

A *Decade* of
Telehealth Policy

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National Telehealth
Resource Center
for Policy

TEN-YEAR
ANNIVERSARY
Report



Center for Connected
Health Policy

THE NATIONAL
TELEHEALTH POLICY
RESOURCE CENTER

In Memoriam



*This 10 year report is dedicated to the memory of **Mario Gutierrez**, CCHP Executive Director from 2011-2017. Mario was the visionary who first put CCHP on the path to becoming the NTRC-P and we would not be where we are today without his kind heart, commitment and leadership. He is dearly missed.*



From the Executive Director

In the early months of 2012, the Center for Connected Health Policy (CCHP) faced a decision of potentially great significance. The U.S. Health Resources and Services Administration Office of Rural Health Policy Office for the Advancement of Telehealth had released a Funding Opportunity Announcement for their Telehealth Resource Center Grant Program and the incumbent contractor for the National Telehealth Resource Center for Policy (NTRC-P) contract would not be reapplying.

Our young and ambitious team of four knew that this funding opportunity represented far more than potential new grant dollars. If successful, it would move CCHP from a statewide organization to a national one. It would enable CCHP to serve in a key support role to 12 Regional Telehealth Resource Centers and a National Telehealth Resource Center for Technology. And it would enable CCHP to demonstrate its ability to serve as powerful convener, investigator, resource, and change maker across various spaces of the burgeoning telehealth world.

Jumping ahead to present day, September 1, 2022 marks CCHP's ten-year anniversary as the federally designated National Telehealth Resource Center for Policy. For the past decade, CCHP has tracked and followed policy development for all 51 jurisdictions in the United States (District of Columbia included) as well as at the federal level providing us with the unique opportunity to observe and study the development of state and federal telehealth policy in the United States. This past decade also happens to be the period that encompasses some of the most significant telehealth policy developments seen thus far.

In celebration of this ten-year milestone, CCHP is offering this overview of the development of telehealth policy from 2012 – 2022. This is not meant to be a deep dive into all elements of telehealth policy's evolution. Given the complexities and nuances of the policies, much more time and space would need to be devoted to such a study to paint a complete picture. This report is meant to provide an overview of some of the more significant developments that CCHP has been able to capture and follow over the years given our unique position and the impact of seemingly unrelated events or factors have on telehealth policy development. Considering the increased interest in telehealth policy, CCHP believes this report will be useful to provide context on how telehealth policy came to be where it is today, particularly for those who may be newer to the field.

This document is not only a report of what has transpired, but a means of setting the stage for the next chapter. And while our devoted staff have grown wiser over these past ten years, we remain young at heart, devoted, nimble and feisty. As such, you might consider the pages that follow both a telling of what we have learned and also an invitation to collaborate in the work to come.

Sincerely,
Mei Kwong
Executive Director



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NOTE: For all charts included in this report, the data is taken from the Spring editions of CCHP’s *50 State Telehealth Policies and Reimbursement Reports*. The numbers may have changed later in the year, but for consistency of data, the Spring edition was selected.





The States – Telehealth Policy

IN THE BEGINNING – SETTING A BASELINE (STATES)

CCHP received its initial infusion of National Telehealth Resource Center for Policy (NTRC-P) grant dollars on August 31, 2012 – with a contracted responsibility to begin its work only 24 hours later, on September 1. Initially CCHP only received an award for the first year of a four-year cycle and was required to re-apply five months later in January 2013 for the remaining years. Given this need to reapply less than a few months after receiving the award, and to justify a renewal, CCHP had to demonstrate a significant achievement within the first six months of the project.

The recognition of this challenge resulted in the first-ever 50 State Project, a compendium of all of the states' telehealth Medicaid policies, laws and regulations. In CCHP's research for preparing its original proposal for the NTRC-P, we found that no single source existed that contained all of the telehealth Medicaid policies. As Medicaid serves a significant portion of the US population, not having that information seemed like a significant void. There was one publication that gathered some of the policies into one document but it was several years old and had not been updated. It was an obvious choice to make the creation of this compendium CCHP's first project.

As we began our Medicaid research, it quickly became apparent that only having a resource of all the Medicaid telehealth policies would still be inadequate. In addition to Medicaid policies, states

have private payer laws related to telehealth and jurisdiction over other non-reimbursement related policies such as licensure that impact the use of technology to provide health services. We came to recognize that if a thorough job was to be done, we would need to look at not only Medicaid policies, but state statutes and regulations related to telehealth.

At that time, the CCHP team included three full-time and one part-time staff members (Mario Gutierrez, Mei Kwong, Laura Stanworth and Steve Robitaille). Of those staff members, only one – the Policy Associate (Mei Kwong) – worked in policy. A Project Coordinator (Christine Calouro) was promptly hired to collaborate with the Policy Associate to research, compile, organize, design and publish this 50-state work. An approach and research framework were developed by the two and CCHP began the monumental task of researching and compiling information into what would eventually become the *State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia (50 State Report)*.

Based upon some initial surveys and interviews conducted, CCHP settled on a total of 11 categories for the issues that seemed to generate the most questions or confusion. These categories were:

- Definition of telehealth/telemedicine
- Reimbursement for Live Video

- Reimbursement for Store and Forward
- Reimbursement for Remote Patient Monitoring (RPM)
- Reimbursement for Email/Phone/FAX
- Consent
- Location
- Transmission/Facility Fees
- Online Prescribing
- Private payer laws
- Licensure

Over the years, CCHP has maintained these same 11 categories. Ten years of consistent review has enabled us to track the fluctuations in importance or interest within the categories as a result of shifting influences and priorities within the healthcare field. For example, for much of the past decade, policies around Email/Phone/Fax have remained relatively static with most states explicitly noting these modalities were not considered telehealth. That line of thinking has changed in the past two years with events precipitated by COVID-19 which saw a rise in the use of audio-only, and greater acceptance of it as an additional modality.

