State Telehealth Laws and Reimbursement Policies

Spring 2021

EXECUTIVE SUMMARY:

A Comprehensive Scan of 50 States and D.C. Findings & Highlights

Historically, The Center for Connected Health Policy (CCHP) has released twice a year (Spring and Fall) updates to its "State Telehealth Laws and Reimbursement Policies" report in the form of a PDF report document that details all the telehealth policies for all 50 states and the District of Columbia. Over the years this has evolved to include an update to CCHP's online database of the same information. In 2021 the information in the State Telehealth Laws and Reimbursement Report has transitioned exclusively to a new and improved online database tool. This online database tool allows CCHP to easily update each state's information whenever there is a change instead of updating only in the Spring and Fall. Additionally, while there will no longer be a single PDF report with every state, the information from the online database can still be exported for each state into a PDF document using the most current information available on CCHP's website. CCHP will continue to produce these bi-annual summary reports of the status of telehealth policies across the United States in the Spring and Fall each year to provide a snapshot of the progress made in the past six months. It is hoped that this transition will result in more timely policy information that is easier for users to navigate and understand. The information for this summary report covers information through February of 2021.

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Mei Kwong, CCHP Executive Director, or Amy Durbin, Policy Advisor at info@cchpca.org.

A special thank you to CCHP Policy Associates Christine Calouro and Veronica Collins for their invaluable contributions to this report. For further information, visit cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

Mei Wa Kwong, JD
Executive Director
April 2021

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INTRODUCTION

The Center for Connected Health Policy's (CCHP) Spring 2021 analysis and summary of telehealth policies is based on its online telehealth policy database tool. It highlights the changes that have taken place in state telehealth policy between the Fall 2020 release of CCHP's telehealth policies report, and Spring 2021 (with research conducted in February 2021). This summary offers policymakers, health advocates, and other interested health care professionals an overview of telehealth policy trends throughout the nation. For detailed information by state, see CCHP's telehealth policy database tool which breaks down policy for all 50 states and the District of Columbia.

Please note that for the most part, states continue to keep their temporary telehealth COVID-19 emergency policies siloed from their permanent telehealth policies. These temporary policies are not included in this executive summary, although they are listed under each state in the online telehealth policy database tool. In instances where the state has made policies permanent, CCHP has incorporated those policies into this report.

METHODOLOGY

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the primary resources for the online telehealth policy database tool, from which the findings in this summary are taken. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, transmittals or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in the database tool specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources.

Every effort was made to capture the most recent policy language in each state as of February 2021. It should be noted that even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. For purposes of this summary, CCHP only counts states as reimbursing for a specific modality or removing a restriction if there is documentation to show that the Medicaid program has implemented a statutory requirement to reimburse for that modality or eliminate a restriction. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP's report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming this.

The survey focused on three primary areas for telehealth policy including Medicaid reimbursement, private payer laws and professional regulation/health & safety requirements. Within each category, information is organized into various topic and subtopic areas. These topic areas include:

- **Medicaid Reimbursement:**
  - o Definition of the term telemedicine/telehealth
  - o Reimbursement for live video
  - o Reimbursement for store-and-forward
  - o Reimbursement for remote patient monitoring (RPM)
  - o Reimbursement for email/phone/fax
  - o Consent issues
  - o Out-of-state providers

- **Private payer laws:**
  - o Definitions
  - o Requirements
  - o Parity (service and payment)

- **Professional Regulation:**
  - o Definitions
  - o Consent
  - o Online Prescribing
  - o Cross-State Licensing & Compacts
  - o Professional Board Standards

KEY FINDINGS

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system or practitioner provides health care services in multiple states. In most cases, states have moved away from duplicating Medicare's restrictive telehealth policy, with some reimbursing a wide range of practitioners and services, with little to no restrictions. One of the most common trends with live video reimbursement was the addition of eligible services to the list of telehealth eligible services, with applied behavioral analysis being the most common service addition mentioned in Medicaid manuals. Additionally, in the wake of the COVID-19 pandemic, some states do seem to be adopting the Center for Medicare and Medicaid Services' (CMS) communication technology-based services (CTBS) codes, including the virtual check-in and remote evaluation of pre-recorded information, audio-only service codes and remote physiologic monitoring. This development is discussed further in subsequent sections.

