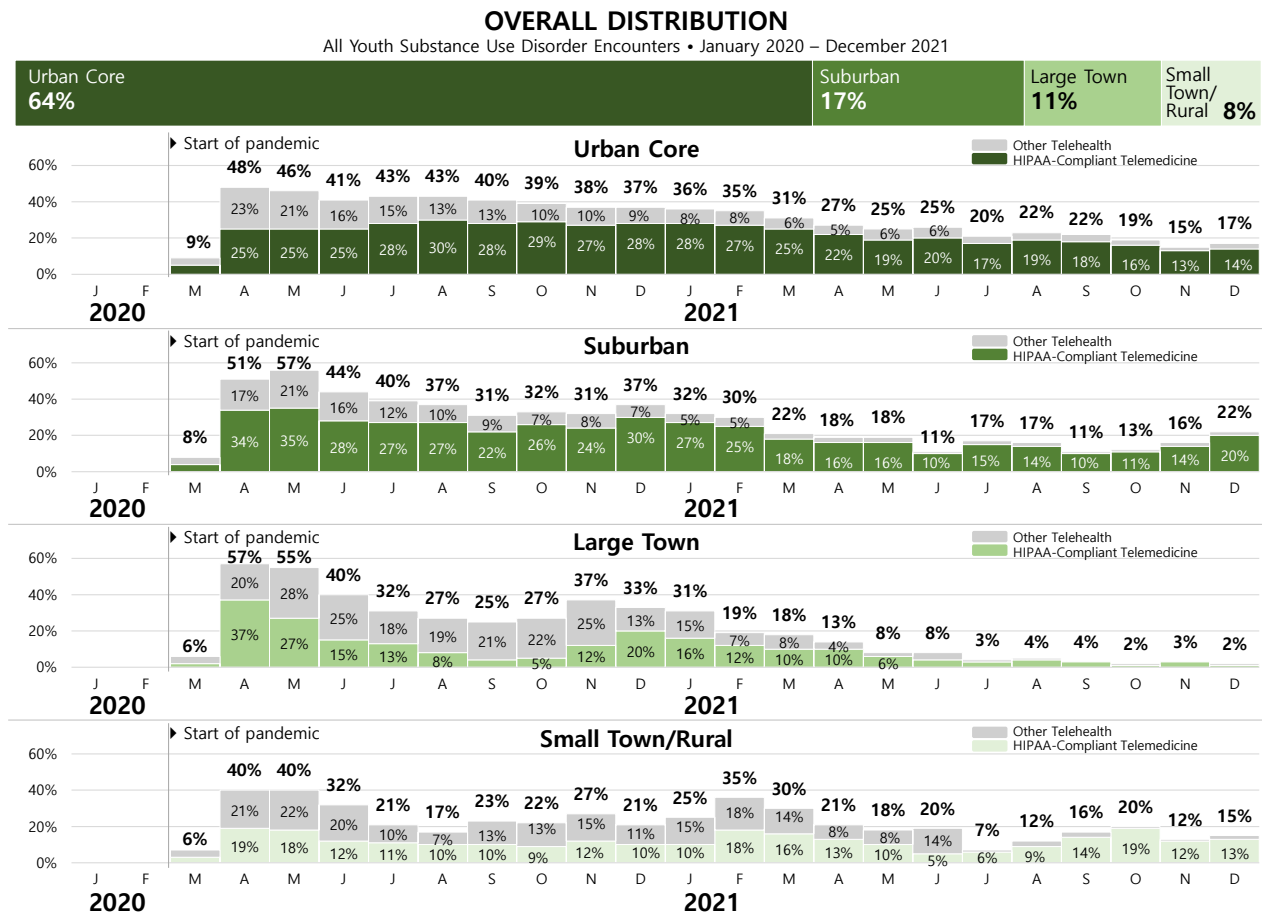
For youth SUD services as well, telehealth rates were highest in urban core and suburban census tracts—40 and 37 percent across the first complete year of the pandemic (April 2020-March 2021), respectively. The majority of SUD encounters (81 percent over the two-year study period; see horizontal bar chart within Figure 9) were delivered in these areas. As such, statewide SUD telehealth rates shown in Figure 2 more closely resemble urban core and suburban telehealth rates than they do large town or small town/rural rates. In contrast, telehealth rates were lowest for large town and small town/rural census tracts. One-quarter to one-third of all SUD service encounters delivered between April 2020 to March 2021 to children residing in in large town and small town/rural census tracts were delivered via telehealth (28 percent small town/rural; 33 percent large town).

