



EVELYN SANGUINETTI

LIEUTENANT GOVERNOR
STATE OF ILLINOIS

October 29, 2018

The Honorable Bruce Rauner
Governor, State of Illinois
Office of the Governor
207 State House
Springfield, IL 62706

Dear Governor Rauner,

At your direction, the Illinois Department of Healthcare and Family Services in partnership with the Lieutenant Governor convened the Medicaid Advisory Committee Telemedicine Taskforce to develop a telemedicine strategy for the existing Medicaid program to help improve access to healthcare and assist the State in its goal of integrating physical and behavioral health services. After substantial review and preparation, it is with great pleasure that we present to you the attached recommendations on behalf of the Medicaid Advisory Committee Telemedicine Taskforce.

Sincerely,

Handwritten signature of Evelyn Sanguinetti in black ink.

Evelyn Sanguinetti
Lieutenant Governor

Handwritten signature of Patricia Bellock in black ink.

Patricia Bellock
Director of Healthcare and
Family Services

Handwritten signature of Howard Peters in black ink.

Howard Peters
HAP, Inc.

Additional Attachments:

- List of Recommended Changes to the Medicaid Program
- State Telehealth Laws and Reimbursement Policies Key Findings

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Medicaid Advisory Committee - Telemedicine Taskforce Membership

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Mr. Howard Peters, HAP, Inc.

Members

Mr. Tom Allen, Blue Cross Blue Shield

Dr. Nina Antoniotti - SIU Med

Ms. Katie Bohling, Lurie Children's Hospital

Mr. Brian Colgan, Illinois Lieutenant Governor

Ms. Kelly Cunningham, Healthcare & Family Services

Mr. Eric Foster, Illinois Association of Behavioral Health

Mr. Patrick Gallagher, Illinois Health & Hospital Association

Mr. Raul Garza, Aunt Martha's

Dr. Arvind Goyal, Healthcare & Family Services

Ms. Angela Grover, Presence Health

Ms. Sheila Guither, OSF HealthCare

Ms. Angie Hampton, Egyptian Health Department

Ms. Sherrie Harlow, Southern Illinois Healthcare

Ms. Nancy Kaszak, Illinois Telehealth Initiative

Mr. Marvin Lindsey, Community Behavioral Healthcare Association

Ms. Kimberly McCullough, Healthcare & Family Services

Dr. Gurpreet Mander, St. John's Hospital, and the Illinois Telemedicine Network

Mr. Joe Provateare, Robert Young Center

Ms. Meryl Sosa, Illinois Psychiatric Society

Ms. Lisa Valinoti, ISMS

Mr. Cyrus Winnett, Illinois Association of Medicaid Health Plan

Dr. Daniel Yohanna, University of Chicago

MEDICAID ADVISORY COMMITTEE TELEMEDICINE TASKFORCE (TMT)

RECOMMENDATIONS TO GOVERNOR BRUCE RAUNER FOR THE MODERNIZATION OF ILLINOIS' TELEMEDICINE POLICIES AND PRACTICES IN THE MEDICAID PROGRAM

Executive Summary

The State of Illinois telemedicine laws and policies have not been updated in over a decade. On May 9, 2018, Governor Bruce Rauner announced the creation of the Medicaid Advisory Committee's Telemedicine Taskforce ("TMT"), a workgroup created and co-chaired by the Lt. Governor Evelyn Sanguinetti, Healthcare and Family Services Director Felicia Norwood (replaced by newly appointed Director Patricia Bellock on July 11, 2018), and Medicaid Advisory Committee Chairman Howard Peters.

The mission of the TMT was to develop a telemedicine strategy for the existing Medicaid program to help improve access to healthcare and assist the State in its goal of integrating physical and behavioral health services. In doing so, the TMT was to review best practices within and beyond Illinois to outline a strategy to modernize Illinois' existing services, regulations, and infrastructure in alignment with the State of Illinois' broader health and human services transformation efforts. Any recommendations to support this mission were to be communicated to Governor Rauner, who has already taken a huge step towards achieving many of the recommendations contained in this report

On August 21, 2018, Governor Rauner signed into law several bills approved by the Illinois legislature that expand access to telemedicine moving Illinois to a more progressive state for use of this modality. These new laws are significant to furthering the State of Illinois' health and human services transformation supporting the integration of physical and behavioral healthcare.

The TMT supported this legislation and believes that by signing these bills into law, Governor Rauner and the legislature made an important step towards achieving the recommendations contained in this report. Illinois' Medicaid telemedicine practices can now be modernized, expanding eligible patient settings, provider types, technologies and reducing service limitations. In general, the TMT provides recommendations for changes across these areas to align telemedicine reimbursement with in-person care.

The TMT believes that the recommendations contained herein will permit healthcare services to be delivered via telemedicine to more Medicaid beneficiaries, including all types of patients, in any Medicaid-eligible location that is clinically-appropriate from any Medicaid-eligible professional authorized to provide services in the State of Illinois.¹

¹ A clinically appropriate location is one that is private, confidential, and safe for the patient and provider.

OVERVIEW

Telemedicine laws and policies continue to be reviewed and updated in all 50 states and the District of Columbia. Many states are beginning to expand their telehealth practices in their Medicaid programs in a myriad of different ways. According to the Center for Connected Health Policy (CCHP), no two states are alike in how telehealth is defined and regulated.

“While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters. These differences create a confusing environment for telehealth participants to navigate, particularly when a health system or practitioner provides health care services in multiple states²”

However, states differ in all areas, including: definitions of telemedicine and/or telehealth, Medicaid reimbursement, use of telemedicine modalities (synchronous - live video, and asynchronous - store and forward), remote patient monitoring, email/phone fax (rarely allowed), transmission/facility fees, location of services, patient consent requirements, licensure, on-line prescribing, and private payer reimbursement policies.

The twenty-two (22) member Telemedicine Taskforce, which included providers, advocacy groups, and healthcare associations representing various constituencies from around the state, heard from many key stakeholders, gathering information, reports, and recommendations on how telemedicine might positively impact the State’s Medicaid program.

There was a total of 46 recommendations received across five (5) areas including³:

1. Telemedicine Modalities

- (Synchronous-Live Video and Asynchronous-Store and Forward)
- Remote Patient Monitoring

2. Place of Service

- Originating Site
- Distant Site

3. Provider Eligibility

4. Service Eligibility

5. Reimbursement Rates

Many states have advanced the utilization of telemedicine in their Medicaid programs. While no state Medicaid program is the same, many existing models and pilots in other states provide a framework for telemedicine reform in Illinois.

² State Telehealth Laws and Reimbursement Policies, A Comprehensive Scan of the 50 States and District of Columbia

³ Telemedicine Taskforce List of Recommended Changes to the Medicaid Program

Additionally, some providers throughout Illinois have applied broad telemedicine reform to their care models in an effort to improve care while reducing cost. While the Illinois Medicaid Program currently does not reimburse providers for many of the services they currently offer, much can be learned from the experiences of the providers who utilize telemedicine – many of which make up the TMT. Examples of some of the types of services include tele-dentistry, tele-behavioral health, school-based telemedicine services, tele-stroke, remote patient monitoring, and the use of tele-medicine to serve rural communities.

While many states have advanced the utilization of telemedicine in their Medicaid programs, there were few states that have models that would squarely fit into the State of Illinois' healthcare service delivery model and be looked upon as a best practice for Illinois' Medicaid population.

In applying the lessons learned in other states and among Illinois providers, the Illinois Department of Healthcare and Family Services can customize best practices to improve access, quality, and outcomes while protecting against increased costs.

THE TELEMEDICINE TASKFORCE'S OVERARCHING PRINCIPLES FOR TELEHEALTH IN ILLINOIS

Illinois' telehealth laws have not been updated for nearly a decade so the legislative and regulatory infrastructure to allow providers to use telehealth needs to be updated.

Telemedicine Taskforce members identified three overarching principles early on to facilitate telemedicine use by providers: Expand who can use telemedicine to deliver care, the place where care can be delivered or received, and align payment for telemedicine with rates for in-person care.

Updating the Illinois Telehealth Act and the Public Aid Code would create a framework for safe and timely delivery of care throughout the state. The Telemedicine Taskforce recommends:

- All Medicaid-eligible, professionals authorized to provide services in the State of Illinois be able to deliver care via telehealth, where appropriate;
- Permit telemedicine to be delivered to any patient, in any location that is clinically-appropriate from any location where a Medicaid-eligible professional is authorized to provide services; and Care delivered using telehealth be fully aligned with in-person care through parity in compensation with in-person, Medicaid-eligible provider payment rates.

