



## State Policy Toolkit Improving Access to Covered Services for Telemedicine

Telemedicine (called telehealth in some states) has allowed states to recognize the value of innovative health policy reforms that achieve significant cost savings and improved health outcomes. Through education, outreach, and engagement of key stakeholders, we have witnessed a growth in state-level legislative and regulatory activity affecting the coverage and utilization of telemedicine. ATA is committed to establishing innovative policies and practices within states, communities, and organizations that fully realize the benefits of telehealth.

This toolkit offers a list of suggested policy changes, model legislative language, talking points, and a guide for promoting discussion and potential action for telehealth policy changes.

### IMPORTANT FEATURES OF GOOD TELEHEALTH POLICY

**No Artificial, Non-Medical Restrictions** – States, like most payers, often impose a variety of restrictions on telehealth. Goal #1 is to remove them and Goal #2 is to prevent new ones. Examples of such obstructive policies include: geography/distance limitations, requirements for an established patient-provider relationship or in-person exam, patient setting and provider-type restrictions, and limits on applicable technology.

**State-wide Parity for Coverage** – Telehealth-provided services should be covered to the extent and in a similar manner as in-person services. At the state level this includes three major payers: private insurance, Medicaid, and state employee coverage. The most progress for parity is with private insurance. Notably 19 states require such parity and many have more than 10 years successful experience this requirement.

**Flexibility** – Although telehealth is dynamic and evolving, state statutes are often static and can be inflexible. Legislation should establish clear and basic priorities for which states can build on for future health policy improvements. A state should regularly assess existing telehealth policies for improvements, and update those policies when new clinically appropriate telehealth applications are developed. Remember that repealing provisions can be just as arduous as adding them.

### OVERVIEW OF CURRENT TELEHEALTH COVERAGE AND REIMBURSEMENT

#### *MEDICAID*

All states allow reimbursement for physician services that do not require direct interactions with a patient such as for radiology or reading an EKG. Forty-four states have some Medicaid coverage for other remote video or store and forward services, usually for services in rural areas. The details of state Medicaid coverage vary widely and are seldom exactly the same as in-person coverage for a specific service.

- 39 states have some coverage for **telemental health**: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North

Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

- 17 states have some form of coverage for **home telehealth**: Alabama, Alaska, Arizona, Colorado, Indiana, Kansas, Kentucky, Minnesota, New Mexico, New York, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, and Wisconsin.
- 11 states have some form of coverage for **remote patient monitoring**: Alabama, Alaska, Colorado, Kansas, Minnesota, New York, Pennsylvania, South Carolina, South Dakota, Texas (rules under development) and Washington.
- 7 states have some form of coverage for **store-and-forward based services**: Alaska, Arizona, California, Illinois, Minnesota, Oklahoma, and South Dakota.

The variations in Medicaid policies for telehealth relate to service coverage, payment methodology, distance requirements, eligible patient populations and health care providers, authorized technologies, and patient consent. Some states prefer to follow Medicare's statutory and regulatory guidance on telehealth services when devising their own state plans, which may result in the authorized coverage of only real-time audio-video interactions, while excluding remote monitoring and store-and-forward transmissions, or coverage in only rural areas or limited clinical settings. These policy decisions can also be driven by resistance to outside competition by established providers, budget constraints, public health needs, available infrastructure, or provider readiness – or simply tradition. Unfamiliarity of successful telehealth policy models and a poor understanding of how telehealth can be integrated into existing health delivery systems have resulted in disparate coverage.

Telehealth coverage is not guaranteed to be applied to all services that are offered in-person. For example, Idaho's Medicaid program will only reimburse for a limited number of mental health services delivered via telehealth. Michigan requires a minimum distance of 50 miles between an originating and distant site to qualify for Medicaid reimbursement.

However, good examples also exist. New Mexico is one of few states that reimburses for telehealth-provided services delivered in the home and school. Other states like California have enacted policies containing provisions worth modeling. California's telehealth provisions are a good example of concise policymaking that recognizes telehealth as a legitimate delivery method, and also omits artificial barriers such as requiring in-person contact or limiting the type of setting for a telehealth encounter:

*Section 14132.72 – Welfare and Institutions Code*

*(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.*

*(c) In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. Nothing in this section or the Telehealth Advancement Act of 2011 shall be construed to conflict with or supersede the provisions of Section 14091.3 of this code or any other existing state laws or regulations related to reimbursement for services provided by a noncontracted provider.*

*(d) The department shall not require a health care provider to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.*

*(e) For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.*

## ***PRIVATE INSURANCE COVERAGE***

Nineteen states have enacted laws mandating the coverage of telehealth-provided services under private health insurance plans:

California (1996)	Maryland (2012)	Oklahoma (1997)
Colorado (2001)	Michigan (2012)	Oregon (2009)
Georgia (2006)	Mississippi (2013)	Texas (1997)
Hawaii (1999)	Missouri (2013)	Vermont (2012)
Kentucky (2000)	Montana (2013)	Virginia (2010)
Louisiana (1995)	New Hampshire (2009)	
Maine (2009)	New Mexico (2013)	

Considerable progress has been made over the past few years, but not been without its challenges. Many commercial insurers continue to oppose legislative proposals that require them to cover telehealth-provided services at a rate comparable to that of in-person services, even when they offer such services themselves.