Patterns for large town and small town/rural census tracts diverged in 2021 as overall telehealth rates fell. By December 2021, youth receiving SUD services via telehealth became a rarity in large town areas, accounting for only 2 percent of SUD services. In small town/rural areas, SUD telehealth rates were more persistent, accounting for 15 percent of SUD services in December 2021 (caveat: these small/town rural rates have relatively small sample sizes thus fluctuate from month to month). At the end of 2021, small town/rural telehealth rates still trailed urban/suburban telehealth rates (15 percent vs. 17 and 22 percent), but the gap had narrowed considerably from earlier in the pandemic.

FIGURE 9

### Telehealth Rates for Youth SUD Services, by Urban/Rural Geography

PROPORTIONS OF SUD SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



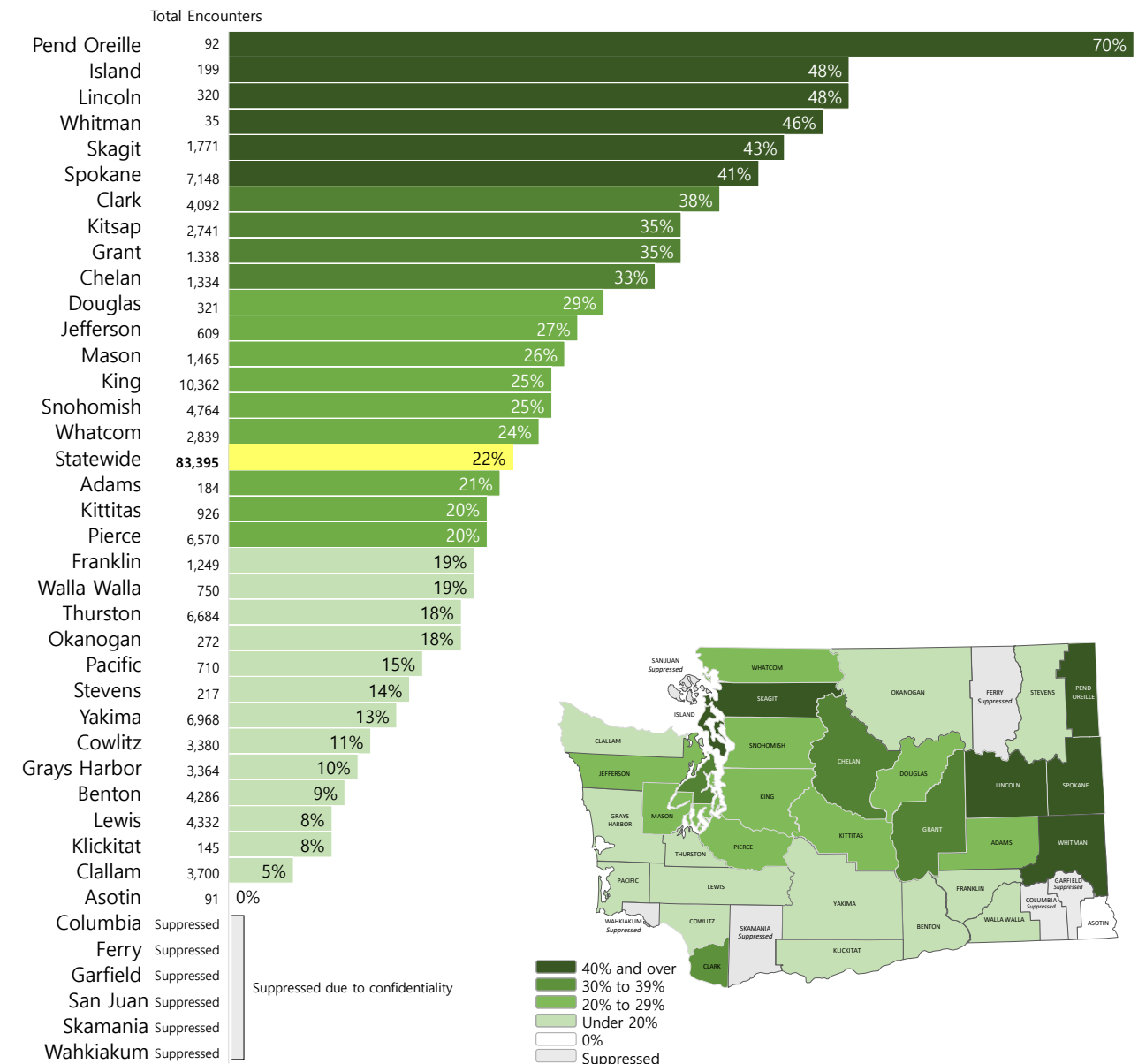
NOTES: Urban/rural classification is based on the census tract of the client's residence on the date of encounter. Telehealth subcategory rates may not sum to total rates due to rounding. Percentage labels are not shown for values below five percent.