The Telemedicine Taskforce provided recommendations for **Providers, Place, and Payment**.

Recommendation on Providers: Full telemedicine alignment with in-person care. If a provider is currently a Medicaid-eligible professional authorized to provide services in the State of Illinois; the provider should be able to deliver care via telehealth where appropriate. The State of Illinois already has a process identified for persons to become Medicaid-eligible providers which includes licensing or certification and oversight.

The specific comments/recommendations on provider access:

- Telehealth to manage suboxone and medication assisted treatment (*CHBA, #14 on table*)
- Telehealth for buprenorphine prescribing and allowing certified APNs and PAs to provide services (*IPS, #15 on table and CBHA, #35 on table*)
- Allow community-based SUD licensed treatment provider to deliver services using telehealth (*IABH, #27 on table*)
- Allow LCSW and licensed clinical psychologists to deliver services using telehealth (*IABH, #42 on table*)
- Allow pediatric pulmonologists to deliver services using telehealth (*U of C, #43 on table*)
- Allow clinical psychologists, clinical social workers, clinical professional counselors (*Illinois Telehealth Initiative, #18*)
- Amend Section 140.403(b)(1)(B) change to “The distant site provider must be an eligible Illinois Medicaid participating provider” (*Illinois Telehealth Initiative, #32 on table*)
- Remove requirement that tele-presenter be a certified healthcare professional (*Lurie Children’s Hospital, #34 on table*)
- The distant site provider must be an eligible Illinois Medicaid participating provider (*SIU, #37 on table*)
- Allow licensed clinical social workers and licensed clinical psychologists to use telehealth (*SIUI, #40 on table*)
- Any licensed clinician in good standing with the State of Illinois should be able to provide care via telehealth as long as it is clinically indicated (*Presence Health, #41 on table*)

The Telemedicine Taskforce believes that these changes will advance the Department of Healthcare and Family Services’ strategic initiatives that rely on timely access to the appropriate level of provider care. The State of Illinois, like many other states, is facing a shortage of providers. Telemedicine may help to address some of the shortage challenges.

Recommendations Regarding Place: The Telemedicine Taskforce believes that restrictions on the originating-site and distance-site for the delivery of telehealth unnecessarily limit the delivery of care. The Taskforce recommendation is to permit telemedicine to be delivered to any patient, in any location that is clinically-appropriate from any Medicaid-eligible professional authorized to provide services in the State of Illinois.

The specific comments/recommendations regarding place:

- Define originating sites as the location of the patient at the time the service is rendered (*Illinois Telehealth Institute, #16 on table*)
- Medicaid locations should be expanded to all healthcare facilities (*Lurie Children’s Hospital, #19 on table*)
- Hospitals and residential facilities should be eligible for the HCPCs technical component (*SIU, #21 on table*)
- Remote monitoring for individuals with chronic conditions and telehealth diabetic retinopathy (*Canary Telehealth, #2, 3 on table*)
- Allow telehealth access to adolescents and adults being served in a SUD licensed residential treatment facility (*IABH, #26 on table*)

- Allow hospice and home health care providers to use telehealth for remote monitoring and symptom management (*OSF Healthcare, #44, 45 on table*)
- Add emergency departments, inpatient hospital settings, skilled nursing facilities, schools and assisted living facilities (*Illinois Telehealth Initiative, #17*)
- Include SUD centers licensed by SUPR (*SIU, #20 on table*)

The Telemedicine Taskforce believes that these changes will advance the Department of Healthcare and Family Services strategic initiatives that rely on timely access to care services and routine care management that can prevent more expensive, adverse events for those patients managing chronic conditions. By removing barriers such as transportation and stigma, providers will be able to deliver appropriate care when and where the patient needs to receive it.

Recommendations Regarding Payment: The charge of the Telemedicine Taskforce was to address delivery of care under the Medicaid program. Members of the Taskforce noted that private payer parity should be a component of the Taskforce recommendations; however, its mission was to review telemedicine use in the Medicaid program only. TMT recommends that payment for care delivered using telehealth be compensated at the existing in-person Medicaid-eligible provider payment rates. Additionally, healthcare delivered via telehealth under the existing Medicaid Managed Care contracts should be considered in-network and eligible for payment.

The specific comments/recommendations regarding payment are as follows:

- Require private payers to reimburse for healthcare delivered with telehealth same as in person healthcare delivery (*Lurie Children’s Hospital, #9*)⁴
- Appropriate payment should be made for consultations that are provided with store-and-forward technologies (*Medical Home Network, #1 on table*)
- Increased rates for tele-psychiatry (*CBHA, #10 on table*)
- Strike all references to payment policy that treats encounter clinics separate from all other Medicaid-eligible facilities or providers for the purposes of paying the facility fee or professional component. (*SIU, #11 on table*)
- Strike additional documentation required to deliver telehealth and treat it the same as in person care (*SIU, #23 on table*)
- Both patient and provider site eligibility and reimbursement should align with those that are currently eligible and reimbursed for in-person services to Medicaid beneficiaries; and aligned under one term “telehealth” (*IHA, #12 on table*)
- Telehealth should be reimbursed in the same manner and at the same level as in-person services (*Presence Health, #13 on table*)
- Strike all separate references to encounter clinics and pay the professional component to the distant site is eligible (*SIU, #22 on table*)
- Support all payers cover telehealth services in the same manner as the in-person services (*IHA, #24 on table*)
- Illinois should reimburse for patient evaluation and management where patients spend a majority of their time – at home, work or school (*Presence Health, #25 on table*)

⁴ Recommendations for private payers do not fall within scope of the mission of the Medicaid Advisory Committee Telemedicine Taskforce.

- Illinois should reimburse for care delivered where patients spend a majority of their time – at home, work, or school (*Presence Health, #25 on table*)
- Support network adequacy language to clarify that providers considered in-network for an in-person service will not be denied by Medicaid FFS or MCOs for that service delivered via telehealth (*Illinois Telehealth Network, #33 on table*)

The Telemedicine Taskforce asserts that an equitable payment structure will ensure that access can be created where needed, and patients can get the care they need when they need it. Care avoidance results in exponentially larger costs per patient for the Medicaid program. A review of current rates of payment for Medicaid providers, and psychiatrists in particular, was a recommendation made by members of the Taskforce. The Department of Healthcare and Family Services acknowledges that provider payment can sometimes be a determining factor for participation in the Medicaid Program; however, rate increases for specific providers were not part of the scope of the Telemedicine Taskforce.

Some of the recommendations presented by the Taskforce did not fit into any specific category. These additional suggestions are listed below.

ADDITIONAL RECOMMENDATIONS FROM THE TASKFORCE:

- Consider the ISMS Telemedicine Principles (*Illinois State Medical Society, #7 on table*)
- The goals of telemedicine should be driving value (*Medical Home Network, #8 on table*)
- Allow physicians and advanced practice professionals to work at the top of their licenses (*Illinois Telehealth Initiative, #31 on table*)
- Eliminate separate references to tele-psychiatry in the definition of telehealth (*SIU, #30 and #38 on table*)
- Update the Handbook for Practitioners, Handbook for Providers of Encounter Clinics to reflect changes to telemedicine policy. (*SIU, #4, 5 on table*)
- Clearly define eligibility for use of telemedicine in schools and expand wherever possible (*Recommendation provided verbally during presentation at TMT mtg.*)

EVIDENCE-BASED APPROACH

In its federally approved 1115 Demonstration Waiver application, the State of Illinois defines its strategy to improve health outcomes:

“Illinois is one of the largest funders of health and human services (HHS) in the country. With \$32 billion spent across its HHS agencies, amounting to more than 40% of its total budget. The State is deeply invested in the health and well-being of its 12.9 million residents and 3.2 million Medicaid members.⁵ There is an urgent need to get more from this investment: The State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.

To this end, Illinois has embarked on a transformation of its HHS system. The transformation, which was announced by Governor Bruce Rauner in his 2016 State of the State address, “*puts a strong new focus*

⁵ State Fiscal Year 2015 Illinois DHFS claims data

on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individual from institutions to community care to keep them more closely connected with their families and communities.”

The HHS transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes:

- Prevention and population health
- Paying for value, quality, and outcomes
- Rebalancing from institutional to community care
- Data integration and predictive analytics
- Education and self-sufficiency”

The Department of Healthcare and Family Services believes the work of the Telemedicine Taskforce can further the Department’s defined strategic priorities. The testimony, research, and supporting documentation collected by the Taskforce shows that the delivery of care via telehealth can help to advance the quality of care while improving access and driving down costs.

