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Medicaid Policies on Telehealth Services: A Comparative Analysis

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This report was prepared under a contract with the Maine Health Access Foundation. All opinions, inferences, and analyses presented herein are the product of authors and do not necessarily reflect the official position of the Maine Health Access Foundation.

Due to the changing nature of the information presented within this report, readers are encouraged to verify current state and federal laws before relying on information included herein. Further, readers should always consult with legal counsel to ascertain the facts specific to their situation.

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Medicaid Policies On Telehealth Services: A Comparative Analysis

Executive Summary

In April 2006, Governor John Baldacci released the first biennial State Health Plan¹. One key goal is to: *“Seek innovations in telemedicine to assure our most rural citizens have access to a full array of health care choices and that the system of care reaches every part of Maine and strengthens rural health capacity.”*

The Maine Health Access Foundation (MeHAF) commissioned this report to support better utilization of Maine's extensive telehealth infrastructure to advance universal access to high quality care.

This report provides a comparative analysis of telehealth policies for purposes of assisting in the research, evaluation and development of a rational and comprehensive telehealth policy for Maine's Medicaid program, MaineCare. As part of this study we examined the telehealth reimbursement by the federal Medicare program, private payers and other state Medicaid programs. As requested by MeHAF, we specifically examined six target states: Alaska, Kentucky, Massachusetts, New Hampshire, Texas and Vermont. The New England states were included for purposes of regional comparison even though the scope of their Medicaid reimbursement was acknowledged to be extremely limited.

CTeL prepared a suggested model regulation based, in part, on MaineCare's current policies and on best practices identified by target states. This model act is designed to give the state flexibility to incorporate telehealth technologies that will enhance rather than limit patient access to needed in-person and telehealth technologies. It also attempts to comprehensively address telehealth services in a way that supports MaineCare's commitment to safe, quality care, patient choice, and equitable treatment of telehealth providers. It acknowledges the benefits of telehealth services as well as the importance of local rural health infrastructure and addresses budget and cost effectiveness issues in deploying these tools to meet the challenges of the growing demands on our health system.

Information is provided on the policies adopted by other states and data related to federal telehealth expenditures. In general, neither the states nor the federal government have seen major costs associated with expansions in telehealth policies. At the federal level the major expansions in telehealth statutory policy have resulted in an almost negligible increase in provider payments. While it is difficult to measure any offset savings or the value of improved access, it is clear that these program expansions, which have been in place for a number of years, have not resulted in any significant negative fiscal impact.

The model act and modifications that we have prepared take these results into account and provide the state with some additional tools to utilize in deploying telehealth technology for the benefit of MaineCare patients.

¹ <http://mainegov-images.informe.org/governor/baldacci/healthpolicy/2007%20State%20Health%20Plan.pdf>

Introduction

In December 2005, MeHAF contracted with the Center for Telehealth & E-Health Law (CTeL) to primarily provide a comparison and analysis of Medicaid policies in six specified states: Alaska, Kentucky, Massachusetts, New Hampshire, Texas, and Vermont and copies of the relevant statutes where available. In addition, where the data is already available, provide an overview of Medicare and private payer policies for telehealth, a brief overview of some of the legal issues facing telehealth, and sample language for more comprehensive MaineCare regulations.

By understanding what other states are doing with regard to telehealth reimbursement and examining both federal and state statutory and regulatory language, MeHAF can determine whether these examples might serve as a model to improve access to care for Maine's Medicaid beneficiaries.

The six states were selected for several reasons. Massachusetts, New Hampshire and Vermont were selected because of their presence in the New England region. Alaska was selected because of the extent of its telehealth networks, its geographic isolation, rural nature, and the remote location of many of its citizens. Kentucky and Texas were chosen because of the wide variety and comprehensive nature of their telehealth policies. Texas, like Maine and Alaska, also shares an international border.

Maine has certain physical, geographical and economic characteristics that could influence the type of telehealth policy most appropriate for the state. Maine is the northernmost state in the New England region and the easternmost state in the United States. It is bordered on the west and south by New Hampshire (the only state that borders on only one other state), and adjacent to the Canadian provinces of Quebec to its northwest and New Brunswick to its northeast. Maine is a large, sparsely populated state with a land mass that exceeds all of the other New England states combined (see Table 1).

Table 1. Population Ranking and Land Mass Ranking – Selected Comparison States

Rank/Locale	Residents/(National Rank) ²	Land Mass (Sq. Miles)/(National Rank) ³
State		
Texas	22,050,200 (2)	261,914 (2)
Massachusetts	6,360,110 (13)	7,839 (45)
Kentucky	4,065,700 (26)	39,732 (36)
Maine	1,283,700 (40)	30,865 (39)
New Hampshire	1,276,580 (41)	8,969 (44)
Alaska	634,180 (47)	570,374 (1)
Vermont	612,710 (49)	9,249 (43)

As shown in Table 2, forty percent (40%) of Maine's population of 1,283,700⁴ lives in metropolitan areas⁵. Greater Portland is the largest urban area with over 100,000 inhabitants.

² Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements). See "Notes to Demographic and Health Coverage Topics Based on the CPS" at <http://www.statehealthfacts.kff.org/methodology>.

³ Almanac - U.S.; Department of Commerce, Bureau of the Census

⁴ 2003-2004, <http://www.statehealthfacts.kff.org>.

Sixty percent (60%) of the population resides in non-metropolitan areas in contrast to the seventeen percent (17%) in the United States as a whole.

As shown in Table 2, Maine has significantly fewer people, approximately forty percent (40%), living in metropolitan areas than all of the other comparison states except for Vermont with twenty-eight percent (28%). This is in stark contrast to the United States as a whole where an overwhelming eighty-three percent (83%) live in metropolitan areas. Additional information regarding Maine and the comparison states is available from the Census Bureau at www.census.gov.

Table 2. Population Distribution by Metropolitan Status, Maine (2003-2004), US (2004)

	US	ME	AK	KY	MA	NH	TX	VT
Metropolitan	83%	40%	51%	46%	97%	64%	86%	28%
Non-Metropolitan	17%	60%	49%	54%	3%	36%	14%	72%

The geographic distribution of Maine's population presents special challenges to the state's health delivery system. It would appear that the state could benefit significantly through the use of telehealth services.

The Office of MaineCare Services, formerly the Bureau of Medical Services, was created to administer Maine's Medicaid program. Medicaid, a joint federal-state program, provides health coverage to certain types of individuals or eligibility groups, such as categorically needy, medically needy, or special groups, the latter includes approximately 44.7 million low-income persons nationwide, nearly 22 million children, and nursing home coverage for low-income elderly.

MaineCare Services coordinates the programs and benefits, assures that the Agency operates under consistent policies in keeping with its goals and federal mandates, and provides accountability necessary to determine that they are administered in an effective and efficient manner. Information about programs and health care benefits that MaineCare Services administers is available at <http://www.maine.gov/dhhs/bms/>.

Background

The Center for Telehealth & E-Health Law is one of the foremost authorities on public policy information related to telehealth in the United States. CTeL was founded as the Center for Telemedicine Law in 1995 by the Mayo Clinic, the Cleveland Clinic Foundation, Texas Children's Hospital, and the Midwest Rural Telehealth Consortium to overcome the legal and regulatory barriers to telehealth, perform policy analysis, and educate federal and state policymakers, providers, network administrators and the general public on telehealth. CTeL has authored numerous reports and studies for state agencies and the federal government on telehealth and provided critical analysis of issues facing telehealth for telehealth networks and providers around the United States as well as internationally.

⁵ Metropolitan areas are defined as including at least one city with 50,000 or more inhabitants, or a Census Bureau defined urbanized area of at least 50,000 inhabitants and a total metropolitan population of 100,000 or more (75,000 in New England)

In the Department of Commerce's 1997 Report to Congress, "telemedicine" referred to "the use of electronic communication and information technologies to provide or support clinical care at a distance."⁶ Telehealth is a broader concept considered more provider neutral. Telemedicine is considered by some to encompass only physician services. Telehealth is viewed by many to include a broader range of providers all operating within their scope of practice. For the purposes of this report, telehealth is defined as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. The overall goal of telehealth is to provide patients with the right care, at the right time, by the right provider. Telehealth technology has been used for a variety of reasons and some of its benefits may include:

- Improving timely access to primary care, specialists, and consultants
- Increasing health system efficiencies
- Reducing transportation expenses
- Improving quality of care
- Enhancing communications among providers, and between providers and patients
- Overcoming geographical barriers to providing care
- Overcoming professional clinical shortages
- Enhancing preventive services
- Supporting self-care
- Providing more timely care
- Attending to biosurveillance and homeland security
- Reducing unnecessary evaluations through electronic health records
- Reducing severity as more care is available offering earlier clinical interventions
- Intervening earlier reducing the need for specialty or emergency care
- Augmenting less costly care provided in the home
- Reducing mortality and intensive care bed days through utilizing monitoring
- Supporting clinical education and respite for providers practicing in remote areas

Telehealth services have been provided in the United States for the past 40 years. Unfortunately, no one source exists that catalogues the number of telehealth encounters in the United States. The 2006 report, *Universities and State Activities: Telemedicine, Telehealth, Informatics, and Research*,⁷ identified some 228 programs. However, clinical care via video conferencing, remote monitoring, distance learning, transmission of images (such as in radiology, dermatology, pathology), stroke care, and disease management is occurring though not captured in this data. Over 19 federal agencies, as well as the White House, either currently engage in or have expressed an interest in telehealth activities. In fact, in 2003, the Department of Veterans Affairs estimated that it delivered over 280,000 telehealth consultations per year involving 31 clinical specialties. Private entities, state public health agencies, corrections institutions, and schools, are engaging in telehealth as well.

⁶ 1997, Telemedicine Report to Congress, Department of Commerce, p. 1.

⁷ *Universities and State Activities: Telemedicine, Telehealth, Informatics, and Research*, Bloch Consulting Group, 2006.

"Since 1991, the Kansas University Center for Telehealth and Telemedicine (KUCTT) has grown to include 60 locations across the state and has conducted more than 13,000 consultations across 300 specialties. While telehealthcare services are becoming more widespread, they will likely be slow to expand until questions of Medicare and Medicaid coverage are settled. As the Baby Boomers age, particularly in the great expanse of America between the Appalachian and Rocky mountains, the issue of reimbursement for tele-healthcare services, including broadband connectivity, will come to the forefront of a policy discussion driven by the need to contain costs."

National Association of State Chief Information Officers (NASCIO), Issue Brief, Sept. 2004

While telemedicine took root before the middle of the twentieth century, there has been considerable growth in the field since the early 1990s when technology advanced sufficiently to make the delivery of services both clinically and financially feasible. In the early 90's, patients were usually located in a hospital or practitioner's office and they were provided services by a remote specialist. These encounters were often between the patient in a rural location that did not have sufficient medical services and a practitioner in a metropolitan location. The communications technology often consisted of a two-way audio and video conference and sometimes used special peripheral equipment to view images such as skin lesions or ear drums and to hear sounds such as heart conditions or lung sounds.

More recently videoconferencing and other telehealth technologies have been used for direct interaction between providers and patients in their own homes. Remote monitoring of patients in their homes allowed for real time and longitudinal data, e.g., vital signs including blood pressure, pulse, oxygen saturation, blood glucose, and weight, which are then remotely transmitted to a nurse or other health provider at a central location.

As the applications and technology have progressed, the term "telehealth" has become more prevalent. The terms "telehealth" and "telemedicine" often are used interchangeably among researchers, clinicians, and policymakers. Both terms encompass a broad array of technologies and applications, ranging from telephone, radio, and facsimile for data and voice transmission, remote patient monitoring, real-time or synchronous interactive video, store-and-forward, which combines text and images, and in the most extreme and rare instance, telerobotic surgery.

Telehealth is generally considered to be a broader and provider neutral term. However, since the historical and legislative sources cited in this report use both terms, the report defers to the word used by each specific author. Therefore, both terms will be used interchangeably in this document. A glossary of other telehealth related terms is included in Appendix A.

Telehealth may include a wide variety of services, including Care Management, Planning and Patient Support, Clinical Services, and Distance Learning: Education, Training, and Research delivered across a multitude of settings. Some of these applications and services are set forward in Table 3.

Table 3. A Sample of Applications and Services Provided by Telehealth

Management, Planning & Patient Support	Distance Education, Training & Research
• Diabetes care, management & education	• Consumer health information
• Discharge planning	• Consultations, second opinions
• Disease prevention	• Continuing clinical education
• Evaluation, pre-anesthesia	• Diabetes education
• Genetics counseling	• Distance learning
• Interviews, child abuse, domestic violence	• Foster family training
• Patient visitation	• Mentoring

Management, Planning & Patient Support	Distance Education, Training & Research
• Pharmacologic management	• Pre-dialysis education
• Screening	• Research, clinical trials
• Social services	• Simulation
• Support groups	• Virtual reality
• Translation services	
• Triage telephone call center	Administration
	• Meetings
	• Utilization and Quality Monitoring

A Sample of Clinical Services Provided by Telehealth	
• Behavioral/mental health	• Ophthalmology
• Burn care and management	• Pathology
• Cardiology, adult and pediatric	• Psychiatry, adult and pediatric
• Chronic disease management	• Psychological services
• Dermatology	• Public health
• Ear, nose and throat	• Radiology
• Emergency medicine	• Rehabilitation
• Endocrinology (not diabetes)	• Rheumatology
• Gastroenterology	• School
• General practitioner services	• Speech therapy
• Geriatrics	• Wound care
• Home care	
• Nephrology	

Market surveys estimate that in 2004 approximately 3,500 hospitals, clinics, schools and other facilities used some form of telehealth, up from 2,000 six years earlier.

Information included herein is derived from individual interviews with Medicaid staff and key telehealth providers in each state who were asked to supplement or verify the data provided by Medicaid staff. Additional information is based on prior reports done by contractors and grantees of the U.S. Health Resources and Services Administration's (HRSA) Office for the Advancement of Telehealth (OAT), federal resources, statutes, regulations, Medicare and Medicaid coverage manuals where accessible, online legal and legislative databases, conversations with key individuals, as well as extensive review of articles, websites, and white papers.

Dates associated with any legislation, regulations, or statute refers to the date it was originally effective even though in many instances it may have been amended.