## **TALKING POINTS IN SUPPORT OF TELEHEALTH**

ATA is starting to identify and publicize summaries of a few of the leading research studies that evaluated the cost effectiveness, quality of care and patient acceptance of telemedicine. In addition, some leading, validated studies have been identified by many of ATA's Member Groups. This information is available on the ATA web site at <http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine-s-impact-on-healthcare-cost-and-quality.pdf?sfvrsn=4>.

Empower consumer choice -- Patients should be able to choose how they receive a covered service, including considerations for their urgency, convenience and satisfaction. They should not be penalized with higher deductibles, copayments, or coinsurance than that of in-person services for using such cost-saving and quality-improving methods like telehealth to enrich population health.

Reduce disparities in access to care -- For many people access to in-person services is very difficult for a wide variety of reasons, notably their mobility limitations, major distance or time barriers, and transportation limitations (don't drive, have a car or have transit available). Telehealth will allow those living in a community to receive critical and life-saving treatment regardless of economic means, physical ability, or residence.

Enhance physician availability -- Many areas already have a shortage of needed health care providers. This is exacerbated by policies in most states that do not allow interstate practice of medicine, requiring all clinicians to obtain their state's license. Another problem that communities face is a lack of providers willing to treat patients who subscribe to a particular payer (usually for reimbursement reasons). Despite health insurance reforms that are taking place, these problems are only expected to worsen. Telehealth and policy changes that allow interstate licensure can reduce provider practice costs, improve their productivity, and facilitate triaging for specialty care.

Improve quality of care -- It is important to identify key health status indicators in the state that can be improved with telehealth access (e.g. infant mortality, stroke related disability, hospital and emergency room readmissions, medication adherence).

Innovative payment and service model design -- Each state, as the regulator of insurance policies offered to its

citizens, has a strong and vital interest in taking advantage of health care delivery innovations, especially to improve quality, reduce costs, improve timely access to needed care, and improve citizen satisfaction. Complementing telehealth delivery with innovative payment models like value-based purchasing or medical homes will foster a modern and collaborative healthcare environment.

## **REBUTTING COMMON ARGUMENTS OPPOSING TELEHEALTH COVERAGE**

Increased Costs – Costs for the state and policyholders are a key consideration for legislators. State action often involves an analysis of state budget impact. The situation is very different between private insurance coverage and state-funded services.

Some opponents have made claims that there is not enough evidence related to cost and utilization for telehealth and have used assumptions that it would result in increased insurance premiums. For example, in 2012, Vermont legislators were considering a parity bill that would cover private insurance and Medicaid. One of the state's third party administrators for the state employee health insurance plan claimed that if passed, the bill would cause an increase in provider consultations and ultimately a .1 - .2 percent increase in premiums. Alternatively, Maine, which considered a parity bill in 2009, reported that parity would have no direct fiscal impact on State agencies and programs. Legislators in both states successfully enacted their parity bills into law. Other states like Mississippi and Montana recently passed their respective parity bills with overwhelming bipartisan support and without issuing fiscal notes.

In addition to some of the studies that have been published, it is important to note that Medicare (the payer with the most people covered for telehealth) spending for telehealth was only about 49¢ per year per covered beneficiary in 2011 (this is a gross, not net cost).

### *Regarding private insurance parity:*

- Parity legislation does not increase covered services, but explicitly recognizes telehealth as a way to deliver the covered services. This is unlike other common insurance mandates, such as vision services.
- Many private insurers already cover telehealth-provided services under their benefit coverage. For example, if a policy covers “physician services” then there is no basis to deny a telehealth-provided covered physician service. If politically important, legislators could include a provision, as did Oregon, which states: “*This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan or to reimburse a health professional who is not a covered provider under the plan.*”
- There has also been expressed concern that, if barriers to access are removed, policyholders will excessively use their benefit. There is no evidence to support this claim.

### *Regarding Medicaid parity:*

Telehealth coverage in most states is still relatively small so it is hard to predict budget impact or growth in usage as telehealth services become more robust and visible. It can also be difficult since each state's plan varies in its reimbursement policy. In addition, a rapidly growing number of Medicaid recipients are covered under managed care plan that often involve competitive bidding and capitated payments instead of fee-for-service.