All fifty states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Additionally, because of the allowance in most states to utilize telephone as a form of telehealth during COVID-19, some states are taking steps to broaden its permanent definitions of telehealth or telemedicine by removing the explicit exclusion of telephone or including audio-only services within the definition itself.

One of the states with the most significant changes to their telehealth policy was Massachusetts which passed a comprehensive telehealth law to require reimbursement for both Medicaid and private payers if the services are covered in-person and it is appropriately delivered through telehealth. The law contained some unique elements including specifying that the rate of payment for telehealth services provided via interactive audio-video technology and audio-only telephone may be greater than the rate of payment for the same services delivered by other telehealth modalities. It also provided payment parity for in-network providers of behavioral health services delivered via interactive audio-video technology or audio-only telephone only. Additional findings include:

- Fifty states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service.
- Twenty-two state Medicaid programs reimburse for store-and-forward. However, three states (NC, OH, VT) solely reimburse store-and-forward as a part of CTBS, which is limited to specific codes and reimbursement amounts. Additionally, three jurisdictions (MS, NH, and NJ) have laws requiring Medicaid reimburse for store-and-forward but as of the creation of this edition, have yet to have any official Medicaid policy indicating this is occurring.
- Twenty-six state Medicaid programs provide reimbursement for RPM. As is the case for store-and-forward, two Medicaid programs (HI and NJ) have laws requiring Medicaid reimburse for RPM but at the time this report was written, did not have any official Medicaid policy. Additionally, one state (Ohio) only reimburses the remote physiologic monitoring codes CMS does.
- Fourteen state Medicaid programs (Alaska, Arizona, Colorado, Maryland, Maine, Minnesota, Missouri, North Carolina, New York, Ohio, Oregon, Texas, Vermont and Virginia) reimburse for all three, although certain limitations apply.

While this Executive Summary provides an overview of findings, it must be stressed that there are nuances in many of the telehealth policies. To fully understand a specific policy and all its intricacies, the full language of it must be read utilizing CCHP's telehealth policy database tool. Below are summarized key findings in each category area contained in the database as of February 2021.

Definitions

States alternate between using the term "telemedicine" or "telehealth". In some states both terms are explicitly defined in law and/or policy and regulations. "Telehealth" is sometimes used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" prefix are also becoming more prevalent. For example, the term "telepractice" is being used frequently as it relates to physical and occupational therapy, behavioral therapy, and speech language pathology. "Telesychiatry" is also a term commonly used as an alternative when referring specifically to psychiatry services.

Some states put specific restrictions within the definitions, which often limit the term to "live" or "interactive", excluding store-and-forward and RPM from the definition and subsequently from reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. However, due to the allowance for telephone in many COVID-19 temporary policies, a few states are beginning to amend their definitions to either remove the explicit exclusion of telephone or explicitly include audio-only services in their telehealth/telemedicine definitions. All fifty states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both.

Medicaid Reimbursement

Modalities: Live Video, Store-and-Forward, Remote Patient Monitoring (RPM), Email/ Phone/Fax

All 50 states and the District of Columbia have some form of Medicaid reimbursement for telehealth in their public program. However, the extent of reimbursement for telehealth delivered services is less clear in some states than others.

Live Video

The most predominantly reimbursed form of telehealth modality is live video, with every state offering some type of live video reimbursement in their Medicaid program. However, what and how it is reimbursed varies widely. Some Medicaid programs, for example limit reimbursable services to a specific list of CPT codes, such as Ohio, while other states, such as California, reimburses for live video across a wide variety of medical specialties. In addition to restrictions on specialty type, many states have restrictions on:

- The type of services that can be reimbursed, e. g. office visit, inpatient consultation, etc.;
- The type of provider that can be reimbursed, e. g. physician, nurse, physician assistant, etc.; and
- The location of the patient, referred to as the originating site.

Since Fall 2020, many states added additional services that could be reimbursed via live video to their list of eligible services, including South Dakota for speech therapy and diabetes self-management, Hawaii and New Mexico for Applied Behavioral Analysis and Ohio also added many new codes to their list of eligible services.