Additionally, CCHP established other specifications that helped solidify this document as a reliable, trusted and needed tool in telehealth policy. These include:

- For each of the issue areas, Medicaid policies, state laws and regulations needed to be examined and captured.
- The policy will only be added to the *50 State* if there was some state official documentation of the existence of the policy, either a law in place, Medicaid manual policy or even an all-provider letter. In the early years this requirement led

to some controversy as there were one or two states that insisted telehealth policy existed, but could not point to any official documentation and were excluded from the report.

- A link to every source of information needed to be provided. This requirement existed for two reasons: CCHP could not simply cut and paste all of the policy for each source into its own work as it would soon become unwieldy and confusing for the reader and second, it provided a direct governmental/official source of the information. This also requires CCHP to regularly check links as they can change as states make updates.
- The information needed to be updated at regular intervals. The *50 State* would only be useful if the information was not outdated. This is likely one of the most important reasons that the *50 State Report* is so relied upon by not only the telehealth field, but government, researchers and others because the information is updated on a regular basis. Even though CCHP lacks the resources to provide constant or immediate updates, users of the *50 State Report* know that the information is updated every few months and the provision of source links allow them to check the information.

Over the next four months, the Policy Associate and Project Coordinator conducted research for this project, recognizing almost immediately the wide variations that existed between states that has led to a statement CCHP often makes, “No two states are alike.” As the research work continued, CCHP was also simultaneously building its website which was required under the NTRC-P grant. Included in

that website build was a place to house the 50 State Report. We challenged ourselves to consider how this vast collection of information could be as user friendly as possible to the reader. While there was never a doubt that we would provide a PDF of the report, work began on creating an interactive map on the website that would allow a visitor to access all relevant policy information for each state by simply clicking on that state in the map housed on CCHP’s website.

The *50 State Report* and website were completed and launched in March 2013. The response was overwhelmingly positive. For the first time, the telehealth field was able to find in one location existing reimbursement policies, regulatory requirements and state laws on telehealth for all 51 jurisdictions. CCHP was also able to establish a baseline for state telehealth policy in which to compare subsequent years and watch how policy evolves.

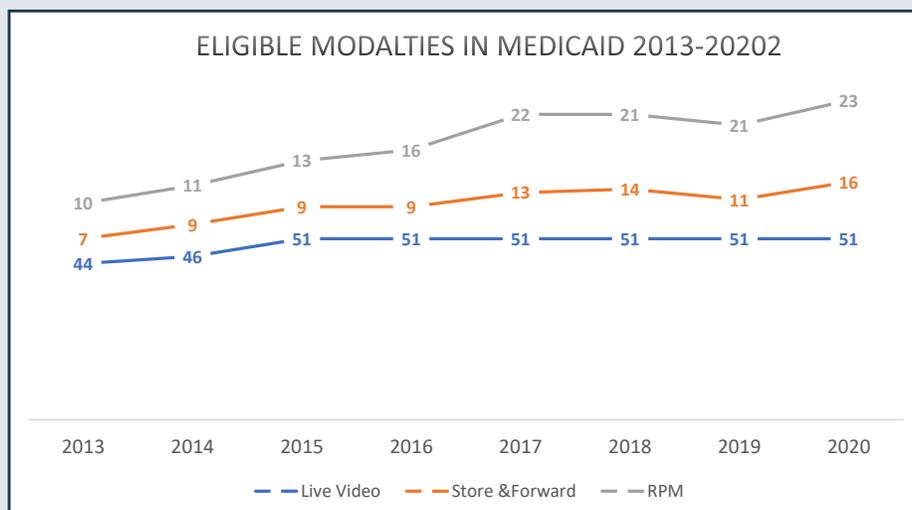
STATE TELEHEALTH POLICY EVOLUTION – MEDICAID

Over the past decade there has been a significant development of state telehealth policy. To provide a general idea, CCHP’s first 50 State Report was 170 pages. The last PDF version created in 2021 was over 500 pages. There are several reasons to explain this growth, but two particular causes stand out:

- Other policy decisions or environmental factors that are not focused or specifically related to telehealth, but nonetheless, have an impact on telehealth policy
- Complexities of telehealth policy itself

A review of influences on the development of policies regarding what modalities are reimbursed in Medicaid programs helps to clarify the impact

FIGURE 1



1) There may be a question as to why RPM and store and forward dipped in numbers between 2017 and 2018 and 2018 and 2019, respectively. For those years, CCHP removed certain states from the previous editions’ counts. While we may have counted a state the previous year because legislation was passed directing Medicaid to implement policy for the modality, the Medicaid policies may not have been published at the time we conducted our research for the following year’s report. Adhering to one of our established tenants, unless the policy can be found in a published format, we do not count it and it was removed from the following year’s count.

of non-telehealth specific policies. Examining data from *50 State Reports* from 2013 – 2020, Figure 1, highlights that certain modalities had more Medicaid reimbursement policies adopted than others. (NOTE: The information is captured from reports published in the Spring of the year and this period was specifically chosen to not have COVID-19 impact the information. COVID-19's impact on telehealth policy will be discussed later in this report.)

In comparison to RPM, there has been a much slower adoption of store and forward policies. Comparing 2013 with 2018, RPM reimbursement in Medicaid doubled. While there can be multiple reasons for this increase in RPM policy and store and forward's slower growth, two possible explanations are detailed below.