Many of the recommendations may require changes to administrative rules, state law and state plan amendments, as well as require the Department of Healthcare and Family Services to apply for federal funding to support any expansion. While cost is not the only factor that should be considered, at a minimum, it must be evaluated as telemedicine usage is expanded. An increase in quality, access and outcomes are the primary goals that should be considered in the implementation of the Taskforce’s recommendations.

HFS has proposed the following framework to implement the Taskforce recommendations:

- Support the **transformation of the behavioral healthcare delivery system** for Medicaid beneficiaries to achieve the integration of physical and behavioral healthcare for Medicaid patients in Illinois;
- **Manage Medicaid patients with chronic conditions** to increase patient outcomes and decrease the cost of care for this population;
- **Evaluate technology and infrastructure** needs via government funded pilots to determine if Illinois has adequate resources to allow access to technology across the state;
- **Increase awareness** of options for care delivery via telemedicine to patients and providers;
- **Create access to existing services** via telemedicine_

Improved care delivery via telemedicine can help ensure timely care in the most appropriate setting and help facilitate the integration of physical and behavioral healthcare in primary, specialty and hospital settings which is the goal of the State of Illinois Better Care Behavioral Health 1115 Waiver. Below are the recommendations of the Taskforce within each of the areas of the HFS framework:

Support transformation of behavioral health to achieve the integration of physical and behavioral care for Medicaid patients in the state

- Telehealth to manage suboxone and medication assisted treatment (CBHA, #14 on table)
- Telehealth for buprenorphine prescribing and allowing APNs and PAs to provide services (IPS, #15 on table and CBHA, #35 on table)
- Allow community-based substance use disorder (“SUD”) licensed treatment provider to deliver services using telehealth (IABH, #27 on table)
- Allow LCSW and licensed clinical psychologists to deliver services using telehealth (IABH, #42 on table)
- Hospitals and residential facilities should be eligible for the HCPCs technical component (SIU, #21 on table)
- Allow telehealth access to adolescents and adults being served in a SUD licensed residential treatment facility (IABH, #26 on table)
- Increased rates for tele-psychiatry (CBHA, #10 on table)
- Require private payers to reimburse for healthcare delivered with telehealth same as in person healthcare delivery (Lurie Children’s Hospital, #9)
- Include SUD centers licensed by SUPR (SIU, #20 on table)
- Allow licensed clinical social workers and licensed clinical psychologists to use telehealth (SIU, #40 on table)
- Strike or adopt “group psychotherapy is a covered service equal to in-person care (SIU, #46 on table)

Manage Medicaid patients with chronic conditions to increase patient outcomes and decrease cost of care for this population. The below preliminary report for the Illinois Diabetes Commission and IDPH, examines the financial toll of various chronic diseases on the State’s Medicaid Program looking at CY2017 data and includes an analysis of the top nine (9) conditions.⁶

Illinois Diabetes Commission Report Data on HFS Payments by Disease for SFY 2017 as Identified by Specific Diagnosis Only (1)							
Condition (2)	# of Medicaid Population with Service for Condition	% of Medicaid Population with Service for Condition	Service Payments (3)	Pharmacy Payments	# with Service for Condition enrolled in Managed Care (4)	Total Payments	Costs per Person
Diabetes	202,027	6.50%	\$142,582,805	\$241,665,751	111,714	\$384,248,556.50	\$1,901.97
Arthritis	108,267	3.48%	\$51,503,852	\$110,419,850	52,690	\$161,923,701.80	\$1,495.60
Asthma	135,071	4.34%	\$46,104,870	\$201,556,356	92,539	\$247,661,225.80	\$1,833.56
Cancer	240,051	7.72%	\$381,871,299	\$86,470,439	144,269	\$468,341,738.04	\$1,951.01
Chronic Heart Disease (CHD)	47,856	1.54%	\$48,129,483	\$16,918,062	19,008	\$65,047,545.84	\$1,359.23
Chronic Heart Failure (CHF)	57,002	1.83%	\$75,945,710	\$5,662,433	24,523	\$81,608,143.53	\$1,431.67
Substance Use Disorder (SUD)	119,208	3.83%	\$87,109,381	\$21,586,018	74,824	\$108,695,398.87	\$911.81
Mental Health	329,245	10.59%	\$329,551,834	\$75,387,994	265,503	\$404,939,827.39	\$1,229.90
Hypertension	283,025	9.10%	\$155,977,026	\$31,700,105	156,263	\$187,677,131.00	\$663.11
Stroke	23,897	0.77%	\$93,629,011	\$23,619,158	10,461	\$117,248,169.03	\$4,906.40

This report generated for the Illinois Diabetes Commission and IDPH, is an examination of the financial toll of various chronic diseases on the state Medicaid program looking at the in SFY2017. Only individuals who received services directly linked to a specific diagnosis for the chronic diseases being examined where included in this data. Please note that due to the Affordable Care Act (ACA) and Medicaid expansion, along with move from ICD9 to ICD10, the results from this report may vary from previous reports.

1.) This report includes an analysis of data from the Medicaid population of 3,107,897 as of the end of SFY2017 (June 30, 2017).
 2.) A single individual may have received services for several of the chronic diseases listed in this report in SFY2017 (i.e. Diabetes and CHD), so they may be identified multiple times in the disease counts.
 3.) Service amounts contained herein are lower than previous year’s reports due to the elimination of claims where the conditions listed were not the primary diagnosis. The Department determined that including these claims in the report arbitrarily inflated costs for these individuals as the primary diagnosis may not have any relationship to the client having one of the chronic conditions, i.e. back surgery and CHD.
 4.) Reflects the number of beneficiaries enrolled in Managed Care at the time of services.

⁶ Preliminary Data on HFS Payments by Disease for State Fiscal Year 2017 as Identified by Specific Diagnosis Only

The Telemedicine Taskforce recommendations that support chronic disease management within HFS' framework are as follows:

- Allow pediatric pulmonologists deliver services using telehealth (*U of C, #43 on table*)
- Define originating sites as the location of the patient at the time the service is rendered (*Illinois Telehealth Institute, #16 on table*)
- Remote monitoring for individuals with chronic conditions and telehealth diabetic retinopathy (*Canary Telehealth, #2, 3 on table*)
- Allow hospice and home health care providers to use telehealth for remote monitoring and symptom management (*OSF Healthcare, #44, 45 on table*)
- Eliminate separate category for tele-psychiatry and align under uniform telehealth, allowing care coordination and remote monitoring potentially limiting group therapy and dental assessments (*Illinois Telehealth Initiative, #18*)

Ensure Illinois has adequate infrastructure to allow access to technology across the state

- Create grants to encourage collaboration between all who need telehealth (*CBHA, #6 on table*)
- Better infrastructure downstate to support telehealth (*CBHA, #28 on table*)
- Access federal grants for pilot programs

Increase awareness of options for care delivery via telemedicine to patients and providers.

While increasing awareness for care delivery via telemedicine was not a formal recommendation from members of the Telemedicine Taskforce, HFS believes that it is important to educate providers and patients on its availability to allow care to be delivered via telecommunications and paid at the appropriate Medicaid-eligible provider rate. This outreach and education initiative can be fully integrated into the education and awareness efforts around Integrated Health Homes and the 1115 Waiver pilots, as well as the efforts underway to streamline payment and communication efforts across the managed care organizations to providers and patients.

CONCLUSION AND NEXT STEPS

Telemedicine expansion continues throughout the United States whether it is in Medicaid, Medicare or with private insurers. The focus on increased access, better outcomes, and reducing cost is not unique to Illinois. Like in most other states, telemedicine expansion provides a tremendous opportunity for Illinois to address the needs of its underserved communities and most vulnerable citizens.

Overall, the Telemedicine Taskforce makes the following recommendations to the Governor:

1. All Medicaid-eligible professionals authorized to provide services in the State of Illinois be able to deliver care via telehealth, where appropriate;
2. Permit telemedicine to be delivered to any patient, in any location that is clinically-appropriate from any location where a Medicaid-eligible professional is authorized to provide services; and
3. Care delivered using telehealth should be fully aligned with in-person care and compensated at the same rate as in-person, Medicaid-eligible provider payment rates.

While the general recommendation of the Telemedicine Taskforce is for expansion in the three p's: provider, place, and payment, as a first step in making these broad changes, the Taskforce recommends the State of Illinois adopt policies that fall within the rules of the Centers for Medicare and Medicaid Services to ensure that the state continues to receive federal funding for the services.