County-level variation in telehealth rates was large for SUD services, ranging from 0 percent to a high of 70 percent. Small numbers of youth SUD encounters delivered in some rural counties contributed to the higher variation; this explains why counties with the very highest and lowest telehealth rates were rural counties. SUD telehealth rates were highest for Pend Oreille (70 percent; largely rural), Island (48 percent; largely rural), and Lincoln (48 percent; largely rural) counties and lowest (among counties with reportable data) for Asotin (0 percent; largely rural), Wahkiakum (1 percent; largely rural), and Skamania (3 percent; largely rural) counties. See Figure 10 below for complete details.

FIGURE 10

### Telehealth Rates for Youth SUD Services, by County

PROPORTIONS OF SUD SERVICES THAT WERE DELIVERED VIA TELEHEALTH, CY 2021



NOTE: County is based on the client's residence on the date of encounter. Excludes a small number of encounters (<0.1%) for which the child's county of residence is unknown. Data is suppressed due to confidentiality in six counties where the number of total SUD service encounters or the number of SUD service encounters delivered via telehealth was greater than 0 but less than 11.

# Telehealth Utilization by Demographics

Telehealth utilization varied notably by age group, but very minimally by race/ethnicity.

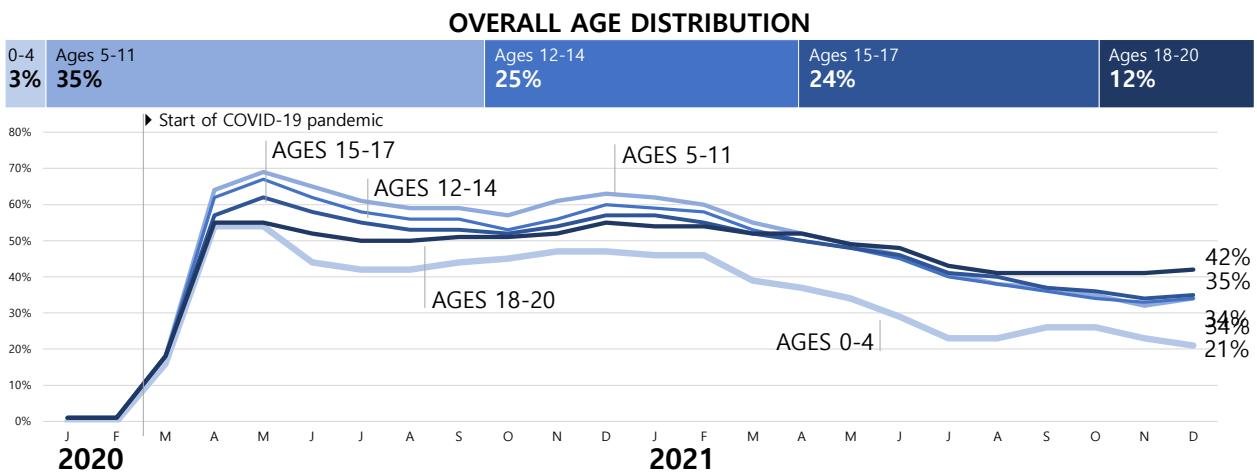
## Mental Health Outpatient Services

Utilization of telehealth for receiving MH OP services differed across age groups, and those age patterns varied across different phases of the pandemic (see Figure 11). During the initial telehealth spike in April to May 2020, MH OP telehealth rates were highest for children ages 5 to 14. This pattern continued during the first complete year of the pandemic (April 2020-March 2021) when the age-specific telehealth rates were: 60 percent for ages 5 to 11; 57 percent for ages 12 to 14; 55 percent for ages 15 to 17; 52 percent for ages 18 to 20; and 44 percent for ages 0 to 4. In 2021, telehealth rates declined most slowly for transition-age adults ages 18 to 20, who retained the highest telehealth rates (42 percent) as of December 2021. For this tech-savvy age group, the pandemic may have helped establish telehealth as a convenient option to receive MH OP services both at home and on the go that continues to