Medicare Telehealth Policies

Current Medicare Policy

Medicare, administered by the Centers for Medicare & Medicaid Services⁸ (CMS) is the federal health insurance for more than 42.1 million elderly and disabled Americans, including individuals age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease. The expanding role of Medicare in reimbursement began when the

⁸ Additional information on CMS payments for telehealth services can be obtained through the CMS website located at: <http://www.cms.gov>.

105th Congress passed the Balanced Budget Act of 1997 (BBA), which mandated Medicare reimburse telemedicine care and fund telemedicine demonstration projects.

Medicare policy has often been used as a guide for setting state Medicaid or private insurance policies. As such, it may be helpful in guiding Maine in the development of a more comprehensive policy. However, as will be shown later in this report. Many states, and some private insurance plans, have already developed telehealth policies that are more expansive than the current federal program.

Medicare currently pays for telehealth services in a number of different ways. Telehealth services are currently being paid in some form or another under:

- Medicare managed care contracts;
- Hospital DRG payments;
- Support for Critical Access Hospitals;
- Certain Physician services traditionally recognized as not requiring face-to-face interactions with patients:
- Physician Payments as authorized by BIPA and federal regulations;
- Facility fee payments as authorized by BIPA and federal regulations;
- Telehealth and chronic care demonstration projects;
- Prospective payment for home care services; and
- Certain durable medical equipment payments.

While much attention is focused on the Medicare policy for fee-for-services payments to physicians, this focus ignores the much broader range of telehealth activities routinely paid for by the Medicare program. The following three examples illustrate the scope of payment opportunities under certain fixed or capitated Medicare programs:

- Managed Care. Medicare managed care contractors also have substantial flexibility to use their fixed payments to incorporate new technologies including telehealth services into their service delivery plans.
- Hospitals. Hospitals receive compensation for in-patients in the form of fixed payments under Part A of the Medicare program for a particular diagnosis for each patient. The payments are referred to as Diagnosis Related Group or “DRG” payments. Physicians receive a separate payment under Part B for the services they render to hospital in-patients. Hospitals have considerable flexibility on how to spend their DRG payments. There are no restrictions that would prohibit them from using these funds to offset some of the costs of maintaining telehealth technologies. However, there is no modification in the DRG amount to take into account added costs related to the use of telehealth services.
- Home Health Care Agencies. Home health agencies also receive a fixed payment for providing an array of services to certain homebound patients. With some limitations discussed below, these agencies may use their capitated payments for telehealth technologies.

In addition, CMS has historically paid for certain telehealth applications that traditionally do not involve face-to-face encounters between physicians and their patients. These applications

include teleradiology and EKG or EEG interpretation in most of the country. Some carriers also provide coverage for telepathology.

CMS also pays for certain durable medical equipment that may or may not have telehealth components. This equipment could include glucometers, holter monitors, apnea monitors, and a variety of other DME that has been adapted to include telehealth features.

Finally, CMS has paid for telehealth services as part of various demonstration projects over the last decade. Some of these projects were established by Congress and intended to specifically evaluate the use and value of telehealth technologies. In other cases, a demonstration project focusing on a specific disease such as the Chronic Disease Demonstration will incorporate new technologies as part of the overall project. In these cases, CMS has made special arrangements for Medicare payments.

History of Medicare Policy

Prior to 1997, there was no explicit statutory basis for Medicare telehealth payments. However, CMS was making payments for certain physician services such as teleradiology and to a more limited extent telepathology.

In 1997, the 105th Congress passed the Balanced Budget Act of 1997 (BBA). This law mandated telehealth payment and established several demonstration projects. BBA is the first major statutory change in the Medicare statute specifically authorizing telehealth payments. Section 4206 of the BBA required the Secretary of Health and Human Services to make Medicare payments for:

“professional consultation via telecommunications systems with a physician...or a practitioner.... furnishing a service...to a beneficiary under the Medicare program residing in a county in a rural area.... that is designated as a health professional shortage area...notwithstanding that the individual physician or practitioner providing the service is not in the same location as the physician or practitioner furnishing the service to that beneficiary.” Section 4206 (a), Balanced Budget Act of 1997

The statute further specified that the Secretary should establish a methodology for determining the amount of payments for these services with the following limitations:

- (1) the payment shall be shared between the referring physician or practitioner and the consulting physician or practitioner. The amount of such payment shall not be greater than the current fee schedule of the consulting physician or practitioner for the health care services provided.
- (2) The payment shall not include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for any such charges or fees.
- (3) The payment shall be made subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).
- (4) The payment differential of section 1848(a)(3) of such Act shall apply to services provided by non-participating physicians. The provisions of section 1848(g) of such Act

and section 1842(b)(18) of such Act shall apply. Payment for such service shall be increased annually by the update factor for physicians' services determine under section 1848(d) of such Act... Section 4206 (b), Balanced Budget Act of 1997

Concerns over the restrictive nature of the BBA telehealth provisions were exacerbated by the regulations published by CMS to implement this statute. The full text of the 1997 Act appears at B. In 1999, CMS promulgated administrative rules to implement the provisions specified in the BBA. Medicare began accepting claims in January 1999 and reimbursed interactive telemedicine care for Medicare beneficiaries who were treated in rural HPSAs. The full text of the implemented regulations appears at Appendix C. The statute and the new rules were seen by some telehealth advocates to be extremely restrictive given the then current realities of telehealth practice. An example of the comments by telehealth providers appears at Appendix D.

After several attempts to amend the 1997 law and refine telemedicine reimbursement, the push to improve rural access to telemedicine prevailed in mid-December 2000, when Congress passed the Benefits Improvement and Protection Act of 2000 (BIPA) (PL 106-554). This law replaced the telehealth provisions of BBA 1997 with an entirely new authority for telehealth reimbursement. The entire text of this section of BIPA appears in Appendix E. Section 223 (b) of BIPA:

- Requires the Secretary to pay for telehealth services that are furnished via a telecommunications system by a physician or a practitioner to an eligible telehealth individual enrolled in the Medicare program notwithstanding that the individual physician or practitioner provide the service in the same location as the beneficiary.
- Establishes a facility fee to the originating site equal to \$20 in 2001 and adjusted for inflation thereafter.
- States that in order to qualify for either a physician telehealth payment or a facility fee, the telehealth encounter must originate in one of the following sites:
 - The office of a physician or a practitioner;
 - A critical access hospital;
 - A rural health clinic;
 - A federally qualified health center or;
 - A hospital.
- Also requires that in order to qualify for either a physician telehealth payment or a facility fee the telehealth encounter must originate:
 - § In a health professional shortage area;
 - § In a county that is not a Metropolitan Statistical Area; or
 - § From an entity that was a federal telemedicine demonstration project that has been approved by HHS as of December 31, 2000.
- Specifies that the payment amount to the provider be equal to the amount the provider would have been paid if the service were provide without the use of a telecommunications system;
- Eliminates the requirement that the physician payment be split between the originating site and the physician providing the service;

- Eliminates the requirement that each patient be presented by a physician and instead provides that such a presenter is only required when the distant provider or practitioner determines it is medically necessary;
- Permits telehealth store-and-forward reimbursement only in Alaska and Hawaii;
- Telehealth services are defined to include professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000 by HCPCS codes 99241-99275, 99201-99215, 90804-90809, and 90862 and any additional codes as specified by the Secretary on an annual basis; and
- Clarifies that home health agencies may use prospective payment dollars to pay for home health services. However, telehome care visits will not count as a visit for purposes of triggering a higher or lower payment level. Also telehome care visits may not substitute for in-person visits specified in a physician certified plan of care.

The statutory changes contained in BIPA are significant in several regards. One of the most important changes involves payments to the originating sites. The Medicare telehealth reimbursement system was originally structured so that the physician at the originating site and the remote physician split the professional fee that would otherwise have been paid to the remote physician. This design was considered to be fundamentally flawed on several grounds. First, it seemed to invite fraud and be inconsistent with the direction of both federal anti-kickback statutes and state laws prohibiting fee splitting. In essence the originating physician gets a “cut” of every referral made to the remote physician regardless of the time or degree of involvement of the originating or presenting physician. Objections were raised by providers and by both federal and state regulators that this would invite excessive utilization.

The Congress used the “fee-split” methodology as a crude attempt to provide minimal financial support for the technology and service costs at the originating sites. However, the payments were not necessarily directed to the entity incurring those costs. For these reasons, Congress replaced the “fee split” with a nominal direct payment to the originating site. This payment was initially set at \$20 and then adjusted for inflation in subsequent years.

This approach ensures that the physician providing a service equivalent to an in-person encounter will receive a full professional fee and that the originating site will receive some payment for the costs associated with facilitating the encounter. The physician providing the service remotely does not receive any extra payment at the receiving end for the costs of any telemedicine equipment. There are no incentives or inducements in the form of fee-splitting or other arrangements that might be inconsistent with the anti-kickback statute.

The regulations implementing BIPA were published on August 2, 2001 (Proposed Rule) and November 1, 2001 (Final Rule) in the Federal Register and appear in Appendix F. In addition, CMS published two important documents regarding the telehealth home care provisions in BIPA. They appear in Appendix G. On an annual basis, the Medicare Reimbursement policy for telehealth services has been updated by CMS as part of the annual revisions to the physician fee schedule. Regulatory changes to the telehealth provisions since November 1, 2001 appear in Appendix H. The primary regulatory changes that have been adopted include:

- ESRD-related services as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318
- Medical Nutritional Therapy (MNT) including expanding eligible providers to include certified registered dietitians and other nutritional professionals

Table 4 below specifies the comprehensive list of Telemedicine Current Procedural Terminology (CPT) Codes[®] that are eligible for physician and practitioner payment as of December 31, 2005.

Table 4. Current Procedural Terminology (CPT)[®] and HCPCS Codes for Telemedicine

Eligible Service	CPT [®] & HCPCS Codes
Consultations	99241-99275
Office or other outpatient visits	99201-99215
Psychiatric diagnostic interview examination	90801
Individual psychotherapy	90804-90809
Pharmacologic management	90862
Diabetes outpatient self-management training sessions	HCPCS codes G0108-G0109
End Stage Renal Disease related services	HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317 and G0318
Speech and audiologist services	92541-92548, 92551-92588, 92597
Individual medical nutritional therapy	HCPCS codes G0270, 97802 and 97803

With regard to reimbursement for End Stage Renal Disease (ESRD) services, CMS clarified that only those facilities authorized under § 1834(m) of the Social Security Act may serve as originating sites for telehealth services under Medicare. ESRD or dialysis facilities are not defined in law as an originating site. In addition to the national coverage decisions articulated above, CMS allows local intermediaries to make local determinations which may expand Medicare coverage for telehealth services.

Summary of Current Medicare Guidelines for Reimbursement of Telehealth Services
<ol style="list-style-type: none"> 1. Eligible practitioners: Physicians, physician assistants, nurse practitioners, clinical psychologists, clinical social workers 2. Originating sites: Non-metropolitan statistical areas, hospitals, critical access hospitals, physician offices, federally qualified health centers, federal telemedicine sites 3. CPT Codes: <ol style="list-style-type: none"> a. Evaluation and Management 99241-99275, 99201-99215, 90801, 90804-90809, 90862 b. Dialysis G Codes (no initial management) c. Medical Nutrition Therapy G0270, G0271, 97802-97804 <p>Medical Nutrition Therapy Self-Management G0108, G0109</p>

Costs: Anticipated vs. Actual

The actual costs associated with the various expansions in the Medicare telehealth policy have fallen far short of expectations. In 1999, the Congressional Budget Office (CBO) estimated that expansions enacted in BIPA would cost less than \$50 million in 2001 and \$300 million between 2001 and 2005. Data from 2001 suggests that telehealth spending was less than \$50 *thousand*, not million that year, as discussed below.

In order to understand the amount paid by Medicare for telehealth services, it is important to have some knowledge of the Medicare payment processing system. Fees for telehealth services generally fall under Medicare Part B, which includes payments for physician services, non-physician practitioner services, clinical laboratory services, durable medical equipment, prosthetics and orthotics, hospital outpatient department services, ambulatory surgical center services, ambulance services, home health services, and prescription drugs. Medicare uses two separate claims processing systems to process all payments for Medicare Part B claims: (1) carriers and (2) fiscal intermediaries. Fiscal intermediaries process Part B claims that originate in hospital outpatient department settings, some home health services, and skilled nursing facility services. The remaining and majority of Part B claims are processed by carriers.

There are inherent challenges in assessing claims data attributable to telehealth regardless of whether it comes from either carriers or fiscal intermediaries. Carrier data, which is available through public use files available for purchase by the public for research purposes, lags. Currently, the most recent data available is from 2004. While there are specific CPT codes that are used for reimbursement of telehealth services, these codes reflect the facility fee or “hub” component of the Medicare payment. Medicare also reimburses the physician under a consultation CPT code for services provided at the remote or “spoke” site. Modifiers are used to distinguish telehealth consultations from other types of consultations within these physician consultation codes. The publicly available datasets compiled from the Medicare carriers claims data does not consistently included all CPT code modifiers from year to year.

With regard to the fiscal intermediaries, the lack of standardization and interoperability among fiscal intermediaries, results in data that is almost entirely unavailable. Further, payments made by a fiscal intermediary are first estimated and then later reconciled. The phenomenon of this moving target of payments makes analysis of this data extremely difficult. These factors alone make it inherently problematic at a given moment to know with any certainty the Medicare claims history for telehealth services originating and/or provided in outpatient hospital settings or skilled nursing facilities.

Consequently, estimating how much Medicare has actually spent for telehealth services is difficult. Carrier claim data indicates that Medicare authorized payments for facility fees for 7,841 telehealth encounters at the hub site where the patient was located totaling \$125,437 in 2004. However, the facility fee is only part of the equation. As noted above, Medicare also reimburses for the physician consultation services delivered from the remote or spoke site. Determining the amount of corresponding payments for physician consultation services delivered is not possible due to the manner in which the data was collected and reported. Given that there were only 7,841 in facility fees paid, one could infer that the corresponding costs associated with physician reimbursement are small. The data indicates the range of reimbursement for physician consultation services is \$33 to \$168 per encounter, but while physician consultation services are billed by CPT codes, the lack of telehealth modifiers in the public use files makes the cost of telehealth indistinguishable from other physician consultation services.