Related to this, expansion may require changes to administrative rules, state law, and state plan amendments, as well as require the Department of Healthcare and Family Services to apply for federal funding to support certain expansion. While cost is not the only factor that should be considered, at a minimum, it must be evaluated as telemedicine usage is expanded. An emphasis on increased quality, access, and outcomes are the primary goals that should be considered in the implementation of changes to Illinois' Medicaid program.

Secondly, it is the recommendation of the Telemedicine Taskforce that an independent third-party organization, with the support of the Illinois Department of Healthcare and Family Services, conduct an analysis on the impact of the proposed changes highlighted in this document. Additionally, the third-party organization and HFS should work with the Governor's Office of Management and Budget to determine how such an expansion may impact the state's budget outlook.

Further, HFS should research and apply for any federal opportunities including those that will further the four areas within the recommendation framework that may increase outcomes, access to care, and quality or reduce cost in the Medicaid program. As federal support is pursued, specific attention should be given to those opportunities that assist the state of Illinois in addressing the opioid crisis, chronic disease management, and broadly support Illinois efforts to transform the behavioral health delivery system in the Illinois Medicaid program. HFS must make changes to its operating practices to ensure the appropriate implementation of the recommendations and educate providers and patients on any changes.

Lastly, HFS should monitor and track the impact of the use of telemedicine in the Medicaid Program to determine if it improves access, quality, and outcomes and reduces costs. A report should be provided to the Medicaid Advisory Committee on utilization, cost-avoidance, outcomes and quality made via telemedicine access expansion, and future opportunities for expansion beginning January 1, 2020, and on the same day every year thereafter.^A

^A The Illinois Department of Healthcare and Family Services is reviewing all of the recommendations received from the Telemedicine Taskforce and believes that an appropriate approach within the rules and regulations of the Center for Medicare and Medicaid Services to adopting these suggested changes will help to ensure quality, appropriate utilization, and contain costs.

Telemedicine Taskforce
List of Recommended Changes to the Medicaid Program - Sorted By Focus Area
as of 6/5/2018

No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
1	Asynchronos		Reimbursement for telemedicine services should be considered and include appropriate payment for review and consult on "store and forward" technologies.	Patrick K. Maguire/Medical Home Network
2	Chronic Conditions	Remote Monitoring for Individuals with Chronic Conditions.		Carla Robinson/Canary Telehealth, Inc.
3	Chronic Conditions	Telehealth Diabetic Retinopathy		Carla Robinson/Canary Telehealth, Inc.
4	Handbooks & Guidance		13) A-220.6.7 Telehealth Provisions for Medicaid providers are explained and outlined in the Handbook for Practitioners, Oct 2016. This handbook will need to be updated with the changes made to the Medicaid regulations for TeleHealth. Many states update the Medicaid language but forget to amend and update the Handbook for Practitioners, leaving the practitioner in a quandary as to how to proceed with billing for services. (HFS 220 pg. 35-36)	Nina Antoniotti/Southern Illinois University
5	Handbooks & Guidance		14) D-210.2 Telehealth Provisions for Medicaid providers are explained and outlined in the Handbook for Providers of Encounter Clinics, June 2015. This handbook will need to be updated with the changes made to the Medicaid regulations for TeleHealth. Many states update the Medicaid language but forget to amend and update the Handbook for Practitioners, leaving the practitioner in a quandary as to how to proceed with billing for services. (HFS 200, pg. 16-18)	Nina Antoniotti/Southern Illinois University
6	Incentives		Grants to encourage collaboration between all who need telehealth, and equipment, especially CMHCs.	Marvin Lindsey/Community Behavioral Health Association

Telemedicine Taskforce
List of Recommended Changes to the Medicaid Program - Sorted By Focus Area
as of 6/5/2018

No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
7	Information - Shared ISMS Telemedicine Principles		None	Lila Valinoti/Illinois State Medical Society
8	Miscellaneous		The goals of a telemedicine program should be driving value (increasing access, reducing cost, improving the patient and provider experience, and leading to better health outcomes) by: Leveraging technologies that allow patients to reach the right provider, at the right time, in the least onerous way that is appropriate for their condition and sufficient to adequately examine the relevant information.	Patrick K. Maguire/Medical Home Network
9	Payment		2) Lack parity law requiring private payers to reimburse in full.	Katie Bohling/Lurie Children's Hospital
10	Payment		2) Better rates for telepsychiatry	Marvin Lindsey/Community Behavioral Health Association
11	Payment		8) Strike all references to payment policy that treats encounter clinics separate from all other Medicaid eligible facilities or providers for the purposes of paying the facility fee or professional component. Paying both components (professional fee and facility fee) is complicated and causes delay in payment to the provider and increases costs for the encounter clinic to break out and process payments to other health care facilities/providers.	Nina Antoniotti/Southern Illinois University

Telemedicine Taskforce
List of Recommended Changes to the Medicaid Program - Sorted By Focus Area
as of 6/5/2018

No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
12	Payment	Clarity Around Reimbursements	Illinois Medicaid telehealth regulations were written ten years ago and many stakeholders - including providers, patients and payers - are confused about what is reimbursable. Both patient and provider site reimbursement eligibility should align with facilities that are currently reimbursed for in-person services to Medicaid beneficiaries. Similarly, provider eligibility should align with existing Illinois Medicaid participating providers delivering in-person services. We also support amending current definitions to align all types of service under one term: telehealth. This would in turn support future coverage parity between medical services and psychiatric services delivered via telehealth, which are currently segmented further by varying provider and facility eligibility.	Patrick Gallagher/Illinois Hospital Association
13	Payment		3) Telehealth should be reimbursed in the same manner and at the same level as comparable in-person services.	Angela Grover/Presence Health
14	Pharmacy		4) Telehealth to manage suboxone? Other medication assisted treatment	Marvin Lindsey/Community Behavioral Health Association
15	Pharmacy		17) For IPS, Telepsychiatry for buprenorphine prescribing is very important for patients with opioid addiction in rural areas where there are very few waived prescribers.. Please see below and let me know your thoughts as to whether we could have physicians, APNs and PAs do telepsychiatry for MAT based on the fact that President Trump said the opioid crisis is a public health emergency	Meryl Sosa/Illinois Psychiatric Society

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No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
16	Place	Eliminate the Restrictions on Originating Sites (Patient Sites) - Unnecessary restriction of originating sites and vagueness regarding licensed hospital outpatient departments. Skilled nursing facilities, developmental centers, emergency departments, inpatient facilities, residential psychiatric facilities and schools as well as the home are excluded.	Change Language in Section 140.403(a)(4) to "Facility Fee means the reimbursement made to any Medicaid certified eligible facility or provider organization as originating sites, as defined in 89 Ill. Adm. Code 148.25(d) including substance abuse centers licensed by the Department of Human Services-Division of Alcoholism and Substance Abuse (DASA)," and to define an originating site as "the location of the patient at the time the service is rendered."	Nancy L. Kaszak/Illinois Telehealth Initiative
17	Place	Outdated Regulations - IHA member hospitals view the current Medicaid telehealth requirements as burdensome and not reflective of current practice.	1) Originating Sites (where patient is located at the time of service): Expansion of coverage in the following focus areas: Facility Eligibility(Potential Limits=Home): Emergency Departments, Inpatient Hospital Settings, Skilled Nursing Facilities, Schools, Assisted Living Facilities. Provider Eligibility: All Illinois Medicaid Participating Providers, Telepresenter. Staff Presence Requirement (Potential Limits=No Staff Presence Requirement): Staff Immediately Available (On Site) Staff Presence Eligibility: Telepresenter. Specific Telepsychiatry Staff Presence Eligibility: Eliminate Category for Telepsychiatry so Staff Presence Requirements Are Uniform For All Telehealth Services.	Nancy L. Kaszak/Illinois Telehealth Initiative
18	Place		2) Originating Sites (where the provider rendering telehealth services is located): Expansion of Coverage in the following focus areas: Facility Eligibility: Emergency Departments, Inpatient Hospital Settings, Outpatient Hospitals, Skilled Nursing Facilities. Provider Eligibility: Clinical Psychologists, Clinical Social Workers, Clinical Professional Counselors. Specific Telepsychiatry Provider Eligibility: Eliminate Separate Category for Telepsychiatry to Provider Eligibility Requirements are Uniform for All Telehealth Services; Service Reimbursement: Care Coordination and Remote Monitoring potentially limiting group psychotherapy and dental assessments.	Nancy L. Kaszak/Illinois Telehealth Initiative
19	Place		3) Medicaid locations be expanded to all healthcare facilities.	Katie Bohling/Lurie Children's Hospital