be valuable. Young children ages 0 to 4 had the lowest telehealth utilization rate throughout the pandemic, possibly driven by two factors: (1) Early epidemiological evidence suggesting that young children, on average, had less risk for serious COVID outcomes than older persons; and (2) the unique challenges in providing early childhood mental health services remotely.

FIGURE 11

### Telehealth Rates for Children’s MH OP Services, by Age Group

PROPORTIONS OF MH OP SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



NOTE: Overall age distribution may not sum to 100 percent due to rounding.

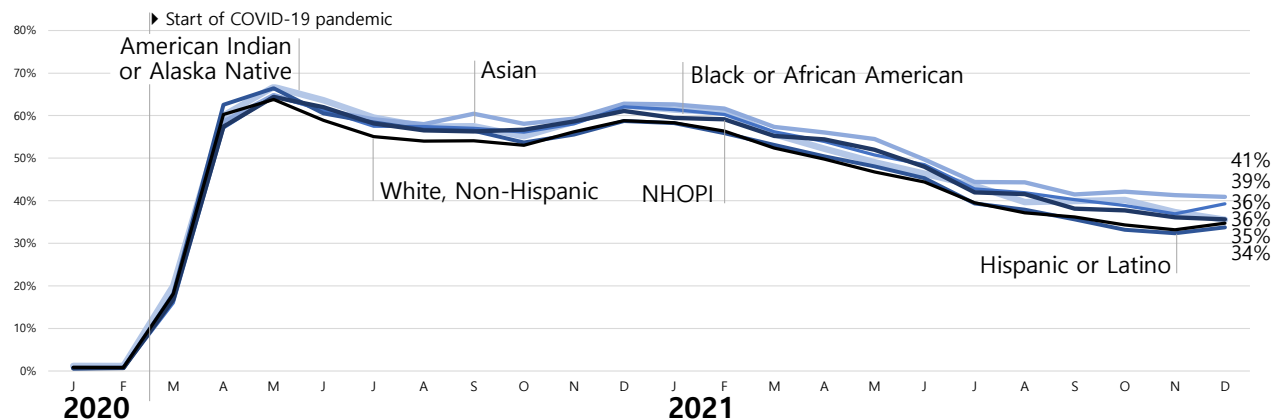
Telehealth rates for MH OP showed smaller differences across race/ethnic groups than across age groups throughout the pandemic; see the tightly clustered trends in Figure 12. During the initial pandemic telehealth spike in early 2020, telehealth rates were high in all groups with the highest among American Indian and Alaska Native children and youth (67 percent in May 2020). Over CY 2021, Asian children and youth who received MH OP services had the highest telehealth utilization (dropping to 41 percent by December 2021), whereas Hispanic or Latino and non-Hispanic white children had the lowest telehealth rates (dropping to 34 and 35 percent respectively by December 2021). Note that race/ethnicity patterns may be influenced by geographic distribution of race/ethnic populations, with Washington’s Hispanic and Latino children being disproportionately located in rural areas where telehealth rates are lower and Asian children being disproportionately located in urban areas where telehealth rates are higher.<sup>5</sup>

<sup>5</sup> Authors’ analysis of child population of urban/rural counties, based on 2022 urban/rural classifications from the Washington State Office of Financial Management (OFM); <https://ofm.wa.gov/washington-data-research/population-demographics/population->

FIGURE 12

### Telehealth Rates for Children’s MH OP Services, by Race/Ethnicity

PROPORTIONS OF MH OP SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



NOTES: Race/ethnic groups are not mutually exclusive; clients with more than one race/ethnicity are included in multiple groups. Encounters for which client’s race/ethnicity is unknown (<1 percent) are not presented. NHOPI=Native Hawaiian or Other Pacific Islander.