Table 11. Payment Data for Telehealth Facility Site Fee, HCPCS code Q3014,

Year	Allowed Services	Allowed Charges	Payment	Average Allowed Charge (adjusted for inflation)
2001	294	\$5,880	\$4,614	\$20.00
2002	1,596	\$31,836	\$23,199	\$19.95

2003	4,389	\$90,181	\$69,291	\$20.55
2004	7,841	\$161,879	\$125,437	\$20.65

To estimate the amount that Medicare spends on physician consultations for telehealth services, data from the 2004 Medicare Part B Extract and Summary System (BESS) was examined. Providers can bill for physician consultations under CPT codes 99241 through 99275, as noted above. In 2004, the average Medicare payment for a physician consultation in these codes was \$101, after beneficiary coinsurance. Accordingly, one could assume that each facility encounter had a corresponding physician consultation that was billed under a CPT code between 99241 and 99275, which averaged \$101. As a result, Medicare spending on the consultation, or spoke portion of the encounter, would total \$791,941.

Table 12. Model for Estimating Outlays for Telehealth Encounters by CPT Code

CPT Codes	Number of Physician Consultations	Total Physician Consultations Billed for each CPT Code	Average Medicare Payment (Less Coinsurance)	Extrapolation of Possible Average Total Costs for Telehealth Based on 7,841 Encounters
99241-99275	31.2 million	\$4.1 billion	\$101	\$791,941

However, this is only part of Medicare’s reimbursement for telehealth services. The carrier system data includes only physician and supplier data. Telehealth services provided in an outpatient hospital department, skilled nursing facility, or other facility that bills through an intermediary are not included in this data.

Given the small number of encounters that have been paid through the carrier system, if the same volume of service is also being experienced through the intermediary system, Medicare spending for telehealth services, including the resulting consultation costs, would have been \$1.6 million in 2004, which is about **one-thirtieth** or less of the \$50 to \$60 million per year that CBO estimated when BIPA was enacted.

On the Medicaid side, telehealth specific data also can be difficult to obtain given the fact that CMS has given Medicaid agencies the discretion whether to use CPT code modifiers. State data is available, but not easily accessible. Claims information has been requested from Alaska, Kentucky, and Texas, but the data was not available at the time this report was finalized. When that data becomes available, it will be shared with MeHAF.

Developing More Accurate Estimates – Policy Implications

In the 106th Congress, several pieces of legislation were introduced to broaden the scope of Medicare reimbursement for telehealth services and to clarify parts of the BBA. However, a major concern in revising the telemedicine reimbursement provisions was the exceedingly high cost affixed to telemedicine reimbursement legislation by the Congressional Budget Office as a result of the analysis of spending and revenue effects related to legislative proposals. This is often referred to as “scoring.” CMS claimed that enacting the legislative changes contemplated would cost between \$20 million and \$1 billion. However, in 2000, the Center for Telemedicine

Law,⁹ with funding from the Office for the Advancement of Telehealth, coordinated a project to use available telemedicine reimbursement claims data to develop a more accurate funding projection. In fact, based on data at the time of the study, only 1,350 claims had been paid by CMS through the end of FY 2002 at a cost of \$50,000. The results of this project clearly indicated that expanding telemedicine reimbursement would have minimal financial impact on the program. Data from this report was accepted by CBO in scoring the proposed telemedicine reimbursement revisions.

Members of Congress have questioned the variance of Centers for Medicare and Medicaid (CMS) and Congressional Budget Office (CBO) costing projections of proposed telehealth provisions, based on econometric models, with actual outlays. For example, CMS projections ranging from \$20 million to more than \$1 billion as a result of BIPA provisions have, to date, proven to be far greater than actual. CMS reports that, by the end of FY 2002, only 1,350 billings for telehealth coverage specified under BIPA have been approved, amounting to less than \$50,000 in reimbursement. The CBO substantially lowered its estimates based in part on data provided by Office for the Advancement of Telehealth (OAT) and the Center for Telemedicine Law (CTL). The CTL/OAT estimates of expanding telemedicine payments under BIPA ranged from \$50-\$100 million over five years.
Innovation, Demand, and Investment in Telehealth, U.S. Department of Commerce, 2004.

Another example of the degree to which expenditures related to telehealth services has been over estimated is illustrated in Table 13. CMS had prospectively estimated that the 12 month 1999 telehealth expenditures would be somewhere between \$60 and \$690 million. The CMS figure turned out to be 3,000 to 30,000 times as high as the actual expenditures in a subsequent 18 month period between April 1 and September 30, 2000.

Table 13. CMS Projections vs. Actual Outlays for Telehealth Encounters

CMS Projections (12 months 1999)	Actual Outlays (18 months, April 1, 1999 - Sept 30, 2000)
\$60-\$690 million	\$20,000 (301 telehealth encounters)

Thus far both CMS and CBO appear to have consistently overestimated the potential fiscal impact of telehealth policy changes. However, as noted above, CBO has started to incorporate claims data to revise and reduce the estimates for various telehealth policy expansions.

Private Pay Telehealth Policies

In a 2004 report from the U.S. Department of Commerce, it was estimated that 64.4% of America’s health care is insured through private payers.¹⁰ Private insurance can cover telehealth services either on a voluntary basis or as a result of a state legislative mandate.

We are aware of at least five states with a statutory requirement that private insurance cover telehealth services. These states are: Louisiana (1995); California (1996); Oklahoma (1997); Texas (1997); and Kentucky. Copies of these state laws are included as Appendix I. Two of the states with mandated private telehealth benefits (Texas and Oklahoma) are within the study scope of this report and are described in greater detail below.

⁹ Some portions of the Medicare section are taken from the 2002 Reimbursement Report done by the Center for Telemedicine Law, now the Center for Telehealth & E-Health Law under contract to HRSA’s Office for the Advancement of Telehealth, available online at <http://telehealth.hrsa.gov/licen/index.htm#part1>.

¹⁰ Innovation, Demand, and Investment in Telehealth, US Department of Commerce, 2004.

In 1997, Texas modified its insurance laws to require payments for telehealth related services. The relevant provision reads:

Sec. 3. A health benefit plan shall not exclude a service from coverage solely because the service is provided through telemedicine and not provided through face-to-face consultation.

The statute also defines telemedicine in a manner that includes interactive “audio video, or other electronic media to provide health care” but excludes “services performed using a telephone or facsimile machine.” Art. 21.53F. Sec. 1 (2).

The Kentucky Code was modified by the State Legislature in 2000 to include specific language mandating private insurance coverage. The relevant provision is similar to the Texas statute and reads:

(1) (a) A health benefit plan shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through face-to-face consultation if the consultation is provided through the telehealth network established under Section 2 of this Act. A health benefit plan may provide coverage for a consultation at a site not within the telehealth network at the discretion of the insurer.

(b) A telehealth consultation shall not be reimbursable under this section if it is provided through the use of an audio only telephone, facsimile machine, or electronic mail. 17A KRS Chapter 304.

In a survey conducted by AMD Telemedicine, Inc. in 2003, it was established that private payers were reimbursing for telehealth services either on a mandatory or voluntary basis in 25 states.¹¹ Of the 72, 38 or 53 percent indicated that they were able to obtain some private insurance payments for certain telemedicine applications. According to the survey, private insurers at that time were more likely to follow the reimbursement policy set by their local Blue Cross Blue Shield plans rather than the federal Medicare policy. Only three of the 38 providers receiving commercial insurance coverage indicated that they received payments for store-and-forward technologies. A copy of the AMD report appears as Appendix J.

Pam Whitten, PhD and Laurie Buis, M.S.I., at Michigan State University recently updated the 2003 AMD report and presented their findings at the 2006 American Telemedicine Association Meeting. The report states that 57 percent of respondents indicate that they receive some form of commercial insurance coverage for telehealth activities. This is a four percent increase over the 2003 study. The report further notes that 81 percent of those receiving private telehealth coverage indicate that there are no differences in the reimbursement rates when compared with traditional encounters. The report also found that private insurance accounted for 40 percent of the total telehealth payments received by providers that indicate they receive some private pay coverage. The survey identified 133 insurance carriers that are being billed for 75 clinic specialties. A copy of the Whitten/Buis report appears as Appendix K.

¹¹ www.amdtelemedicine.com/private_payer/index.cfm.

While there are some significant limitations to both the AMD and the Whitten/Buis study, it is clear that private insurance can play a significant role in supporting telehealth services. Voluntary coverage of a wide variety of telehealth services appears to be expanding. For example, in April 2006, Empire Blue Cross Blue Shield (EBCBS) in New York announced that it would begin reimbursing physicians¹² who offer online consultations to its more than 400,000 HMO members. EBCBS will pay \$25 for each appropriate consult. The decision was based on an 18-month demonstration project in which approximately 3,000 patients and 300 physicians accessed test results, requested prescription renewals or refills, made appointments, and communicated with one another across a secure messaging platform.

We reviewed literature and surveyed a variety of providers in the six target states to obtain information on private payment policies in these key states. No private insurance carriers in Massachusetts were identified that explicitly reimburse for telehealth services. However, in the summer of 2004, Blue Cross Blue Shield of Massachusetts (BCBSMA) began a pilot project with 200 physicians and 250 patients affiliated with Beth Israel Deaconess Medical Center to pay for E-visits, i.e., a secure online messaging system that supports electronic communications between physicians and patients. Physicians were to receive \$19 for each E-visit and patients were to make a \$5 co-pay. According to a senior manager at BCBSMA, the total \$24 E-visit will be less expensive than a typical office visit and is expected to be more time efficient than office visits or exchanging telephone calls with patients. Beth Israel is expected to provide approximately 500 E-visits. Additional information about the outcomes of this project was not available at the time this report was finalized.

According to the OAT,¹³ various unspecified commercial insurance companies pay for telehealth services in Vermont. Additional research was not undertaken to determine the names of the companies who make such payments. No private payers in New Hampshire have been identified that pay for telehealth services.

According to the OAT,¹⁴ Blue Cross/Blue Shield is a private payer of telehealth services in Alaska¹⁵ and there are a large number of private payers of telehealth services in Kentucky, including: Aetna, Anthem Blue Cross Blue Shield, Beechstreet PPO, UKHMO, CHA Health, Bluegrass Health Network, C&O Employee's Hospital Association CCN PPO, CHAMPVA/Tricare, Cigna, Cooperative Care Bluegrass Care Alliance, Community Health Partnership, Cumberland Health Care, Inc., Direct Care America, Harrod Community Health Plan, Hospice of the Bluegrass, Humana, National Provider Network PPO, One Health Plan, PPO Next/Healthstar/PHN, and United Healthcare.

The expansion of telehealth technologies in the private insurance market is a very interesting development. Private insurers face many of the same economic pressures faced by Medicare and Medicaid. However, they generally have greater administrative flexibility to modify or adapt their rules. Changes in coverage policies do not necessarily involve the sometimes complicated procedural or political steps required to modify the federal or state statutory provisions that define Medicare and Medicaid. That fact that they appear to be embracing telehealth technologies is one market sign of the value of these services. If the private insurers

¹² iHealth Beat, April 3, 2006. *New York Insurer to Pay for Online Consultations*.

¹³ Available online at <http://telehealth.hrsa.gov/grants/grantee.htm>.

¹⁴ Available online at <http://telehealth.hrsa.gov/grants/grantee.htm>.

¹⁵ Available online at <http://telehealth.hrsa.gov/grants/grantee.htm>.

found that paying for telehealth consultations resulted in an expensive and inappropriate expansion of utilization, they would curtail this practice. Insurers appear to be headed in the opposite direction. Likewise, if the use of these technologies did not improve a patient's health but instead resulted in more extensive medical treatment, it is unlikely they would enjoy private support. This appears to be one area where the large private payers may be moving forward independently.

In conclusion, a substantial and increasing number of private insurers are voluntarily providing coverage for telehealth applications. While additional research needs to be conducted on a carrier-by-carrier basis, it appears that in most cases there is no differential between the telehealth payment and the payment provided for an in-person encounter. A limited number of states have even passed legislation requiring private insurance not to discriminate against telehealth technologies as a service delivery option.

Medicaid Telehealth Policies

The focus of this portion of the report is an analysis of Medicaid policies. While this report examines six comparison states, MeHAF has requested that we also draw on previous reports and studies regarding reimbursement activities in other states where appropriate. While there have been a number of attempts to inventory state Medicaid policies, the results are inconsistent and limited in depth. This is due to the fact that in most states telehealth policy is not a result of a specific statutory change but rather a combination of statutory, regulatory, or policy provisions. In some cases, there may be no explicit policy underpinning payments for telehealth. A few states acknowledge in interviews that they know they make such payments but they have no way of tracking or accounting for such expenditures. This presents a major challenge in trying to make comparisons, contrasts, or even inferences from the data.

Currently, no single resource exists to access information on the reimbursement expenditures for telehealth at the state or federal levels for either government or private payers. Information has been solicited on the most requested outlays for telehealth by CMS, but that data is not yet available for inclusion in this report. When the data becomes available, it will be shared with MeHAF. The lack of readily available data presents a major challenge in trying to make comparisons, contrasts, or even inferences from incomplete data in the compressed time for this report.

CMS has given the state Medicaid programs discretion as to whether they should reimburse for telehealth services and whether to use CPT[®] code modifiers to track and identify telehealth reimbursement or use established new procedural codes to do so. According to the CMS website:

Reimbursement for Medicaid-covered services, including those with telemedicine applications, also must satisfy Federal requirements of efficiency, economy, and quality of care. With this in mind, states are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology. For example, states covering medical services that utilize telemedicine may reimburse for both the provider at the hub site for the consultation, and the provider at the spoke site for an office

visit. States also have the flexibility to reimburse any additional cost (i.e., technical support, line-charges, depreciation on equipment, etc.) associated with the delivery of a covered service by electronic means as long as the payment is consistent with the requirements of efficiency, economy, and quality of care. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service.
Emphasis added.

In terms of medical codes used as a basis for identifying, tracking and reimbursing for telemedicine, some states use modifiers to the existing CPT codes. The modifiers “TM” and “TV” are commonly used to make this distinction. Other states have developed their own local codes to distinguish telemedicine services. It is this flexibility that makes the tracking and analyzing reimbursement for telehealth services difficult.