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No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
20	Place		2) "Facility Fee means the reimbursement made to any Medicaid eligible facility or provider organization as originating sites as defined in 89 ILL. Adm. Cde 148.25(d) including substance abuse centers licensed by the Department of Human Services-Division of Alcoholism and Substance Abuse (DASA)."	Nina Antoniotti/Southern Illinois University
21	Place		7) Strike Hospitals and other residential facilities are expending additional resources to provide access to care and should be eligible for the HCPCs technical component.	Nina Antoniotti/Southern Illinois University
22	Place		9) Strike all separate references to encounter clinics and pay the professional component to the distant site at the rate the distant site is eligible (encounter rate or standard cpt code rate for non-encounter providers).	Nina Antoniotti/Southern Illinois University
23	Place		10) Strike all as these requirements for documentation are not required in Section 140.28 for in-person care and should not be required for TeleHealth visits. The more TeleHealth is treated as the same as in-person care, the less complex the regulatory environment and more adoption of TeleHealth will occur throughout the needed areas in the state of Illinois.	Nina Antoniotti/Southern Illinois University
24	Place		The IHA's immediate telehealth priority is for Medicaid to have greater telehealth coverage by allowing additional sites of service and additional types of clinical staff to be covered and reimbursed. Additionally, we would support that all payers cover telehealth services in the same manner as the in person services. In other words, if an in person service has a telehealth equivalent, it should be covered and reimbursed in an equivalent manner.	Patrick Gallagher/Illinois Hospital Association
25	Place		2) Illinois should reimburse for consultations or care delivered where patients spend a majority of their time - at home, work or school. Expansion of both originating sites and receiving sites is critical for delivering the right care at the right time.	Angela Grover/Presence Health

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No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
26	Place		1. Access to Telehealth for Adolescents and Adults being served in SUD licensed residential treatment facility with either co-occurring health and mental health conditions	Eric Foster/IABH
27	Place		1. Community-based SUD Licensed treatment provider being approved/authorized as an originating site location.	Eric Foster/IABH
28	Place/Infrastructure		3) Better infrastructure downstate to support telehealth.	Marvin Lindsey/Community Behavioral Health Association
29	Place/Infrastructure		12) The type of interactive telecommunication system utilized at the originating and distant sites shall be documented. Strike as unnecessary.	Nina Antoniotti/Southern Illinois University
30	Place/Infrastructure		1) Amend definition list once all other proposed changes have been made. Use one term – telehealth – to define all types of services available. Proposed definition: "Telehealth" means the use of telecommunications services to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non -interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section." Eliminate any separate reference to TelePsychiatry	Nina Antoniotti/Southern Illinois University

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No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
31	Providers	Provider shortages/advanced practice professionals: Illinois Medicaid rules unnecessarily restrict the use of Medicaid eligible practitioners when care is delivered via TeleHealth. Due to shortages of health professionals in both urban and rural areas, practice boards have eased scope-of-practice requirements and many states' Medicaid agencies are reimbursing for more care delivered by advanced practice professionals.	1.) Allowing physicians and advanced practice professionals to work at the top of their licenses can create greater value for the healthcare delivery system as a whole, by improving practice productivity, patient health, revenue, staff satisfaction and workforce retention.	Nancy L. Kaszak/Illinois Telehealth Initiative
32	Providers		2) Providing clarity on the current regulations for mental health-focused advanced practice professionals and other Medicaid eligible advanced practice professionals would be helpful. Any clinician licensed, in good standing with the state of Illinois and registered under the IMPACT program should be able to provide care via TeleHealth. We recommend the language in Section 140.403(b)(1)(B) be changed to "The distant site provider must be an eligible Illinois Medicaid participating provider."	Nancy L. Kaszak/Illinois Telehealth Initiative
33	Providers	Network Adequacy. Additional Medicaid Clarifications to Sought from State Partners	We support additional network adequacy language to clarify that providers preferred by the patient and considered in-network for an in-person service will not be denied by Medicaid fee-for-service or MCOs for that service delivered via telehealth (when applicable). In addition, we support language to clarify that an immediately available in person service preferred by the patient will not be denied by Medicaid fee-for service or MCOs due to the availability of an alternative service delivered via telehealth preferred by insurers.	Nancy L. Kaszak/Illinois Telehealth Initiative
34	Providers		1) Requirement that the Tele-presenter be a certified healthcare professional should be removed	Katie Bohling/Lurie Children's Hospital
35	Providers		1) Allow tele-health services by NPs/APNs due to lack of psychiatrists.	Marvin Lindsey/Community Behavioral Health Association

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No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
36	Providers		3) "An appropriately trained telepresenter must be present with the patient when medically Necessary."	Nina Antoniotti/Southern Illinois University
37	Providers		4) "The distant site provider must be an eligible Illinois Medicaid participating provider." Section 140.403	Nina Antoniotti/Southern Illinois University
38	Providers		5) Strike all separate provisions for TelePsychiatry. TelePsychiatry is not treated differently than other medical professionals in any other state. All other language changes proposed would govern those providers in the behavioral health sciences, the same as all other professional disciplines.	Nina Antoniotti/Southern Illinois University
39	Providers		11) Strike as unnecessary. State law as well as federal OBRA and COBRA requires communication from consulting providers to referring providers.	Nina Antoniotti/Southern Illinois University
40	Providers		15) Any changes in reimbursement policies that address coverage for Licensed Clinical Social workers (LCSW) and Licensed Clinical Psychologists (LCP) should also include provisions that allow for the use of TeleHealth, as defined by HFS in the proposed changes noted above.	Nina Antoniotti/Southern Illinois University
41	Providers		1) Any licensed clinician, in good standing with the state of Illinois should be able to provide care via telehealth as long as it is clinically indicated.	Angela Grover/Presence Health
42	Providers		2. Increased access for both SUD licensed treatment providers and Community Mental Health Centers to utilize Telehealth to support connecting patients with a aftercare/continuing care placement in order to increase connections to services post treatment and reduce unnecessary re-admissions	Eric Foster/IABH
43	Remote Monitoring	Shortage of Pediatric Pulmonologists resulting in long wait times for treatment.	Mobile-Health and Remote Monitoring	Satyananarayan Hegde/University of Chicago Pediatric Services at Edward & Elmhurst Hospitals