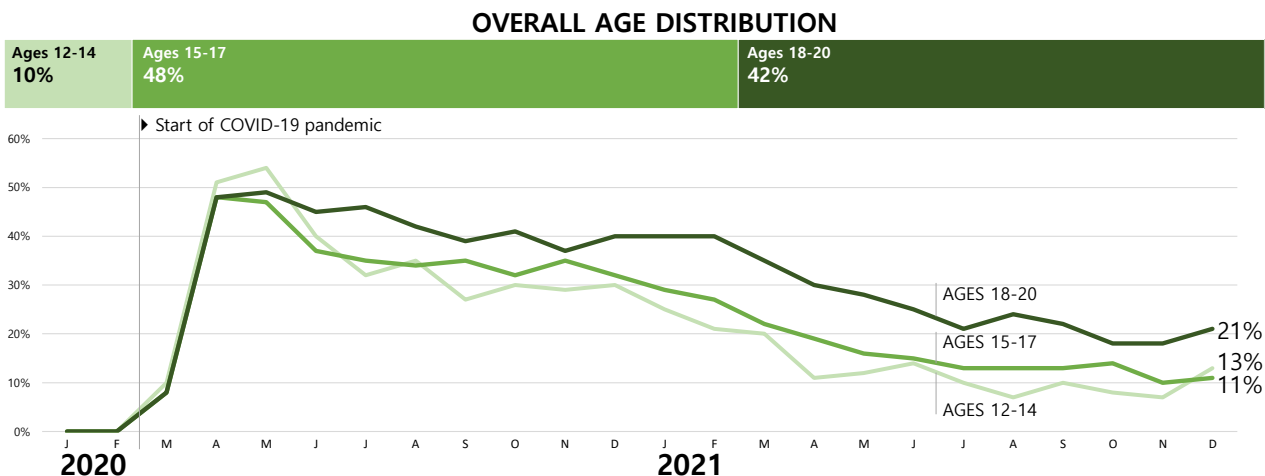
### Youth Substance Use Disorder (SUD) Services

Age patterns observed were somewhat different for SUD services, measured in this report only for youth ages 12 to 20, as SUDs are rare for younger children. Across most of the two-year period analyzed (January 2020 to December 2021), transition-age youth ages 18 to 20 had the highest SUD telehealth rates (42 percent on average in the first complete year of the pandemic, falling to 21 percent by December 2021). The second highest SUD telehealth rates were for youth ages 15 to 17 (34 percent on average between April 2020 and March 2021, falling to 11 percent by December 2021) and lowest were for youth ages 12 to 14 (despite the highest early pandemic spike, 32 percent on average between April 2020 and March 2021, falling to 13 percent in December 2021). See Figure 13 for additional details.

FIGURE 13

### Telehealth Rates for Youth SUD Services, by Age Group

PROPORTIONS OF SUD SERVICES THAT WERE DELIVERED VIA TELEHEALTH, JANUARY 2020 – DECEMBER 2021



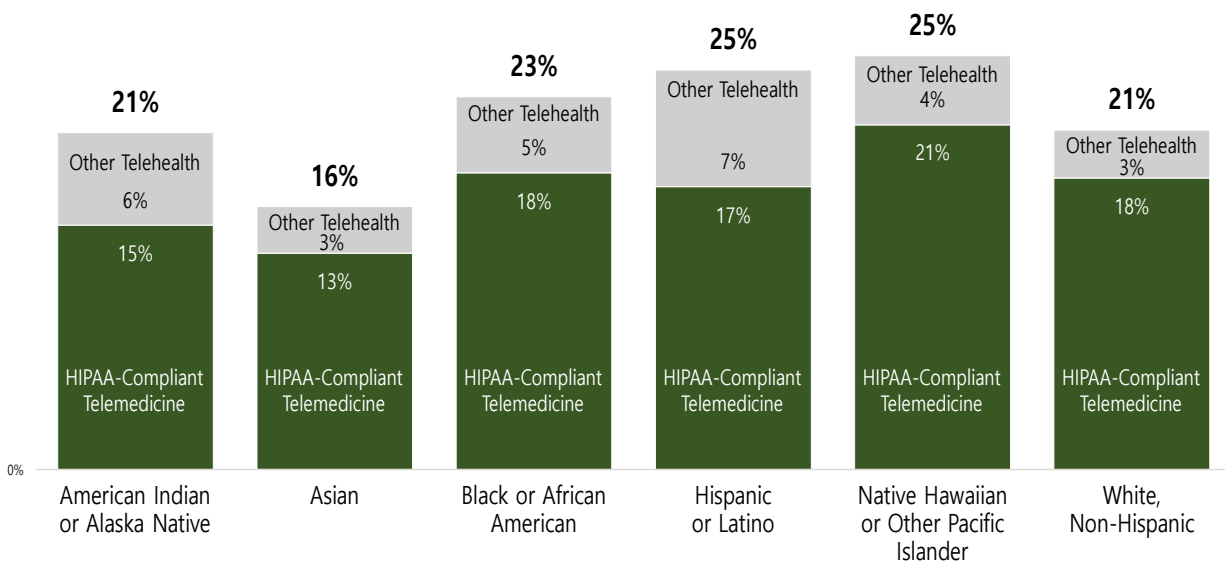
[estimates/population-density/population-density-and-land-area-criteria-used-rural-area-assistance-and-other-programs](#)) and 2019 Child Population by Race or Ethnicity in Washington data tables downloaded from the KidsCount Data Center (<https://datacenter.aecf.org>).