We are aware of at least three major efforts to determine the scope of state Medicaid reimbursement. Research performed in 2003 by CTeL found 27 states that provided some form of Medicaid payment for telehealth. According to CMS, as of December 15, 2005, 18 states were identified as paying for telehealth services. Finally, the Office for the Advancement of Telehealth (OAT) published a Grantee Directory in 2006 that listed 13 states that provided Medicaid payments.

Table 5 compares the results of these three sources. The cumulative result when all of the reviews are combined would indicate that as many as 44 states make some form of telehealth payment for encounters with Medicaid recipients. However, through our previous work, we are particularly aware of the challenges associated with collecting this data. To date, a truly comprehensive review of state policies has never been completed. In many cases, the States do not have telehealth policies or they are poorly documented. In other cases, very little data is collected to track reimbursement associated with telehealth encounters. For example, many states permit certain forms of telehealth payment but do not require the provider to attach a modifier that could be used to track expenditures. In these cases, the impact of a change in reimbursement policy cannot be determined.

Table 5. - State Medicaid Reimbursement Policies

CMS List 2005 (18)	CTeL List 2003 (27)	OAT Directory 2006 (13)	Anecdotal Information Additional States CTeL 2006 (1)	Composite List (44)
Arkansas	Alabama	Alabama	Indiana	Alabama
California	Arizona	Florida		Arizona
Georgia	Arkansas	Hawaii		Arkansas
Illinois	California	Idaho		California
Iowa	Colorado	Massachusetts		Colorado
Kansas	Florida	New York		Florida
Louisiana	Georgia	Ohio		Georgia
Minnesota	Kentucky	Oregon		Hawaii
Montana	Louisiana	Pennsylvania		Idaho
Nebraska	Maine	Rhode Island		Illinois
North Carolina	Massachusetts	Vermont		Indiana
North Dakota	Mississippi	Wisconsin		Iowa
Oklahoma	Missouri	Wyoming		Kansas
South Dakota	Nebraska			Kentucky
Texas	Nevada			Louisiana
Utah	New Jersey			Maine

CMS List 2005 (18)	CTeL List 2003 (27)	OAT Directory 2006 (13)	Anecdotal Information Additional States CTeL 2006 (1)	Composite List (44)
Virginia	New Mexico			Massachusetts
West Virginia	North Carolina			Minnesota
	Ohio			Mississippi
	Oklahoma			Missouri
	Oregon			Montana
	South Carolina			Nebraska
	Tennessee			Nevada
	Texas			New Jersey
	Utah			New Mexico
	Virginia			New York
	Washington			North Carolina
				North Dakota
				Ohio
				Oklahoma
				Oregon
				Pennsylvania
				Rhode Island
				South Carolina
				South Dakota
				Tennessee
				Texas
				Utah
				Vermont
				Virginia
				Washington
				West Virginia
				Wisconsin
				Wyoming

As a result of the limited data for some comparison states, in addition to the data from the comparison states Table 6 includes information on the current state of telehealth reimbursement for four other states -- California,¹⁶ New Mexico, Missouri, and Virginia.

Of the six initial comparison states, three (Alaska, Kentucky, and Texas), the state Medicaid agencies reimburse for telehealth. Telehealth specific data also can be difficult to obtain given the fact that CMS has given Medicaid agencies the discretion whether to use CPT code modifiers. State data is available, but not easily accessible. Claims information has been requested from Alaska, Kentucky, and Texas, but the data was not available at the time this report was finalized. When that data becomes available, it will be shared with MeHAF. As stated previously, the lack of adequate and appropriate use of CPT code modifiers makes existing reimbursement data inadequate.

In the remaining three states, Massachusetts, New Hampshire, and Vermont, telehealth services are not reimbursed by the state Medicaid agencies. Table 6 below provides an overview of the types of services reimbursed, background on how telehealth was approved in the state, overview of whether the service is reimbursed at the same rate as an in-person encounter, the use of CPT reimbursement code modifiers, and whether a Medicaid beneficiary has the right to refuse telehealth services.

Table 6. Reimbursement for Telehealth for Selected States

¹⁶ See California Telemedicine & eHealth Center, Telemedicine Reimbursement Handbook <http://www.cttconline.org/documents/Telemedicine%20Reimbursement%20Handbook.pdf>.

State	Reimbursement by Type of Service	Background on How Telehealth Is Approved	Rate Same As In-person	CPT Code Modifier	Patient Right to Refuse T/H
AK	All clinical services are reimbursed. Physician Exam (Physician to (Physician) and (Physician to Patient), Nurses, Physician Assistant, other providers, store-and-forward, remote monitors.	Telehealth Advisory Council convened by U.S. Senator Ted Stevens. Recommendations made to Medicaid based on the goals to improve quality and reduce transportation costs.	Yes	GT, GQ	Yes
CA	All evaluation and management codes are reimbursed. Physician Exam (Physician to Patient), Nurses, Physician Assistant, other providers, store-and-forward for dermatology and ophthalmology.	Stakeholders built bipartisan coalition; petitioned elected policymaker with support from health department.	Yes	Specialty modifiers	Yes
KY	Clinical services reimbursed. Provider must be a licensed physician, nurse practitioner, physician's assistant, dentist, or oral surgeon. Limited to specialty care in legislation. Physician Exam (Physician to Patient), Nurses. Radiology is provided for separately. Interactive video is required. New Medicare waiver for 14 explicitly defined public school clinics providing primary care via telehealth. Maximum of four telehealth visits for medical care per year for each beneficiary, and maximum of 12 visits for mental health care per year.	The program began with a small group of top executives at the UK medical center, who were on the leading edge of telehealth and felt that UK should become one of the early pioneers. They received their first federal grant in 1994 and began to build the program. After the successful passage of state legislation in 2000, the Kentucky TeleHealth Network was created. This was a statewide telehealth initiative that included all three medical schools in the state and many rural health care facilities.	Yes	GT	Yes
MA	Does not reimburse for telehealth beyond radiology.	N/A	N/A	N/A	N/A
ME	Clinical services approved by Office of MaineCare Services based on individual applications from providers. No payments for technical aspect of the telemedicine service at either the originating or receiving site. The application requires a compelling benefit for the Medicaid beneficiary due to physical, social or geographical issues.	Reimbursement based on written approval from Medical Director, Office of MaineCare Services. Providers must apply listing procedure codes, rationale	Yes	GT	Yes
MO	All outpatient CPT codes, excluding mental health. Physician Exam (Physician to Patient), Nurses, Physician Assistant, excludes mental health.	Pilot Project; Medicaid pilot project approved with University of Missouri, approved after showing costs wouldn't skyrocket. Mental health excluded initially because of cost concerns.	Yes	GT	Yes
NH	Does not reimburse for telehealth.	N/A	N/A	N/A	N/A
NM	Reimburses for clinical services. Physician Exam (Physician to Physician) and (Physician to Patient), Nurses, Physician Assistant, other providers.	Legislation. Payment recommended under NM Telehealth Act of 2004 (H.B. 581). Made on a case-by-case basis at the determination of the state Medicaid agency.	Yes	GT	Unknown
TX	See Appendix P. Physician Exam (Physician to Patient), Nurses.	Statute	Yes	GT	Yes
VT	Does not reimburse for telehealth.	N/A	N/A	N/A	N/A
VA	All CPT codes approved by Medicare. Physician Exam (Physician to Patient), Nurses, Physician Assistant, other providers, radiology.	N/A	Yes	GT	Yes

Targeted State Medicaid Reimbursement Analysis

New England States (Massachusetts, Vermont, and New Hampshire)

As part of this study CTeL was requested to examine three New England states (Massachusetts, Vermont, and New Hampshire) to determine the extent to which they have established telehealth reimbursement programs. As part of this review we examined state statutes, regulatory provisions, policy guidance and conducted telephone interviews with state Medicaid officials and with individual telehealth providers in each state.

Our review confirms the preliminary guidance that we provided to MeHAF prior to the onset of this study -- these three states have not adopted any meaningful Medicaid reimbursement policy for telehealth services. According to Medicaid staff in Massachusetts and verified with several key telehealth providers in the state, Massachusetts Medicaid does not explicitly reimburse for telehealth services. The State Medicaid statute, regulations, and policy manuals do not appear to address telehealth services. The situation is similar in Vermont and New Hampshire. Currently there are no Medicaid policies for telehealth services in New Hampshire or Vermont. Despite repeated attempts, Medicaid staff in Vermont declined to discuss the status of Medicaid reimbursement for telehealth services simply stating that Vermont does not reimburse for telehealth services. Two additional resources within Vermont further verified this position.

We have attempted to reconcile our findings with previous surveys of state Medicaid funding (see chart on page 19). New Hampshire was not listed in the CMS, the CTeL or the OAT study as providing telehealth reimbursement.

The 2005 CMS study also did not list Vermont or Massachusetts as providing Medicaid payments. However, the OAT survey listed Vermont as providing payments and relied on provider reports of insurance coverage. We contacted the relevant OAT grantee and, based on that conversation and our discussions with Vermont Medicaid, we are confident that Vermont does not explicitly cover telemedicine.

Massachusetts is more interesting. Both the CTeL and the OAT review indicate Massachusetts may make payments in this area. However, based on our interviews with both state and private sector officials, this does not appear to be an appropriate categorization.

It is possible that Massachusetts and Vermont have been reported as covering telemedicine either because of self-reporting errors or because providers functioning under fixed capitated payments are given the flexibility to employ telehealth technologies and have cited Massachusetts as a payer for this reason.

However, many telehealth programs do exist in these states. For example, a large number of Massachusetts telehealth projects have been funded through federal grants, private donations, and/or a commitment from hospitals and networks to fund through other resources, presumably endowments or other available operational funds. A list of some of the telehealth projects in Massachusetts is included at Appendix L. A few Vermont-based entities have also been awarded federal grants to provide telehealth services, including the Community Health Center of Burlington and the University of Vermont/Fletcher Allen Health Care.

New Hampshire's sparse population and its close proximity to national centers of excellence in Massachusetts may help to explain the lack of a more comprehensive telehealth system in the state. However, the Department of Veterans Affairs maintains medical centers and clinics within New Hampshire that regularly use telehealth technologies.

A 2005 report, *Planning and Implementing a Statewide Telehealth Program in New Hampshire*,¹⁷ (Appendix M) stated that there are only some isolated examples of telehealth in New Hampshire, including a continuing medical education program at Dartmouth-Hitchcock Medical Center, home health monitoring, radiology, and developmental pediatric consultations. The authors suggest that these programs are struggling due to the lack of a network of telehealth providers. Further, they call for a coordinated state-wide effort as one way to support rural hospitals that are lacking certain sub-specialty care or need back up for their lone radiologist, for example, who becomes ill, dies, goes on vacation, or attends a continuing education program. The report states:

There is consensus among a diverse group of people and organizations in New Hampshire that the State is ready for and would benefit from a statewide program. There are examples (e.g., teleradiology, home health telemonitoring, distance continuing medical education, developmental pediatric consultations) of telehealth already occurring in New Hampshire that would benefit from and flourish with the support of a statewide program. . . .

New Hampshire is ideal for a statewide telehealth program that will improve access to healthcare and make the current healthcare system more efficient and effective for New Hampshire residents. The State has well known geographic barriers to care, completely lacks some specialty providers in parts of the state, and has large areas designated as federally underserved for primary and mental health care. Additionally, New Hampshire also has several resource-rich areas with tertiary medical centers that have the ability to provide specialty care through telemedicine. Thirty-seven percent of the population of New Hampshire lives in a rural area. An even greater proportion of Maine's elderly population lives in rural areas. The proportion of New Hampshire's population classified as elderly is expected to triple over the next 20 years. Home health monitoring in all areas of the state reduces hospitalizations, allowing elderly patients to remain in their homes. This ultimately translates into saved Medicaid dollars for the state. Also, fetal telemonitoring in emergency rooms throughout the state can eliminate the potentially catastrophic outcomes that result from high risk pregnancies.

The report cites medications as one of the largest costs to the New Hampshire Medicaid program with eight out of ten medications used for the treatment of mental illness. Its authors suggest that medication management through a telepharmacy program could improve patient compliance, provide more timely assessment of the effectiveness of the medication, and provide an opportunity to make more timely adjustment to the dosage or type of medication being prescribed, and consequently, reducing overall costs to the Medicaid program.

¹⁷ *Planning and Implementing a Statewide Telehealth Program in New Hampshire*, Kazal, Louis A., Jr., Dartmouth Medical School, and Conner, Anne M., North Country Health Consortium. The report is available online at http://www.vdh.state.va.us/primcare/center/vtn/conference_presentations/48.pdf.

The reasons why there are not more active Medicaid payment programs in the other New England states is somewhat unclear. Maine appears to have the largest and most fully developed rural telehealth network which presumably is a substantial reason the current Maine Medicaid policy permitted telehealth services on a "approved" basis. Massachusetts has a number of telehealth projects emanating from its nationally recognized medical facilities. These projects may either be suggested as part of a federal grant, considered part of the academic mission, or rely on private pay from in and out of state sources. New Hampshire and Vermont appear to be more in the developmental stages with regard to local telehealth applications. Also, all three of these states may provide considerable indirect support for telehealth through their various managed care or capitated payment systems.

ANALYSIS OF TELEHEALTH AND MEDICAID POLICIES IN STATES OUTSIDE OF NEW ENGLAND

Alaska

Background

Alaska has had substantial success in receiving funding and delivering telehealth projects and garnering support from elected and local leaders. Some of the prominent programs and projects include the **Alaska Federal Health Care Access Network (AFHCAN)**, <http://www.afhcan.org>, which has mobilized some 248 sites including military installations, Alaska Native health facilities, regional hospitals, small village clinics, and Alaska public health nursing stations. Funding for the AFHCAN program has come from federal grants and contracts, Medicare, Medicaid, and Blue Cross/Blue Shield.



The success of Alaska telehealth is based on Alaska's geography, climate, income levels, and other factors creating a recognizable need to improve access to care by prominent stakeholders including hospitals, clinics, physicians, nurses, tribal leaders, private health businesses, state and national government leaders, and others. Those stakeholders working with the Commissioner of Public Health participated in the planning, articulated the need, developed comprehensive legislative and regulatory language, sought buy-in from other stakeholders, created the infrastructure, and established the program as a priority for Alaska.

