



The
Reforming
States
Group

REPORT

Telehealth Private Payer Laws: Impact and Issues

by the Center for Connected Health Policy

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Foreword

State health policy leaders are faced with the challenge of addressing the diverse health care needs of the populations they serve. As they look for ways to expand patient access to care, especially in rural areas, they turn to the potential of telehealth or telemedicine, the use of technology to deliver health care to patients in a setting different from that of the provider. There would seem to be great potential here—advancements in technology have made these services more reliable and affordable. There is greater access to high-speed broadband and wireless communication as well as more interest in value-based payments for care. While a substantial body of evidence for telehealth exists, its use is not widespread.

State leaders have been looking at ways to expand and clarify telehealth reimbursement policies, especially as they relate to private payers. Since 2010, there has been nearly triple the number of states that have enacted legislation related to telehealth care. These laws range in scope and features. Many contain limiting factors, such as the language used in the law; whether there is payment parity between the service provided via telehealth or in person; the type of telehealth modality used; location of service; and type of provider who can offer the service.

To get a better understanding of these laws and to assess their impact on telehealth utilization, the Center for Connected Health Policy assessed the response by selected commercial payers to telehealth private payer laws. The report was written by Center for Connected Health Policy staff—Mei Wa Kwong, JD, policy advisor and project director; Christine Y. Calouro, MA, program associate; and Laura M. Nasser, MA, program associate.

The report, which was commissioned by the Reforming States Group (RSG), grew out of the group's interest in the topic. Supported by the Milbank Memorial Fund since 1992, the RSG is a bipartisan group of state executive and legislative leaders who meet annually to share information, develop professional networks, and commission joint projects.

Telehealth continues to offer great potential to improve the convenience and effectiveness of care. It is our hope that this report will provide evidence and experience to help leaders and decision makers develop policies that promote the appropriate utilization of telehealth modalities and expand access to care for the populations they serve.

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Introduction

Health systems across the country face increasing pressure to expand access to care, while improving the efficiency and quality of that care in the face of limited resources. Consequently, state policymakers have shown a growing interest and receptivity to the use of telehealth technologies to help meet these demands. Telehealth is defined as the use of electronic technology to provide diagnostic and treatment services, enhanced communication and care coordination, patient monitoring, and education from a distance. This virtual communication can be between two health care providers, or between the health consumer and the provider. Transmittal and response can be in the more widely utilized and known “real time” live video; asynchronous or “store-and-forward” communication, which uses a secure email platform and is not in real-time; or through remote patient monitoring (RPM).

Telehealth care modalities have been in use for decades and have been shown to be as effective in many situations as in-person care, yet they are not as widely used as they might be. While telehealth may not be appropriate for all health care interactions since some situations require physical interaction between patient and provider, a substantial body of literature and evidence demonstrates the benefits of telehealth.

Studies have found that telehealth has been used effectively in a multitude of specialties such as mental health, dermatology, and treatment of chronic diseases. In 2012, Wootton published a literature review of remote control trials for management of five chronic conditions: asthma, chronic obstructive pulmonary disease, diabetes, heart failure, and hypertension. The review included over 1,300 studies.¹ After a thorough analysis, he found a total of 141 remote control trials in which 148 telemedicine interventions had been tested with nearly 37,000 patients. He determined that 108 of the trials were favorable toward the telemedicine intervention, and 38 trials showed no statistical difference between the telemedicine intervention and traditional care. This meta-analysis showed that in 99% of the studies, telemedicine interventions were as good as or better than traditional approaches to care.

The US Department of Veterans Affairs (VA) and the correctional system have been long-time users of technology to provide care without a provider physically present with the patient. A VA report in 2013 showed home telehealth services reduced bed days of care by 59% and hospital admissions by 35%, while clinical video telehealth services reduced bed days of care for mental health patients by 38%. In terms of cost savings, home telehealth (where the patient is home and receives services from a provider in another location) reduced health care costs by roughly \$2,000 per person per year, while clinical video telehealth saved roughly \$34.45 per consult and store-and-forward telehealth saved roughly \$38.81 per consult in travel costs for the patient.²

But it is not just government organizations such as the VA and corrections facilities that are benefiting from telehealth. For example, the use of RPM to reduce hospital readmissions,³ as well as address chronic conditions, as the Wootton study also noted, have led to better results than traditional in-person approaches.⁴ The use of store-and-forward for dermatological assessments has been effective and is accepted by both providers and patients.⁵

In recent years, several other factors have played a role in improving the policy and practice environment that make telehealth a more attractive option in health care delivery. These factors include:

- advances in technology that make these services more reliable and less expensive;
- greater access to high-speed broadband and wireless communication;
- increased health coverage for millions of Americans through passage of the Affordable Care Act (ACA), although the availability and distribution of primary and specialty care providers remains skewed; and
- the movement toward value-based payments for care.

This perfect storm of factors has led to an increased interest by state and federal policy-makers to consider incorporating telehealth into the growing demands on health systems and payers. Even with the expected rollback of the ACA, states will still find themselves in the challenging position of addressing the growing health needs of their populations, potentially with less federal assistance.

Bipartisan efforts to reform Medicare telehealth-related policies have repeatedly stalled in Congress, yet states have been quite active in expanding telehealth reimbursement policies, particularly as they relate to private payers. In the last few years, one of the most common forms of telehealth-related legislation is private payer laws that require payers to treat telehealth-delivered care the same way as in-person care. Since 2010, 23 states and the District of Columbia have passed some form of a private payer law, yet prior to 2010, only eight states had laws (among the first laws passed were those in California and Oklahoma in 1997).⁶ Across states, the laws range in scope and features, adding complexity to a telehealth policy environment in which no two states are alike.

Although private payer telehealth laws are gaining momentum, there has not been a comprehensive analysis of these laws and the impact they have on expanding the use of and payment for telehealth-delivered services.

To further understand and assess the impact of telehealth private payer laws on utilization, the Center for Connected Health Policy (CCHP) conducted a five-month study (September 2016 to January 2017) that sought to accomplish the following:

- Assess and describe the response by selected commercial payers to telehealth private payer laws.
- Describe the effects of telehealth private payer laws on utilization.
- Assess any influence these laws had on state Medicaid telehealth policies.
- Provide suggestions to improve private payer laws and their impact.

In addition to addressing these issues, this report flags potential issues policymakers may wish to address to expand greater utilization of telehealth modalities. While private payer laws vary in using the term “telemedicine” or “telehealth,” this report will use the term “telehealth” as representative of both terms. Additionally, while many people, including those in the media, may call these laws “telehealth private payer parity laws,” this paper will use the term “telehealth private payer laws.”

Private Payer Laws Analysis

As of September 2016, 31 states and the District of Columbia have passed telehealth private payer laws.⁷ (For a list of states, see Appendix B, Table 1.) While these laws share some common features, no two state laws are exactly alike. Additionally, implementation of these laws varies from state to state. Some telehealth private payer laws may contain factors that limit the scope of telehealth reimbursement or use in delivering services, similar to what is seen in Medicare policy—and this may have been the intent of policymakers when crafting the language. Investigating the specific reasons behind the decision to include these factors was beyond the scope of the project. However, it is possible to analyze the comprehensiveness of the enacted telehealth private payer laws by examining the law in each state and its impact on the commercial plans. (Additionally, some of the enacted laws are possibly second or third attempts to get legislation passed. A summary of the failed telehealth private payer laws over the last few years can be found in Appendix A.)