Rates across race and ethnic groups varied somewhat more for SUD telehealth services, compared to MH OP, and were more unstable across time (note that lower numbers of SUD service encounters, split into subgroups, possibly influenced this greater variation and instability). For example, SUD telehealth rates for young Black or African American clients were the lowest of all groups in mid-2020 but climbed to the highest by December 2021. Additionally, race/ethnicity patterns were not consistent across MH OP and SUD. Asian youth had the lowest SUD telehealth rates in 2021 (16 percent) but the highest MH OP telehealth rates in the same year. Native Hawaiian or Pacific Islander and Hispanic or Latino youth had the highest SUD telehealth utilization in 2021, with one-quarter (25 percent) of their SUD services being delivered remotely. See Figure 14 below for details on rates for CY 2021 (rates are aggregated over the year due to the instability in rates associated with small group sizes).

FIGURE 14

### Telehealth Rates for Youth SUD Services, by Race/Ethnicity

PROPORTIONS OF SUD SERVICES THAT WERE DELIVERED VIA TELEHEALTH, CY 2021



NOTES: Race/ethnic groups are not mutually exclusive; clients with more than one race/ethnicity are included in multiple groups. Encounters for which the client's race/ethnicity is unknown (< 1%) are not presented here. Telehealth subcategory rates may not sum to total rates due to rounding.

## Discussion

This analysis describes the rapid rise of telehealth utilization during the COVID-19 pandemic among children and youth on medical assistance receiving mental health and substance use disorder services in Washington State. Telehealth utilization in this report includes both HIPAA-compliant and non-HIPAA-compliant technologies, the latter of which were specially authorized for use at the outset of the pandemic.

The rapid expansion of telehealth services during COVID-19 revolutionized the delivery of behavioral health services to children and youth. The importance of delivering many services remotely to maintain safety in the early phases of the pandemic altered long-standing practices of delivering mental health and SUD services in person, with few exceptions. Within a matter of weeks in March and April 2020, providers and patients quickly shifted to delivering many types of MH OP and SUD services remotely. Although telehealth rates have fallen dramatically since the early phases of the pandemic, this method of service delivery continued to account for significant portions of both MH OP (35 percent) and SUD services (16 percent), as of December 2021. The decline of telehealth rates in 2021 was not uniform; results show that telehealth continued at high rates for some services and groups (e.g., services for transition-age youth ages 18 to 20).

It is important to keep in mind that the rates presented here may underestimate true utilization of telehealth for youth behavioral health services, particularly at the outset of the pandemic, and that distributions presented by month, service or telehealth modality, geography, or demographics may differ from true distributions. The COVID-19 lockdown in March 2020 and the need to transition from in-person to remote services came swiftly and with little warning, leaving providers with inadequate time to plan service delivery changes, data system changes, or changes in billing/encounter practices. The Health Care Authority's COVID-19 pandemic encounter guidance anticipated possible underreporting, instructing providers to use a specific modifier and place of service code to represent HIPAA-compliant telemedicine if the provider's electronic health record (EHR) allowed, while also stating it was acceptable to not do so if the EHR did not allow this. Similarly flexible guidance is given for the category of other telehealth as well (HCA, 2020b).

