American Telemedicine Association

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ATA State Telemedicine Toolkit

Improving Access to Covered Services for Telemedicine

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State Policy Toolkit
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Telemedicine (called telehealth in some states) has allowed states to implement innovative health policy reforms that achieve significant cost savings and improve health outcomes. ATA has been instrumental in the development and passage of these reforms, providing education, outreach and engagement for key stakeholders at the state level. ATA is committed to establishing and promoting effective state policies and practices, to help states—and their citizens—realize the full potential of telemedicine.

This toolkit is a resource for individuals looking to develop and/or influence telehealth policy at the state level. It includes lists of suggested policy proposals, model telehealth legislation, talking points, and a guide for promoting discussion and 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. 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. These restrictions are often arbitrary and provide no consideration for professional medical discretion, provider shortages or patient limitations. The primary goal of any responsible telehealth policy should be to eliminate these unreasonable, unnecessary restrictions on the practice of telemedicine.

State-wide Parity for Coverage – Telehealth-provided services should be covered to the same extent—and in a similar manner—as in-person services. At the state level, the payment for telemedicine involves three major payers: private insurance, Medicaid, and state employee coverage. Surprisingly, the most progress for parity is with private insurance, with most states themselves missing the boat on telemedicine's cost-savings. Notably 23 states require such parity and many have more than 10 years successful experience with 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 on which states can build 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.

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-eight states have some Medicaid coverage for other remote video or store-and-forward services. The details of state Medicaid coverage vary widely and are seldom the same as in-person coverage for a specific service.

- 48 states have some coverage for **telemental health**: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

- 23 states have some form of coverage for **home telehealth**: Alabama, Alaska, Arizona, Colorado, Indiana, Kansas, Kentucky, Massachusetts, Minnesota, Mississippi, Nebraska, New Mexico, New York, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, and Wisconsin.

- 17 states are authorized to cover **remote patient monitoring**: Alabama, Alaska, Colorado, Indiana, Kansas, Massachusetts, Minnesota, Mississippi, Nebraska, New York, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Vermont, and Washington.

- 13 states are authorized to cover **store-and-forward based services**: Alaska, Arizona, California, Illinois, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, Oregon, Tennessee, Texas, and Virginia.

The variations in telehealth Medicaid policies relate to service coverage, payment methodology, distance requirements, eligible patient populations and health care providers, authorized technologies, and patient consent. Some states 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. In 2013, Michigan rescinded their minimum distance requirements of 50 miles between an originating (patient) and distant (provider) site to qualify for Medicaid reimbursement.

However, good state-practices also exist. New Mexico is one of few states that reimburses for telehealth-provided services delivered in the home and school. 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

Twenty-seven states and the District of Columbia have enacted laws mandating the coverage of telehealth-provided services under private health insurance plans:

Arizona (2013)
Arkansas (2015)
California (1996)
Colorado (2001)
Georgia (2006)
Hawaii (1999)
Indiana (2015)
Kentucky (2000)
Louisiana (1995)
Maine (2009)
Maryland (2012)
Michigan (2012)
Minnesota (2015)
Mississippi (2013)
Missouri (2013)
Montana (2013)
Nevada (2015)
New Hampshire (2009)
New Mexico (2013)
New York (2014)
Oklahoma (1997)
Oregon (2009)
Tennessee (2014)
Texas (1997)
Vermont (2012)
Virginia (2010)
Washington (2015)
Washington, DC (2013)

Considerable progress has been made over the past few years, but not without its challenges. Many commercial insurers continue to oppose legislative proposals that require them to cover services when not provided in-person 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 the leading research studies on 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, co-payments or coinsurance relative to that of in-person services.

Reduce disparities in access to care -- Many people have a difficult time accessing in-person healthcare due to mobility limitations, major distance or time barriers, and transportation limitations (lack of a car or public transit.) Telehealth enables this vulnerable population 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 state policies that do not allow interstate practice of medicine and require all clinicians to obtain multiple state licenses. Moreover, patients in some areas may lack readily accessible providers within their payer/insurance network. Despite the health insurance reforms that are taking place, these problems are only expected to worsen. Telehealth and policy changes that improve network adequacy and allow interstate licensure can reduce provider practice costs, improve their productivity, and facilitate triaging for specialty care.

Improve quality of care – In many cases telehealth can improve key health status indicators within a state. It is

important to identify and monitor the affect that telehealth has on these indicators--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 – Cost is a key consideration for legislators. Any state action will involve a thorough analysis of state budget impact.

Some opponents of telemedicine have made claims that there is not enough evidence related to cost and utilization for telehealth, and have argued that it would result in increased insurance premiums. However, the actual cost analyses rarely show a significant impact. 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.

Regarding private insurance parity:

- Parity legislation does not increase covered services, but explicitly recognizes telehealth as a way to deliver existing covered services. This is unlike other common insurance mandates, such as vision services.

- Many private insurers already include telehealth-provided services under their benefit coverage. For example, if a policy covers "physician services" then there is no basis to deny a covered physician service via telehealth. 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 program varies in its reimbursement policy. In addition, a rapidly growing number of Medicaid recipients are covered under managed care plans that 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. In 2013, Maryland legislators considered 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. In 2014, MD legislators and state health officials revisited this issue and ultimately supported the enactment of telehealth parity for all Medicaid beneficiaries.

Mandating Parity -- Commercial insurers often oppose, as a philosophical principle, almost any state requirement. Although telemedicine parity would not impose coverage of new services, 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 of telehealth is restricted by an outdated federal law. In contrast, federal Medicaid law gives the states flexibility for telehealth coverage – and the Medicare restrictions do not apply. States are not required to submit a state plan amendment (SPA) to offer coverage of telemedicine if coverage and reimbursement is comparable to in-person services. 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 claim. There have been very few liability claims. Instead, the more recordable nature of telemedicine improves documentation and verification. It should be noted that some increasing case law points toward provider 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 (PPACA). 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: Telemedicine or Telehealth means health care services provided to a patient from a provider who is at a remote location.

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.

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 chronic care management, 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)
    - 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 statues 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 State Policy Resource Center includes a listing of major legislation, state telemedicine gaps analyses, and ATA's series of 8 State Medicaid Best Practices on specific telehealth applications (e.g. telemental health, home telehealth and remote patient monitoring, school-based telehealth, store-and-forward, etc.)
  (http://www.americantelemed.org/policy/state-policy-resource-center)

- ATA's online wiki for telehealth information. This includes state-specific pages about legislation and regulation regarding coverage and reimbursement (www.atawiki.org)

- ATA State Telemedicine Legislative & Regulatory Trackers. These tools provide live, up-to-the-minute updates pertaining to telemedicine policy. Each listing includes details on a bill or rule, the corresponding sponsor, language, status and scheduled hearings.
  (http://www.americantelemed.org/policy/state-policy-resource-center)

- For ATA members there are additional resources on the Hub (http://hub.americantelemed.org):

    - 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--

        - ATA State Forums facilitate discussions and support growing member interest in state level activity regarding telemedicine. Policy decisions affecting practice standards, licensure portability, reimbursement, and research are gaining momentum and will require information sharing, education and outreach. Members of the Forums are encouraged to engage in discussions and develop strategies to advance pro-telemedicine policies. This includes, but is not limited to:
            - Sign-on letters and public comments
            - Public testimony
            - Education and outreach of licensing boards and state legislatures

        - 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.

- National Telehealth Policy Resource Center and Regional Telehealth Resource Centers (www.telehealthresourcecenter.org)

- Center for Telehealth and e-Health Law (www.ctel.org)