Interviews with Medicaid staff indicate that telehealth care services are reimbursed under the same conditions and CPT codes as in-person care; however, the qualifier "TM" is used to denote that the service was provided via telehealth. The legislation allows for the type of services to be expanded or contracted. Alaska Medicaid has provided reimbursement for physician specialists, services to tribal health agents in villages, mental health services to private and tribal facilities, therapy services, and audiology, among others.

Alaska Regulations

Included in Appendix N, Alaska Administrative Code (AAC) 7 AAC 43.1200, effective December 15, 2002, directs the states medical assistance division to make payment for medical services furnished through telemedicine applications as an alternative to traditional methods of delivering services to Medicaid recipients as provided in AS 47.07 and Chapter 43 of the Alaska Administrative Code. To receive payment under 7 AAC 43.1200 -7 AAC 43.1290, the use of telemedicine applications must comply with the standards set out in 47.07 and AAC Chapter 43 for the medical service provided by the type of provider, including provisions that ensure the efficiency, economy, and quality of service, as well as clearly define limitations of the service.

In 7 AAC 43.1210, Telemedicine Applications Limitations, effective December 15, 2002, the Medicaid agency is directed to reimburse for a telemedicine application if the medical services are rendered through one of the following methods of delivery provided in the specified manner:

- (1) live or interactive; to be eligible for payment under this paragraph, the service must be provided through the use of camera, video, or audio conference equipment on a real-time basis; medical services provided by telephone or facsimile machine are not eligible for payment under this paragraph;
- (2) store-and-forward; to be eligible for payment under this paragraph, the service must be provided through the transference of digital images from one location to another to allow a consulting provider to obtain information, analyze it, and report back to the referring provider; store-and-forward method includes transferring information by sound, images, or images on videotape;
- (3) self-monitoring or testing; to be eligible for payment under this paragraph, the services must be provided by a telemedicine application based in the recipient's home and a provider is only indirectly involved in the provision of the service.

The division will only make a payment for a telemedicine application if the service is limited to: (1) an initial visit; (2) a follow-up visit; (3) a consultation made to confirm a diagnosis; (4) a diagnosis, therapeutic, or interpretive service; (5) a psychiatric or substance abuse assessment; or (6) psychotherapy or pharmacological management services on an individual recipient basis.

Essentially, the site where the patient is located, commonly referred to as the spoke site, and the site where the provider is located, commonly referred to as the hub site, are each reimbursed as they would be in an in-person encounter. Just as in a traditional in-person encounter, a patient may be seen by more than one provider. For example, a patient can see a primary care provider in a clinic and then see a specialist in a remote city using telehealth services in that clinic on the same day. If the services provided by both the primary care provider and the specialist are billable for in-person encounters, they are billable and will be paid by Alaska Medicaid. However, Alaska Medicaid does not pay a facility fee for equipment or telecommunications costs to either site. There is an exception that allows clinics to bill a small administrative fee for

a patient who uses telehealth at that clinic, but does not have any other billable services at that clinic. This might occur if a primary care provider refers a patient to see a specialist using telehealth, but the patient must go to another clinic in order to receive the telehealth service. We are told that this feature of the regulations is seldom used.

Further, 7 AAC 43.1220, Conditions for Payment, effective December 15, 2002, states the Medicaid division will (a) reimburse for telemedicine applications provided by a treating, consulting, presenting, or referring provider for a medical service covered by Medicaid and that is provided within the scope of the provider's license; (b) A treating or consulting provider must use applicable modifiers as described in 7 AAC 43.104 for billing for a telemedicine application; (c) A presenting, referring, or consulting provider is subject to the conditions for payment that are described in 7 AAC 43.025; and, (d) A presenting provider is only eligible to receive Medicaid reimbursement for a live or interactive telemedicine application as described in 7 AAC 43.1210(a)(1).

7 AAC 43.1230 excludes reimbursement for service provided by telemedicine for home and community-based waiver services; pharmacy services; durable medical equipment services; transportation services; accommodation services; end-stage renal disease services; direct-entry midwife services; private-duty nursing services; personal care attendant services; and visual care, dispensing, or optician services.

7 AAC 43.1230, effective December 15, 2002, excludes reimbursement for certain services delivered by telehealth. Claims are to include standard telehealth CPT codes, “TM” for telemedicine along with “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system). Staff noted, however, that it is common for services delivered by telehealth to be billed without the modifier specifying it was a teleconsultation, making it difficult to determine the quantity of services delivered by telehealth.

Local Reaction and Experience with State Telehealth Policies

Medicaid staff noted that they believed a large number of telehealth services were not billed even though they benefit Medicaid patients. One reason cited was the high turnover of personnel in billing offices. While billing issues are not unique to telehealth, this is a source of lost revenue and impacts the quality of data available as a result.

Beginning in 1999, the Alaska Telehealth Advisory Council (ATAC) commissioned surveys and reports to assess the readiness for telehealth in the private sector, generate clinical encounters for evaluation and development of telehealth reimbursement guidelines, demonstrate interoperability capabilities of several different delivery systems, develop an easy, time efficient telehealth consultation process, research reimbursement, propose guidelines and regulations for Medicaid reimbursement of telehealth, and recommend specific Medicaid payment and coverage policies to include types of services, restrictions, and guidelines to maximize in-state services.¹⁸

Alaska Telehealth Advisory Council Telehealth Core Principles

- Any entity that becomes engaged in statewide telehealth in Alaska should ensure equal access, when financially realistic, to all Alaskans who would benefit from this technology.

¹⁸ <http://www.alaska.edu/health/downloads/Telemed/05.Ch1.pdf>, p. 42-43.

- All entities participating in telehealth must assure that their systems meet interconnectivity and interoperative standards and participate in the coordination of other telehealth efforts in the state of Alaska.
- All telehealth applications should be acceptable to both the patient and the provider and easy to use.
- All entities that participate in telehealth must determine their financial viability for the long term, including provision of professional capacity development and training as an ongoing component of operating expenses.
- All participants in telehealth in Alaska should engage in a needs assessment and evaluation of services.

ATAC's mission was to:

- Explore and document the potential for and challenges to telehealth development and delivery in Alaska, using the best professional information available.
- Propose a framework for rational development and deployment of statewide capacity for telehealth/telemedicine systems.
- Establish core principles to ensure a coordinated, cost-effective, and integrated approach to telemedicine in Alaska.
- Consider ways to assess effectiveness, efficiency, and the improvement through telemedicine, if any, in equity of access to health services for all Alaskans.
- Recommend a long-term process for addressing issues as they emerge with changing technologies and practice patterns.

Among the recommendations adopted by the Commission were:

Alaska is to adopt a policy by which Medicaid fees for telehealth services will reimburse a portion of the practitioners' start-up and ongoing costs for technical applications.

The amount of payment for teleconsultations shall not exceed the current fee schedule amount for the service rendered in the traditional manner.

Telehealth services be restricted no more than those same services delivered via face-to-face, non-telehealth means.

At the initial consultation, the referring provider is to be reimbursed for an office visit and the consulting practitioner receive 100% of a fee for services delivered during the consultation just as they would in a traditional in-person visit.

The goal of the legislative changes made to the Medicaid program was neither to expand nor reduce coverage, but rather to allow for the delivery of health care through telemedicine at the discretion of the provider.

**Alaska Telehealth Advisory Council
Fiscal Working Group Principles**

- Patients should be served in the least restrictive environment. Care provided to the patients should be as close to home as feasible.
- All telehealth care providers billing for Medicaid services must be enrolled with Medicaid.
- All reimbursable services must be covered in the current Medicaid benefit package.
- Payments will not be made for use of telemedicine technology (purchase, maintenance, or training).
- Technical and consultants' fees, both in store-and-forward, will be reimbursed according to the established fee schedule.
- Modifiers will be developed to identify telehealth services and to facilitate the collection of data.
- Remote monitoring services will be covered for established technologies, (e.g., EKG, perinatal monitoring).
- There will be no geographic barriers to reimbursement—payment will be made whether the patient and/or provider are located in rural or urban sites.

While the Commission met only a limited number of times, it convened five working groups to address legal, fiscal, communications policy, professional development, and oversight. The Commission's fiscal working group presented several principles and recommendations related to Medicaid reimbursement, which were later adopted: (1) modify reimbursement codes to capture telemedicine encounters and procedures, either through programmatic or regulatory change, and (2) set a standard Medicaid reimbursement rate for telehealth services.

Alaska Medicaid knows that the services are being used and anecdotally believe that there are cost benefits, but according to Medicaid staff, they have not tracked utilization or costs, since the priority was to improve and ensure access to care for Alaskans as opposed to cost reduction. However, utilization is difficult to track since the TM modifier is often not used to denote a telehealth encounter. For all practical purposes, since reimbursement is the same whether the code is included or not, there is no incentive to add the code. Further exacerbating the accuracy of the data is the high turnover in billing staff.

Kentucky

Background

Kentucky like Alaska has had substantial success in receiving funding and delivering telehealth projects and garnering support from elected and local leaders, in large part due to the work by the University of Kentucky and the creation of a statewide telehealth network. Kentucky Administration Regulation 907 KAR 3:170, approved and effective February 28, 2006, governs telehealth services and reimbursement. The regulation specifies a covered service, limitations, eligible providers, reimbursement, confidentiality and data integrity, informed consent, medical records, and appeal rights.

Kentucky Regulations

907 KAR 3:170, effective February 28, 2006, specifies that a telehealth service shall be covered if medically necessary and requires the use of two way interactive video; a referral by a health care provider specified in Section 4(2) of this administrative regulation; a referral by a recipient's provider for those cases in which a recipient has been assigned to a case management system for chronic health system abuses if the comparable non-telehealth service requires a referral from a Kentucky Patient Access and Care System provider and a referral by a recipient's assigned case management provider. The regulation limits the coverage of telehealth services for non-

community mental health centers (CMHC) to a maximum of four telehealth services per recipient per year if provided for a recipient age twenty-one years and older, the evaluation and management consultation CPT codes 99241 through 99275 may be billed as a telehealth service if provided by an eligible medical specialist, or for a recipient under the age of twenty-one (21) years. The evaluation and management consultation CPT codes 99241 through 99275 may be billed as a telehealth service if provided by a medical specialist; and a psychiatric diagnostic evaluation CPT code 90801 and individual psychotherapy CPT codes 90804 through 90809 may be billed as a telehealth service if provided by a psychiatrist. The entire text of the Kentucky code appears at Appendix O.

907 KAR 3:170 further states that coverage for a telehealth service for a licensed CMHC shall be limited to twelve psychiatric services per recipient per year and shall be billed using only specified diagnostic CPT service codes: 90801 for a diagnostic interview examination; 90862 for medication management; 90887 for an outpatient collateral; 90804 for an individual psychotherapy; or 90847 for an outpatient family therapy.

Under the regulation, eligible providers include a medical specialist at a hub site who shall be enrolled as a Medicaid provider pursuant to 907 KAR 1:671 and 907 KAR 1:672 and shall be, for a non-CMHC, a licensed physician in one of the following specialties or subspecialties:

- dermatology;
- emergency medicine;
- internal medicine subspecialty;
- general surgery or a surgery subspecialty;
- neurology;
- obstetrics and gynecology;
- a pediatric subspecialty;
- psychiatry;
- radiology or radiation medicine; or
- a licensed oral surgeon.

Additional requirements must be met for a licensed CMHC.

With regard to reimbursement rates, 907 KAR 3:170 states that Kentucky Medicaid shall reimburse a medical specialist located at a hub site for a telehealth service at an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010. Reimbursement shall not be made for transmission costs. The bill must use the appropriate evaluation and management CPT code with the addition of the two letter "GT" modifier.

The regulation further specifies requirements related to confidentiality, data integrity, informed consent, maintenance of medical records, and appeal rights.

806 KAR 17:500, *Basic Health Benefit Plan Requirements* requires the coverage of telehealth services as provided in KRS 304.17A-138 for health benefit plans defined under KRS 304-17A-005(18). 907 KAR 1:713, *Managed Behavioral Health Care Initiative (1915b Waiver)*, and specifically allows for the use of telemedicine technology for consultative service, initial evaluation, or direct treatment, provided that the plan for telemedicine is approved by the medical director of the managed behavioral health organization and the department, and the

qualified mental health professional who provides the telemedicine is authorized by the managed behavioral health organization for the telemedicine procedure.

10 KAR 3:020, effective July 16, 2001, establishes and funds telehealth network training centers located at the University of Kentucky, the University of Louisville and other sites in western and eastern Kentucky to be determined for the purpose of promoting telehealth activities. The training centers are to be equipped and staffed to provide technical training for telehealth applications, oversee the development of continuing education programs designed to familiarize practitioners throughout the Commonwealth with telehealth applications, and to help implement those applications.

10 KAR 3:050, established protocols and standards for telehealth network training centers and rural sites requiring that every rural site and every telehealth training center to participate in the development and operation of clinical services for the benefit of its patients by: promoting the referral of patients to existing telehealth clinics; developing new telehealth clinics; and seeking to recruit consulting clinicians to perform telehealth services. A telehealth encounter in Kentucky is guided by the consulting clinician and is interactive, except for an application not normally interactive, such as radiology, pathology, or echocardiography. The regulation specifically gives the referring clinician, consulting clinician, patient or the patient’s family the right to decline telehealth services in favor of a traditional face-to-face encounter.

“The program began with a small group of top executives in the UK medical center. They were on the leading edge of this idea and felt that the University should become one of the early pioneers. They received their first federal grant in 1994 and began to build the program. Over time, the network spawned other telehealth networks in the state, and these networks eventually covered a broad area of eastern KY with over 40 network sites. After the successful passage of state legislation in 2000, the Kentucky TeleHealth Network (KTHN) was created. This was a statewide telehealth initiative that included all three medical schools in the state and many rural healthcare facilities. The University of Louisville was brought into the network along with several western Kentucky sites to create a true statewide telehealth network.”