States like California, Colorado, Kentucky, Texas, and Vermont have all conducted fiscal analyses for their enacted telemedicine expansion legislation which reported minimal or no fiscal impact on the state or Medicaid programs. Recently Maryland legislators considered 2 bills that would have expanded the coverage of

telemedicine-provided services under their Medicaid program. Unlike the aforementioned states, Maryland's fiscal analysis included estimates by the state's Department of Health and Mental Hygiene which suggested that telehealth coverage would cause a 2 percent increase in the use of physician services and ultimately increase Medicaid expenditures by \$6.3 million in FY 2014 and \$8.5 million in FY 2015. Despite these costs, the Maryland Health Department estimated a net savings of \$0.9 million in avoided transportation costs and \$1.6 million in avoided emergency department admissions.

Mandating Parity -- Commercial insurers often oppose, as a philosophical principle, almost any state requirement. Here is some alternate language that could be proposed to address these concerns:

- a) *This section shall not be interpreted to authorize a plan to require the use of telemedicine when the health care provider has determined that it is not appropriate.*
- b) *A plan may subject coverage of a telemedicine service under this section to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service provided in person.*

Other challenges to telehealth parity bills involve protections on cost-sharing. Some opponents claim that private insurers should be allowed to apply different or greater charges to patients who use telehealth. If allowed, such a policy would not achieve parity. Provisions like the one below, act as a consumer protection against such deviant practices. If a private payer states that they will cover a healthcare service, then a consumer should expect that service will be covered at the same rate whether in-person or via telehealth.

*A health insurer may require a deductible, copayment, or coinsurance amount for a healthcare service delivered through telehealth, provided, that the deductible, copayment, or coinsurance amount may not exceed the amount applicable to the same service when it is delivered in person.*

Medicare Influence – As the nation's largest single payer for health care, Medicare is often used by other payers for guidance on specific aspects. Unfortunately, Medicare coverage is restricted by an outdated law. In contrast, federal Medicaid law gives the states flexibility for telehealth coverage – and the Medicare restrictions have no application to Medicaid. States have the option/flexibility to determine whether (or not) to cover telemedicine; what types of telemedicine to cover; where in the state it can be covered; how it is provided/covered; what types of telemedicine practitioners/providers may be covered/reimbursed (as long as such practitioners/providers are “recognized” and qualified according to Medicaid statute/regulation) and how much to reimburse for telemedicine services.

Malpractice – Another argument that may be posed is that telemedicine increases a provider's medical liability. This is largely a baseless scare. There have been very few liability claims. Instead, the more recordable nature of telemedicine improves documentation. It should be noted that some increasing case law points toward liability for not using telehealth as it becomes the new standard of care.

“Essential Health Benefits” – There is still some false but lingering opposition to private insurance parity related to each state's definition of “essential health benefits” developed in response to the federal Patient Protection and Affordable Care Act. In such cases telehealth should be recognized not as a “benefit,” but as a way to provide a benefit. Of course, services that are not otherwise covered by the insurance company would not be covered when delivered via telemedicine. Providers may only bill procedure codes in which they are already eligible to bill.

## **MODEL STATE LEGISLATIVE LANGUAGE**

### ***Telemedicine for Quality Improvement and Healthcare Modernization Act***

A bill to expand patient access to healthcare services, improve quality of care and reduce costs through the use of telemedicine

**PREAMBLE:** Telemedicine can efficiently improve access and quality of care for underserved patients by providing consultations and specialty care. Remote monitoring and home telehealth can help the chronically ill stay at home and out of hospitals and emergency rooms, dramatically reducing costs. Today, more and more people are taking advantage of telemedicine and e-health opportunities. But such services are not available for everyone and action is needed in the states to assure that all Americans receive the benefits available through telemedicine.

**DEFINITION:** The definition of telemedicine services shall be the use of synchronous video conferencing, remote patient monitoring, and asynchronous health images or other health transmissions supported by mobile devices (mHealth) or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the provider is located relating to the health care diagnosis or treatment of a patient.

**PRIVATE COVERAGE:** Health insurers, health care subscription plans, and health maintenance organizations shall provide coverage for the cost of telemedicine services when the services are appropriately provided through such means.

**UTILIZATION REVIEW:** Decisions denying coverage of services provided via telemedicine shall be subject to utilization review procedures.

**EXCEPTIONS:** The requirements of the bill shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made. The bill does not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, or to policies or contracts designed for issuance to persons eligible for coverage under Medicare, or any other similar coverage under state or federal governmental plans.

**MEDICAID:** The state's Medicaid plan shall not deny coverage on the basis that coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the recipient and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. Specifically included is statewide coverage, services originating from a recipients home or wherever else they may be, all health professionals authorized to provide services by a telehealth method to the extent otherwise covered in the State's plan, and timely asynchronous telehealth services.