Store-and-Forward

Store-and-forward services are only defined and reimbursed by twenty-two Medicaid Programs. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered 'telehealth'). In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in "real time," automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether in those states. Of those states that do reimburse for store-and-forward services, some have limitations on what will be reimbursed or if they do not reimburse for the modality, they carve out special exceptions. For example, Maryland's Medicaid program specifies that while they don't reimburse for store-and-forward, they do not consider use of the technology in dermatology, ophthalmology and radiology to fit into the definition of store-and-forward.

In addition to the states above, three other states have laws requiring Medicaid reimburse for store-and-forward services, but CCHP has not been able to locate any official Medicaid policy indicating that they are in fact reimbursing. They include Mississippi, New Hampshire, and New Jersey. In some cases, although a definition of telehealth or telemedicine applicable to their Medicaid program included store-and-forward, there was no further indication of the modality being reimbursed, or the only specialty referenced was teleradiology which CCHP does not count as store-and-forward reimbursement for purposes of this list. Store-and-forward is slowly being introduced in some states through specific CPT codes that include store-and-forward in its description. For example, Hawaii recently allowed for the reimbursement of one specific teledentistry code (D9996) that specifically allows for asynchronous review of information by a dentist. Additional states have allowed for store-and-forward reimbursement as a result of reimbursement for CBTS, some of which include the store-and-forward modality in its description. CBTS is discussed further in a subsequent section, but its important to understand that three (OH, NC, VT) out of the 22 states that reimburse for store-and-forward do it through these CTBS codes.

Remote Patient Monitoring (RPM)

Twenty-six states have some form of reimbursement for RPM in their Medicaid programs. Since Fall 2020, four states (NC, ND, OK and OH) added reimbursement for remote patient monitoring. However, one state (Ohio) added reimbursement only for specific remote physiologic monitoring codes modeled after CMS reimbursement. Many of the states that offer RPM reimbursement also have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical conditions for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected. Hawaii and New Jersey Medicaid have laws requiring Medicaid reimburse for RPM but at the time this report was written, did not have any official Medicaid policy regarding RPM reimbursement. Texas, which previously only offered home telemonitoring to patients with a diagnosis of diabetes or hypertension expanded by now offering home telemonitoring to clients 20 years of age or younger, who have end stage solid organ disease, is an organ transplant recipient, or requires mechanical ventilation.

Email & Telephone

While telephone or audio-only service delivery has historically rarely been an acceptable form of delivery, that is slowly changing with the advent of COVID-19, and the need to reimburse the modality to reach people without access to high-speed broadband that allows for live video interaction. Fifteen state Medicaid programs now allow for telephone reimbursement in some ways. Sometimes they only reimburse specific specialties such as mental health, or for specific services such as case management. Three out of the fifteen states are counted as reimbursing for telephone as a result of reimbursement for a CTBS code that allows for audio-only interaction, including interprofessional consultations (eConsults) in California. Secure electronic messages are also beginning to be allowed through reimbursement of the eVisit code, which describes non-face-to-face communication using an online patient portal.