By Bob Pyke, Jr., RN, CPNP, <http://telehealth.net/interviews/sprang.html>

Table 7. Overview of Kentucky Telehealth Provisions

907 KAR 3:170	Section Title	Summary
Section 2 (2a-d)	Covered Service	Two-way interactive video
		Referral by eligible health care provider
		Referral by a Medicaid provider who is enrolled as a primary care case manager in the Kentucky Patient Access and Care System, if required for a non-telehealth encounter
		Referral by a lock-in provider is applicable
Section 4 (1-2)	Eligible Providers	A medical specialist at the hub site enrolled as a Medicaid provider and shall be (a) for a non-Community Mental Health Center, a licensed physician in one of the following (subspecialties: dermatology, emergency medicine, internal medicine subspecialty, general surgery or surgery subspecialty, neurology, obstetrics and gynecology, pediatrics subspecialty, psychiatry, radiology or radiation medicine, or licensed oral surgeon.
		A medical specialist at the hub site enrolled as a Medicaid provider and shall be (b) for a licensed Community Mental Health Center, a psychiatrist, advanced registered nurse practitioner.
		A health care provider requesting a telehealth service shall be an enrolled Medicaid provider who is a licensed physician, advanced registered nurse practitioner, certified physician assistant working under physician supervision, licensed dentist or oral surgeon, or a licensed CMHC.

Section 5 (1-4)	Reimburse- ment	Shall reimburse a medical specialist located at a hub site for a telehealth service (a) an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010 or (b) if a licensed Community Mental Health Center in accordance with 907 KAR 1:045.
		A medical specialist shall bill for a service using the appropriate evaluation and management CPT codes as specified in Section 3 of this regulation with the addition of the two letter "GT" modifier.
		The presence of a health care provider requesting a telehealth service at the time of the telehealth service is not required unless requested by a medical specialist at the hub site.
		Reimbursement shall not be made for transmission costs.

Texas

Background

Like Alaska and Kentucky, Texas has been extremely successful in garnering support from elected and unelected public policymakers. Texas has promulgated numerous regulations that address a variety of aspects related to the provision of telehealth services making it one of the most comprehensive set of state policies on telehealth in the nation. Not only does Texas address basic provider eligibility and reimbursement policies, it also provides for a telehealth advisory board, guidance for care for specified Medicaid recipients, and establishes pilot projects, among others.

Texas Regulations

Reimbursement for telemedicine services are governed by Texas Administrative Code. 1 TAC § 355.7001, *Telemedicine Services*, November 27, 2005, specifies that, in accordance with the existing Medicaid reimbursement methodology, the following providers as eligible for reimbursement of telemedicine services:

- physicians;
- advanced practice nurses;
- certified nurse midwives;
- hospitals;
- federally qualified health centers;
- and rural health clinics.

(Also, see 1 TAC § 355.8085, § 355.8281, § 355.8161, § 355.8061, § 355.8261, and § 355.8101, and 30 TexReg 7722.) Texas Medicaid staff indicated that a rule is under consideration that will add the title of physician’s assistant to the list of eligible practitioners and it is considering a 42-site telemental health pilot project. The text of the Texas Telehealth Code provisions appears at Appendix P.

TAC § 354.1432, *Benefits and Limitations*, November 27, 2005 specifies that telemedicine services are a health care benefit of the Texas Medicaid program, including direct “face-to-face” interactive video communications with the client. Teleradiology and telepathology are exceptions to the direct face-to-face requirement. Telemedicine hub site providers may be

reimbursed only for consultation or interpretation using interactive video as defined by Medicaid telemedicine medical policy and as currently reimbursed under the Texas Medicaid program.

Limitations on Texas Telehealth Benefits

Approved Sites	Sites Not Approved	Other non-qualifying Encounters
practitioner's office rural health clinic federally qualified health clinic inpatient hospital outpatient hospital emergency room ICF-MR facility	nursing facilities skilled nursing facilities client homes	Telephone conversations Chart reviews Emails Faxes

In VTCA § 531.0216, *Participation and Reimbursement of Telemedicine Medical Service Providers Under Medicaid* directs the commission, effective September 1, 2005, to develop and implement a system to reimburse providers of services under the state Medicaid program for services performed using telemedicine medical services. The commissioner shall

- review programs and pilot projects in other states to determine the most effective method for reimbursement;
- establish billing codes and a fee schedule for services;
- provide for an approval process before a provider can receive reimbursement for services;
- consult with the Department of State Health Services and the telemedicine advisory committee to establish procedures to identify clinical evidence supporting delivery of health care services using a telecommunications system;
- establish pilot studies;
- annually review health care services considering new clinical findings, to determine whether reimbursement for particular services should be denied or authorized;
- further establish pilot programs in designated areas of the state;
- establish a separate provider identifier for telemedicine providers; and establish a separate modifier for service eligible for reimbursement. The commission is directed to encourage physicians, teaching hospitals, small rural hospitals, federally qualified health centers, and state-owned health care facilities to participate as telemedicine providers.

VTCA § 531.0217, *Reimbursement*, September 1, 1997, directs the Health and Human Services (HHS) Commission to establish a rule to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician at the same rate the Medicaid program reimburses for a comparable in-person medical service. The claim may not be denied solely because an in-person medical service between a physician and patient did not occur. A health care facility that received reimbursement under this section for telemedicine medical service by a physician who practices in that facility or a health professional who participates in a telemedicine medical service shall establish quality of care protocols and patient confidentiality guidelines to ensure the service meets legal requirements and acceptable patient care standards. The commission may not require a telemedicine medical service if an in-person consultation with a physician is reasonably available where the patient resides or works. The commission shall require facilities and providers of telemedicine to make a good-faith effort to identify and coordinate with existing providers to preserve and protect existing health care systems and medical relationships in an area. If the patient receiving telemedicine medical services has a primary care physician or provider and consents to the notification, the commission will require

that the primary care physician or provider be notified of the telemedicine consultation for the purpose of sharing medical information. The statute further provides that the Texas Board of Medical Examiners, in consultation with the commissioner, adopt rules to ensure appropriate care, including ensuring quality of care is provided to patients who receive telemedicine services; prevent fraud and abuse; and define those situations when a face-to-face consultation with a physician is required after a telemedicine service.

VTCA § 531.0217, September 1, 1997, also directs the commissioner to establish an advisory committee to coordinate state telemedicine efforts and assist the commission in evaluating the policies for telemedicine medical services; evaluating the types of programs receiving reimbursement; and, coordinating the activities of state agencies interested in the use of telemedicine medical services.

VTCA § 531.02163, *Telepresenters*, September 1, 1997, directs the commissioner to establish and adopt minimum standards to permit the use of trained health professionals in presenting patients who are Medicaid recipients for telemedicine consultations to be conducted by physicians at distant sites. The commission shall provide reimbursement to a physician for overseeing a telemedicine consultation at a hub site if the telepresenter at the remote site is another physician or is an advanced practice nurse, registered nurse, or physician assistant under physician delegation and supervision throughout the consultation.

VTCA Health & Safety Code § 35.0041, *Children with Special Health Care Needs, Participation and Reimbursement of Telemedicine Medical Service Providers*, effective June 14, 2001, states that policies of the Texas Department of Health Programs must provide reimbursement to providers using telemedicine or telehealth in a cost-effective manner that ensures a child with special health needs of services appropriately performed using telemedicine medical services comparable to services available to a child without use of telemedicine services. Further, a provider for a service performed using telemedicine will be reimbursed at an amount equal to a provider not using telemedicine services. The policies must provide reimbursement if the department determines that reimbursing multiple providers of different services who participate in a single telemedicine service is cost-effective in comparison to obtaining the services from providers without the use of telemedicine, lodging, transportation, and other direct costs.

VTCA § 531.02162, *Medicaid Service Provided Through Telemedicine Medical Services and Telehealth Services to Children with Special Health Care Needs*, effective September 1, 2003, directs the commissioner to establish policies that permit reimbursement under Medicaid and the children's health insurance program provided through telemedicine to children with special health care needs. The policies must prevent unnecessary travel and encourage efficient use of telemedicine in all suitable circumstances, and ensure, in a cost-effective manner, that a child with special health needs receives services appropriately performed using telemedicine medical services comparable to services available to a child without use of telemedicine services.

Effective September 1, 2005, VTCA § 531.02175, *Pilot Program for Telehealth or Telemedicine Consultation for Certain Medicaid Recipients*, directs the executive commissioner to develop and implement a pilot program under which Medicaid recipients in need of mental health services are provided those services through telehealth or telemedicine. The program will enhance delivery of mental health services, ensure adequate supervision of professionals, and determine whether extension of the use of telehealth would improve the delivery of mental health

services. The commissioner may not require mental health services be provided by telehealth or telemedicine if an in-person consultation is reasonably available where the recipient resides or works.

Effective September 1, 2005, under VTCA § 531.02172, *Telemedicine Advisory Committee*, the commissioner shall establish an advisory committee to assist the commission in evaluating policies for telemedicine medical consultations under § 531.02163 and § 531.0217 and for the telehealth pilot project under § 531.02171; ensuring the efficient and consistent development and use of telecommunication technology for telemedical consultations and telemedicine medical services or telehealth services reimbursed under government funded health programs; monitoring the type of programs receiving reimbursement under § 531.0217 and § 531.02171; and coordinating the activities of state agencies concerned with the use of telemedical consultants and telemedicine medical services or telehealth services. It further specifies representation on the Committee.

In November 2005, the Texas Health and Human Services Commission adopted regulations affecting Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. (See 30 TexReg 4891, published August 26, 2005.) Section 354.1434, *Reimbursement for Telemedicine Providers* specifies that the remote site provider retains the plan of care, confidentiality, and informed consent. § 354.7001, *Telemedicine Services*, repeals § 355.7001 and replaces it with § 355.7001 to update terminology and to reorganize the rule content to identify and clearly delineate those responsibilities that are reimbursement and program activities.

Local Reaction and Analysis

While Texas has put comprehensive policies in place, according to Medicaid staff, it has not done much analysis of the data. Like Alaska while it uses CPT code modifiers, the modifier is not consistently utilized, thereby, making analysis difficult and unreliable. Texas Medicaid is embarking on a new pilot project to determine the cost-effectiveness of the program and is expected to yield more data than has been available to Medicaid previously. It is expected to commence in the summer of 2006.

Suggested Model Maine Telehealth Regulation

MeHAF has requested that we provide a suggested model state Medicaid Regulation that could serve as a basis for incorporating telehealth into the state program. Factors that we were asked to consider in evaluating the applicability of other state statutes and regulations include issues involving adaptability of the statute to evolving technologies, cost, access to care, and quality of care. There is no individual state that has developed a template that could easily be adapted to Maine or other states contemplating modifying their Medicaid programs. Over 40 states provide some form of Medicaid payment for telehealth services. In some cases, this has been accomplished through statute. In many states, the telehealth payment policy has evolved either through state regulations or policy determinations.

We have developed the attached Model Regulation drawing on our understanding of Maine's current payment policy and drawing in part on alternatives that other states and the Federal government have adopted either through statutory or other means. A copy of a letter outlining

the process we understand is currently in place for obtaining telehealth reimbursement in Maine is attached in Appendix Q. Maine appears to be reviewing individual provider requests for telehealth services through a case-by-case review process. At this time there do not appear to be overall guidelines defining what types of services are payable or what the limitations are on the range and scope of acceptable services other than a prohibition on telephone delivered services.

A number of states have made relatively simple modifications to their Medicaid statutes to acknowledge that they will pay for telehealth services. Of the target states that we were asked to examine for MeHAF, Alaska is the closest to this model. California is probably the first of the states to make such modification. The Alaska and California provisions provide for a limited number of exceptions or limitations to the overall design. For example, both states prohibit payment for telecopies and phone calls.

Other states provide an explicit list of the acceptable services that may be paid under the state telehealth Medicaid policy. This approach limits the state's flexibility to adapt the program. Any modification in coverage requires action by the State Legislature or the promulgation of new regulations. Kentucky is a good example of a state which has adopted this approach. The Kentucky statute enumerates those services for which telehealth can be utilized. If the service is not listed, it is not payable.

The draft model regulation for Maine is set forth on the following two pages. The model language attempts to comprehensively address telehealth services (now being reviewed on a case-by-case basis) in a way that supports MaineCare's commitment to safe, quality care, patient choice, equitable treatment of telehealth providers, and acknowledgment of both the benefits of telehealth services as well as the importance of local rural health infrastructure.

Model State Medicaid Telehealth Reimbursement Regulation

- (1) Reimbursement for telehealth services shall be made to a provider enrolled in MaineCare who is authorized to provide services under the MaineCare program in the same manner as reimbursement for the same service provided through a traditional in-person mode of delivery.
- (2) In order for a provider to be eligible to receive MaineCare Payments for Telehealth services, the provider must submit to the Department of Health and Human Services the following information:
 - (a) the name of the provider, their MaineCare ID number and licensure level;
 - (b) a list of the procedures that will be utilized and a statement by the provider that telehealth services will only be utilized in circumstances where they are clinically appropriate and necessary for the benefit of the patient;
 - (c) a statement explaining the rationale for needing telehealth capabilities for the services being proposed;
 - (d) a policy stating what specific criteria will be utilized to determine when telehealth services are appropriate rather than face-to-face encounters;
 - (e) a plan for quality assurance activities specifically related to patient satisfaction and outcomes related to telehealth service;
 - (f) educational information that will be provided to the MaineCare member at the time of their visit. This information should be written at a 6th grade comprehension level, and at a minimum it should include the following information:
 - (i) Description of the telehealth equipment and what to expect;
 - (ii) Explanation that the use of telehealth for this service is voluntary and that the same service is available in face-to-face setting, although there may be a delay in

- being able to access the service in person;
- (iii) Explanation that the member is able to stop the telehealth visit at any time and request a face-to-face service without prejudice.
- (iv) Explanation that MaineCare will pay for transportation to a distant appointment if needed; and
- (v) HIPAA compliance information regarding the telehealth encounter.

(g) such other information determined by the Department as necessary to protect patients and ensure the integrity of the program.

(3) The Department of Health and Human Services may establish policies (a) limiting the procedures or settings where MaineCare payments may be made to providers of telehealth services; and (b) to sanction or exclude providers from MaineCare who fail to adhere to state requirements regarding telehealth payment policies under MaineCare.

(4) The Department of Health and Human Services may establish an “origination site fee” to reimburse some or all of the costs associated with maintaining a site to transmit telehealth information regarding a patient to the MaineCare provider authorized to provide services. In establishing such a fee, the Director may take into account the necessity of providing support to the originating site in order to recover costs borne by the originating site taking into account all other alternative sources of support.