The first possible explanation includes the Affordable Care Act (ACA) which established the Hospital Readmission Reduction Program (HRRP) in 2012. Under this program, hospitals would be penalized if they had a higher than expected 30-day readmission rate for certain conditions. Hospitals were seeking ways to avoid being penalized for readmissions and RPM showed significant promise as a potential tool. A search of PUBMed found 2,794 results for a search of the term "remote patient monitoring" for a publication date range of 2012-2016. For 2012-2014 there were 1,666 results. The interest in utilizing RPM to address requirements under HRRP and the number of studies being conducted and published potentially had an influence in the adoption of RPM policies. During those same time periods, a search of PUBMed revealed 175 results for store and forward during 2012-2014 and 321 for 2012-2016. It is possible less research on a modality provides less information for a convincing argument to policymakers to adopt certain policies. (A search of the term "asynchronous" was also conducted but it turned up too many results unrelated to telehealth). The above shows that a

piece of health policy that on the surface is unrelated to telehealth (hospital readmissions), could still have impact and significance in the development of telehealth policy, something we anticipate will continue as the years progress.

The second potential factor is the growing complexity of telehealth policy due to the specific limitations being placed on the use of telehealth. Often there can be many facets to a question that someone may think has a simple answer. For example, the question is, "Will I get reimbursed by my Medicaid program if I provide the service via telehealth?" The short but incomplete answer may be "yes". However, the answer would be incomplete because there may be other policies that impact the use of telehealth such as, "Is the service you're providing covered under the payer's reimbursement policies for telehealth? Are you one of the professionals the payer will allow and reimburse if you provide services via telehealth?" Often there may not be a straight "yes" or "no" answer and the more accurate answer is usually, "It depends." As an example, we can look at telehealth policy for live video policy in the District of Columbia's Medicaid program (DC Medicaid).

In looking at DC Medicaid telehealth policies in the September 2012 through April 2016 editions of the *50 State Report*, there was no Medicaid policy regarding live video. However, in the first half of 2016, there was a statutory requirement under DC Code 31-3863 that required Medicaid to pay for telehealth services if the same service was covered when delivered in-person. By June 23, 2016, DC Medicaid had put their policies for live video in place. Therefore, if in 2016 one asked whether DC Medicaid covered live video, the answer would have been "yes." However, there was an additional policy that required a provider be with the patient at the

time of the telehealth interaction.² This extra element was added to the live video policy and could play a factor on how widely telehealth may be used.

To meet the requirement could be burdensome to the staff of whatever facility the patient was at during the telehealth interaction as a staff member needed to be physically with the patient, something that was not required had the patient had an in-person interaction. Therefore, more is being required of the originating site staff and may be a disincentive for that facility to utilize telehealth as it may not be the most efficient use of their time and resources. Additionally, this requirement limits types of settings where telehealth may take place. For example, the home would be eliminated because likely in many cases there will not be a health care provider in the home with the patient. (DC Medicaid also had a specific list of eligible originating sites that did exclude the home.³) However, by the Fall of 2018, the patient with a provider requirement was removed by DC Law 22-126, The Telehealth Medicaid Expansion Amendment Act of 2018⁴, showing a change in a significant piece of policy within two years.

There are, of course, other factors that impact the development of telehealth policy, particularly for Medicaid programs. The health of a state's budget plays a significant role in whether they will be expanding Medicaid policies. The priorities and beliefs of who is in charge of the Executive Office and/or Legislature may also be a factor. However, what we can take away from the foregoing is that:

- Telehealth policy was growing on the state level over the last decade
- It was complex

- Non-telehealth related factors potentially played a role in ultimately deciding on the final policy adopted

What can be said is that telehealth policy is a very complex subject that rarely provides an easy “yes” or “no”, or even a short answer, and at times what may seem to be a very expansive policy may not actually be. The nuances and multiple facets of telehealth policy put a different face on what a particular piece of policy actually means and how broad it truly is.