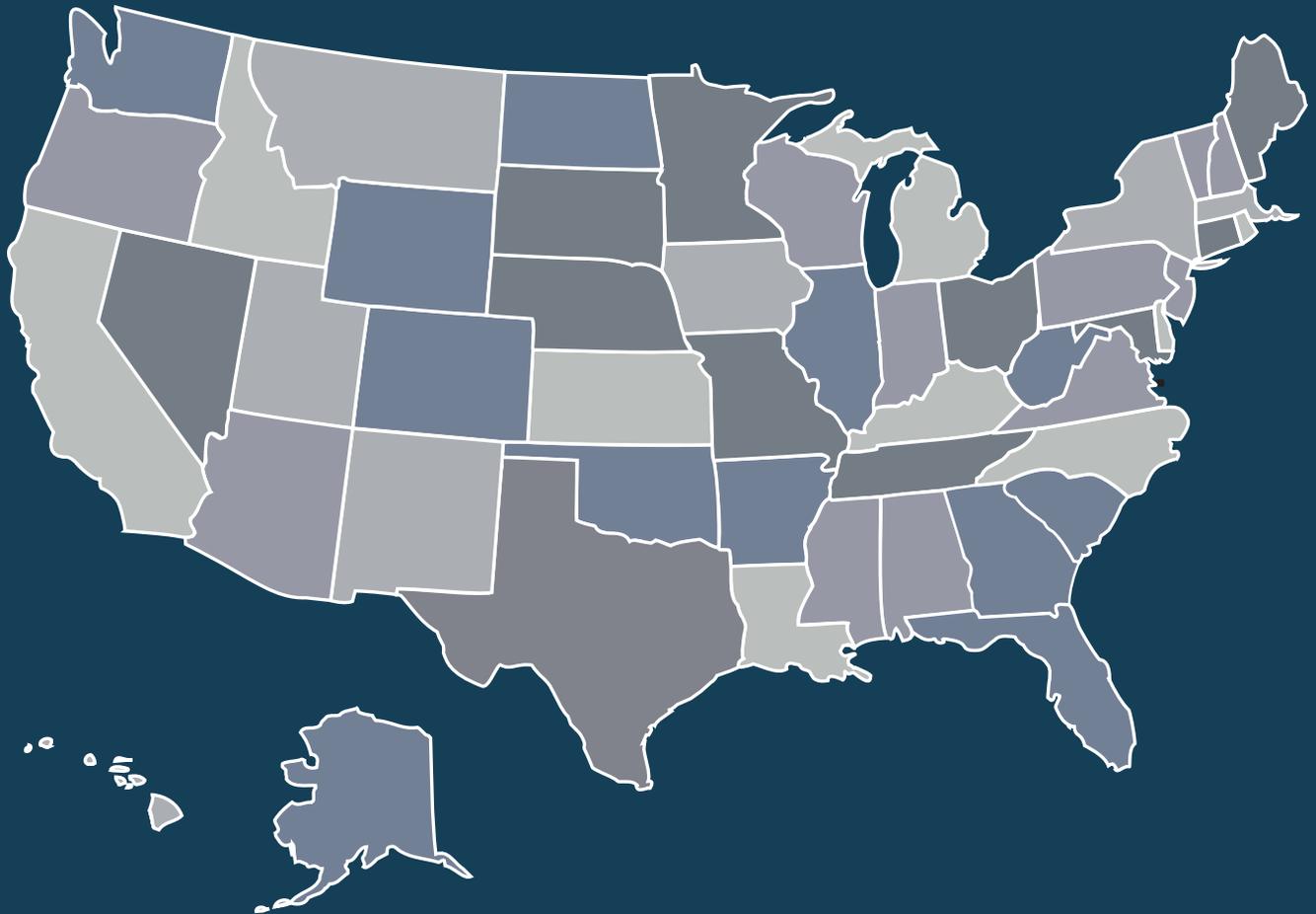
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No.	Area of Focus	Summary of Challenge	Overview of Recommendation(s)	Submitted by Name/Organization
44	Remote Monitoring		1. Identify criteria and provide coverage for Hospice and Home Health providers when utilizing remote monitoring and video contact for disease/symptom management when appropriate.	Sheila Guither/OSF Healthcare
45	Remote Monitoring		2. Identify opportunities for Hospice and Home Health providers to utilize remote monitoring services and video to prioritize the type of visit needed (virtual or in-home) based on patient condition.	Sheila Guither/OSF Healthcare
46	Service		6) Strike or adopt the following language: "Group psychotherapy is a covered service equal to in-person care"	Nina Antoniotti/Southern Illinois University



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STATE TELEHEALTH LAWS AND REIMBURSEMENT POLICIES

A COMPREHENSIVE SCAN OF THE 50 STATES AND DISTRICT OF COLUMBIA



SPRING 2018

State Telehealth Laws and Medicaid Program Policies

Introduction

The Center for Connected Health Policy's (CCHP) Spring 2018 release of its report on "State Telehealth Laws and Reimbursement Policies" offers policymakers, health advocates, and other interested health care professionals the most current summary guide of telehealth-related policies, laws, and regulations for all 50 states and the District of Columbia. States continue to pursue their own unique set of telehealth policies as more and more legislation is introduced each year. Some states have incorporated policies into law, while others have addressed issues such as definition, reimbursement policies, licensure requirements, and other important issues in their Medicaid Program Guidelines.

While this guide focuses primarily on Medicaid fee-for-service policies, information on managed care is noted in the report if it was available. The report also indicates any particular areas where we were unable to find information. Every effort was made to capture the most recent policy language in each state as of April 2018. Recently passed legislation and regulation have also been included in this version of the document with their effective date noted in the report (if applicable). This information also is available electronically in the form of an interactive map and search tool accessible on our website cchpca.org. Consistent with previous editions, the information will be updated biannually, as laws, regulations and administrative policies are constantly changing.

Telehealth Policy Trends

While many states are beginning to expand telehealth reimbursement, others continue to restrict and place limitations on telehealth delivered services. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends are evident when examining the various policies. Live video Medicaid reimbursement, for example, continues to far exceed reimbursement for store-and-forward and remote patient monitoring (RPM). However, over the past year there has been a slight uptake in Medicaid policy allowing for store-and-forward as well as remote patient monitoring reimbursement, although generally on a limited basis. For example, Connecticut is allowing for store-and-forward reimbursement for physician-to-physician email consults (known as eConsult) exclusively, while Missouri has added store-and-forward and RPM reimbursement, but limited it to specific specialties. Nevada recently incorporated store-and-forward reimbursement by noting that they will cover asynchronous telehealth and lists no further limitations. Some states are veering away from standard definitions, such as Maryland which now allows reimbursement of asynchronous dermatology, ophthalmology and radiology, but excludes these specialties from the definition of store-and-forward. Other states have passed wide ranging laws requiring telehealth reimbursement in their Medicaid program in recent years, but some Medicaid programs have yet to respond with official regulation or documentation in their provider manuals indicating they are indeed reimbursing services via telehealth. Other noteworthy trends include the addition of the home and schools as an eligible originating site in some states, and the inclusion of teledentistry as a specialty qualifying for Medicaid reimbursement and/or required to be reimbursed by private insurers.

Additionally, some states have begun creating special exceptions or allowances to use telehealth for certain situations, such as Maryland allowing the home to be an originating site for the hearing impaired, or Utah passing a private payer law but only for telepsychiatry. Laws and regulations allowing practitioners to prescribe medications through live video interactions has also increased, as well as a few states even allowing for the prescription of controlled substances over telehealth within federal limits. This has mainly been a result of the opioid epidemic and the need to prescribe controlled substances used in medication assisted therapy treatment.

A few additional significant findings include:

- Forty-nine states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service. This number has increased by one (RI) during this update.
- Fifteen state Medicaid programs reimburse for store-and-forward. However, three additional states (HI, NY and NJ) have laws requiring Medicaid reimburse for store-and-forward but as of the creation of this edition, yet to have any official Medicaid policy indicating this is occurring.
- Twenty state Medicaid programs provide reimbursement for RPM. As is the case for store-and-forward, three state Medicaid programs (HI, NY and NJ) have laws requiring Medicaid reimburse for RPM but don't have any official Medicaid policy. Kentucky Medicaid is also required to create a RPM pilot, but CCHP has not seen any evidence that the pilot has been established.
- Nine state Medicaid programs (Alaska, Arizona, Illinois, Minnesota, Mississippi, Missouri, Oklahoma, Virginia and Washington) reimburse for all three, although certain limitations apply.

How to Use this Report

Telehealth policies are organized into eleven categories that address the distinct issues of definition, Medicaid reimbursement by type of service, licensing, and other related requirements. The first column indicates whether policy has been codified into law and/or in state regulation. The second column indicates whether the policy is defined administratively in the Medicaid program, unless otherwise noted. In many instances the specific policy is found in law and/or regulations and administrative policy, but that is not always the case. This report primarily addresses the individual state's policies that govern telehealth use when seeking Medicaid coverage for service. However, we have also included a specific category that describes whether a state has established any specific policies that require private insurers to pay for telehealth services. A glossary is also available at the end of the report.

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Mei Kwong, CCHP Executive Director or Christine Calouro, Program Associate, at info@cchpca.org. We would also like to thank our colleagues at each of the twelve HRSA-funded Regional Telehealth Resource Centers who contributed to ensuring the accuracy of the information in this document. For further information, visit cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

Mei Wa Kwong, JD
Executive Director
May 2018

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

A Comprehensive Scan of the 50 States and the District of Columbia: Findings and Highlights

The Spring 2018 release of the Center for Connected Health Policy's (CCHP) report of state telehealth laws and Medicaid reimbursement policies is the fifteenth updated version of the report since it was first released in 2013. It is now updated on a biannual basis, in spring and fall. An interactive map version of the report is available on CCHP's website, cchpca.org. Due to constant changes in laws, regulations, and policies, CCHP will continue to update the information in both PDF and map formats twice a year to keep it as accurate and timely as possible.

It should be noted that even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. Throughout the report, CCHP has notated changes in law that have not yet been incorporated into the Medicaid program, as well as laws and regulations that have been approved, but not yet taken effect.

Methodology

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the report's primary resources. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, transmittals or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in this report specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources. Newly approved regulations related to specific telehealth standards for various professions are noted in the "Comment" section of the state's page.

The survey focused on eleven specific telehealth-related policy areas. These areas were chosen based upon the frequency they have appeared in discussions and questions around telehealth reimbursement and laws. These areas are:

- Definition of the term telemedicine/telehealth
- Reimbursement for live video
- Reimbursement for store-and-forward
- Reimbursement for remote patient monitoring (RPM)
- Reimbursement for email/phone/fax
- Consent issues
- Location of service provided
- Reimbursement for transmission and/or facility fees
- Online prescribing
- Private payer laws
- Cross-state licensure

Key Findings

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system or practitioner provides health care services in multiple states. In most cases, states have moved away from duplicating Medicare's restrictive telehealth policy, with some reimbursing a wide range of practitioners and services, with little to no restrictions.