Critically important in this study was the analysis of the actual language and structure of each telehealth private payer law. We found that how the law was written can determine the expansiveness of reimbursement and can predict telehealth utilization. Opinions vary among health care systems, providers, and commercial insurers about what is considered “progressive” telehealth private payer law language. That said, there are specific factors contained in some telehealth private payer laws that recognize telehealth-delivered care to be on a par with services provided in person and attempt to treat them comparably. However, the appearance of these characteristics may come with limitations or caveats that separate and slow the utilization of telehealth. One example is limiting the definition of telehealth to only one modality, when there are three modalities available: live video, store-and-forward, and remote patient monitoring.

Private Payer Laws Evaluation Factors

Payment

- Did the legislation allow for some form of telehealth private payer reimbursement?
- Did the legislation contain a mandate?
- Did the legislation require parity in payment?

Modalities

- Did the legislation allow for live video reimbursement?
- Did the legislation allow for store-and-forward reimbursement?
- Did the legislation allow for remote patient monitoring reimbursement?

Location

- Did the legislation refrain from placing a geographic limitation?
- Did the legislation refrain from limiting originating sites?

Providers

- Did the legislation refrain from limiting providers?
- Did the legislation refrain from limiting specialties?
- Did the legislation refrain from requiring a telehealth-specific informed consent?
- Did the legislation refrain from requiring a health care provider to be present at the originating site?

Other

- Did the legislation exclude a requirement that makes a mandate “subject to terms and conditions”?
- Did the private payer law include Medicaid?

To understand these differences among states with telehealth private payer laws, CCHP analyzed the existing laws. This examination provided an initial baseline for each state on its telehealth private payer reimbursement policy according to key characteristics. However, while this examination provided a baseline perspective, nuances of written language and the absence of language were seen to affect how the policy was applied. It should also be pointed out that the absence of any one factor did not necessarily have a negative or restrictive impact. For example, if a telehealth private payer law only defines telehealth as the use of live video, a private payer may still choose to include other modalities in its covered benefits. In CCHP's examination of the telehealth laws among the states, there do not appear to be any statutory limitations on providing payment for a health service via any of the modalities, although there may be other regulatory factors that govern the provision of services via those modalities (such as having a valid medical license, how to establish patient-provider relationship, etc.).

To conduct this assessment, CCHP used the following key criteria to determine the relative impact of these laws on telehealth use and reimbursement:

1. Inclusion/exclusion of language—Is the presence or lack of certain language or phrases a help or hindrance to the utilization of telehealth?
2. Parity in payment—Does the law require that a payment amount for telehealth-delivered services be equal to that which is given for in-person services?
3. Modality—Are there any limitations on what type of telehealth modality can be used?
4. Location—Are there any limitations on where a telehealth service can take place?
5. Providers and specialties—Are there any limitations on the types of provider who may provide services via telehealth and/or the types of specialty it can be used for?

Fourteen questions were developed to address these factors. (See page 6.) The questions were structured so that an answer of “yes” was considered a positive result in favor of progressive telehealth policy and a limitation was not seen as being in place. Each factor was rated with a score of “1” if the response to the question was a “yes,” and a score of “0” if it was a “no.” A detailed explanation of the methodology employed and specific scoring for each state with a telehealth private payer law can be found in Appendix B.

Baseline Results of Analysis

The results of the analysis yielded both common and different features among the state laws. It was difficult to single out any one factor that had the greatest impact on the utilization of telehealth because many of these factors were interconnected and one could affect others.

Inclusion/Exclusion of Language

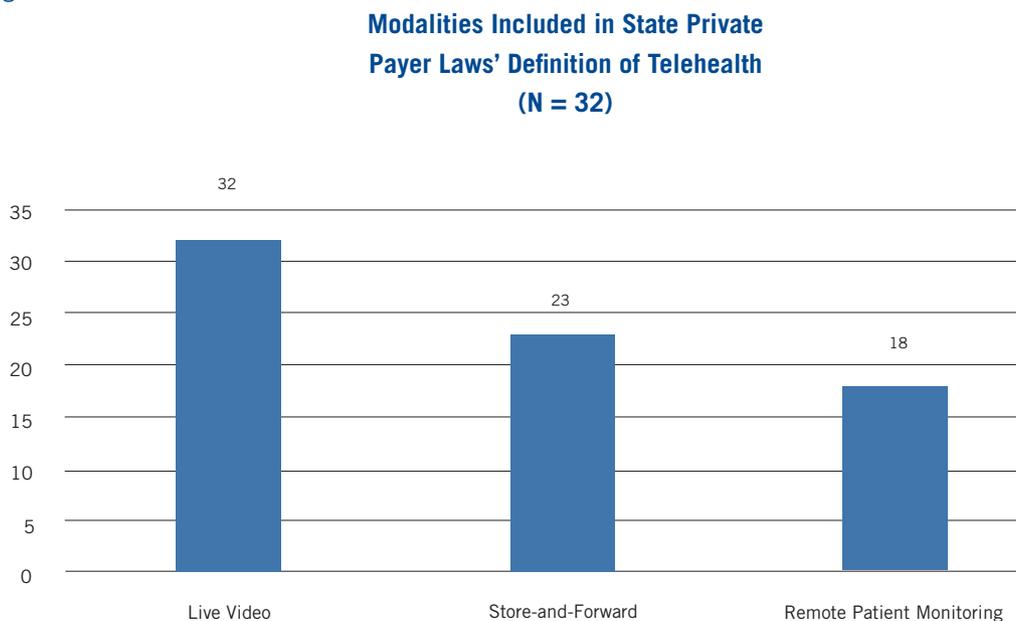
Overall, the vast majority of state telehealth private payer laws contained some limiting factors. Only Minnesota scored a perfect score of 100% (based on the scoring system described above). Arizona and Montana received the lowest scores of 57.1%. However, the numbers represent only part of the story. While a state law may have received a “0” score for a factor, the presence or absence of a factor did not necessarily mean that telehealth

as it would be if delivered in person. In fact, our research indicates that only three state telehealth private payer laws have an explicit mandate for payment parity. Therefore, in 28 states and the District of Columbia, commercial health plans are only required to cover a telehealth-delivered service if the service is covered if delivered in person, but are not legally required to reimburse at the same rate as is paid for in-person delivered services. This gives private payers the flexibility to set lower or higher rates of reimbursement for telehealth-delivered services.

Modality

In all the states with a telehealth private payer law, live video is the modality most often referred to in the definition of telehealth. Store-and-forward and RPM appeared less frequently (See Figure 1.). (Only 71.9% of the state laws included store-and-forward and 56.3% included RPM.) If these modalities are not explicitly described in a state’s definition of telehealth, the private payer can use its discretion as to whether and how much to pay for the service, if at all. As noted earlier in the paper, these other modalities, particularly RPM, have great potential to improve health outcomes for patients and bring down costs, but the exclusion of these modalities in the law allows private payers to exclude services delivered via these modalities from their reimbursement policies.

