State Telehealth Laws and Medicaid Program Policies

CCHP

Fall 2024

SUMMARY REPORT:

The Highlights & Findings of a Comprehensive Scan of 50 States, D.C., Puerto Rico and the Virgin Islands.

The Center for Connected Health Policy's (CCHP) Fall 2024 Summary Report of the state telehealth laws and Medicaid program policies is now available as well as updated information on our online Policy Finder tool. The most current information in the online tool may be exported for each state into a PDF document. The following is a summary of the current status of telehealth policy in the states (and jurisdictions) given these new updates. Traditionally, CCHP has released bi-annual summary reports each Spring and Fall to offer a snapshot of progress over the previous six months. However, last year CCHP announced a shift to an annual reporting schedule, with three rounds of updates to each jurisdiction in the Policy Finder throughout the year. CCHP is committed to providing timely policy information that is easy for users to navigate and understand through our Policy Finder. Additionally, sections of CCHP's policy finder addressing COVID temporary policy as well as policy related specifically to federally qualified health centers (FQHC) (which had been included in CCHP's online policy finder in previous years) have been phased out. COVID telehealth policies that have been made permanent or extended for multiple years have been incorporated into the appropriate relevant sections of the policy finder. Some FQHC policy addressing telehealth explicitly can also still be found in CCHP's policy finder, often under the Medicaid section in the applicable general topic area. **The information for this summary report covers updates in state telehealth policy made between October 2023 and early September 2024, with states being last updated between late May and early September 2024.**

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Amy Durbin, Policy Advisor or Christine Calouro, Senior Policy Associate at info@cchpca.org. For further information, visit cchpca.org.

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

Mei Wa Kwong, JD, Executive Director

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Introduction

The Center for Connected Health Policy's (CCHP) Fall 2024 analysis and summary of telehealth policies are based on information contained in its online Policy Finder. The Summary Report provides highlights on certain aspects of telehealth policy and the changes that have taken place between Fall 2024 and the previous edition, Fall 2023. The research for this edition of the Summary was primarily conducted between late May and early September 2024. This summary offers the reader an overview of telehealth policy trends throughout the nation. For detailed information by state, see CCHP's online telehealth Policy Finder which breaks down policy for all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands.

Methodology

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the primary resources for the online Policy Finder, from which the findings in this summary are taken. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, state PowerPoint presentations, bulletins or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in the policy finder specifically focuses on fee-for-service; however, managed care plan information has also been included if available from the utilized sources.

The information is organized in the policy finder into three major categories:

1. MEDICAID REIMBURSEMENT
2. PRIVATE PAYER LAWS
3. PROFESSIONAL REQUIREMENTS

Within each of the three major categories, information is organized into various topic and subtopic areas in CCHP's policy finder. These topic areas include:

- **MEDICAID REIMBURSEMENT:**
  - Definition of the term telemedicine/telehealth
  - Reimbursement for live video
  - Reimbursement for store-and-forward
  - Reimbursement for remote patient monitoring (RPM)
  - Reimbursement for email/phone/fax
  - Consent requirements
  - Out-of-state providers
  - Miscellaneous
- **PRIVATE PAYER LAWS:**
  - Definitions
  - Requirements
  - Parity (service and payment)
- **PROFESSIONAL REQUIREMENTS:**
  - Definitions
  - Consent
  - Online Prescribing
  - Cross-State Licensing
  - Licensure Compacts
  - Professional Board Standards
  - Miscellaneous

Every effort was made to capture the most recent policy language in each state at the time it was reviewed between late May and early September 2024. Note that in some cases, after a state was reviewed, it is possible that the state may have enacted a policy change that CCHP may not have captured. In those instances, the changes will be reviewed and catalogued within our Winter online policy finder update, and changes incorporated into the 2025 annual summary report. CCHP also reports on significant changes for each state that was updated in the previous month in our newsletter, which is released the second Tuesday of each month (subscribe to the CCHP newsletter). Additionally, even if a state has enacted telehealth policies in statute, these policies may not have been officially incorporated into its Medicaid program. For purposes of this summary in regard to Medicaid, CCHP only counts states as reimbursing for a specific modality or removing a restriction if there is documentation to show that the Medicaid program has explicitly implemented a policy or statute. Requirements in newly passed legislation related to Medicaid will be incorporated into the findings of future editions of CCHP's summary report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming implementation.