As noted previously, even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. In the findings below, there are a few cases in which a law has passed requiring Medicaid reimbursement of a specific telehealth modality or removal of restrictions, but Medicaid policies have yet to reflect this change. CCHP has based its findings on **current** Medicaid policy according to those listed in their program regulations, manuals or other official documentation. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP's report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming this.

Below are summarized key findings in each category area contained in the report.

Definitions

States alternate between using the term "telemedicine" or "telehealth". In some states both terms are explicitly defined in law and/or policy and regulations. "Telehealth" is sometimes used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" prefix are also becoming more prevalent. For example, the term "telepractice" is being used frequently as it relates to physical and occupational therapy, behavioral therapy, and speech language pathology. "Telesychiatry" is also a term commonly used as an alternative when referring specifically to psychiatry services. Many professional boards are also adopting definitions of telehealth specific to their particular profession, in some cases, creating many different definitions for the term within a state's administrative code. For example, Wyoming passed legislation encouraging each Board to adopt their own definition of the term "telehealth". This has the potential to add to the already complex telehealth policy environment.

Some states put specific restrictions within the definitions, which often limit the term to "live" or "interactive", excluding store-and-forward and RPM from the definition and subsequently from reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. Forty-nine states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Only Alabama lacks a legal definition for either term.

Medicaid Reimbursement

Forty-nine states and the District of Columbia have some form of Medicaid reimbursement for telehealth in their public program. The only state that we determined did not have any written definitive reimbursement policy is Massachusetts.

However, the extent of reimbursement for telehealth delivered services is less clear in some states than others. For example, Iowa's Medicaid program issued a broad regulatory statement confirming that they do provide reimbursement for telehealth in 2016. This policy change came as a result of IA Senate Bill 505 which required the Department of Human Services to adopt formal rules regarding their longstanding (although unwritten) policy to provide reimbursement for telehealth. However, the rule that was adopted simply states that "in person contact between a provider and patient is not required for payment for

services otherwise covered and appropriately provided through telehealth as long as it meets the generally accepted health care practices and standards prevailing in the applicable professional community.” Neither the legislation nor the rule provides a definition of telehealth, which leaves the policy vague and up for interpretation. Therefore, it is unclear whether store-and-forward or RPM services would fall under the umbrella of this telehealth policy.

It should be noted that Massachusetts employs managed care plans in its Medicaid program. We did not examine whether the participating managed care plans provided any form of telehealth reimbursement.

Live Video

The most predominantly reimbursed form of telehealth modality is live video, with every state offering some type of live video reimbursement in their Medicaid program (except Massachusetts). However, what and how it is reimbursed varies widely. The spectrum ranges from a Medicaid program in a state like New Jersey, which will only reimburse for telepsychiatry services, to states like California, which reimburses for live video across a wide variety of medical specialties. In addition to restrictions on specialty type, many states have restrictions on:

- The type of services that can be reimbursed, e. g. office visit, inpatient consultation, etc.;
- The type of provider that can be reimbursed, e. g. physician, nurse, physician assistant, etc.; and
- The location of the patient, referred to as the originating site.

These restrictions have been noted within the report to the extent possible.

While only Rhode Island has added reimbursement for live video (through an addition to the program’s fee schedule) since Aug. 2016, many states have made adjustments to their policies, in many cases broadening reimbursement to include more specialties, services (CPT codes) and eliminating originating site restrictions. For example, reimbursement for teledentistry has grown significantly over the past year, with AZ, CA, GA, HI, MN, MO, MT, NC, NY, WA all offering reimbursement in the specialty. Other states are taking steps to eliminate unnecessary restrictions. This was evident in the state of Vermont during this update, which took steps to eliminate provider type restrictions in their Medicaid program (now only requiring that a provider be enrolled in the Medicaid program), as well as eliminated the need to document the reason that the visit was occurring over telemedicine as opposed to in-person.

Store-and-Forward

Store-and-forward services are only defined and reimbursed by a handful of state Medicaid Programs. In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in “real time,” automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether in those states. Of those states that do reimburse for store-and-forward services, some have limitations on what will be reimbursed. For example, California only reimburses for teledermatology, teleophthalmology and teledentistry. Currently, fifteen state Medicaid programs reimburse for store-and-forward. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered ‘telehealth’). Maryland’s Medicaid program specifies that while they don’t reimburse for store-and-forward, they do not consider use of the technology in dermatology, ophthalmology and radiology to fit into the definition of store-and-forward. Because these are specialties that typically fit into the store-and-forward definition in other states (for example, California), Maryland was included as reimbursing for store-and-forward for purposes of this report. States that do reimburse for store-and-forward include:

- Alaska
- Arizona
- Connecticut
- California
- Georgia
- Illinois
- Maryland
- Minnesota

- Mississippi
- Missouri
- New Mexico
- Nevada
- Oklahoma
- Virginia
- Washington

In addition to the states above, three other states have laws requiring Medicaid reimburse for store-and-forward services, but CCHP has not been able to locate any official Medicaid policy indicating that they are in fact reimbursing. They include New Jersey, New York and Hawaii. Note that Hawaii and New York both have approved Medicaid State Plan Amendments allowing them to reimburse for store-and-forward within their Medicaid programs but CCHP is still awaiting official written Medicaid policy indicating that they are actively reimbursing for store-and-forward.

It should also be noted that Connecticut has limited reimbursement to a very specific type of store-and-forward they term “eConsult”, which is a certain secure email system that allows healthcare providers to engage in email consultations with each other regarding a particular patient.

Remote Patient Monitoring (RPM)

Twenty states have some form of reimbursement for RPM in their Medicaid programs. As with live video and store-and-forward reimbursement, many of the states that offer RPM reimbursement have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical conditions for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected.

For example, Colorado requires the patient to be receiving services for at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes. Further, the patient must still meet other conditions. In this update, CCHP noted that Utah eliminated their remote patient monitoring pilot program, however they are still counted as reimbursing for RPM because they maintain a home telemetry program.

Maine passed legislation in 2017 requiring the Department eliminate certain requirements associated with their RPM reimbursement, including that a patient have a certain number of ER visits or hospitalizations, which the Medicaid program has now implemented. Alaska’s Medicaid program has the least restrictive RPM reimbursement policy, requiring only that services be provided by a telemedicine application based in the recipient’s home with the provider only indirectly involved in service provision.

The states that currently offer some type of RPM reimbursement in their Medicaid program are:

- Alabama
- Alaska
- Arizona
- Colorado
- Illinois
- Indiana
- Kansas
- Louisiana
- Maine
- Minnesota
- Mississippi
- Missouri
- Nebraska
- Oklahoma
- South Carolina
- Texas
- Utah
- Vermont
- Virginia
- Washington

As is the situation with store-and-forward, Hawaii, New York and New Jersey all have laws requiring the Medicaid programs reimburse for RPM, however there is no official written Medicaid policy indicating that they have implemented it and how a provider can seek reimbursement, therefore CCHP has not counted

them in its official count. Additionally, while Kentucky Medicaid is required to establish a RPM pilot project, CCHP has not been able to locate any official announcement from their Medicaid program of such a pilot. Also, RPM is sometimes reimbursed through other state Departments separate from Medicaid, for example, South Dakota, where RPM is reimbursed through their Department of Aging Services.

Note that the states listed are only for RPM in the home where some specific information related to technology or telecommunication could be found. Some states reimburse for home health services, but no further details of what modality was reimbursed could be located. Additionally, some states may already be reimbursing for tele-ICU (a form of RPM); however, these were not included.

Email/Phone/Fax

Email, telephone, and fax are rarely acceptable forms of delivery unless they are in conjunction with some other type of system. States either are silent or explicitly exclude these forms, sometimes even within the definition of telehealth and/or telemedicine.

Transmission/Facility Fee

Thirty-two states will reimburse either a transmission, facility fee, or both. Of these, the facility fee is the most common. Policies often stipulate a specific list of facilities eligible to receive the facility fee. Medicare also reimburses for a facility fee for the originating site provider.