Figure 2.



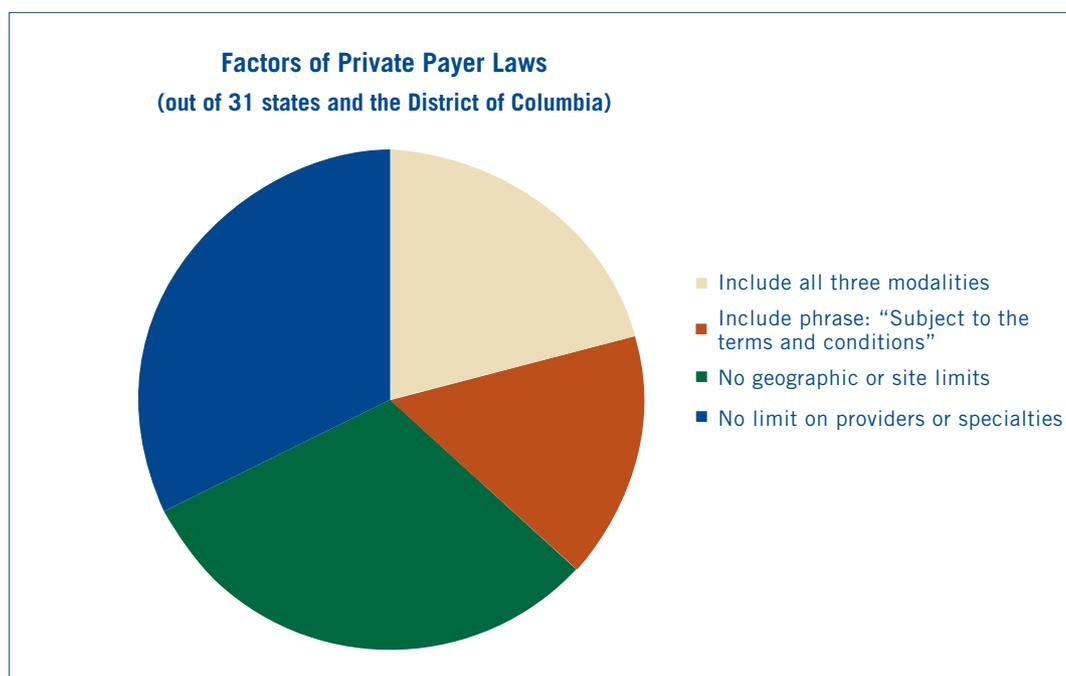
Source: Data from the Center for Connected Health Policy analysis of private payer laws.

Location

Restrictions that limit where a telehealth service can be provided (the patient’s location), either geographically or by site, appear less often in private payer laws in comparison to the restrictive policies of Medicare. Medicare limits the location of where a patient may

receive a service via telehealth to specifically defined “rural” health professional shortage areas or to nonmetropolitan statistical areas. This limitation has been cited as a significant barrier to the use of telehealth since only certain parts of the country qualify.⁸ The fact that most state telehealth reimbursement laws lack these limitations indicates that states tend to view telehealth-delivered care as benefiting more than just the rural underserved population. (Only Arizona contains a geographic limitation, and it will be eliminated in January 2018.) Just four out of the 31 states and the District of Columbia have some type of site limitation. Not having any site restrictions allows private payers to pay for services that take place in less traditional health care locations such as the workplace or home and advances one of the important strengths of telehealth-delivered care, which is providing care anywhere the health consumer is located. However, most laws also do not prohibit restrictions on sites, which would allow providers to still limit where a patient may receive telehealth-delivered services.

Figure 3.



Source: Data from the Center for Connected Health Policy’s analysis of private payer laws.

Providers and Specialties

Most telehealth private payer laws refrained from requiring that the law be applied to a specific list of providers or specialties. This language in the law theoretically enables health care providers other than physicians to be reimbursed within private payer policies. Audiologists, speech pathologists, physical therapists, and others could presumably be eligible for reimbursement, depending on the parameters of the plan. However, language that requires that all services and providers be reimbursed may not necessarily be present in the actual

law. A law may simply omit any mention of providers or specialties, leaving the payer with the ability to impose certain limitations, such as reimbursement for only a narrow set of services such as physicians' office consultations.

Other Factors

Other factors that were examined in CCHP's analysis of telehealth private payer laws were selected based on the potential negative effect they could have on provider behavior. These factors could be seen by providers as additional burdens they would not have to face if providing services in person and could discourage them from using telehealth, because resources to meet these requirements might outweigh the benefits of utilizing the technology. One such requirement is to have a separate informed consent (which in some states can be written and/or oral) specifically for telehealth. There is debate in the field regarding the impact of the additional informed consent. Some believe that requiring an additional informed consent gives the impression that telehealth is more "dangerous" than in-person care and may prejudice patients and deter them from agreeing to the use of the technology. Others view it as an opportunity to provide education and information to patients. And some believe that requiring a form of consent deters providers from using telehealth because it is yet another administrative burden. Though the impact and effects of an additional informed consent are debatable, it was flagged in this analysis due to its potential influence on providers.

Also included in this analysis was whether there was any language specifically related to reimbursement in the Medicaid program. The results were mixed. Nearly one-third of the states did have some Medicaid provision within their telehealth private payer law. This is important because in some states Medicaid may be the largest payer. Not including Medicaid could have the unintended consequence of depriving many beneficiaries of access to services that could be delivered via telehealth. Additionally, as will be discussed in a later section, private payers may adopt telehealth payment policies that mirror either Medicare or Medicaid telehealth policies. How a Medicaid program shapes its telehealth reimbursement policies can have a significant impact on the payment policies of private plans operating in their state.

Key Takeaways from Private Payer Law Analysis (See Figure 3.)

- Inclusion or exclusion of certain language may create barriers to the utilization of telehealth by allowing payers to limit the types or uses of services that are reimbursed.
- Very few telehealth private payer laws mandate parity in payment amount.
- Store-and-forward and RPM are less likely to be included in a telehealth private payer law.
- Unlike Medicare, telehealth private payer laws tend not to include explicit exclusions on types of services, providers, and limitations on locations, both geographic and site.

Private Payer Interviews

To gain a deeper understanding of the impact of the private payer parity laws among the states, CCHP conducted interviews with selected commercial health plan executives. The representatives of the plans included medical officers, vice presidents, counsel, and designated telehealth policy representatives. The interviews were conducted to determine how the telehealth private payer laws affected these plans, how they developed the plans to be in compliance with the law, and how some of the factors identified in the previous section on the payment policies of health plans influenced the plans.

Standardized interviews were conducted with willing commercial payers in six selected states. Questions were developed to address the five previously identified factors that impact utilization of telehealth. These questions were designed to assess how plans dealt with each of the factors that have an impact on telehealth utilization, especially if a law's vague or omitted language gave private payer plans latitude in developing their telehealth policies. CCHP also asked about the availability of data to determine the extent to which there had been greater receptivity for telehealth among the commercial plans given the existence of a telehealth private payer law.