(5) The Department of Health and Human Services shall have the authority to enter into agreements with patient monitoring services to improve the quality of care and reduce MaineCare costs by providing telehealth monitoring services to MaineCare patients. If telemonitoring services are provided for patients eligible for and receiving home and community benefits under MaineCare, these services may not substitute for required in-person visits specified in the authorized plan of care.

(6) Nothing in this section shall limit the ability of a provider receiving payment under a capitation agreement from utilizing telehealth services as a component of their services to MaineCare patients.

Outlined below is a side by side explanation of the key provision in this model regulation. The key provisions are:

<u>Provision</u>	<u>Description and Rationale</u>
(1) Reimbursement for telehealth services shall be made to a provider enrolled in MaineCare who is authorized to provide services under the MaineCare program in the same manner as reimbursement for the same service provided through a traditional in-person mode of delivery.	(1) This is a statement of general policy. It is limited by Sections (2) and (3) below. The objective of the bill is to provide a statutory framework for telehealth reimbursement policy in Maine that is adaptable to evolving technologies but provides MaineCare a process and the flexibility to define specific requirements for participation in the program. Some states limit in the statute the types of procedures and circumstances where telehealth may be utilized. Such a detailed approach limits the flexibility of the state to modify its payment policies to reflect new applications or respond to financial or administrative concerns.
(2) In order for a provider to be eligible to receive MaineCare Payments for Telehealth services, the provider must submit to the Department of Health and Human Services the following information: <ul style="list-style-type: none"> (a) the name of the provider, their MaineCare ID number and licensure level; (b) a list of the procedures that will be utilized 	(2) This section incorporates the existing requirements for telehealth reimbursement promulgated by MaineCare as requirements to participate in the program. No changes were made to this list with the exceptions of reinforcing clinical necessity as a criteria for telehealth under (b) and adding a new subsection (g) that would allow the Department to add additional

<u>Provision</u>	<u>Description and Rationale</u>
<p>and a statement by the provider that telehealth services will only be utilized in circumstances where they are clinically appropriate and necessary for the benefit of the patient;</p> <p>(c) a statement explaining the rationale for needing telehealth capabilities for the services being proposed;</p> <p>(d) a policy stating what specific criteria will be utilized to determine when telehealth services will be appropriate rather than face-to-face encounters;</p> <p>(e) a plan for quality assurance activities specifically related to patient satisfaction and outcomes related to telehealth service;</p> <p>(f) educational information that will be provided to the MaineCare member at the time of their visit. This information should be written at a 6th grade comprehension level. At a minimum it should include the following information:</p> <p>(i) Description of the telehealth equipment and what to expect;</p> <p>(ii) Explanation that the use of telehealth for this service is voluntary and that the same service is available in face-to-face setting, although there may be a delay in being able to access the service in person;</p> <p>(iii) Explanation that the member is able to stop the telehealth visit at any time and request a face-to-face service without prejudice.</p> <p>(iv) Explanation that MaineCare will pay for transportation to a distant appointment if needed;</p> <p>(v) HIPAA compliant information regarding the telehealth encounter;</p> <p>(g) such other information determined by the Department as necessary to protect patients and ensure the integrity of the program.</p>	<p>criteria for participation. We used the term "telehealth" rather than telemedicine, reflecting the range of current providers utilizing these technologies within the scope of their state practice acts.</p> <p>We did not incorporate language limiting payments only to "Maine-based" providers. Such a provision raises significant federal constitutional issues. However, Maine could limit payment to "Maine licensed" provider. The latter provision could be established when the policies promulgated through subsection (3) or through statutory language.</p>
<p>(3) The Department of Health and Human Services may establish policies (a) limiting the procedures or settings where MaineCare payments may be made to providers of telehealth services; and (b) to sanction or exclude providers from MaineCare who fail to adhere to state requirements regarding telehealth payment policies under MaineCare.</p>	<p>(3) This section gives the state the flexibility to place additional limits on procedures or settings for telehealth MaineCare payments. It is purposefully broad to give the state maximum flexibility to adapt its payment policy to emerging technologies as well as program management issues. The section also provides authority to sanction non-compliant providers.</p>
<p>(4) The Department of Health and Human Services may establish an "origination site fee" to reimburse some or all of the costs associated with maintaining a site to transmit telehealth information regarding a patient to the MaineCare provider authorized to provide services. In establishing such a fee, the Director may take into account the necessity of providing support to the originating site in order to recover costs borne by the originating site taking into account all other alternative sources of support.</p>	<p>(4) We have included a section permitting MaineCare to make payments to originating sites. These costs are reimbursable in many states and under Medicare. However, they are not permitted in Maine. This provision recognizes the need to maintain rural health infrastructure and avoid lengthy wait times for services and the costs associated with transporting the patient to a Hub site. MaineCare can define both the amount and the circumstances for these payments.</p>
<p>(5) The Department of Health and Human</p>	<p>(5) This section was added to give the state flexibility</p>

<u>Provision</u>	<u>Description and Rationale</u>
Services shall have the authority to enter into agreements with patient monitoring services to improve the quality of care and reduce MaineCare costs by providing telehealth monitoring services to MaineCare patients. If telemonitoring services are provided for patients eligible for and receiving home and community benefits under MaineCare, these services may not substitute for any required in-person visits specified in the authorized plan of care.	to make payments for home monitoring in order to improve patient care, reduce MaineCare costs and avoid hospitalization, nursing home and medical costs by enhancing patient health services in the home. However, language is included to ensure these services do not substitute for required provider visits.
(6) Nothing in this section, shall limit the ability of a provider receiving payment under a capitation agreement from utilizing telehealth services as a component of their services to MaineCare patients.	(6) This section is intended to clarify that providers operating under capitation agreements have the ability to use appropriate telehealth technologies and nothing in this legislation is intended to limit that flexibility.

Optional Regulatory Provisions

In addition to the basic framework set out above, there are a number of model supplemental provisions that have been adopted by states to further refine their telehealth policies. Outlined below are several examples for consideration.

Prohibition on Payment for Telephone and Facsimile Interactions.

Many states have been quite concerned that permitting telehealth payments may encourage physicians to submit claims for patient encounters that are comprised of solely a telephone interaction or the receipt and review of a facsimile or email. In order to address this issue, a common provision in many regulation states that no payment will be made for telephone or facsimile interactions. We believe the language in many of these statutes or rules may prove overly restrictive as various forms of wired and wireless telephony are being widely deployed as part of telehealth solutions. For that reason, we offer two alternative supplemental policies. The first is a traditional prohibition. The second provides some flexibility to evaluate potential telephony applications but to provide an alternative reimbursement rate if the service is distinct from a traditional patient encounter.

Model Supplemental Provision (Traditional) – Telephones, facsimiles, and e-mail

A telehealth service shall not be reimbursable under this section as a physician service if it is provided solely through the use of an audio-only telephone, facsimile machine, or electronic mail.

Model Supplemental Provisions (Advanced) – Telephones, facsimiles, and e-mail

(1) A telehealth service shall not be reimbursable under this section as a physician service; it is provided solely through the use of an audio-only telephone, facsimile machine, or electronic mail.

(2) The Commissioner may evaluate requests for audio-only telephone or electronic mail services and establish an appropriate payment rate for

these services to the extent that such services are determined by the Commissioner as (a) enhancing the quality of patient care; and (b) providing a cost-effective alternative to the services that would otherwise be reimbursed by MaineCare.

Private Pay Requirement

This provision would need to have a statutory basis. However, as indicated in the section on private payments, a number of states, including Kentucky and Texas require private insurance to cover telehealth applications. Model regulatory language implementing a new statutory requirement in this area could read as follows:

Model Supplemental Provisions – Private Pay

() A health benefit plan shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through face-to-face consultation.

This model language could be coupled with provisions limiting its applicability with regard to telephone, facsimile and electronic communications. Such language might read:

() A health benefit plan shall not be required to reimburse a provider for services that are limited solely to a telephone, facsimile, or electronic mail interaction with the patient.

Local Providers/ Local Office

Some states are concerned that while reimbursing telehealth services may alleviate some acute access issues, doing so may also discourage providers from maintaining a local point of presence. They are concerned that if a significant portion of services are handled through remote interactions, providers may be less inclined to be available for in-person interactions with patients. We noted that the MaineCare letter outlining the current procedure for obtaining telehealth reimbursement limits reimbursement to Maine-based providers. If Maine wishes to address this issue as part of its telehealth regulation, we would recommend a modification in the requirement. The current approach raises some significant constitutional issues under the interstate commerce clause. The health and safety benefits associated with the current wording are not clearly defined and there are some less restrictive alternatives that accomplish the same objective but do not arbitrarily discriminate against out-of-state providers who are licensed to practice in Maine.

Model Supplemental Provision – Local Office

() Providers seeking to obtain reimbursement from MaineCare for telehealth related services must submit to the Commissioner information on (a) local offices that the provider may have established to service the needs of Maine residents; and (b) written arrangements the provider has established with local health practices to ensure prompt care for any patient care needs that require a face-to-face interaction with the patient or (c) prior authorization.

Store-and-forward Applications

Many states have limited telehealth reimbursement to live interactive encounters between a provider and a patient. However, in recent years there has been growing evidence that certain information can be conveyed to the provider and appropriately be reviewed and evaluated without a live interaction. Teleradiology, teledermatology, telepathology are a few examples of these applications. If a state adopts a restriction on store-and-forward – these exceptions should be maintained in any model provision.

Model Supplemental Provision – Live Interaction (Store-and-forward)

(___). Telehealth physician or practitioner services reimbursed by MaineCare shall be limited to live interactive encounters between the provider or practitioner and the patient with the following exceptions:

- (1) Teleradiology;
- (2) Telepathology;
- (3) Teledermatology; and
- (4) Such other services as the Commissioner shall identify.

SELECTED LEGAL ISSUES RELATED TO TELEHEALTH

There are a number of legal issues that, while not specific to the provision of telehealth services, are worthy of note, especially the professional licensure laws and federal and state laws related to financial arrangement such as prohibitions on self-referrals and anti-kickback statutes.

Professional Licensure

The deployment and acceptance of advanced forms of telecommunications, video conferencing, and the Internet have substantially expanded the types of situations where a health care professional may provide health care services to a patient located in another city, state, or country. This capability has enormous potential to address critical access issues, improve the quality and timeliness of care, and reduce health care costs. These developments present a number of challenges under the current structure of the state-based licensure system utilized in the United States.

Telehealth and e-health are requiring public policymakers, regulators, providers, health advocacy groups, and patients to examine the strengths and weaknesses of the current state-based licensure system. Individual providers and health care systems are increasingly caring for patients in distant states. However, there are still considerable burdens associated with obtaining licenses in multiple states. The time and cost associated with submitting applications for licensure to multiple states can be considerable. In fact, one radiology group has indicated that it costs them nearly \$75,000 for each provider they license and credential in all 50 states. In many states, the applicant is required to appear for a personal interview. These types of limitations effectively discourage medical experts from obtaining multi-state licensure.

The options for state licensure reform have been discussed fairly extensively in the 1997 and 2001 telemedicine reports submitted to Congress by OAT¹⁹. Table 15 created by CTel and included in the 2001 licensure report sets forth general and specific state licensure models. While no one model will fit every state or every provider group, there are two constants: (1) licensure might provide patient and consumer protections and (2), technology has changed the way health care is delivered and health information is accessed. It is incumbent upon federal and state policymakers to ensure that, while they are protecting patients on one hand, that they are not inhibiting the ability of patients to access care and providers to deliver care through telecommunications modalities.

PL 107-251 granted the Secretary of HHS authority to “make grants to State professional licensing boards to carry out programs under which such licensing boards of various States cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.” This authority was funded for the first time as part of the FY ’06 federal appropriation process. Approximately \$750,000 in state incentive grants was included. The Federation of State Medical Boards has been working with a number of states, including several New England states, to develop applications for federal financial support. Extension of this funding was requested in the President’s budget.

The Federation of State Medical Boards (FSMB) adopted a Model Act to Regulate the Practice of Medicine in 1996. In it, FSMB described an “abbreviated, but effective” licensure process for physicians who will not be practicing physically within a state’s jurisdiction. The Act requires physicians who “regularly or frequently” engage in the practice of medicine across state lines to obtain a special purpose license. The Act does not apply to certain consultations or if the practice occurs less than once a month, involves less than ten patients on an annual basis, or comprises less than one percent of the physician’s diagnostic therapeutic practice. The Model Act appears at Appendix R.

In 1998, CTel’s General Counsel, Robert J. Waters, JD, worked with the National Council of State Boards of Nursing (NCSBN) on the creation and implementation of the Nurse Licensure Compact, a mutual recognition model of nurse licensure that allows a nurse to have one license (in his or her state of residency) and to practice in other states (both physical and electronic), subject to each state’s practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted. The full text of the Nurse Licensure Compact is included at Appendix S.

In order to achieve mutual recognition, each state must enact specific legislation authorizing the Nurse Licensure Compact. States entering the compact also adopt administrative rules and regulations for implementation of the compact. Once the compact is enacted, each compact state designates a Nurse Licensure Compact Administrator to facilitate the exchange of information between the states relating to compact nurse licensure and regulation. The RN and LPN/VN Compact began January 1, 2000 and have passed in 23 states, including Maine. The first evaluation²⁰ of the Compact was completed in December 2003.

The following 23 state legislatures in Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico,

¹⁹ GPO No: 0126-E-04(MF) and GPO No. 619-2561/65410

²⁰ The evaluation is available online at <http://ncsbn.org/pdfs/CompactSurvey.pdf>.

North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin have entered the Nurse Licensure Compact. Implementation is pending in Kentucky, Colorado, and New Jersey.