It is also important to interpret these changes in telehealth utilization rates in the context of broader changes to Medicaid caseloads and service delivery patterns over the same time period. The COVID-19 pandemic was not only a public health crisis, but also an economic crisis, resulting in job losses and increases to Medicaid child caseloads starting in April 2020 and continuing through December 2021 and beyond<sup>6</sup>. Over this period, MH OP service encounter volume showed relatively minor fluctuations in 2020, followed by a spike in spring 2021, possibly related to the return of some children to in-person schooling and increased mental health referrals from teachers and other school staff. In mid-to-late 2021, a larger decline in MH OP service volume occurred, that was driven largely by declines in telehealth; in-person encounters remained relatively flat over that period. Please see Figure 1 in recent RDA report, "The Well-Being of Washington State's Children During the COVID-19 Pandemic," for more information on MH OP utilization, as well as trends in mental health diagnoses and emergency department utilization over the pandemic period (Patton et al., 2023). For SUD services, a larger decline in youth SUD services occurred in early 2020 and did not recover by the end of 2021 (RDA, 2023). Behavioral health workforce shortages exacerbated during the pandemic may have contributed to declines in both MH OP volume in 2021 and SUD volume in 2020 and 2021.

After the COVID-19 pandemic established telehealth as a viable option for receiving behavioral health services, some youth may continue to opt for telehealth even as pandemic-related safety concerns recede due to convenience and personal preference. Possible reasons for choosing telehealth may include improved access to services, eliminated transportation obstacles, reduced commute time and missed work, as well as potentially improved gender-affirming care, as supported by past research (D'Angelo et al., 2021; Wood et al., 2021; GAO, 2022). Telehealth may also improve access to behavioral health services for persons who may fear pursuing such services due to stigma. One analysis of telehealth during the pandemic across five states found that privacy was a major benefit of receiving behavioral health services at home, as reported by Medicaid beneficiaries in two states. In Mississippi, receiving mental health services via telehealth "addressed beneficiaries' concerns about visiting a mental health center" (GAO, 2022, p. 28). Possibly reflecting all these reasons, additional research has found that providing health services via telehealth may reduce no-show rates (American Psychiatric Institute, 2021; Drerup et al., 2021). Providers may also prefer telehealth in certain circumstances, although they note that "some patient populations and appointment types are a better fit for in-person services" (Lipschitz et al., 2022).

Despite the potential access benefits of telehealth, Washington's system of care must continue striving to understand and address the digital divide—disparities and barriers to digital literacy and access (Chang et al., 2021). Geographic location, income disparities, educational disparities and other factors yield differential access to telehealth and other types of services provided remotely (e.g., online schooling). Washington State has begun the effort to address this divide by outlining digital equity

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<sup>6</sup> Based on caseload estimates from the Caseload Forecast for Categorically Needy Children, Washington State Caseload Forecast Counsel.



and inclusion initiatives within state broadband goals (DOC, 2021). The DSHS Research and Data Analysis Division is planning a follow-up report to this report examining disparities in broadband internet and computer availability, and their potential implications for telehealth and other remote services in Washington State.

In addition to addressing equity, attending to service quality is key to ensuring the safety and efficacy of treatment for young clients receiving mental and behavioral health services via telehealth. Recent publications have urged the Centers for Medicare and Medicaid Services (CMS) to assess the overall quality of telehealth services (GAO, 2022) as well as to evaluate and support state evaluations of the quality of behavioral health services delivered via telehealth (HHS OIG, 2021). As of September 2021, a few states had identified increased access and reduced costs as benefits of providing behavioral health services via telehealth but none had evaluated the effects on quality measures such as continuity of care or patient safety, according to the HHS Office of the Inspector General (OIG). Several states surveyed by OIG identified quality as an area of concern “particularly for certain types of behavioral health services, such as prescribing, and for services that are delivered audio-only versus audio-video” but some noted that provider training could mitigate quality concerns (HHS OIG, 2021, p.8). As we envision the future of the behavioral healthcare system in a post-pandemic reality, it is essential to further examine telehealth utilization and its implications. Future research should consider the impacts of delivering behavioral health services on access, cost, and quality to understand how telehealth can best be leveraged to improve outcomes for youth receiving behavioral health services.