The criteria used for the selection of these states were (1) a telehealth private payer law had been in place for at least three years, and (2) if any major amendments were made to that law, those amendments must have been in place for at least three years. A goal in the selection process was also to include states that varied in both geography and population. The states selected were California, Mississippi, Montana, Oklahoma, Texas, and Virginia. None of these states had payment parity as part of their private payer laws. All states with an explicit requirement for payment parity failed to meet the three-year enactment requirement. (See Table 1.)

Over a period of four months, a variety of commercial health plans in all six of the selected states were contacted. Initial outreach was made through multiple channels to representatives in the health plans, including media relations and specific staff associated in some way with a plan's telehealth program. CCHP agreed to not identify the participants in these interviews to obtain the most open responses to the questions possible.

It should be noted that some plans declined to participate, but at least two plans in each state were interviewed either via phone or email. Some interviewees were large national plans that have a presence in multiple sample states, while others were limited to one state. Several interviewees provided copies of their telehealth reimbursement policies. Given that some health plans declined to participate, it is possible that the interview sample may have been more biased toward those willing to incorporate telehealth as a reimbursable benefit. To try to counteract this possibility, CCHP conducted online research of telehealth policies of those health plans that declined to be interviewed, as a means of gathering information that responded to the assessment questions. A list of questions used can be found in Appendix C.

Table 1. Selected Sample Private Payer Law Features

State	Parity in Payment	Live Video Included	Store-and-Forward Included	Remote Patient Monitoring Included	No Geographic Limit	No Site Limit	No Limit on Provider	No Limit on Specialty
California	N	Y	Y	Y	Y	Y	Y	Y
Mississippi	N	Y	Y	Y	Y	Y	Y	Y
Montana	N	Y	Y	N	Y	N	N	Y
Oklahoma	N	Y	Y	Y	Y	Y	Y	Y
Texas	N	Y	Y	Y	Y	Y	Y	Y
Virginia	N	Y	Y	Y	Y	Y	Y	Y

Interview Findings

As noted, some private payer laws may appear to require all services delivered via telehealth to be reimbursed as they would if they were provided in person. However, further examination reveals that there may be some flexibility in the interpretation. The specific language included in these laws and other regulations or statutes may impact whether all services are reimbursed the same way that in-person services are or if there are limitations/restrictions imposed by insurance carriers. All payers interviewed had some limitation on their telehealth reimbursement policies in some form or another.

Modality Limitations

While all six sample states' telehealth private payer laws allowed for all three modalities within telehealth to be reimbursed, the majority of selected plans only reimbursed for live video. Some plans provided limited reimbursement for store-and-forward, but only for specific specialties such as dermatology or ophthalmology. RPM was not being reimbursed by any of the selected payers, although several interviewees noted that, in the near future, it might be either a pilot project or an option in a specific type of plan, such as an employer plan.

Provider and Specialty Limitations

Most of the interviewees said they limited the types of services reimbursed if the service was provided via telehealth. One interviewee said it was the policy of the organization to not reimburse for telehealth-delivered services unless an established patient-provider relationship existed. Another interviewee mentioned that the health plan's policies mirrored the Medicaid policies in the state. None of the six states in the sample had specific language in the private payer law regarding what services could or could not be reimbursed if the service was provided via telehealth.

Most plans did not limit the type of provider who could provide services, although they did require the provider to be a member of its network, with one exception discussed below. Some plan manuals required additional actions by the provider that included such things as requiring them to share medical records with a primary care provider or obtaining informed consent (factors which may be required by a state licensing board or law).

Parity in Payment

When interviewees were asked if the reimbursement amount was the same regardless of whether the service took place in person or via telehealth, almost all answered yes. One interviewee said its telehealth reimbursement was slightly less than in-person service because they calculated a lower overhead cost for the telehealth service. Another interviewee was uncertain but believed that the reimbursement amount for telehealth services was the same or slightly less than what was paid in person. It should be noted that none of the six sample states had a mandate on parity of payment in their laws, although nearly all the interviewees were paying the same or near the same amounts per service regardless of delivery method.

Location Limitations

In some cases, the health plans imposed other limitations such as defining the specific sites where the telehealth interaction could take place (doctor's office, clinic, etc.), but none of the interviewees had geographic restrictions such as the ones Medicare places on telehealth (it should be noted that in the interviews only commercial plans were discussed and not Medicare Advantage plans).

Third-Party Providers and Network Providers

Several interviewees noted that their organizations had several options for enrollees to utilize telehealth. One option was using a network provider that offered services via telehealth. Reimbursement to that provider operated much the same as if the service had been provided in person. In addition, several interviewees noted that they contracted directly with a third-party provider that provides online services to their enrollees, usually for less complex, more common cases such as colds or sore throats. These third-party providers were contracted by the health plan and paid according to the terms of the negotiated contract. Interestingly, several of the interviewees said their own network providers could join these third-party provider services and still be network providers, although they would receive the contracted rate for services rendered through the third-party provider. In some cases, a health plan may also have its own asynchronous online system that allows enrollees to communicate with their network providers.

CCHP obtained a copy of a telehealth provider manual for a multistate payer that declined to be interviewed for this report. The manual describes the state's telehealth network program, where the plan has created specific specialty locations that connect with presentation sites (where the patient would be located), thus allowing enrollees to seek telehealth-provided services using their own network providers, not those of a third-party provider. Even though CCHP was unable to interview this payer, the telehealth policy is worth noting because it is a different approach by a payer providing telehealth services.

Utilization and Provider and Consumer Reactions

All the interviewees declined to provide exact figures on telehealth utilization. One interviewee noted that tracking data would be difficult because the organization did not require providers to use the telehealth modifiers of GT (live video) or GQ (asynchronous), which

is typically used when billing for telehealth delivered services, and could not distinguish between an interaction that took place via telehealth or in person. However, the interviewee believed utilization was low. Other interviewees echoed this. When asked for their thoughts about why utilization was low, several reasons were given:

- Patients were reluctant to initially start using telehealth, though once they did, many responded positively. However, there was still a preference by many enrollees to see a provider in person.
- In-network providers were reluctant to utilize the technology for reasons that ranged from lack of training, skepticism that telehealth would provide quality services, or concerns that they could see a loss of business (this was particularly true in at least one case where a plan also engaged a third-party provider).
- Lack of education/awareness that these services were available or understanding exactly what these services could do for enrollees.

When talking about low utilization, several of the interviewees expressed their continued belief in the benefits of telehealth and the hope that there would be greater uptake in its use. However, when asked if they considered expanding their current telehealth policies, several interviewees voiced caution. They noted concerns about efficacy in certain interactions. Most preferred a slower, more thorough approach to expansion that could include their own pilot projects before considering larger changes. While we did not sense any reluctance on the part of the interviewees to move forward with telehealth, it was evident that the interviewees only wanted to reimburse for services for which they felt telehealth could be appropriately used, such as routine office visits.