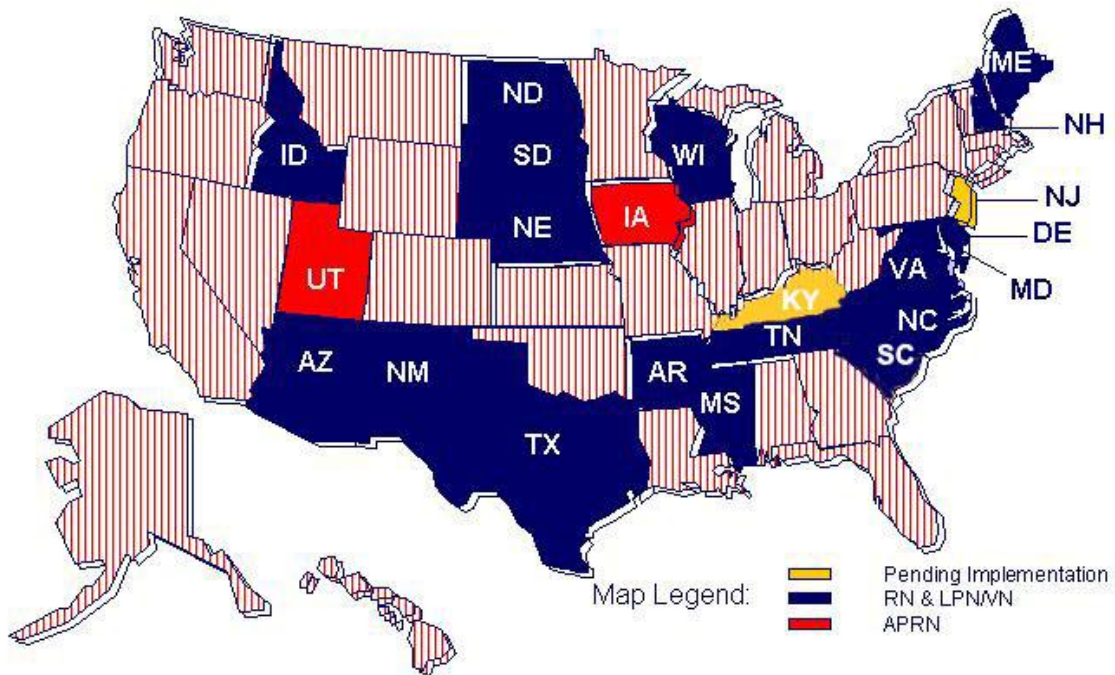


Table 15. General Licensure Models

Consulting Exceptions	With a consulting exception, a physician who is unlicensed in a particular state can practice medicine in that state at the request of and in consultation with a referring physician. The scope of these exceptions varies from state to state. Most consultation exceptions prohibit the out-of-state physician from opening an office or receiving calls in the state. In most states, these exceptions were enacted before the advent of telemedicine and were not meant to apply to on-going regular telemedicine links. However, some states permit a specific number of consulting exceptions per year. Hawaii, Colorado and California allow significant consulting exceptions.
Endorsement	State boards can grant licenses to health professionals in other states with equivalent standards. Health professionals must apply for a license by endorsement from each state in which they seek to practice. States may require additional qualifications or documentation before endorsing a license issued by another state. Endorsement allows states to retain their traditional power to set and enforce standards that best meet the needs of the local population. However, complying with diverse state requirements and standards can be time consuming and expensive for a multi-state practitioner.
Reciprocity	A licensure system based on reciprocity would require the authorities of each state to negotiate and enter agreements to recognize licenses issued by the other state without a further review of individual credentials. These negotiations could be bilateral or multilateral. A license valid in one state would give privileges to practice in all other states with which the home state has agreements.
Mutual Recognition	Mutual recognition is a system in which the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee's home state. Licensure based on mutual recognition is comprised of three components: a home state, a host state and a harmonization of standards for licensure and professional conduct. The health professional secures a license in his/her own home state and is not required to obtain additional licenses to practice in other states. The nurse licensure compact is based on this model
Registration	Under a registration system, a health professional licensed in one state would inform the authorities of other states that s/he wished to practice part-time there. By registering, the health professional would agree to operate under the legal authority and jurisdiction of the other state. Health professionals would not be required to meet entrance requirements imposed upon those licensed in the host state but they would be held accountable for breaches in professional conduct in any state in which they are registered. California has the authority to draft this type of model.
Limited Licensure	Under a limited licensure system, a health professional would have to obtain a license from each state in which s/he practiced but would have the option of obtaining a limited license for the delivery of specific health services under particular circumstances. Thus, the system would limit the scope rather than the period of practice. The health professional would be required to maintain a full and unrestricted license in at least one state. The Federation of State Medical Boards has proposed a variation of this model.
National Licensure	A national licensure system could be adopted on the state or national level. A license would be issued based on a universal standard for the practice of health care in the US. If administered at the national level, questions might be raised about state revenue loss, the legal authority of states and logistics about how data would be collected and processed. If administered at the state level, these questions might be alleviated. States would have to agree on a common set of standards and criteria ranging from qualifications to discipline.
Federal Licensure	Under a Federal licensure system health, professionals would be issued one license, valid through the US, by the Federal government. Licensure would be based on Federally established standards related to qualifications and discipline and would preempt state licensure laws. Federal agencies would administer the system. However, given the difficulties associated with central administration and enforcement, the states might play a role in implementation.

Licensure laws are important to the deployment of telehealth services. The availability of potential telehealth providers can be severely limited if a state has a conservative approach to interstate practice. For a number of years, there has been some discussion about the New England states collaborating on some form of regional licensure. While there have been a

number of meetings in this regard, considerable work would be necessary to adopt and implement a regional physician licensure agreement.

At this time, Maine and the other New England states adhere to the Northeast Region State Medical Boards Statement of Principle with regard to telemedicine. The relevant provision states, "except for consultation defined by our several states, provision of all medical services shall require a full license in the state in which the patient encounter will occur." Signatories include: Maine, New Hampshire, New York and Vermont. The complete text of the agreement appears at Appendix T. CMS has also indicated that it will defer to the states with regard to licensure issues. When the state of the originating site permits a non-locally licensed physician to provide a service, Medicare will pay as long as all other program requirements are met. However, the reimbursement rate will be based on the remote physician's location, not the patient location.

National Clearinghouse on Internet Prescribing

The other issue that might affect local telehealth services involves prescribing medications for patients for whom the physician has not conducted an in-person examination. Many states, including Maine, have responded to abusive practices involving prescription medications and the Internet by limiting the ability of a physician to provide certain services to patients with whom they have not conducted a live in person examination. Maine is one of these states. See Appendix U. This requirement could impede even locally licensed physicians' ability to provide certain otherwise accepted telemedicine services. For example, a teledermatologist might not be able to write a prescription for a patient he or she had only interacted with via videoconference. These requirements affect both locally licensed as well as remotely licensed physicians. If physicians are not appropriately licensed to provide service, they may not be paid under either Medicare or Medicaid and may also be subject to civil or criminal sanctions.

Related to licensing is the potential fallout due to online pharmacies prescribing and dispensing prescription medications to consumers without a physical examination or prior relationship between the physician and the patient. The Federation of State Medical Boards established the National Clearinghouse on Internet Prescribing (NCIP) in September 2000 to collect and disseminate information on "rogue" Internet pharmacy websites. This initiative achieves three broad goals:

1. Foster cooperation and collaboration among state and federal regulatory authorities, including the Department of Justice, the Drug Enforcement Administration, the Food and Drug Administration, and the Federal Trade Commission; national associations such as the National Association of Boards of Pharmacy, the National Association of Drug Diversion Investigators, the National Association of Controlled Substances Authorities, the National Association of Attorneys General, representatives of the pharmaceutical industry, and the media;
2. Serve as an information clearinghouse to facilitate communication among all entities that play a role in regulating Internet pharmacy operations and the physicians associated with them; and,

3. Investigation. Clearly, there is an important role for legislators and regulators to play in ensuring a safe health care system. Policymakers are encouraged to discuss the impact of their proposed policies with leaders who are extremely knowledgeable about legal and regulatory issues facing telehealth.

Anti-Kickback Statutes

Federal and state fraud and abuse laws can have a significant impact on the deployment of telehealth technologies. Often the remote locations have limited financial resources and medical staff. The supply of additional providers is usually tied to a larger medical system or group practice. The natural tendency of the larger facility or group practice is to support access in the rural areas by subsidizing the deployment of technology in the rural areas. However, if the rural site is legally separate from the entity donating the equipment and if one purpose of the donation of equipment might be perceived as an inducement for referrals the arrangement is likely to run afoul of either federal or state fraud and abuse provisions.

The Medicare and Medicaid Patient Protection Act of 1987 (42 U.S.C. § 1320a-7b) establishes criminal penalties for certain financial arrangements involving parties participating in either the Medicare or Medicaid programs. This law is commonly referred to as the “anti-kickback” statute. The Office of the Inspector General at the Department of Health and Human Services has the authority to prosecute violations of the Act. As stated by the OIG,

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services payable by a federal health care program. See section 1128 B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals or items or services payable by a federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. OIG Advisory Opinion No. 04-07

The anti-kickback statute raises a number of concerns for a medical center that would like to deploy telehealth technologies for free in a local physician’s office, if that physician is a potential referral source. While one of the primary purposes of telehealth technologies is to provide access to specialty services, installing this equipment at anything less than fair market value could violate the kickback statute. The punishment for violations is substantial:

Violation of the statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. The OIG may also initiate administrative proceedings to exclude persons from Federal health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act. OIG Advisory Opinion No. 04-07.

The statute was enacted principally to address two related concerns: (1) federal health program costs are increased by arrangements that create incentives to refer patients to the extent that either the referred patients do not actually require some or all of the referred services or the provider to whom the patients are referred is a higher cost or lower quality alternative; and (2) additionally, the related concern is that federal health program patients incur necessary costs, i.e. cost sharing, and/or are placed at health risk by receiving unnecessary or substandard items or services.

The Stark Law (§ 1877 of the Social Security Act) prohibits physicians from making referrals to certain entities in which they have direct or indirect interests. While a particular arrangement might violate both the anti-kickback statute and the Stark Law, two separate, but closely related laws, only the OIG has the authority to issue opinions regarding the anti-kickback statute, while opinions about the Stark Law are issued by the CMS.

With regard to telehealth, the Office of the Inspector General (OIG) at the federal Department of HHS has issued two major advisory opinions related to telehealth issues. On December 28, 1999, the OIG in the Department of HHS issued Advisory Opinion No. 99-14²¹ In this opinion, the OIG stated that it would not impose sanctions on a hospital that deployed telemedicine equipment to spoke sites utilizing Telemedicine Grant Program funding provided by the Office of the Advancement of Telehealth and the Office of Rural Health Policy. The OIG noted that under these circumstances including:

- (1) the clear congressional policy favoring the study and development of rural telehealth networks;
- (2) the oversight of the Telemedicine Network by the ORHP/OAT during the grant period;
- (3) the health system's representation that it has fully complied with the terms of all of its TGP grants;
- (4) the comprehensive range of telemedicine services provided through the network;
- (5) the limited remuneration during the post-grant period; and
- (6) the significant community benefit to rural citizens through the increased access to health care.

The purpose of the advisory opinions is to provide meaningful advice on the application of the anti-kickback statute and other OIG-sanctioned statutes in specific factual situations. While advisory opinions do not technically apply beyond the facts and the parties involved. The OIG published these opinions in order to give the health community the benefit of its thinking on particular enforcement issues.

The OIG has issued at least two other opinions that identify specific telehealth arrangements that, while providing "remuneration" to a potential referral source, would not give rise to prosecution under the statute. On June 17, 2004 the OIG issued Advisory Opinion No. 04-07. This opinion permits a health system to provide professional consultative services to low income children through school-based health centers. While the State or Federal government did not reimburse for these services, the OIG concluded there were benefits conferred on the school based health centers, the consulting practitioners at the hub site, and the patients. Nevertheless, the OIG

²¹ Advisory Opinion No. 99-14 is available online at http://oig.hhs.gov/fraud/docs/advisoryopinions/1999/ao99_14.htm.

concluded that there were sufficient safeguards in place to reduce the risk that the remuneration would generate appreciable referrals of Federal healthcare business and that there was a substantial community benefit associated with the screening services that would result from the telemedicine deployment. OIG Advisory Opinion No 04-07. Finally, the OIG examined the use of telemedicine equipment as part of an advisory opinion in 1998 where the OIG concluded it would not impose sanctions on an arrangement for the provision of telemedicine equipment between an ophthalmologist and an optometrist where the optometrist would pay fair market value, and the lease would fit within the equipment rental safe harbor. OIG Advisory Opinion No. 98-18. All three of these Advisory Opinions are attached at Appendix V.

While the HHS Inspector General has indicated that participants in each of these three programs would not be prosecuted, any provider contemplating such an arrangement would be well advised to work with legal counsel to ensure it is appropriately structured. Likewise, federal and state officials may want to consider carefully crafted exceptions or safe harbors to their fraud and abuse laws to permit resource sharing that is wise and an essential element of telehealth partnerships.

Conclusion

Maine's current telehealth policy appears to be consistent with that of many other states that have populations dispersed in rural areas and have developed telehealth networks. Despite many other differences, Alaska, Kentucky and Texas are similar to Maine in this regard.

The other New England States that we studied (Vermont, New Hampshire, and Massachusetts) do not appear to have an established Medicaid policy. It is possible that payments under Medicaid managed care contracts or under Medicaid fixed fee or capitation arrangements might be used for telehealth activities. However, it is fair to conclude that at this time they do not have an established program for paying physicians under a fee for service arrangement for telehealth encounters.

In this report we have not only provided background on federal Medicare, state Medicaid, and private pay policies regarding telemedicine, we have also drafted a suggested model regulatory framework for Maine and potential supplemental provisions that the state consider. These provisions are based on Maine's current policy for telehealth reimbursement. The presumption is in favor of promoting telehealth technologies, but the system is designed so that the State maintains control and can evaluate significant expansions in a manner that will protect the patient and avoid any unintended consequences.

We have recommended that MaineCare maintain flexibility in its approach to telehealth reimbursement. Telehealth technologies and service delivery models are rapidly evolving and can play a significant role in providing the residents of Maine enhanced access to essential and specialty health care services. We have included language to permit the Commissioner to approve payments for certain limited technological costs at the origination sites and for remote monitoring services that are cost effective and improve patient care. We have also provided supplemental language to: limit payment for telephone and facsimile interactions, define when store-and-forward (non-interactive) encounters are reimbursable; and provide evidence that the telehealth provider has made arrangements for the in-person care for patient's requiring face to face interactions.

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