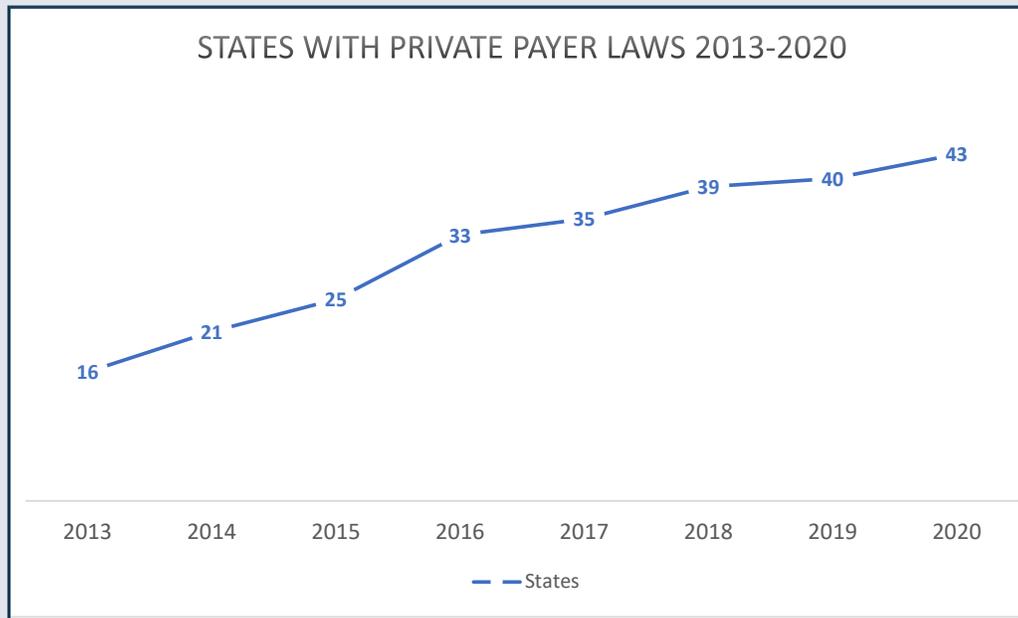
COMMERCIAL PAYER LAW

Over the past decade, there has been significant progression in adopting telehealth private payer laws. These laws impact how commercial health plans operating in a state address telehealth and they vary significantly. At one end of the spectrum, there are laws that enable health plans to cover telehealth delivered services if the plan wishes. At the other end, there are laws that mandate that health plans cover telehealth delivered services in the same manner as they would have had the service been delivered in-person, in addition to reimbursing those services the same amount as in-person delivered services. The latter, parity in payment, is a more recent widespread development. When CCHP first became the NTRC-P, most assumed private payer laws included payment parity. However, when most of these state laws were closely examined, the majority of telehealth private payer laws at that time only ensured parity in coverage. Although many commercial payers did pay the same amount for telehealth-delivered services in almost all states, they were not legally mandated to do so.

2) District of Columbia, Physicians Billing Manual, Sec 12-7, pages 48-50. (July 12, 2016 edition),

3) Ibid,

4) <https://code.dccouncil.us/us/dc/council/laws/22-126>

FIGURE 2


For example, in 2015 many in the media reported that New York passed a telehealth private payer law that required parity in payment for telehealth delivered services.⁵ However, the bill, SB 7852⁶, lacked language that would require payment parity for telehealth services, despite what was reported. This lack of statutory payment parity language led to a health insurer issuing a letter to mental health providers that they will only be reimbursing for half the rate the provider would have received if telehealth was used to provide the service. The payer was not violating any law as they were not required to pay for telehealth delivered services at the same amount that would have been paid for in-person services. This led many to realize some states lacked this specificity of language in their existing laws and spawned numerous debates on whether telehealth

should be paid the same as in-person services. For a time, explicit payment parity laws remained few with only a handful of states adopting such language. That began to change with COVID-19 as will be discussed later.

OTHER STATE POLICY ISSUES

Beyond reimbursement and coverage, other major policy issues that states addressed in the past decade also impacted telehealth in some way. Two of these issues include prescribing and licensure and while some of the policies may not have targeted telehealth specifically, they nonetheless had an influence.

5) Fierce Healthcare, “New York enacts telehealth parity law,” (January 12 2015). <https://www.fiercehealthcare.com/it/new-york-enacts-telehealth-parity-law> (Accessed Aug 2, 2022).

6) SB 7852 - <https://trackbill.com/bill/new-york-senate-bill-7852-requires-insurers-and-medical-assistance-for-needy-persons-to-provide-coverage-for-the-provision-of-telehealth-services-700231/> (Accessed Aug 2, 2022).

Prescribing

As the use of telehealth grew, questions regarding prescribing began to increase as a provider may not be able to fully treat a patient if they are unable to prescribe necessary medication. (NOTE: Prescribing of controlled substances when using telehealth is regulated by Federal law and you will often see references in states' statutes back to this when touching upon the use of telehealth to prescribe). States took varied approaches to the prescribing issue when telehealth was utilized. The approaches were:

- Legislation/regulations specifically allowing for the use of telehealth to prescribe.
- Legislation/regulations that focused more on establishing the patient-provider relationship.
- Legislation/regulations that included language addressing both the previously mentioned methods.

As with much of telehealth policy, live video was the more widely accepted way to prescribe and/or establish a patient-provider relationship. Most states for much of the past decade specifically noted that questionnaires or asynchronous online platforms that did not have some interactive video component would not be sufficient to establish a patient-provider relationship or prescribe. However, in recent years, there have been a few states such as California⁷ that have broadened the channels to asynchronous options to establishing the patient-provider relationship.

As the United States faced an opioid crisis (also a federally declared public health emergency), many states, particularly hard-hit ones, began to explore the use of telehealth to address the needs of those

diagnosed with a substance use disorder (SUD). Policies to use telehealth for SUD treatment like medication assisted therapy (MAT) were only being discussed and explored before the COVID-19 pandemic hit. MAT often requires the prescription of medication. As it did with telehealth in general, Coronavirus expedited the exploration of using telehealth to provide MAT services for those diagnosed with SUD.

Licensure

Licensure has always been, and continues to be, a significant policy issue for discussion in the telehealth realm. However, back in 2012, the most common way for states to specifically address the telehealth and licensure issue was to issue a telehealth license. In 2013, nine state medical boards issued special licenses or certificates in some way related to telehealth. (Tennessee's medical and osteopathic boards both were issuing such licenses at this time) Other states had narrow policies that either allowed for reciprocity or made certain exceptions such as proximity to borders with certain states or infrequency of interaction within state borders, but overall, providers were required to be licensed by the state and for the majority of states, that policy still holds true today.

Over the next decade the number of states with specific telehealth licenses remained fairly consistent at nine, though some states repealed these laws/policies and others adopted them. However, the policy solution that gained the most traction during this time in regards to addressing the licensure issue was the creation of licensure compacts. Compacts are agreements between states on how to address a particular issue. Licensure compacts address how

7) California Business & Professions Code Sec. 2242.1(a).

licensing of practitioners with out-of-state health licenses should be dealt with. While the Nurse Licensure Compact has existed for over two decades, it was not until the Interstate Medical Licensure Compact (IMLC) became active in 2015⁸ that a more significant link with telehealth was drawn. As more states joined the IMLC, other health professions also began to establish licensure compacts.