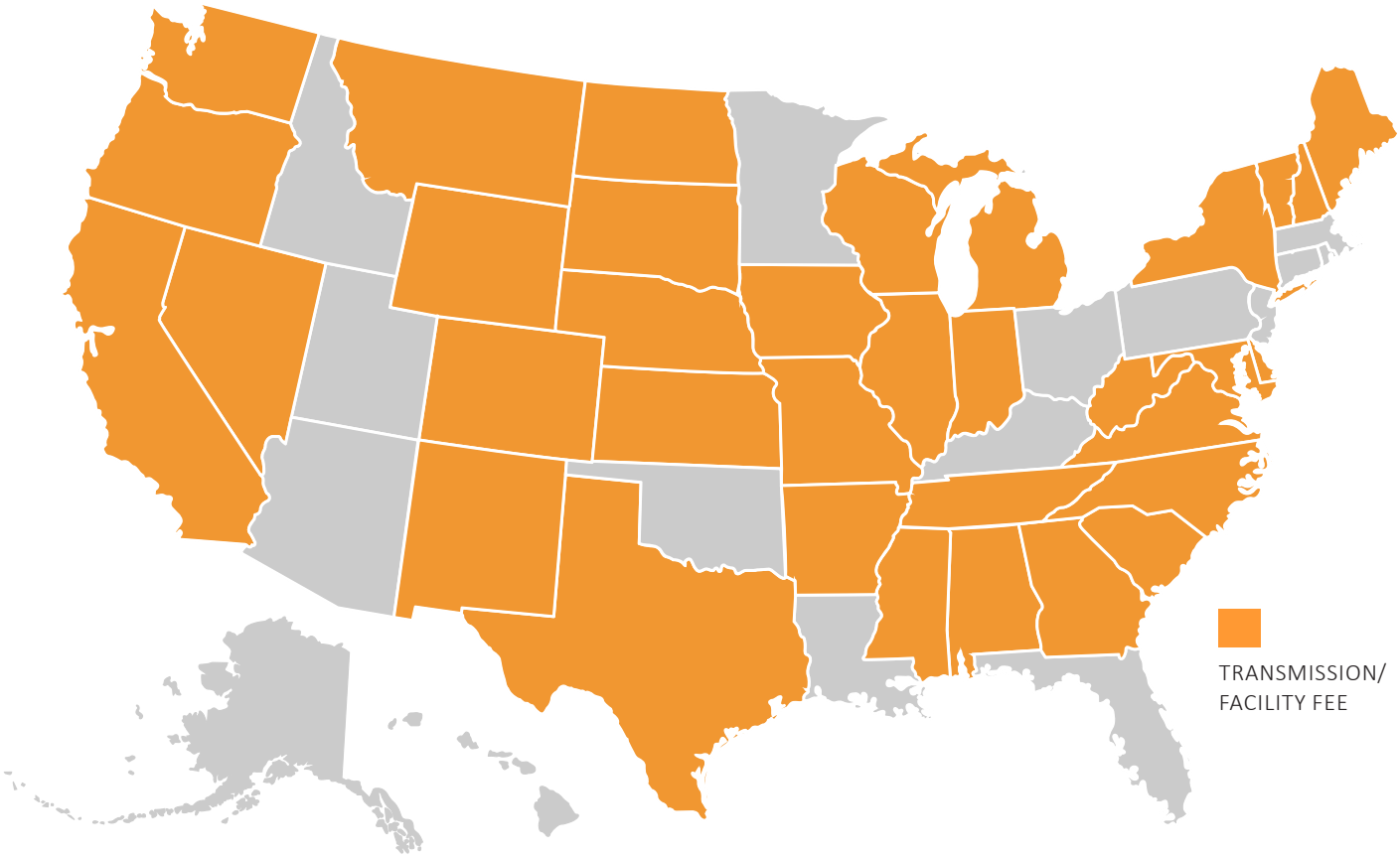
Communication Technology Based Services (CTBS)

One of the most common changes CCHP noticed since Fall 2020 is several states adding reimbursement for CTBS, including the virtual check-in (G2020) and remote evaluation of pre-recorded information (G2012), audio-only service codes, and remote physiologic monitoring codes. States with the addition of these codes within their telehealth policies included Arizona, North Carolina, Ohio and Vermont. In cases where those codes were added and the state has no other form of reimbursement for the modalities (i.e. store-and-forward, telephone and RPM), it should be noted that coverage is extremely limited. Those codes were originally reimbursed in Medicare as an alternative to traditional telehealth as CMS considers telehealth to replace a service typically delivered in-person. CTBS are services that would not normally occur in-person, but due to the advancements of technology, can now be provided effectively. Thus, CMS created CTBS codes as a way to allow for greater use of technology to deliver services, but would not have the telehealth restrictions apply. States have taken various approaches to adopting these codes even though they are not met by the same restrictions Medicare is in federal law. We have found that often Medicaid programs allow CTBS codes to fall under the umbrella of telehealth but utilize Medicare's same coding system to identify and reimburse for them. From previous research, some states also take the approach of adding the codes into their physician fee

schedules and keeping them completely separate from their telehealth policies. For purposes of CCHP's database and this summary report, only CTBS codes that have been incorporated into states telehealth policies are included, as state Medicaid fee schedules were not examined as a source for this summary. In CCHP's Summary Chart, states that solely reimburse a modality through the CTBS codes have been identified by adding an asterisk (*).

