



# State Telehealth Laws and Medicaid Program Policies

Fall 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 Spring 2021 the information in the State Telehealth Laws and Reimbursement Report transitioned exclusively to a new and improved online database tool, called the ‘Policy Finder’. This online database tool has continued to be updated each month since, allowing users to navigate each state’s updated information as soon as CCHP makes it available. Additionally, the information from the online database can be exported for each state into a PDF document using the most current information available on CCHP’s website. CCHP plans to 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. CCHP is committed to providing timely policy information that is easy for users to navigate and understand through our [Policy Finder](#). The information for this summary report covers updates in state telehealth policy made between June and September 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, Amy Durbin, Policy Advisor, or

Christine Calouro, Policy Associate at [info@cchpca.org](mailto:info@cchpca.org). A special thank you to CCHP Policy Associate Veronica Collins for her invaluable contributions to this report. For further information, visit [cchpca.org](http://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  
October 2021

This project was partially funded by The National Telehealth Policy Resource Center program by Award #1 U67TH43496-01-00 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

The Center for Connected Health Policy is a program of the Public Health Institute.



# INTRODUCTION

The Center for Connected Health Policy's (CCHP) Fall 2021 analysis and summary of telehealth policies is based on its online [Policy Finder](#) database tool. It highlights the changes that have taken place in state telehealth policy between the initial release of CCHP's Policy Finder in Spring 2021, and Fall 2021. The research for this Fall 2021 executive summary was conducted between June and September 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 Finder tool which breaks down policy for all 50 states and the District of Columbia.

Please note that many 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 Policy Finder under the COVID-19 category. In instances where the state has made policies permanent, or extended policies for multiple years, 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 at the time it was reviewed between the months of June and September 2021. In some cases, after a state was reviewed, they passed a significant piece of legislation. In order to incorporate those significant changes, CCHP conducted a scan for these instances in late September and incorporated language from those enacted bills where appropriate. It should be noted that even if a state has enacted telehealth policies in statute, 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 for that policy. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP's summary report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming this.

This survey focused on three primary areas for telehealth policy including Medicaid reimbursement, private payer laws and professional 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
- o Licensure 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. The main areas where changes were made over the past six months fall in the three buckets that CCHP uses to categorize information within its policy finder: Medicaid policy, private payer policy, and regulation of health professionals. Changes were also highly influenced by temporary expansions made during the COVID-19 pandemic. Some states took approaches to extend their pandemic policies multiple years into the future, while others made policies (or portions of their COVID policies) permanent. Still others have not adopted their more lenient COVID policies at all. Connecticut, for example, passed a new temporary law (active until June 30, 2023) which not only requires Medicaid to reimburse for synchronous, asynchronous store-and-forward transfers, remote patient monitoring and audio-only modalities if the provider is in-network, but also places similar requirements on private payers as well.

In Medicaid, it was common for states to make slight adjustments to their telehealth policies to add or clarify the services that can be delivered via telehealth, types of professionals that can deliver care through telehealth or the types of settings a patient could be in during a telehealth interaction. For example, Iowa clarified that an intern psychologist can provide telehealth services to Medicaid members. Mississippi clarified federally qualified health centers (FQHC) and rural health clinics (RHC) could be distant site providers, and added the home as an originating site. And, Arkansas now specifies that both the home is an eligible patient site and that group meetings may be performed via telemedicine. Although reimbursement for audio-only telephone has become pretty standard during the COVID-19 public health emergency (PHE), less than half of state Medicaid programs explicitly are reimbursing for the modality permanently, and many that are have placed restrictive parameters around its reimbursement.