Key Takeaways from Private Payer Interviews

- Most interviewees limited telehealth reimbursement to services provided via live video.
- Most interviewees limited the types of services they will reimburse if provided via telehealth.
- Policies from other sectors such as licensing boards affected the payers' policies on telehealth.
- Most of the interviewed payers were paying the same amount for telehealth services that they would if the service was delivered in person.
- At least initially, both patients and providers were reluctant to utilize telehealth.
- Telehealth was greatly underutilized.
- Both patients and providers had a lack of understanding/awareness that the plan would pay for telehealth-delivered services.
- While supportive of telehealth, the interviewees noted that they would need to be convinced that expanding payment for services and/or use of other modalities to deliver care was beneficial.

Medicaid Policies

To assess whether there was any correlation between changes in telehealth private payer laws and those in a Medicaid program, CCHP interviewed Medicaid representatives or examined Medicaid policies for the six sample states where private payer interviews were conducted. Half of the sample states, California, Mississippi, and Oklahoma, included a Medicaid policy factor within the private payer law they adopted.

Representatives of each of the state Medicaid programs were interviewed, and the telehealth policies of the respective states described in their Medicaid provider manual were researched and identified. The list of questions asked can be found in Appendix C.

Most of the states interviewed had a Medicaid telehealth policy in place before the telehealth private payer law was enacted, and, in the majority of states, the law's passage had little or no impact on their policies, unless there was a specific provision that applied, such as in California. When California updated its telehealth laws in 2012, it included private payer provisions along with specific reforms of telehealth coverage policies directed at the Medicaid program.

Medicaid telehealth policies tended to have similarities with private payer policies, with private payers sometimes replicating Medicaid policy. Live video was the most common modality reimbursed in Medicaid programs, as it was for private payers. Medicaid programs tended to be more explicit about defining telehealth or telemedicine as “live” or “real-time” or “interactive.” In Texas, however, another term was used to describe one of the other modalities, such as “telemonitoring” for RPM. California was one of the few (and the only state in the sample selection) that reimbursed for store-and-forward, but only in specific specialties: dermatology, ophthalmology, and dentistry. Additionally, as with many private payers, these Medicaid programs reimburse at the same rate for telehealth as they would for in-person delivered services.

The Medicaid programs in this interview sample did not limit the geographic location of where a patient may receive services. Several interviewees, including those from Montana and Oklahoma, stated that geographic hurdles impeded access to providers—and such hurdles were one reason to institute a telehealth policy. However, half of the sample states (Mississippi, Texas, and Virginia), in fact, had specific site location limits on where a patient may receive services, typically limiting services to some type of licensed health facility.

Half of the sample states' Medicaid programs described specific lists of eligible providers and services available for telehealth reimbursement, whereas the other half included fewer details on who and what could be reimbursed for telehealth delivered services. Representatives from Montana noted that one of the main reasons the state sought to reimburse for telehealth in its Medicaid program was the severe shortage of providers in the state's rural/frontier areas. This urgent need may be the reason for Montana's less detailed and possibly broader telehealth policies when compared with those of other states.

While some states reported that reaction to telehealth-delivered care from providers and enrollees had been positive, they cited some challenges providers face when initiating and maintaining these services. These challenges included the cost of equipment to start a telehealth program and, most significantly, confusion over how to bill—despite the length of time most of these programs have been in place.

In the interviews, it was noted that telehealth policies from other sectors have an impact on the utilization of telehealth by providers. State licensing boards such as the medical board may impose certain requirements on their licensees as to how telehealth is used in their practices. These factors may create enough of a burden to discourage a provider from utilizing the technology. The impact of the licensing board policies echoes some findings in the private payer interviews.

Oklahoma Medicaid noted that it conducts, on average, 10,000 telehealth visits annually. The Texas Medicaid program is legally required to provide a report to the legislature every two years. The most recent report (December 2016) notes that utilization of telehealth has grown steadily over the years, with the number of providers increasing as well. Behavioral health remains a much in-demand service.⁹ Although representatives from Virginia did not have figures, they estimated that telehealth is being underutilized in Medicaid. Other interviewees did not provide utilization data or information.

Key Takeaways from Medicaid Interviews

- Private payer laws have little impact on Medicaid telehealth policies unless they are explicitly written into the law.
- Some Medicaid programs have defined lists of services and providers for which they will reimburse, while others have broader policies.
- Providers face challenges in implementing telehealth programs, such as cost of equipment and understanding how to bill.
- Other sectors' policies, such as licensing boards' requirements, affect the spread of telehealth.
- Most Medicaid programs pay the same for telehealth-delivered services as they do for in-person services.

Discussion

Based on the findings of this study, several issues have emerged regarding the underutilization of telehealth-delivered care in states, despite attempts to encourage its use with the passage of private payer reimbursement laws.

Examples of Potentially Problematic Private Payer Law Language

All sample states listed below lack language in their telehealth private payer laws that would require payment parity for telehealth-delivered services.

Language that provides health plans latitude to limit reimbursement to certain services:

California – Health & Safety Code Section 1374.13(c)

No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, *subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.*

Virginia – Code of Virginia Section 38.2-3418.16(C)

An insurer, corporation, or health maintenance organization shall not exclude a service for coverage *solely* because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

Language that explicitly limits the services that are required to be reimbursed:

Arizona – Arizona Code Section 20-841.09(A) & (E)(1)

All contracts issued, delivered or renewed on or after January 1, 2015 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the subscriber and a health care provider and provided to a subscriber receiving the service in a rural region of this state.

“Health care services” means services provided for the following conditions or in the following settings:

- (a) Trauma
- (b) Burn
- (c) Cardiology
- (d) Infectious diseases
- (e) Mental health disorders
- (f) Neurological diseases including strokes
- (g) Dermatology

Language that limits where reimbursable telehealth services may take place:

Tennessee – Code Title 56. Insurance Section 56-7-1002(a)(4)

“Qualified site” means the office of a healthcare services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal Medicare regulations, a federally qualified health center, any facility licensed under title 33, or any other location deemed acceptable by the health insurance entity.

Location Limitations

Limits on where patients may receive services appeared to have minimal restrictions either in statute or private payer policies. Geographic limitations were practically nonexistent, and private payers were more willing to allow nontraditional sites such as the home and workplace to act as originating sites for telehealth services (although Medicaid programs tended to stay with health care facilities as eligible sites).

However, other factors provided room for some private payers to create limitations within their telehealth policies, either intentionally or not.

Inclusion/Exclusion of Language

Private payer laws, generally aimed at encouraging uptake in the use of telehealth, may not have been crafted to provide the expanded opportunities for telehealth that policymakers intended. The absence of specific language or inclusion of ambiguous language can create situations that impede the greater utilization of telehealth. For example, just over 41% of the states with private payer laws have a variation of the phrase “subject to the terms and conditions of the policy of the payer” embedded within that law. Yet, the definition or intent of that phrase is unclear and open to interpretation. For providers such as large medical systems, this ambiguity can create a billing nightmare when multiple payers have different terms and conditions for telehealth care.

Virginia provides an example of a “loophole” in the private payer law. The law states, “An insurer, corporation, or health maintenance organization shall not exclude a service for coverage *solely* because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact...”¹⁰ If a payer finds a reason not to cover a telehealth service that is not based on the use of telehealth, it would be well within the law.