Transmission/Facility Fee

Thirty-four states will reimburse either a transmission, facility fee, or both. Of these, the facility fee is the most common. Policies often stipulate a specific list of facilities eligible to receive the facility fee.



Eligible Providers

While many state Medicaid programs are silent, some states limit the types of providers that can provide services at the distant site through telehealth. These lists vary from being extremely selective in the provider types that are eligible (for example, Pennsylvania which only allows physicians, certified registered nurse practitioners, certified nurse midwives, and select mental health facilities), to more expansive eligible provider lists, such as in Virginia, which includes over sixteen provider types. Since Fall 2020, CCHP did not notice an uptick in the provider types eligible for reimbursement, except for several states clarifying that federally qualified health centers and rural health clinics can qualify as distant site providers, as explained in the following section.

Federally Qualified Health Centers & Rural Health Clinics

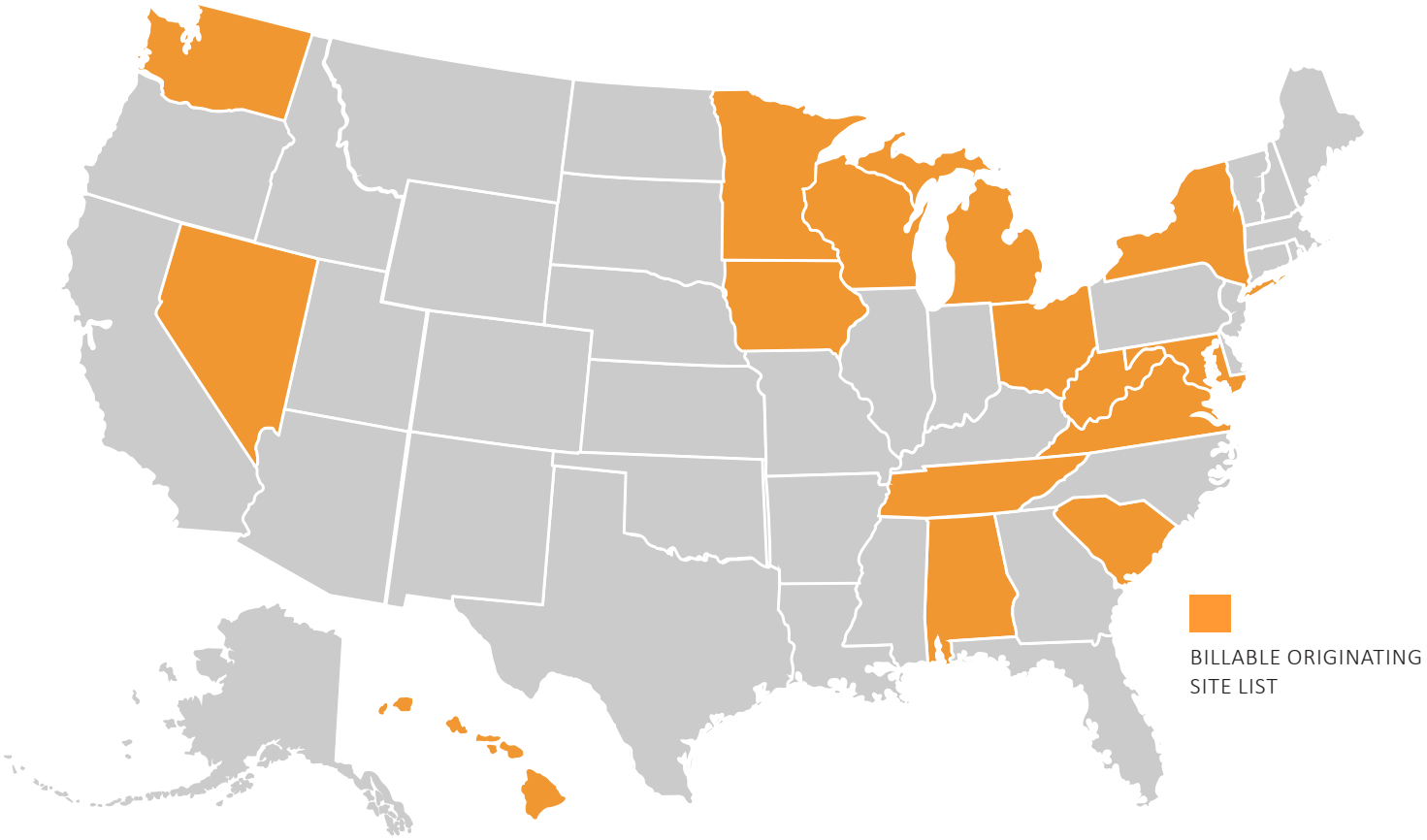
Because federally qualified health centers (FQHCs) and rural health clinics (RHCs) bill as entities rather than as providers, telehealth eligible provider lists often exclude them or do not have an explicit mention of these entities. Medicare has also excluded these clinics from billing for telehealth delivered services as distant site providers (although they do qualify for the originating site facility fee).