It was also common for states to make modifications to their telehealth private payer reimbursement law language to alter the definition of telehealth/telemedicine. This typically included an expansion of the definition to be broader in scope so that it entails more than just live video, although often with some caveats. For example, Arkansas' private payer law now stipulates that telemedicine does not include audio-only communication, unless the audio-only communication is real-time, interactive, and substantially meets the requirements for a healthcare service that would otherwise be covered by the health benefit plan. Iowa revised their law to include 'real-time interactive electronic media', but still excludes audio-only telephone from the definition of telehealth. Requirements around payment parity were also a common change, with eight states passing a law requiring the reimbursement amount is the same whether a service is provided via telehealth or in-person since Spring 2021. Illinois, for example, now requires reimbursement parity for in-network or tiered network health care professionals or facilities, including services provided via audio-only. Iowa is another example of a state requiring reimbursement of covered services is made on the same basis and same rate as in-person mental health services.

Finally, there is a noticeable shift in telehealth policy towards tightening of professional requirements around the use of telehealth by providers. For example, Michigan passed new consent requirements for social work, athletic trainers, massage therapists, acupuncturists and veterinary medicine. Texas is another state that added practice standards (including a consent requirement and prescribing rules) for teledentistry specifically. West Virginia adopted emergency telehealth practice standard regulations to implement a previous law that passed (W. VA Code 30-1-26(b)) for five professions, including dentistry, nursing, osteopathic medicine, social work and medicine. While many states have had these types of standards for several years, the rate at which new telehealth standards are being adopted has increased significantly within the last six months.



### 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. Michigan is the only state to add reimbursement for store-and-forward since Spring 2021. Additionally, three jurisdictions (MS, NH, and NJ) have laws requiring Medicaid reimburse for store-and-forward but as of the creation of this edition, don't have any official Medicaid policy indicating this is occurring.
- Twenty-nine state Medicaid programs provide reimbursement for RPM. States that added RPM since Spring 2021 included Washington, Michigan and California. As is the case for store-and-forward, three Medicaid programs (NH, 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, two of the states (OH and CA) only reimburse the remote physiologic monitoring codes CMS does.
- Twenty-two states reimburse for audio-only telephone in some capacity (often limitations apply); however, Michigan only reimburses for it when used for provider-to-provider electronic consultations.
- Eleven state Medicaid programs including Arizona, California, Maine, Michigan, Minnesota, North Carolina, Ohio, Oregon, South Carolina, Texas, Washington, reimburse for all four modalities, 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 Finder. Below are summarized key findings in each category area contained in the Policy Finder as of September 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, and “teledentistry” for dental services. “Telepsychiatry” 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 some 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, some 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

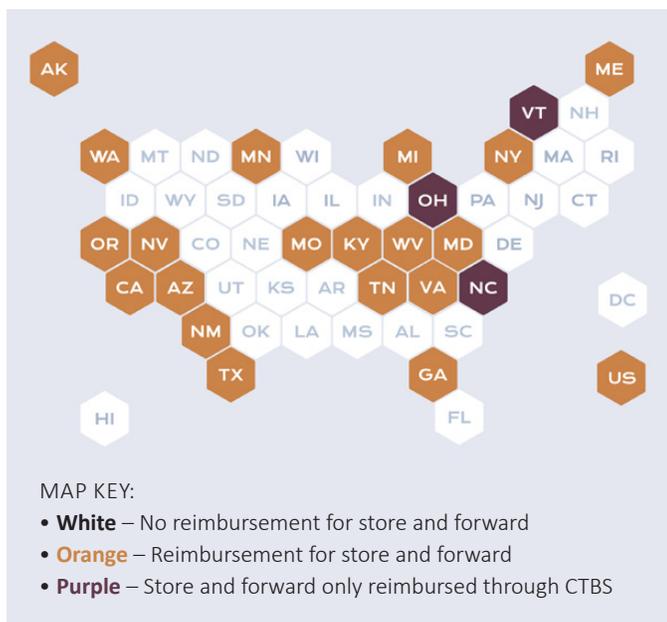


Medicaid programs, for example limit reimbursable services to a specific list of CPT codes, such as Ohio, while other states, such as California, leave it open ended, reimbursing for all covered benefits or services as long as appropriate, and meeting procedure code definition and confidentiality and patient rights requirements. In general, the main restrictions Medicaid programs typically place on live video telehealth include:

- 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 Spring 2021, many states added additional services that could be reimbursed via live video to their list of eligible services, including group meetings in Arkansas, Utah added covered services for mental health and substance use disorder, and Minnesota is now allowing Individualized Education Program (IEP) services to be provided via live video as well as store-and-forward.