Federal Telehealth Policy

Federal telehealth-specific policy is primarily concentrated in the Medicare program. While there are other federal statutes or regulations that specifically address or impact telehealth, it is in the Medicare program where the largest development of telehealth-specific policy by the federal government exists. Medicare telehealth policy has been built through both legislative and administrative action by the Centers for Medicare and Medicaid Services (CMS), the agency that oversees Medicare.

LEGISLATIVE ACTION

Telehealth reimbursement in Medicare was established in the Balanced Budget Act of 1997 which authorized reimbursement for telehealth delivered services to begin in 1999.⁹ Subsequent changes to Medicare telehealth policy were made in 2000 with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 and the Medicare Improvements for Patients and Providers Act of 2008. Several additional changes have also been made in subsequent years.

These legislative actions create the majority of the current telehealth policies that exist in Medicare today including the limitations on its use. Most in the telehealth field already know these limits but in short:

- The patient is required to be in a specifically defined geographic area and a specific type of site when the telehealth interaction takes place.
- The type of provider who can be reimbursed by the Medicare program when telehealth is used is limited to a specific list of practitioners.
- Though federal law does state specific categories of services that are covered, there is also flexibility for CMS to add additional services.

Modalities that can be used and still have the service reimbursed by Medicare are mentioned in federal statute, but there is also some administrative wiggle room for the administering agency. In federal law, the type of modality allowed for the delivery of covered services in Medicare is called a “telecommunication system.” However, “telecommunication system” is not defined in statute. Furthermore, when implementing the law, during the regulatory process, CMS added the word “interactive” before “telecommunication system,” therefore, the agency has always only considered live video as the only modality that Medicare will cover. (NOTE: Federal law does allow for store-and-forward to be used and reimbursed if it is provided in a telehealth demonstration program located in Hawaii or Alaska). Additional changes were made in subsequent years, but they were very narrow and specific. (See Figure 3).

8) Federation of State Medical Boards, “Interstate Medical Licensure Compact Established With Seventh State Enactment; Formation of Compact Commission Triggered,” (May 19, 2014). <https://www.fsmb.org/siteassets/advocacy/news-releases/2015/seven-states-enact-compact.pdf> (Accessed July 27, 2022).

9) Kasich, J. HR 2015 – 105th Congress (1997-1998): Balanced Budget Act of 1997.

FIGURE 3

LEGISLATIVE ACTIONS ON PERMANENT TELEHEALTH POLICY IN MEDICARE		
YEAR	ACT	MAJOR CHANGE MADE
1997	Balanced Budget Act of 1997	Established payment for telehealth in Medicare
2000	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	Expanded the telehealth policies in Medicare by allowing for more types of services, locations
2008	Medicare Improvements for Patients and Providers Act of 2008	Added skilled nursing facilities to eligible originating sites
2018	Bipartisan Budget Act	Allowed the home to be eligible originating site for end stage renal disease (ESRD) services and eliminates geographic limitation for these services. Allowed tele-stroke to be used in both rural and urban hospitals, geographic limitation would not apply.
2018	Support for Patients and Communities Act of 2018	Allowed for those being treated for substance use disorders (SUD) to be treated in the home via telehealth for these services as well as mental health services if the enrollee is co-diagnosed.
2020	Consolidated Appropriations Act	Allowed eligible mental health services to take place in non-rural areas & the home without having to meet any of the previous exceptions if certain conditions are met, such as an in-person visit with the telehealth provider takes place at least six months before the telehealth interaction. Created rural emergency hospital (REH) which will also become an eligible originating site for telehealth starting in 2023.

ADMINISTRATIVE ACTIONS

CMS has taken a series of actions over the past ten years that have altered coverage for services in Medicare when they are delivered via technology. Some of the administrative policy changes have been significant.

Creation of Communications Technology Based Services (CTBS)

In 2013 CMS proposed for the 2014 Physician Fee Schedule (PFS) the addition of a series of codes to cover Chronic Care Management (CCM). CCM

service codes covered care coordination and care management for patients with multiple chronic conditions. Up to this point, these services were paid in some demonstration initiatives, but this would be the first time they were paid under fee-for-service. CCM services are considered non-face-to-face and would utilize some sort of technology, either synchronous or asynchronous, to deliver the services. In other words, telehealth technology can be used to provide these services. However, CCM services were not considered “telehealth” by CMS because there was no in-person counterpart that it was replacing such as a consultation a patient has

with their primary care provider. Therefore, as CCM was not “telehealth,” though telehealth technologies can be used to deliver those services, it also was not subject to the statutory limitations placed on telehealth. CMS placed other requirements on CCM such as patients needed to have two or more comorbidities, but the other statutory limitations placed on telehealth services did not automatically apply.

Eventually, CMS would go on to introduce additional service codes that utilize telehealth technologies but were not considered “telehealth” under Medicare. In the 2019 PFS, CMS finally gave a name to these various codes grouping them under the name of “Communications Technology Based Services” (CTBS). Some CTBS services can be delivered via audio-only. The allowance of this modality for CTBS would play an important, and sometimes confusing, part in COVID-19 policies.

Redefining Terms

In addition to creating new service codes, CMS has also used their ability to redefine terms to help expand telehealth. In 2014, via regulatory action CMS redefined the word “rural” to expand the locations in which telehealth may take place under the Medicare program.¹⁰ In federal statute the originating site needs to be in a non-metropolitan statistical area (MSA) or “rural health professional shortage area (rural HPSA)”, but the latter term is not defined in law, leaving it up to the administering agency to detail the scope. The redefinition allowed for the inclusion of geographic areas located in rural census tracts within MSAs. The avenue used in redefining terms will come into more significant play in more recent times as will be delved into further in the COVID-19 section below.