Location of Service

Although the practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is decreasing, some states continue to maintain this policy. New Hampshire was the last remaining state to follow Medicare's telehealth policy, restricting originating sites to rural health professional shortage areas or non-Metropolitan Statistical Area (MSA), but eliminated the policy with the passage of recent legislation, although other Medicare restrictions on telehealth are still maintained in New Hampshire Medicaid. States that continue to have telehealth geographic restrictions are more ambiguous in their policies. In South Dakota's Medicaid program, they simply state that an originating and distant site cannot be located in the same community. However, only four states currently have these types of restrictions, continuing the trend to eliminate such limitations. States that have removed such a policy in recent years are Colorado, Idaho, Nebraska, New Hampshire, Nevada and Missouri. Although Hawaii and Indiana passed a law prohibiting a geographic limitation for telehealth in their Medicaid program, such language is still present in their regulation and/or Medicaid policy.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site, often excluding the home as a reimbursable site, impacting RPM as a result. Currently twenty-three jurisdictions have a specific list of sites that can serve as an originating site for a telehealth encounter. This number has remained unchanged since April 2017. Additionally, more state Medicaid programs are now explicitly allowing the home to serve as an originating site, with ten states (DE, CO, MD, MI, MN, MO, NY, TX, WA and WY) adding the home explicitly into their Medicaid policy since Aug. 2016. In some cases, certain restrictions apply. Most states that allow the home as an originating site do note that they are not eligible for an originating site facility fee. Some state Medicaid programs only allow the home to serve as an originating site for certain specialties such as mental health, while others require a licensed in-state provider to be physically located within the state in order to enroll as a Medicaid provider (for example California). More states are also allowing schools to serve as an originating site, with sixteen jurisdictions explicitly allowing schools to be originating sites for telehealth delivered services, although restrictions often apply.

Consent

Thirty-one jurisdictions include some sort of informed consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. States with informed consent policies include:

- Alabama
- Arizona
- California
- Colorado
- Connecticut
- District of Columbia
- Delaware
- Georgia
- Idaho
- Indiana
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Mississippi
- Missouri
- Nebraska
- New Jersey
- New York
- Ohio
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

Licensure

Nine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state). States with such licenses are:

- Alabama
- Louisiana
- Maine
- Minnesota
- New Mexico
- Ohio
- Oregon
- Tennessee (Osteopathic Board only)
- Texas

The Tennessee Medical Board eliminated their telemedicine license effective Oct. 31, 2016. Individuals granted a telemedicine license under the former version of the rule may apply to have the license converted to a full license. Under certain circumstances individuals who do not convert to a full license can retain their telemedicine license. Tennessee's Osteopathic Board will continue to issue telemedicine licenses as of this time.

Like Tennessee, Montana and Nevada also both dropped their telemedicine special license in 2016, and are among twenty-two states that adopted the Federation of State Medical Boards (FSMB)'s Interstate Medical Licensure Compact in its place. The Compact allows for an Interstate Commission to form an expedited licensure process for licensed physicians to apply for licenses in other states. States that have adopted the FSMB's Compact language include:

- Alabama
- Arizona
- Colorado
- Idaho
- Illinois
- Iowa

- Kansas
- Maine
- Minnesota
- Mississippi
- Montana
- Nebraska
- Nevada
- New Hampshire
- Pennsylvania (Implementation delayed)
- South Dakota
- Tennessee (Implementation delayed)
- Utah
- West Virginia
- Washington
- Wisconsin
- Wyoming

Still other states have laws that don't specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state's licensing conditions are met.

Online Prescribing

There are a number of nuances and differences across the states. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. States may also require that a physical exam be administered prior to a prescription being written, but not all states require an in-person examination, and some specifically allow the use of telehealth to conduct the exam. Other states have relaxed laws and regulations around online prescribing. For example, while more stringent policies typically exist restricting practitioners from prescribing controlled substances through telehealth, a few states have begun opting to explicitly allow for the prescribing of controlled substances within federal limits. Many of these laws have passed as a result of the opioid epidemic and the need to prescribe certain medications associated with medication assisted therapy (MAT). Most recently, West Virginia passed new legislation explicitly allowing a practitioner to provide aspects of medication-assisted treatment through telehealth if it is within their scope of practice. Michigan and Virginia also passed laws in 2017 allowing for the prescribing of Schedule II-V controlled substances through telehealth under certain circumstances. In addition to more states explicitly allowing for the prescribing of controlled substances using telehealth, some Medicaid programs are also beginning to pay for medication therapy management services when provided through telehealth including, MN, MI and LA.

An increasing number of states are also passing legislation directing healthcare professional boards to adopt practice standards for its providers who utilize telehealth. Medical and Osteopathic Boards often address issues of prescribing in such regulatory standards. This often occurs immediately following the passage of a private payer reimbursement bill in a state. This was most recently the case with North Dakota, whose Board of Medicine passed telehealth practice standards following the passage of the state's first private payer telehealth reimbursement bill in 2017. The new rule does allow a patient and licensee to establish a relationship over telemedicine.

Private Payers

Currently, thirty-eight states and DC have laws that govern private payer telehealth reimbursement policies. Both Iowa and Utah passed telehealth private payer reimbursement legislation, although both laws don't go into effect until Jan. 1, 2019. Additionally, only a few private payer laws require that the reimbursement amount for a telehealth-delivered service be equal to the amount that would have been reimbursed had the same service been delivered in-person. Because so many states now have private payer reimbursement bills, the more common policy change in relation to private payers, is to amend a law to expand its applicability to additional specialties or policy types. For example, Michigan expanded the applicability of their private payer law to dental coverage.

Utah, on the other hand, who just passed their first private payer bill, singles out telepsychiatry services. While they are not the only state to limit private payer telehealth reimbursement requirements to a specific specialty (see Arizona and Alaska), they are the first state to make a distinction between in-network and out-of-network providers in their law. Under the new law (effective Jan. 1, 2019), a health benefit plan is required to cover mental health services for in-network physicians, or out-of-network psychiatrists only if an in-network consultant is not made available within seven business days after the initial request.

Additional Findings & Potential Future Trends

In addition to the findings noted in the various sections above, CCHP took note of two changes in both Maryland and Washington that were noteworthy. Maryland made certain revisions to their Medicaid telehealth reimbursement policy targeted at making telehealth accessible to the hearing impaired. Revisions included adding providers fluent in American sign-language to the list of telehealth eligible providers as well as an exception allowing the home to be an eligible originating site for the hearing impaired. This is the first time CCHP has noted such an exception for this population and could start a trend to build into telehealth policies special exceptions and allowances for populations with very specific special needs.

CCHP also took note of a change made in Washington Medicaid’s program which made significant alterations to their reimbursement of store-and-forward delivered services. Prior to this update, Washington had merely required that store-and-forward be associated with an office visit to be reimbursed. However, now the Medicaid manual states that if a store-and-forward consultation results in a face-to-face visit in person or via telemedicine with the specialist within 60 days of the store-and-forward consult, the agency will not pay for the consult. This may indicate increased attention on ensuring telehealth services are resulting in either a replacement or reduction of services (rather than extra services), as well as cost savings for the insurer. If the implementation of this policy proves successful, there may be other state Medicaid programs and insurers who follow suit with similar policies.

CCHP noted in the April 2017 update of this report, that states were moving away from the GT modifier and utilizing either the newly adopted CMS place of service code 02 or the 95 modifier adopted by the American Medical Association, or a combination of two or more of these has continued. States that CCHP identified in its search that adopted either code are listed below.

02 POS Code	95 Modifier
Iowa	California
Kansas	Hawaii
Minnesota	Texas
Montana	Washington
Utah	
Vermont	
Washington	
Wisconsin	

* Not a complete list.

CCHP did not identify any new states with this policy change in their manuals during this update.

In 2017 Texas and Colorado passed legislation restricting plans from limiting telehealth to a specific technology or application. CCHP previously noted that this could also be a potential trend, as many health insurance companies are now partnering with technology vendor service providers, and in some cases forcing providers and patients into using these vendors. However, while other states have introduced legislation with the same intent, none have been passed thus far.

Additionally, many states are beginning to look at ways telehealth can help meet network adequacy standards, and are incorporating it into criteria used to evaluate whether a health plan has achieved network adequacy.

Current Legislation

In the 2018 legislative session, forty-four states have introduced over 160 telehealth-related pieces of legislation. Many bills address different aspects of reimbursement in regards to both private payers and Medicaid, with some bills making changes to existing reimbursement laws. Many states have also proposed legislation that would direct licensure boards to establish standards for the practice of telehealth within their given profession. **Where appropriate, newly passed and/or approved legislation and regulations are noted for each state. However, many of these changes may not currently be in effect.**

To learn more about state telehealth related legislation, visit CCHP's interactive map at cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.