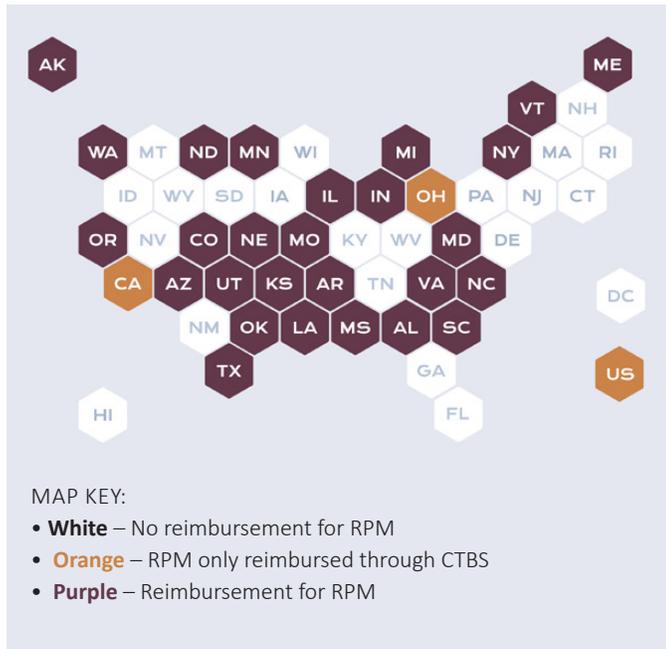
### Store-and-Forward



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.

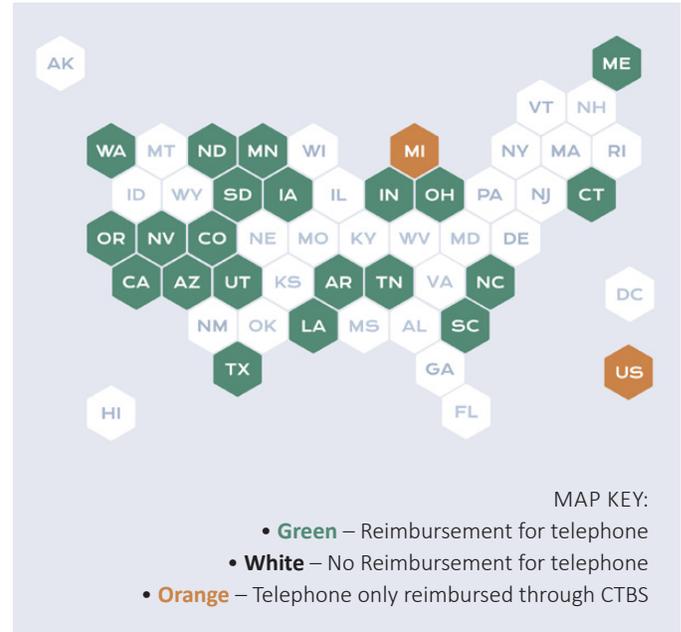
Three additional states (MS, NH and NJ) have laws requiring Medicaid reimburse for store-and-forward services, but CCHP has not been able to locate any official Medicaid policy indicating that they are in fact reimbursing. In some cases, although a definition of telehealth or telemedicine applicable 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 communication Technology-Based Services (CTBS), some of which include the store-and-forward modality in its description. CTBS is discussed further in a subsequent section, but it’s 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-nine states have some form of reimbursement for RPM in their Medicaid programs. Since Spring 2021, three states (CA, MI and WA) added reimbursement for remote patient monitoring. Two states (OH and CA) reimburse only for specific remote physiologic monitoring codes modeled after CMS reimbursement. In California, under a new law, Medicaid is allowed, but not required, to provide reimbursement for RPM. Currently a state plan amendment has been submitted by California to the Center for Medicare and Medicaid Services regarding RPM state policies. Additionally, CCHP has noted three new codes in the Medi-Cal (California Medicaid) Rate Fee Schedule for the same codes Medicare reimburses for remote physiological monitoring (99091, 99453 and 99454). Therefore, CCHP has counted CA as reimbursing with the caveat that it’s only those CTBS codes. 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.