**HEALTH HOME:** The bill shall also require (by date certain) a statewide medical assistance benefit of a health home for individuals with chronic conditions (defined under 42 U.S.C 1396a).

**REPORTING:** The state's Department of Health shall lead an interagency study and report to the Legislature within 12 months on comprehensive plans that include telehealth services and multi-payer coverage and reimbursement for stroke diagnosis, high-risk pregnancies and premature births, and emergency services.

**PROFESSIONAL LICENSING:** The state's health professional licensing boards shall modify, as necessary, requirements for telemedicine-provided practices to be the same as for in-person practices. Further, a professional should be able to consult with an out-of-state peer professional, such as a sub-specialist, without the need for an additional state license.

## PROPOSED STATE ACTION PLAN

Be prepared to plan for a multi-year campaign because it takes time to build legislative support and momentum. Don't be discouraged if your bill does not pass the first year. Here are some ideas to enhance your strategy:

1. Conducting a comprehensive campaign plan needs to include setting short, intermediate and long term goals with an evaluation process as well. It will be critical to analyze the external political environment, complete strengths-weaknesses-opportunities-threats (SWOT) analysis, determine targets and resources to meet the goals.
2. Consider grassroots and target strategies to influence policy successes that align with timelines.
3. Consider a power mapping processes to determine how to influence and gain sponsor support.
4. Develop alliances with state allies that represent key organizations and individuals who can move the issue forward. Some examples include:
  - Consumer groups, or specialty healthcare groups, such as state chapters of the American Heart Association and American Psychiatric Association.
  - State health provider groups, such as the state medical society, the state hospital association, and state telehealth networks
  - State Department of Health. The Department designates critical access hospital designations and medically underserved areas. It also provides data on workforce shortages, health status indicators and emergency preparedness.
  - Commercial insurers that support telehealth services in other states
  - The federally-funded Telehealth Resource Center for your state ([www.telehealthresourcecenter.org](http://www.telehealthresourcecenter.org))
  - Phone, cable, and internet service providers
5. Consider recruiting "power brokers," people who have influence over targets/sponsors. This could be someone like the Secretary of Health or key business executive who has investment in the issue.
6. Recommendations and planning should also include a current review of existing statutes and or regulations that either assist or create barriers for moving telehealth forward. Consider strategies to address issues that may have solutions through a policy process. Examples could include reimbursement for services.
7. Utilize and leverage anecdotal and empirical evidence-based research from national organizations to build case for need, policy language and overall recommendations when considering working on barriers for telemedicine models.
8. Develop a cost vs. benefit analysis including district-level data which may help build your argument for the need. Look at current health data sources regarding health conditions and disparities. One question to consider, what does the health condition cost the state currently untreated vs. addressing care through diverse delivery models like telemedicine.
9. Identify a strong bill sponsor. It is important to have a key legislator introduce the telehealth bill. The following are some key considerations for choosing and supporting a sponsor:
  - Preferably choose a member in the majority party: especially in a highly partisan legislature
  - Also, focus on members of the committee of jurisdiction

- An ideal candidate is someone with a personal passion for telehealth and with strong constituent support for telehealth
- Engage the potential sponsor(s) in community based activities, announcements and ribbon cutting related to telemedicine
- Reach out to members of the National Organization for Black Elected Legislative Women (NOBEL), the National Hispanic Caucus of State Legislators, and the National Black Caucus of State Legislators whose national organizations have already endorsed model telehealth legislation.

## INFORMATION RESOURCES FOR YOU

- ATA’s website for state policy materials. This includes a listing of major legislation and ATA’s series of State Best Practices on specific telehealth applications (<http://www.americantelemed.org/get-involved/public-policy-advocacy/state-telemedicine-policy>)
- ATA’s online wiki for telehealth information. This includes state-specific pages about legislation and regulation regarding coverage and reimbursement ([www.atawiki.org](http://www.atawiki.org))
- National Telehealth Policy Resource Center and Regional Telehealth Resource Centers ([www.telehealthresourcecenter.org](http://www.telehealthresourcecenter.org))
- Center for Telehealth and e-Health Law ([www.ctel.org](http://www.ctel.org))
- For ATA members there are additional resources on the Hub (<http://hub.americantelemed.org/Home>):
  - You can find other members in your state to work with. Use the Directory tab and then “Advance Search” to enter your state. From the results, choose Export to get the resulting contact information in spreadsheet format;
  - Read ATA updates and share your news in the Blog section;
  - Join and participate or start a member group on a topic of interest, such as--
    - Medicaid Telehealth Coverage and Reimbursement Policy A-Team. This policy work group was formed to draft specific Medicaid telehealth proposals and promote ATA involvement with relevant organizations.
    - State legislation and regulation member group. Exchange information about state legislative and regulatory issues related to telehealth, such as private insurance, licensure requirements and portability, telehealth network funding, and online prescribing (not Medicaid).