Parity in Payment

In 28 states and the District of Columbia, private payers were not legally required to reimburse telehealth services at the same rate as in-person services. It did not appear, however, that many private payers were reimbursing less for telehealth-delivered services than for in-person services. However, a recent action by a payer in New York may be the start of a new trend. The passage of the telehealth parity law in New York did not include payment parity language. After the law went into effect, Excellus Blue Cross Blue Shield notified providers in its network that reimbursement for telehealth-delivered services would be 50% less than what was paid for in-person services.¹¹ Excellus was well within the law to establish that policy. While this appears to be an isolated case, it demonstrates that the lack of a clear payment parity mandate in a telehealth law gives health plans the discretion to set its own reimbursement/payment amounts for telehealth care at lower rates than for comparable in-person care, in effect creating a disincentive for providers to utilize telehealth modalities. Minnesota is one of the states with explicit payment parity language and can serve as a model for other states considering amending or passing a telehealth payment parity law.

Modality

As noted earlier, there is evidence that modalities other than live video offer effective care with favorable patient outcomes and cost savings. Yet, while all private payer laws cover live video, 71.9 % and 56.3% include reimbursement for store-and-forward and RPM, respectively. Although there appears to be no restriction on private payers reimbursing for these modalities even if the law does not require them to, many payers, both public and private, are hesitant to do so, preferring to only reimburse for live video and not for the other two modalities. The lack of acceptance of these other modalities ensures that only part of telehealth's potential is realized.

Services and Providers

Few private payer laws impose any limitations on the type of provider or service that can be reimbursed. However, the laws in these states may lack language specifically addressing providers or services, leaving it to the discretion of a private payer to set policies that define reimbursement. In the interviews conducted with private payers, almost all said they did not have limits on the type of provider who may utilize telehealth and be reimbursed. However, the interviewees placed limitations on the type of services reimbursed when the services were provided via telehealth. For example, while a payer may reimburse for a variety of health care providers, the payer may only reimburse for a limited set of services, such as an office consultation, and not for other services a practitioner may provide via telehealth.

Many reasons were given for these limitations, including the need to have an established provider-patient relationship, belief that certain services could not be adequately provided via telehealth, and billing issues using the current procedural terminology (CPT) codes. To receive payment, a provider submits a claim noting the CPT code that correlates to the service provided. But CPT codes were not designed with telehealth in mind. Some codes require in-person contact between provider and patient. Telehealth providers have struggled with these concerns for some time. The discrepancy between facets of telehealth and CPT codes has led to the American Medical Association's recent work on telehealth-specific CPT codes that will presumably address such issues.

As an alternative, some payers ask telehealth providers to bill a general office consultation code, a practice that both Medicare and some Medicaid programs also employ. However, doing this might discourage providers from using telehealth since the amount of reimbursement for a general office consultation may be lower than what the provider is entitled to when billing with the proper CPT code. CPT codes represent an obstacle to using telehealth for every service.

Other Factors that Could Influence Use of Telehealth

Beyond reimbursement policies, other factors play a role in influencing the utilization of telehealth-delivered care. Interviewees from the public and private sectors noted that both provider and patient hesitancy or lack of knowledge of telehealth deter its use. Provider and consumer education are not factors of any existing private payer law. Policymakers may wish to consider how both providers and health care consumers can learn about the benefits of telehealth modalities and any changes in the law. This type of consumer education could take the form of requiring health plans to provide adequate information to providers and enrollees, or the state could consider taking a more active educational role. Additionally, specialized training, especially in Medicaid programs, could be offered to providers so they may better understand how to properly bill for telehealth-delivered services.

Other requirements in law or by licensing boards can place additional burdens on providers utilizing telehealth, which could find their way into private payer policies, as noted earlier in some of the private payer interviews. The actions of state licensing boards can have an impact on the success of a telehealth reimbursement policy. If licensing board policies are too burdensome for licensees, they will hesitate to provide services via telehealth. This reduces the number of telehealth providers and the utilization of telehealth. While it is understandable that regulatory boards wish to ensure the health and safety of patients, these policies should provide licensees with the flexibility to utilize the technology when they deem it appropriate and safe.

Contracting with a third-party provider has become increasingly common among private payers, so much so that many might favor using only a contracted third-party entity to provide services via telehealth under a commercial plan and not involve their established network providers. While none of the interviewees indicated this type of favoritism, CCHP has learned that in two states, not among the six sample states, there is concern that this type of third-party provider contracting is edging out network providers. As interviewees indicated, many third-party contractors only see less complex clinical cases. If in-network telehealth providers are not allowed to utilize and be reimbursed for telehealth care, payers will limit the extent of services and conditions that can be treated via technology and possibly create disparate levels of care. There may also be a lack of integration of information to a primary care provider with the use of the third-party contractors, which impacts the continuity of care for patients.

Conclusion

Telehealth-delivered health care continues to have great promise, but policy obstacles inhibit the full potential of these technologies to achieve the Triple Aim of better health outcomes, improved patient and provider experiences, and increased efficient use of resources to lower costs. It is clear from this study that there is a broad misconception that, because telehealth private payer laws are in place in many states around the country, telehealth is achieving its promise of providing the same patient benefit and payment as in-person care. The reality is that many private payer laws have been weakened by their lack of clarity and often contain clauses that may negate much of the intent of the legislation. More careful crafting of the language for these laws and a more comprehensive implementation plan will assist in greater utilization of telehealth to deliver health services. Also, further analysis should be considered in the future to assess the impact of specific payment parity laws in Delaware, Hawaii, and Minnesota after they have been in place for at least three years.

Considerations for Policymakers

- Consider using explicit language in private payer laws that details the exact intent of policymakers, such as ensuring all modalities are to be reimbursed by private payers.
- Ensure that payment parity language is included in the laws if it is the intent of policymakers to have telehealth reimbursed at the same rate as in-person services.
- Consider inclusion of some type of education component for both providers and consumers.
- Consider a robust, comprehensive telehealth policy within the state Medicaid program.
- Work with state licensing boards to create telehealth policies that allow licensees the flexibility to utilize technologies in delivering care but still take into consideration the safety of the patient.

Appendix A

Failed Past Legislation

Over the last few years, states have introduced a multitude of telehealth legislation. Collectively, most of this legislation failed to pass, although approximately 30% to 40% of bills did pass. Many of these bills involve private payer reimbursement and/or reimbursement in a state Medicaid program. By examining these bills, especially if bills on the same subject passed in subsequent years, a picture begins to emerge about the elements that, if not present, affect the eventual passage or failure of the legislation. Additionally, an examination of this kind also provides a history of a state's attempts at passing private payer and/or Medicaid reimbursement.

Methodology

To translate the failed bills into quantifiable data, two researchers conducted a content analysis. Fourteen factors were examined for private payer bills and 11 factors were looked at for Medicaid bills. The factors were based on the most common features found in telehealth reimbursement language. These factors were also cited as barriers by telehealth advocates if they were missing or restrictive because the opportunities to use and receive reimbursement for telehealth would be limited.

Some legislation included both a private payer and Medicaid reimbursement provision. These bills were evaluated through both the private payer and Medicaid filter noted above.