### Email & Telephone



While telephone or audio-only service delivery has historically rarely been an acceptable modality, that is slowly changing with the advent of COVID-19, and the need to reimburse audio-only interactions to reach people without access to high-speed broadband that allows for live video interaction. Twenty-two state Medicaid programs now allow for telephone reimbursement in some ways, with nine states adding reimbursement to permanent policy since Spring 2021. Sometimes states will only reimburse specific specialties such as mental health, or for specific services such as case management. Michigan is counted as reimbursing for telephone as a result of reimbursement for a CTBS code that allows for audio-only interaction. A new CA law also requires Medicaid to extend telehealth flexibilities related to the delivery of telehealth modalities, including audio-only. Oregon is one of the first states to pass a law requiring Medicaid to reimburse ‘any permissible telemedicine application or technology’ which includes telephone, at the same rate as in-person. Kentucky also addresses the issue in a new law, however they encourage Medicaid-participating practitioners and home health agencies to only use audio-only encounters as a mode of delivering telehealth services when no other approved mode of delivery is available, and as determined allowable by the Department of Medicaid. 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.

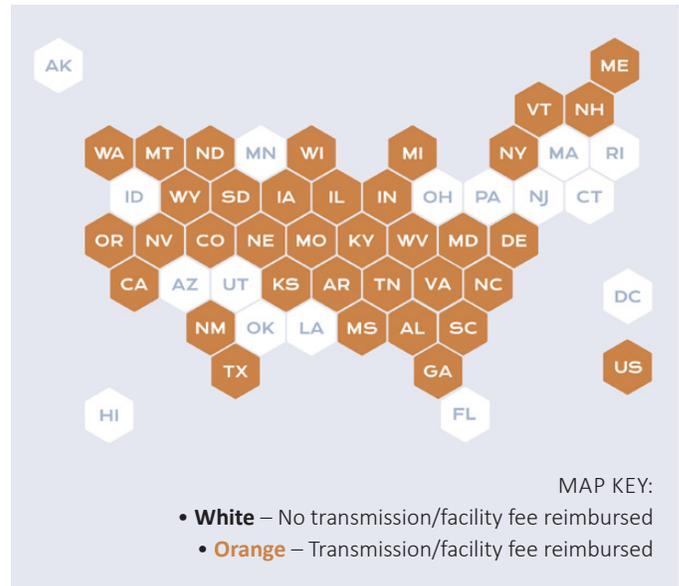


### Communication Technology Based Services (CTBS)

States continue to utilize the CTBS codes established by CMS. This includes the virtual check-in (G2020) and remote evaluation of pre-recorded information (G2012), audio-only service codes, and remote physiological monitoring (RPM) codes. Examples of states that reimburse these codes include 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 State Summary Chart, states that solely reimburse a modality through the CTBS codes have been identified by adding an asterisk (\*).

### Transmission/Facility Fee

Thirty-five 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, Kansas which only allows physicians, physician assistants, advanced practice registered nurses, behavioral science licensees, and speech language pathologists and audiologists), to more expansive eligible provider lists, such as in South Dakota, which includes twenty provider types. Since Spring 2021, the most common additions to eligible provider lists included allied professionals (physical therapists, occupational therapists and speech language pathologists), as well as FQHCs and RHCs that can qualify as distant site providers.

### Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC)

Because FQHCs and 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 Spring 2021, five jurisdictions (DC, KY, MS, NE and VA) have specifically addressed this issue for





Forty-four states and DC include some sort of 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, New Hampshire's consent policy specifically applies to the delivery of medication assisted treatment via telehealth.