OTHER FEDERAL ISSUES

As mentioned earlier, using telehealth to prescribe controlled substances falls under federal law. This law was put into place by the Ryan Haight Act which is why one might hear a telehealth proponent use the short hand of “Ryan Haight” when discussing federal law on prescribing. Federal law provides a specific set of limited scenarios in which a telehealth provider may prescribe a controlled substance to a patient without an in-person examination. Most of these scenarios are very specific and involve the patient being located in some DEA-registered facility or with a DEA-licensed provider. (See Figure 4). One exception is the creation of a registry by the Drug Enforcement Agency (DEA) where if a provider is listed, they would not need to meet any of the other exceptions and thus can utilize telehealth to prescribe. However, this registry, as of July 2022, has yet to even have proposed regulations promulgated despite the Ryan Haight Act being passed in 2008 and despite the Special Registration for Telemedicine Act of 2018 requiring the DEA to do so by 2019.

Another federally controlled policy that could impact telehealth but does not contain any telehealth specific language is the Health Insurance Portability and Accountability Act (HIPAA). Passed in 1996, the Act contains no language specific to telehealth leaving many providers uncertain or confused regarding how to remain HIPAA-compliant when using telehealth technology. HIPAA is a good example of old policy that has not kept pace with the evolution of technology.

10) CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2848 (December 30, 2014). <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2848CP.pdf> (Accessed July 31, 2022).

FIGURE 4

RYAN HAIGHT ACT EXCEPTIONS

When a controlled substance can be prescribed via telehealth when no in-person visit has taken place between the telehealth practitioner and the patient

- Patient with a DEA-registered provider at the time of the telehealth interaction
- Patient is in a DEA-licensed facility at the time of the telehealth interaction
- Telehealth practitioner is an employee or contractor with Indian Health Services (IHS) or tribal organization
- Telehealth practitioner who is an employee or contractor of the Veterans Health Administration and it is a medical emergency situation
- Public Health Emergency is declared
- Special Registry

The Courts

While thus far most of this overview has focused on legislative or regulatory/administrative actions, there is one other source that has impact on telehealth policy: court cases. While some may think these cases only involve malpractice suits, this section examines two other types of cases that have had significant impacts on telehealth policy. Despite the affect on telehealth policy, of the two cases provided below, only one is specific to telehealth.

In 2015, the Iowa State Supreme Court struck down the Iowa Medical Board's ban on using telehealth in medication induced abortions in its decision *Planned Parenthood of the Heartland, Inc. and Jill Meadows v. Iowa Board of Medicine*. In that case, the Iowa Medical Board had placed specific standards that required a patient to be in the physical presence of a physician at the time abortion inducing medication was being taken. The suit filed deemed the standards as unconstitutional due to placing an undue burden on the patient. The Iowa Supreme Court sided with the

plaintiff. However, this decision was at the beginning of significant movement in state telehealth policy as it related to prescribing of abortion inducing medication. After this case, some states began to pass legislation that allowed telehealth to be used to prescribe, but did carve out certain exceptions where it could not be used, such as when prescribing abortion inducing-medication. Given more recent events with the Supreme Court's decision on *Dobbs v. Jackson*, it is anticipated that there will likely be even more development on telehealth policy in this area.

Another case from 2014 also had significant impacts on telehealth policy. In *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, the Supreme Court ruled that a board whose members had a financial interest in the market due to the fact that they are active practitioners could not impose regulations or policies without oversight by a state entity. In this case the North Carolina State Board of Dental Examiners prohibited the application of teeth whitening services by any other person who was not a licensed dentist. Because there were

active practicing dentists on the North Carolina board, they would unfairly benefit from this action that limited competition. The case itself had nothing to do with telehealth, however, it became the basis of a suit filed by Teladoc against the Texas Medical Board the following year where the Board sought to limit virtually delivered medical care and prescribing. The case was eventually settled out of court with the Medical Board agreeing to revise its policies and the legislature acting, however it is another example of the impact court cases have had on the development of telehealth policy.

COVID-19

Until 2020, the development of telehealth policy was on a slow and steady pace with federal policy lagging behind some of the states. However, 2020 would change everything. On January 27, 2020, a national public health emergency (PHE) was declared due to the Coronavirus. States quickly followed and the nation began to shut down leaving mainly only essential services operating. As most of the nation began to severely limit their interactions, the health care system still needed to find a way to deliver services to patients, while also trying to limit contact in the face of a highly contagious disease.

It was at this point that telehealth was looked to as a solution to at least part of the problem. At the time, as has been laid out earlier, the policy environment did not allow for widespread use of telehealth, particularly if patients were in non-traditional medical locations such as the home, where most people were in the early days of the pandemic. Additionally, not all providers could use telehealth to deliver services due to coverage and reimbursement policies and not everyone had access to telehealth due to connectivity

or equipment limitations. Medicare was extremely limited in what was allowed which caused even greater concern as the population covered by the Medicare program were some of the most vulnerable to COVID-19.

This led to what can only be described as a tsunami of telehealth policy changes, on both the federal and state level. As an organization tracking telehealth policy on the federal and state levels, CCHP was constantly dealing with a deluge of changes from 52 different jurisdictions (50 states, DC and the federal government). The first of these actions began in March 2020 and in the following three-month period through May 2020, CCHP issued nearly quadruple the number of notices and analyses of telehealth policy changes done in a typical year for that same period of time. A full list of the federal changes can be found on CCHP's website as well as COVID-19 policies for each state, but an example of some of the most significant federal telehealth policy changes made in response to the pandemic can be found in Figure 5 (on page 15).