Since Fall 2020, several states have specifically addressed this issue. Colorado and North Carolina, for example specified that the definition of a RHC and FQHC encounter does include telehealth, as opposed to solely a face-to-face or in-person interaction. Wisconsin also clarified that community health clinics can serve as both originating and distant sites. All states are either silent on the reimbursement amount or specify that they qualify for the typical prospective payment system (PPS) rate they would receive in person.

Geographic & Facility Originating Site Restrictions

The practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is decreasing. States that continue to have telehealth geographic restrictions are more ambiguous in their policies, making broad statements, such as limiting a distant and originating site provider from being located in the same community. Only four states (HI, MD, MN, SD) currently have these types of restrictions. Some are restricted to only certain specialties, such as Maryland's geographic restriction only applying to mental health, and Minnesota's geographic requirement only applying to Medication Therapy Management Services. Although Hawaii passed a law prohibiting a geographic limitation for telehealth in their Medicaid program, such language is still present in their Medicaid regulation.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site, often excluding the home as a reimbursable site. Currently seventeen jurisdictions have a specific list of sites that can serve as an originating site for a telehealth encounter.



Twenty-six states and D.C. Medicaid programs explicitly allow the home to serve as an originating site, although it's often tied to additional restrictions, and a facility fee would not be billable.

School-Based Health Services

More states are also allowing schools to serve as an originating site, with twenty-eight jurisdictions explicitly allowing schools to be originating sites for telehealth-delivered services, although, as is the case with the home environment, restrictions often apply. The most common modality allowed in schools is live video, and only four states allow a store-and-forward modality to be used (NC, NM, OK and GA). Eleven of these states require parent informed consent for a minor to participate. Services allowed via telehealth in schools vary from state to state but the most common services allowed are therapy services, such as mental health therapy as well as speech, occupational and physical therapy. Therapy service providers are thus the more common provider types allowed in schools, including occupational therapists, speech language pathologists, physical therapists, mental health counselors, social workers, and behavioral health services. Although Texas reimbursed school-based services previously, since Fall 2020, Texas added clarification to their manual specifying that telemedicine medical services provided in a school-based setting are a benefit if the physician delegates provision of services to a nurse practitioner, clinical nurse specialist or physician assistant as long as they are working within their scope of practice and within the scope of their delegation agreement with the physician.

Consent

Forty-three jurisdictions include some sort of informed consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. For example, Iowa recently added an informed consent requirement exclusive to providers licensed under the Board of Dietetics.

Licensure

Nine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state). Florida is the first state in recent years to allow an out-of-state provider to register with their applicable board for the provision of telehealth in their state under certain circumstances, although several states have pending legislation on this topic at the time of writing this report.

A more common practice is the adoption of interstate compacts which allow specific providers to practice in states they are not licensed in as long as they hold a license in good standing in their home state. CCHP is currently tracking six Compacts, each with their own unique requirements to participate. For example, the interstate medical licensure compact allows for an expedited licensure process, where physicians still need to apply for a license in individual states. The following Compacts are currently active and being tracked by CCHP:

1. The Interstate Medical Licensure Compact which has 27 states, DC and the territory of Guam. Two states that had previously joined the Compact (Arizona and Wisconsin) have conditionally repealed the law and asked to withdraw.
2. The Nurses Licensure Compact which currently has 34 state members.
3. The Physical Therapy Compact which currently has 28 state members.
4. The Psychology Interjurisdictional Compact which currently has 15 state members.
5. The Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) has 5 state members.
6. The Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA) has 20 member states.