Each factor was rated with a score of "1" if it appeared in the bill and a score of "0" if it was absent. For example, if a private payer bill allowed for reimbursement for three modalities of telehealth (live video, store-and-forward, remote patient monitoring), the bill was scored as a three—one point for each type of reimbursement. If the bill did not cover reimbursement of any of the three modalities, the researcher scored it as a "0" for each modality.

For private payer bills, a perfect score of "14" (or 100%) was possible or "11" (or 100%) for Medicaid bills.¹² Only failed legislation in the years 2013, 2014, and 2015 were

Private Payer Laws Scoring Factors

- Did the legislation allow for some form of telehealth private payer reimbursement?
- Did the legislation contain a mandate?
- Did the legislation require parity in payment?
- Did the legislation allow for live video reimbursement?
- Did the legislation allow for store-and-forward reimbursement?
- Did the legislation allow for remote patient monitoring reimbursement?
- Did the legislation refrain from placing a geographic limitation?
- Did the legislation refrain from limiting originating sites?
- Did the legislation refrain from limiting providers?
- Did the legislation refrain from limiting specialties?
- Did the legislation refrain from requiring a telehealth-specific informed consent?
- Did the legislation refrain from requiring a health care provider to be present at the originating site?
- Did the legislation exclude a requirement that makes a mandate "subject to terms and conditions"?
- Did the legislation include Medicaid?

examined (the 2016 legislative session had not been completed for all states at the time this research took place). Using LexisNexis, the researchers searched for and selected all private payer or Medicaid reimbursement bills introduced in all 50 states and the District of Columbia in the selected years that did not pass. Some states introduced the same bills simultaneously in both houses. If one bill eventually was passed, the other bill was not included in this analysis.

Once the bills were retrieved either through LexisNexis or through the state's legislative website, two researchers independently scored the bills. Their findings were then compared and, if a difference rate of over 5% was found, the researchers discussed reasons to determine what led to the differences (different interpretation of language, misreading, etc.) and revisited their scoring. Once the differences were below 5%, the lead researcher on the project scored each bill and compared the scores with what the two researchers found. If the difference rate between the lead and the two researcher findings was over 5%, all three researchers met to determine the reasons for the differences. In this study, the scoring on any items between the two parties did not exceed 5%. In cases where the researchers differed on what score to give a feature, the lead researcher made the final determination. Each bill was then given a percentage score, based upon the presence of the positive qualities found in each bill.

Analysis

Twenty-nine states introduced legislation that was related to private payer and/or Medicaid reimbursement for telehealth over the 2013 to 2015 legislative periods. If legislation failed in a previous year, many of the states introduced another private payer bill the following year. Interestingly, not all states that had a bill the following year modified it to contain less expansive features. Several states simply reintroduced the same bill that had failed or had bills that were more expansive than the previous year. Of the 29 states that had failed private payer and/or Medicaid legislation in 2013 to 2015, seven states eventually passed private payer laws. Of those states that passed laws after having failed legislation, those successful bills were generally narrower than the legislation that failed previously.

Appendix A. Table 1. States that Passed Private Payer Laws after Previous Legislation Failed

STATE	FAILED LEGISLATION SCORE YEAR 1	FAILED LEGISLATION SCORE YEAR 2	PRIVATE PAYER LAW IN STATUTE SCORE
Connecticut	85.7%	78.6%	71.4%
Indiana	—	78.6%	71.4%
Illinois	78.6%	64.3%	57.1%
Minnesota	92.9%	100.0%	100.0%
New York	81.8%	81.8%	92.9%
Oklahoma	85.7%	85.7%	85.7%
Rhode Island	85.7%	78.6%	71.4%

Minnesota, New York, and Oklahoma had equivalent or more expansive legislation that eventually passed, but the other states passed scaled-down bills. This indicates that limiting the ambitions of private payer reimbursement may have assisted in eventual passage. Another factor that may have affected the success of legislation was the representative makeup of the state legislatures, but a detailed analysis of this is beyond the scope of this study.

It should be noted that each factor examined was weighted equally. Different parties may weigh certain factors more heavily than others. Therefore, a bill that scored 71.4% may, in some parties' view, be better than a bill that scored 85.7%. For example, one state may view reimbursable live video, store-and-forward, and remote patient monitoring as more important factors than not having an expansive list of providers who are eligible for reimbursement.

Overall, the most common factors found in nearly all bills were:

- A mandate to cover services if they are provided via telehealth;
- Including live video in that coverage of service; and
- Exclusion of a provider with the patient during a telehealth interaction.

The most common factors missing from the legislation were:

- A specific mandate to pay an equal amount for services regardless of whether they were delivered via telehealth or in person;
- Inclusion of store-and-forward and/or remote patient monitoring for reimbursement; and
- Imposing a geographic restriction.

These factors indicate that while policymakers may be comfortable with requiring reimbursement for live video, they are not as open to including store-and-forward and RPM modalities. Additionally, unlike Medicare, which imposes a geographic restriction on telehealth services, state policymakers are less inclined to require that limitation when developing policy that applies to private payers.

Ten of the 29 states with failed legislation included a Medicaid factor in those bills. Most private payer laws ignore Medicaid, though some states will introduce solo Medicaid legislation. There were a variety of reasons for the lack of Medicaid inclusion, including that a state Medicaid program may already be reimbursing for telehealth. For example, 48 states and the District of Columbia currently reimburse for some live video services.¹³ Another likely factor is cost concerns in Medicaid.

However, one significant omission must be addressed in private payer laws—a mandate to pay the same amount for services regardless of how they are delivered, via telehealth or in person. The majority of state private payer laws lacked this specific language. In general, it has not proven to be an issue because private plans appear to be reimbursing the same for services regardless of how they are delivered. However, in 2016 in New York, a private payer issued a notice to its providers indicating that it will pay 50% of what would be paid for in-person service if the service was delivered via telehealth. New York’s private payer law lacks a specific requirement to pay the same amount. This may be the start of a trend in states that do not require a private payer to reimburse for the same amount.

Additionally, another feature noted in the scoring is the inclusion in some private payer laws the phrase “subject to the terms and conditions of the contract.” This phrase, depending on whether there is clear direction in the legislative language, can act as a loophole for private payers to impose limitations on telehealth. Does the phrase refer to contracts between the payer and enrollee? If so, then the terms and conditions will most likely be the common ones seen, such as co-pay language or requirements about seeing an in-network provider. Or does the language refer to contracts between the payer and provider? In this case, the payer may put limitations on how and when telehealth is used.

Appendix B

Detailed Methodology in Calculating Baseline for Current Telehealth Private Payer Laws

The Center for Connected Health Policy selected a set of key factors to examine the impact of when and how telehealth is reimbursed under private payer laws. These factors were identified as those that impact the utilization of telehealth based upon the effect they had under Medicare policy for limiting telehealth expansion. Additional features were selected either because they were common policies in state telehealth reimbursement laws or by their very nature imposed restrictions or mandated policy to encourage use of telehealth. Five distinct factors were looked at:

1. Inclusion/exclusion of language—Is the presence or lack of certain language or phrases a help or hindrance to the utilization of telehealth?
2. Parity in payment—Does the law require that a payment amount for telehealth-delivered services be equal to that which is given for in-person services?
3. Modality—Are there any limitations on what type of telehealth modality to be used?
4. Location—Are there any limitations on where a telehealth service can take place?
5. Providers and specialties—Are there any limitations on the types of providers who may provide services via telehealth and/or the types of specialty it can be used for?