States, depending on where they were on their telehealth policies, took similar actions as federal policymakers in regard to their Medicaid programs. Additionally, as licensure is in the states' purview, many states relaxed their licensure laws and only required that a provider licensed in another state be in good standing.

One of the major developments during the pandemic was the increased allowance of using audio-only to provide services. As noted earlier, pre-pandemic, audio-only was not considered under telehealth in many jurisdictions. Recognizing that access to telehealth live video may not be available to all populations, policymakers on both the state and federal levels allowed for some services to

FIGURE 5
SAMPLE OF TEMPORARY TELEHEALTH COVID-19 POLICY CHANGES (FEDERAL)

PROGRAM/ISSUE	CHANGE
Medicare	<ul style="list-style-type: none"> • Suspended rural location requirement • Suspended site location requirement • Allowed all Medicare eligible providers to provide services via telehealth including federally qualified health centers (FQHC) and rural health clinics (RHC) • Temporarily expanded list of eligible services that can be provided via telehealth • Allowed audio-only to be used to deliver some services
HIPAA	Office of Civil Rights (OCR) issued a guidance that stated they will exercise discretion on HIPAA as providers transitioned quickly to adopting technology to provide services
Prescribing of controlled services	Ryan Haight PHE exception activated, telehealth providers may prescribe controlled substances without an in-person visit or meeting one of the other exceptions.

be provided via audio-only. However, what caused confusion for practitioners is that while some states allowed audio-only to be used, it was not as a replacement for an in-person service but rather was one of the CTBS codes discussed earlier. As the reimbursement rates are different for each code, some providers wondered why they were receiving less for an audio-only delivered consultation than for an in-person consultation when the payer assured payment parity. The reason for this was that the provider was most likely billing for a CTBS code, as directed by the program or payer from whom they were seeking reimbursement. There was no consistency of approaches towards telehealth services and CTBS. Some states include CTBS under their telehealth policies, while others followed Medicare’s example and keep it separate. This is where the confusion about the two tracks of services became more of an issue for providers and why different policies among states can be such a difficult environment to navigate.

Now, two and a half years into the pandemic, we are seeing more and more jurisdictions deciding what their permanent telehealth policies will be going forward or at least for the next year or so.

Post-Public Health Emergency

There have been three approaches taken by policymakers on the federal and state levels to address the temporary telehealth policies:

- Allow the policies to lapse and return to pre-pandemic policies
- Adopt some/all temporary policies permanently
- Extend temporary policies (all or some) to a future point in time (for example June 2023)

STATES

States have taken all three approaches listed above regarding their temporary telehealth policies. However, a great number of states have adopted at least some of their temporary telehealth policies or made changes in their Medicaid programs or state statutes. In 2021, over 200 state bills related to telehealth were passed. Most of the legislation and changes have been focused on coverage and reimbursement in the Medicaid program, and also on private payers.

During the pandemic, some states did issue Executive Orders requesting or mandating health plans cover telehealth to an extent. Sometimes these orders were not needed as many health plans also saw the need for telehealth and made temporary policy changes of their own volition. However, prior to the pandemic, as noted earlier, many states did not have a specific statutory mandate for parity in payment for telehealth as applied to commercial health plans. In the two and a half years of the pandemic, this has changed significantly. Prior to COVID-19 six states had specific statutory payment parity language for telehealth services covered by commercial payers. In the Spring 2022 that number was 21.

Another significant change in policy is the rise of audio-only policies in Medicaid programs. Prior to the pandemic there were only a few states that had narrow and specific audio-only policies in Medicaid, usually for a limited band of services or it was allowed as a back-up should there be no other way to engage with the patient. However, as of Spring 2022, 30 Medicaid programs have some type of audio-only policy. Many of these policies are still for specific

services such as it can only be used to deliver mental and behavioral health services. However, even with these limitations it is much more than what existed pre-COVID-19 and in many cases, these policies are being placed under the umbrella of “telehealth”.

There are some states that have delayed making a decision on permanent policy as they gather more data, so the next year or two will still be one of change on the state level.

FEDERAL

Permanent federal changes have been a little slower in materializing. As noted earlier many of the federal telehealth-specific policies apply to Medicare and are located in federal law. Therefore, Congress would need to act to make many of these major policies permanent. What we do know about what will happen to the temporary telehealth policy waivers post-PHE is that for 151 days after the PHE is declared over, the following temporary telehealth policies will remain:

- FQHCs, RHCs, occupational and physical therapists, speech-language pathologist and audiologists will still be able to continue to provide services via telehealth under the Medicare program and be reimbursed.
- The list of temporarily eligible services that can be provided via telehealth under Medicare will also remain in effect during this period.
- The use of audio-only to provide these services will remain available during this period.
- The geographic and site limitations will still be waived during this 151 day period.