Still other states have laws that don't specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state's licensing conditions are met. During COVID-19 many states have issued temporary waivers of their licensing requirements. Those waivers are not tracked in this report, however the Federation of State Medical Boards is tracking those policies via their chart on State COVID-19 Physician Licensing.

Although its customary to require a provider to be licensed in the state the patient is located in, several boards in New Jersey, including nursing, social worker, psychologist, physical therapy and audiology are now requiring that their licensees hold a license if located in New Jersey, even if only providing health care services to clients located outside of the state. Most states are silent on this issue.

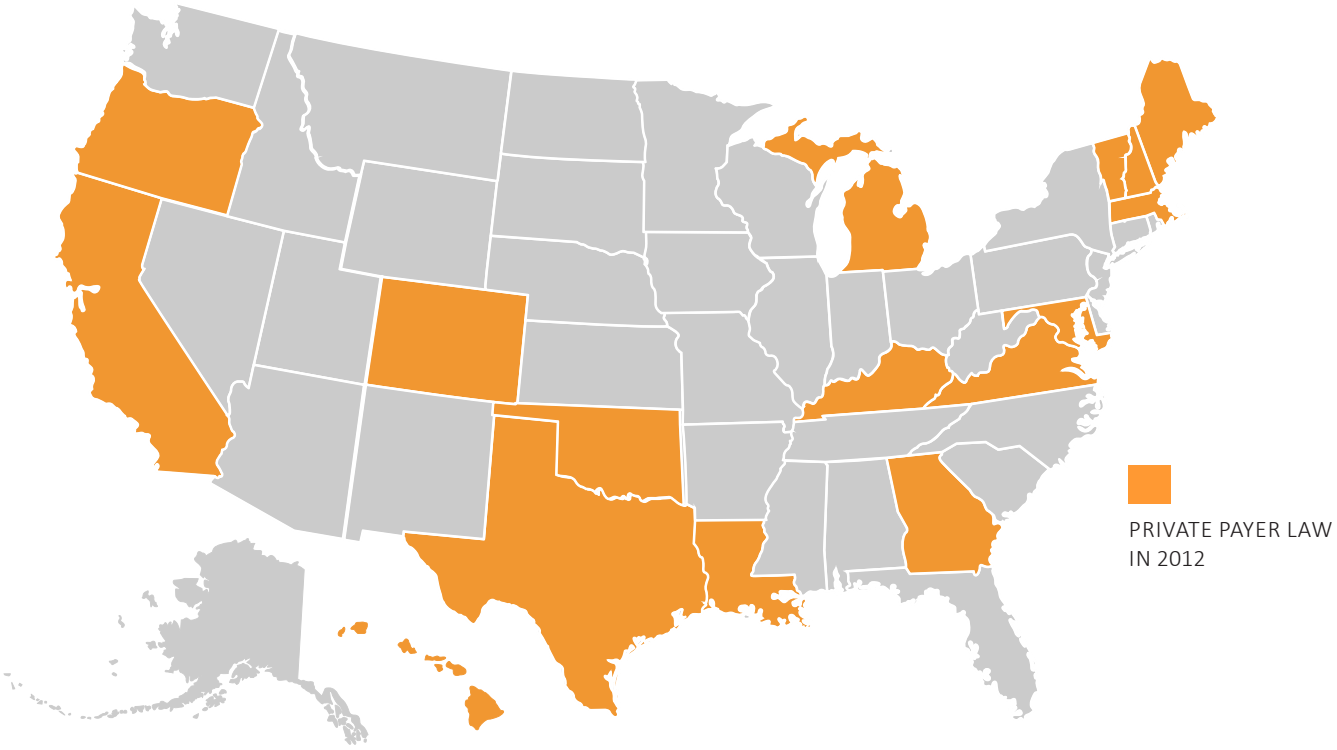
Online Prescribing

There are a number of nuances and differences across the states related to the use of technology and prescribing. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. States may also require that a physical exam be administered prior to a prescription being written, but not all states require an in-person examination, and some specifically allow the use of telehealth to conduct the exam. CCHP notes that in the past year a few states that had been silent previously in regards to whether or not a telehealth interaction could establish a provider/patient relationship clarified that it could, and established parameters and requirements for it. This was most likely brought on by the increased use of telehealth due to the COVID-19 pandemic.