A list of 14 questions (See page 23.) was developed to address the five factors above. The questions were structured so if the answer was “yes,” it was considered a positive result in favor of progressive telehealth policy since no limitation appeared to be in place. Each factor was rated with a score of “1” if the response to the question was a “yes” and a score of “0” if it was a “no.” For example, if a private payer law allowed for reimbursement for three modalities of telehealth (live video, store-and-forward, remote patient monitoring), the bill was given a score of three—one point for each type of modality. If the bill did not provide reimbursement for any of the three modalities, the researcher scored it as a “0” for each modality. The higher the score, presumably the higher the probability that the law would create a more favorable environment for telehealth.

The bills were retrieved either through LexisNexis or through the state’s legislative website with two researchers independently scoring the bills. Their findings were then compared, and if a difference rate of over 5% was found, the researchers discussed reasons to determine what led to the differences (different interpretation of language, misreading, etc.) and resolved their differences until their difference rate was below 5%. The lead project researcher independently scored each bill and compared the score with those of the two researchers. If the difference rate between the lead and the two researchers’ findings was over 5%, all three researchers met to determine the reasons for the differences. In this study, the scoring on any item between the two parties did not exceed 5%. In cases where the researchers differed on what score to give a feature, the lead researcher made the final determination. Each bill was then given a percentage score based upon the presence of the positive qualities found in each bill. See Table 1 for how each law scored.

Appendix B. Table 1. Scoring of Telehealth State Private Payer Laws

State	Mandate to Cover Tele-health	Parity in Payment	Live Video Included	Store-and-Forward Included	Remote Patient Monitoring Included	No Geographic Limit	No Site Limit	No Limit on Type of Provider	No Limit on Type of Specialty	Additional Informed Consent Not Required	Presenter with Patient Not Required	Subject to the Terms and Conditions	Medicaid Included	Score
AK	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N	71.4%
AZ	Y	N	Y	N	N	N	Y	Y	N	Y	Y	Y	N	57.1%
AR	Y	N	Y	N	N	Y	N	Y	Y	Y	Y	N	Y	64.3%
CA	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	78.6%
CO	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	78.6%
CT	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	71.4%
DE	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	85.7%
DC	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	78.6%
HI	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	85.7%
IL	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	57.1%
IN	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	71.4%
KY	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	85.7%
ME	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	71.4%
MD	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	71.4%
MI	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	64.3%
MN	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	N	N	100.0%
MS	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	85.7%
MO	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	85.7%
MT	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	N	57.1%
NE	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	78.6%
NV	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	92.9%
NH	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	78.6%
NM	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	85.7%
NY	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	92.9%
OK	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	85.7%
OR	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	N	N	64.3%
RI	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	N	N	71.4%
TN	Y	N	Y	Y	N	Y	N	Y	Y	Y	Y	N	Y	71.4%
TX	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	85.7%
VT	Y	N	Y	Y	N	Y	Y	Y	N	N	Y	N	Y	64.3%
VA	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	85.7%
WA	Y	N	Y	Y	N	Y	N	Y	Y	Y	Y	N	Y	71.4%

Appendix C

Questions Asked in Private Payer Interviews

- Besides live video, does your organization reimburse for any other modalities, i.e., store-and-forward or remote patient monitoring?
- Does your plan reimburse for eConsult (physician-to-physician secure email consults)?
- Does your plan reimburse the same services through telehealth as you would through in-person? Or do you have a specific list of telehealth codes you will reimburse for?
- Does your plan have any restrictions on location? Can the patient be located in their home?
- Does your plan reimburse at the same rate for telehealth services, as you would for in-person services?
- In the year that the private payer law went into effect, did your plan's telehealth reimbursement policy change at all?
- Does your plan have any data on telehealth utilization that you can share? For example, do you know how many telehealth interactions occur each year under your plan?
- Has there been a noticeable impact on cost, quality, or outcomes?

Appendix D

Questions Asked in Medicaid Interviews

- Why did your state Medicaid decide to reimburse for telehealth?
- What were some of the factors that led your state to shape the current telehealth policies in Medicaid?
- What has been the response to telehealth from Medicaid providers? Enrollees?
- What pros/cons has the state Medicaid program seen in adopting telehealth policies?
- What barriers do you see to greater usage of telehealth to deliver services?
- Is your state Medicaid program considering expanding your telehealth policies?
- Did passage of the state private payer law impact the Medicaid policies in any way?
- Do you have any usage data that you will be able to share?

Notes

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- ⁷ Not all laws have gone into effect.
- ⁸ Hughes M, Bell M, Larson D, Weems J. National Rural Health Association policy brief: telehealth reimbursement. [https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/TelemedicineReimbursementMay2010-\(1\).pdf.aspx?lang=en-US](https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/TelemedicineReimbursementMay2010-(1).pdf.aspx?lang=en-US). Published May 2010. Accessed January 30, 2017.
- ⁹ Texas Health and Human Services Commission. Telemedicine, telehealth, and home telemonitoring services in Texas Medicaid. December 2016.
- ¹⁰ Code of Virginia, Sec. 38.2-3418.16(C).
- ¹¹ Excellus Blue Cross Blue Shield. Important information for our health care provider partners. <http://www.cchpca.org/sites/default/files/uploader/Excellus%20on%20Telemedicine%2005052016%20%28003%29.pdf>. Published April 29, 2016. Accessed January 31, 2017.

- ¹². The Medicaid questions list contains three fewer questions because these elements were not typically found in Medicaid legislation, though they were in private payer legislation. These questions were: (1) Did the legislation require parity in payment? (2) Did the legislation refrain from requiring a health care provider to be present at the originating site? and (3) Did the legislation exclude a requirement that makes a mandate “subject to terms and conditions”?
- ¹³. Center for Connected Health Policy. State telehealth laws and reimbursement policies: a comprehensive scan of the 50 states and the District of Columbia. <http://www.cch-pca.org/sites/default/files/resources/50%20STATE%20PDF%20FILE%20APRIL%202017%20FINAL%20PASSWORD%20PROTECT.pdf>. Published April 2017. Accessed July 17, 2017.

About the Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a nonpartisan public interest organization working to maximize telehealth's ability to improve health outcomes, care delivery, and cost effectiveness. CCHP was established in 2008 with funding from the California Health Care Foundation (CHCF), and is a program of the Public Health Institute, an independent, nonprofit organization dedicated to promoting health, well-being, and improving the quality of life for people throughout California, across the nation, and around the world. CCHP is a resource for California and other state and national health care decision makers providing technical support that can lead to a more receptive policy environment for provision of telehealth services. CCHP conducts objective policy analysis and research, makes nonpartisan policy recommendations, and manages innovative telehealth demonstration projects. In 2012, CCHP became the federally designated National Telehealth Policy Resource Center (NTPRC) providing technical assistance to 12 Regional Telehealth Resource Centers nationwide, and serves as a national resource on telehealth policy issues. The NTPRC-Policy project is made possible by a grant from the Office of the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services. www.cchpca.org/

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