FIGURE 6
MEDICARE TELEHEALTH PERMANENT POLICIES POST-PHE & 151 DAY GRACE PERIOD
(As of Policies Passed July 2022)

POLICY	EXCEPTION
Patient must be located in a rural health professional shortage area or a non-Metropolitan Statistical Area	Treatment of Tele-Stroke Treatment of ESRD Treatment of SUD and co-occurring mental health condition Treatment of eligible mental and behavior health services (if certain conditions met)
Patient must be in a specific location during the telehealth interaction ¹¹	Home is an eligible originating site if: <ul style="list-style-type: none"> • Treatment of ESRD • Treatment of SUD and co-occurring mental health condition • Treatment of eligible mental and behavior health services (if certain conditions met)
Specific list of eligible providers who can use telehealth to deliver services and be reimbursed by Medicare ¹²	---
Use of a telecommunication system to deliver eligible services, CMS has interpreted this to mean an interactive telecommunication system, unless patient is in a telehealth demonstration project in Hawaii or Alaska in which case, store-and-forward may also be used.	Audio-only may be used to deliver eligible mental health services if certain conditions are met.
Specific list of services that are eligible to be provided via telehealth and will be reimbursed by Medicare	Medicare has created a temporary holding place called "Category 3" for some pandemic-eligible services that will remain eligible to be provided via telehealth and reimbursed to the end of 2023.

Some may wonder why there is no exception listed for eligible providers as the 2022 PFS allowed for FQHCs and RHCs to provide mental health services via live video and audio-only. Legislation must be passed to add additional eligible providers to the telehealth eligible list. What CMS did do in the 2022 PFS was redefine what a mental health visit meant for FQHCs and RHCs to include providing those services via live

video and audio-only, if certain conditions were met. This was a redefinition of a term, similar to what was done with the word "rural" discussed earlier, that applies to FQHCs and RHCs and was therefore not considered the use of telehealth. Once again, we see CMS using their ability to define terminology as a way to expand the use of telehealth technologies without having to wait for Congress to act.

11) Physician and practitioner offices, Hospitals, Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers, Hospital-based or CAH-based Renal Dialysis Centers (including satellites), Skilled Nursing Facilities, Community Mental Health Centers, Renal Dialysis Facilities, Patients with End-Stage Renal Disease getting home dialysis, Mobile Stroke Units (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctst.pdf>)

12) Physician, Nurse Practitioners, Physician Assistants, Certified Nurse-Midwives, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Clinical Psychologists and Clinical Social Workers (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctst.pdf>)

It should be noted that what was laid out in the preceding paragraphs could change depending on action by Congress or some other administrative rule. As we have seen in the past, changes in telehealth policy can be achieved in a short period of time.

Looking Forward

The title of this section was deliberately chosen instead of using the more typical “Conclusion” header because this is not the conclusion of CCHP acting as the NTRC-P nor is it the conclusion of the development of telehealth policy. As detailed throughout this report, the telehealth policy landscape is ever-changing and impacted by outside forces, including current events unrelated to telehealth and changes within healthcare broadly.

CCHP welcomes the dynamic nature of this work. Telehealth policy operates within a multi-faceted and highly complex environment where a simple answer may not be available for many questions. As these policies continue to evolve on both the federal and state level, CCHP will continue the work it has done over the past decade for as long as possible.

We are excited to see what comes next and hope you will join us on this journey.

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Our Timeline



Acknowledgments

Over the past ten years, CCHP has been fortunate to employ and collaborate with an exceptional group of individuals and partner agencies. Our work as the NTRC-P would not be possible without the following:

- Health Resources and Services Agency, Office for the Advancement of Telehealth for providing funding for this program
- The Public Health Institute for its support as CCHP’s fiscal agency
- The multitude of funders, both past and present, who have supported CCHP’s work
- The Telehealth Resource Centers, state Medicaid programs and countless others who have worked beside CCHP over the years
- Sandra Shewry, CCHP’s founding Executive Director
- The late Mario Gutierrez, a founding CCHP leader and CCHP’s second Executive Director. Mario was a visionary, loved by many. He was also the Executive Director who first applied for the NTRC-P grant.
- CCHP staff members who joined CCHP during the pandemic, Amy Durbin, Policy Advisor, and Veronica Collins, Policy Associate, who have helped immensely with the continuing policy changes as well as Aria Javidan, Project Coordinator for the National Consortium of Telehealth Resource Center, whose skill in his position is truly appreciated.



CCHP Staff – Fall 2010



CCHP Staff – Fall 2017



CCHP Staff – Winter 2020

Special Thank You

A SPECIAL THANKS FROM Mei Kwong, Executive Director:

“ I want to express my extreme gratitude to my long time colleagues, Laura Stanworth, Deputy Director, and Christine Calouro, Senior Policy Associate, who have been with the NTRC-P from the beginning of its inception and launch. Along with myself, we were the three staff members that for the first six months of COVID-19 were the only staff for CCHP. This trio was responsible for tracking, analyzing, writing, formatting, communicating and distributing all the information related to the telehealth policy changes for the nation. None of that would have been possible without Laura and Christine’s enormous contributions and dedication to ensuring those who needed the information to serve patients and save lives obtained it as quickly and in an as easy to understand format as possible. They have my greatest thanks and admiration in the work they have done and continue to do. ”

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A SPECIAL THANKS FROM Laura Stanworth, Deputy Director:

“ It would be easy to allow our tenacious Executive Director, Mei Kwong, to have the final word in this report. But I can’t let that happen. Instead, I have the privilege to close this report with an expression of gratitude to my longstanding friend, colleague and partner. In 2012, Mario Gutierrez looked to Mei and me to help determine the wisdom in pursuing the national policy telehealth resource center (NTRC-P) contract. Little did we know that the two of us would ultimately be steering the ship for the bulk of the NTRC-P project. After the sudden and unexpected loss of Mario Gutierrez in 2017, Mei stepped in with huge shoes to fill as she took the helm. From that time forward, I have witnessed her ever-present determination, keen wit, powerful analytical mind, readiness to take appropriate risk and her steadfast commitment to CCHP and our family of telehealth resource centers within the National Consortium of Telehealth Resource Centers. The field as we know it today would not be the same without the many years of Mei’s devotion and influence. ”