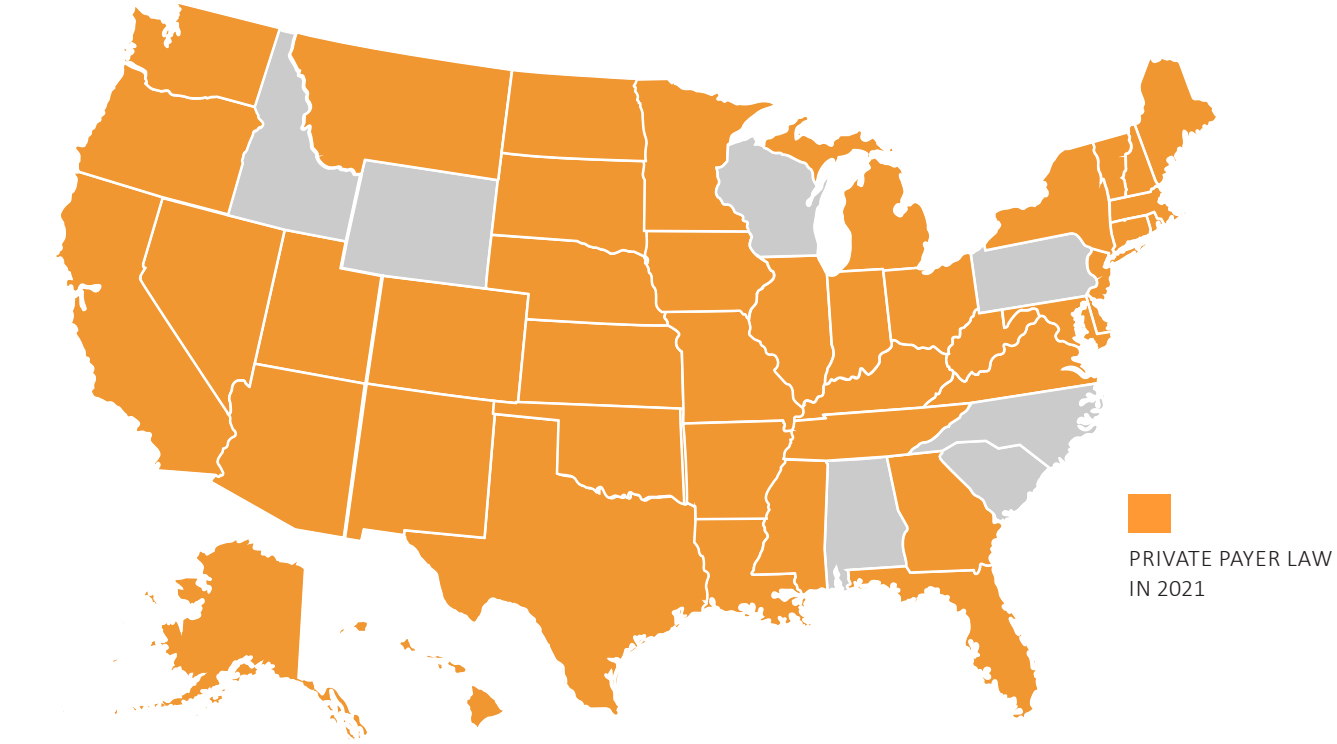
Private Payers

Currently, forty-three states and DC have laws that govern private payer telehealth reimbursement policies. Massachusetts was the only state to make significant changes to their private payer law since Fall 2020, requiring that health care services delivered via telehealth are covered if they would be covered in-person and if appropriate to provide through the use of telehealth. Additionally, it requires the rate of payment for in-network providers of behavioral health services that deliver care through interactive audio-video technology and audio-only telephone to be paid at least the same rate as services delivered via in-person methods. Both California and Washington had previously passed laws that require payers pay the same rate for telehealth delivered services as they do for in-person that went into effect Jan. 1, 2021. Telehealth private payer laws is one of the areas of telehealth policy that has seen the most growth since CCHP's first report in 2012.

PRIVATE PAYER LAW MAP IN 2012:



PRIVATE PAYER LAW MAP IN 2021:



To learn more about state telehealth related legislation, visit CCHP's interactive map at cchpca.org.