## Licensure

Twelve states have professional boards that issue special licenses or certificates or have exceptions to licensing requirements related to telehealth, that may include simply registering with an in-state board rather than obtaining full licensure. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located and licensed, 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). Kansas, Arizona, Utah, and West Virginia all added telemedicine licenses or new licensing exceptions since Spring 2021. Note that in all of these newly added states (besides Utah), providers are still required to obtain some type of waiver or register with the Board. Utah allows out-of-state physicians only if a fee is not being charged (other than to cover the cost of malpractice insurance), or for mental health therapists, only if the client has recently relocated to Utah and only for a maximum of 45 days. Florida and Arizona are two states that have recently relaxed their licensing requirements, requiring only out-of-state telehealth provider to register with their applicable professional board within the state. Additional stipulations in Arizona apply, such as not opening an office within the state or provide in-person health care services.

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 eight 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. Below we have listed the Compacts we are currently tracking along with the number of states each has participating. Not all states

listed below may be currently operating the compact as many just recently passed legislation and have not had the opportunity to start the issuing process.

1. The Interstate Medical Licensure Compact which has 31 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 37 state members and the territory of Guam.
3. The Physical Therapy Compact which currently has 33 state members.
4. The Psychology Interjurisdictional Compact which currently has 26 state members and DC.
5. The Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) which has 15 state members.
6. The Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA) which has 21 member states.
7. The Occupational Therapy Compact which has 9 state members.
8. The Counseling Compact which has 2 state members.

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 issued temporary waivers of their licensing requirements, many of which have now expired but some are still active. Those waivers are not tracked in this report, however the Federation of State Medical Boards is tracking some of those policies via their chart on [State COVID-19 Physician Licensing](#).

Although it's 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. West Virginia has gone as far as to specify a physician-patient relationship can be established through audio-only calls, although audio-visual communication is preferable. States have also increasingly clarified whether or not controlled substances can be prescribed over telehealth, often creating two policies (one for non-controlled substances and the other for controlled substances). An example of this is in Virginia, where their Medical Board released guidance in Aug. 2021 differentiating between the two and tying stricter requirements to the prescribing of controlled substances. It should be noted that federal law also limits the prescribing of controlled substances via telehealth, except in very limited circumstances. Providers would be required to comply with both the federal and state law to be in compliance.

Maine is the first state CCHP is aware of that has tied the issue of prescribing to private payers, prohibiting insurance carriers from placing restrictions on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that are more restrictive than requirements for in-person consultations.

## Private Payers

Currently, forty-three states and DC have laws that govern private payer telehealth reimbursement policies. Although no new states added private payer laws since Spring 2021, a handful of states (KY, VT, RI, OR, OK (effective Jan. 1, 2022), NV, MD, IL and AZ) made modifications to their law, and some even added payment parity. Oregon is an example of a state with a previously robust private payer law, but has made significant adjustments. First, they made the law applicable not only to health benefit plans but also to dental-only plans. They also now require the plans to work to (1) ensure meaningful access to telehealth is achieved, (2)

ensure access to auxiliary aids and services are provided when needed, (3) ensure telemedicine for enrollees who have limited English proficiency or who are deaf or hard of hearing and (4) ensure telemedicine services are culturally and linguistically appropriate and trauma informed. Finally, they also specify that payers are not allowed to reimburse an out-of-network provider at a rate for telemedicine health services that is different than the rate paid to out-of-network providers for in person services. Kentucky also now requires telehealth coverage and reimbursement be equivalent to the same coverage as in-person but at the same time specifies that the health plan and telehealth provider may contractually agree to a lower reimbursement rate for telehealth services.

Since 2012, the number of states with private payer laws has nearly tripled.

To learn more about state telehealth related legislation, visit CCHP's [Policy Finder](https://www.cchpca.org/policy-finder) tool at [cchpca.org](https://www.cchpca.org).