### DATA SOURCE

Data for this report come from ProviderOne, Washington’s Medicaid Management Information System (MMIS) and the Department of Social and Health Services Integrated Client Databases (ICDB; Mancuso & Huber 2021).

### MEASURES

#### Medical Assistance

Medicaid (Title XIX full benefit), State Children’s Health Insurance Program (SCHIP; Title XXI Full Benefit), and Children’s Health Program (state-funded).

#### Mental Health Outpatient Services (MH OP)

Analysis of mental health outpatient services includes claims or encounters from the ProviderOne data system as of July 2022 classified as MH OP services, for children and youth (ages 0-20) enrolled in medical assistance. Service modalities for MH OP were generally based on guidelines in Washington’s Service Encounter Reporting Instructions (SERI) available at <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri>. For encounters unable to be categorized based on SERI guidelines, most were categorized as “all other services” with the exceptions of the following non-SERI procedure codes:

- 96127 “Brief Emotional or Behavioral Assessment” categorized as “Psychological Assessment”
- H2020 “Therapeutic Behavioral Services, Per Diem” categorized as “Other Intensive Services”
- S9482 “Family Stabilization Services, Per 15 Minutes” categorized as “Crisis Services”
- 90839 “Psychotherapy for Crisis; First 60 Minutes” categorized as “Crisis Services”
- 90840 “Psychotherapy for Crisis; Each Additional 30 Minutes” categorized as “Crisis Services”

#### Substance Use Disorder Services (SUD)

Analysis of substance use disorder services includes claims or encounters from the ProviderOne data system classified as substance use disorder services for youth (ages 12-20) enrolled in medical assistance. Service modalities for SUD were based on several ProviderOne fields including claim types, procedure codes, and provider taxonomy codes. Note that a small number of encounters (approximately 2 percent) meet criteria for multiple SUD service modalities; SUD modalities are not mutually exclusive.

#### Telehealth Encounters

Defined as all encounters provided using remote technologies. The two subtypes are below, defined using encounter/billing guidance from the Washington Health Care Authority for the report time period:

- **HIPAA-compliant telemedicine:** Services provided using real-time interactive audio and video technology that “meet[s] the standards required by state and federal laws governing the privacy and security of protected health information,” as specified in the Health Insurance Portability and Accountability Act (HIPAA). For example, a Zoom video call with a mental health counselor would be considered HIPAA-compliant telemedicine. Per billing guidelines from Washington’s Health Care Authority, HIPAA-compliant telemedicine encounters are indicated by use of the ‘GT’ modifier code (“interactive telecommunication”) and/or ‘02’ place of service code (“telehealth”) on service encounters, valid through December 2021. Even pre-pandemic, HIPAA-compliant telemedicine services were allowable for behavioral health services where appropriate.
- **Other telehealth:** At the outset of the COVID-19 pandemic, Washington’s Health Care Authority authorized billers and providers to also use other non-HIPAA-compliant technologies to help maintain client access to services and client and provider safety. As labeled in this report, other telehealth refers to a variety of non-HIPAA compliant telehealth technologies such as the following: audio/video technologies that are non-HIPAA compliant, such as Skype or FaceTime; telephone calls (audio only); emails; and text messages. Per billing guidelines from Washington’s Health Care Authority, other remote services are indicated by use of the ‘CR’ modifier code (“catastrophe/disaster-related”) and/or audio-only telephone procedure codes 99441-99443 on service encounters, valid through December 2021. Note that when the national Public Health Emergency ended on May 11, 2023, the Health Care Authority rescinded authorization for behavioral health services to be provided via email or text messages (HCA, 2023); this occurred after the study time period.

Note that some telehealth encounters may not be flagged as such (and thus may be undercounted) if some providers were using electronic health records unable to be modified quickly to follow HCA's billing guidelines. Underreporting may be more prevalent early in the pandemic, when providers were adjusting their services and corresponding billing practices to include telehealth services.

### Geographic Types

Four-level classification (urban core; suburban; large town; small town/rural) of Washington Census tracts based on primary and secondary 2010 Rural-Urban Commuting Area Codes; revised to account for local conditions such as access to largest urban centers. Completed by RDA in collaboration with WA Department of Health. RDA Version March 2016.

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