Key Findings Overview

Since the COVID-19 pandemic in 2020, Medicaid programs across the United States have gradually stabilized and refined their telehealth policies, making necessary adjustments based on evolving needs. Since CCHP's last 50-state report in Fall 2023, the trends show a continued expansion of telehealth reimbursement in targeted areas, as well as expanded cross-state licensing allowances, while simultaneously implementing guardrails to balance increased access with maintaining high-quality care.

Findings include:

- **Fifty states, Washington DC and Puerto Rico** provide reimbursement for some form of live video in Medicaid fee-for-service. The Virgin Islands does not explicitly indicate they reimburse for live video in their permanent Medicaid policies.
- **Thirty-seven state Medicaid programs** reimburse for store-and-forward. Colorado, Delaware, New Hampshire, and Pennsylvania are the states which added reimbursement for store-and-forward, although each in a limited capacity. Note that some states only reimburse store-and-forward through specific communication technology-based service (CTBS) codes.
- **Forty-two state Medicaid programs** provide reimbursement for remote patient monitoring (RPM). Five states, (Delaware, New Hampshire, New Jersey, Pennsylvania and South Dakota) added reimbursement for RPM since Fall 2023.
- **Forty-five states and DC Medicaid programs** reimburse for audio-only telephone in some capacity; however, often with limitations. Two states, Delaware and West Virginia, added reimbursement for audio-only telehealth in some capacity since Fall 2023.
- **Thirty-one state Medicaid programs** including Alaska, Arizona, California, Colorado, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin reimburse for all four modalities (live video, store-and-forward, remote patient monitoring and audio-only), although certain limitations may apply.
- **Forty-four states, the District of Columbia, Puerto Rico and the Virgin Islands** have a private payer law that addresses telehealth reimbursement. Not all of these laws require reimbursement or payment parity. **Twenty-three states** have explicit payment parity. Both Puerto Rico and Pennsylvania are the two new states that have added private payer policies since Fall 2023.
- **Forty-seven states, DC, and Puerto Rico** include some sort of consent requirement in their statutes, administrative code, and/or Medicaid policies. South Dakota and Montana added consent requirements since Fall 2023.

- **Thirty-eight states, as well as DC** offer some type of exception to licensing requirements. Note that while CCHP's search of statute and regulations was confined to telehealth, if we happened to come across a more general licensing exception, we did include it in our reporting, and in this number. CCHP also found that **twenty-two states as well as the Virgin Islands** have telehealth-specific special registration or licensure processes as an alternative to full licensure for certain providers or as an additional requirement to utilize telehealth. To be counted in this number, the licenses/registrations did need to specifically reference telehealth (or remote care) in some way.
- Many states continue to implement telehealth practice requirements for various professions. While the majority of states have telehealth practice standards in place for certain providers, such as physicians and mental health professionals, more state boards are starting to adopt professional standards for other types of practices, for example acupuncture providers and dietitians.
- While CCHP doesn't keep specific counts of states with prescribing requirements (because there are so many caveats and exceptions), we do include it as a category under Professional Requirements in our Policy Finder. Since Fall 2023, several states have implemented new rules around prescribing via telehealth, especially for controlled substances. Examples can be found in the prescribing section below.

While this report provides an overview of findings, it must be stressed that there are nuances in many of the telehealth policies. To fully understand a specific policy and all its intricacies, the full language of it must be read and can be accessed via CCHP's telehealth Policy Finder. Below are summarized key findings in each category as of September 2024.

Definitions

The way a term is defined can shape the scope of a state's telehealth regulations. For instance, certain states include specific limitations within their definition of telehealth or telemedicine, like the requirement for "live" or "interactive" contact, thereby excluding store-and-forward and remote patient monitoring (RPM) from the definition and, consequently, from general telehealth reimbursement. All fifty states, along with the District of Columbia (DC), Puerto Rico, and the Virgin Islands, have established legal, regulatory, or Medicaid program definitions for telehealth, telemedicine, or both.

States vary in their choice of terminology, switching between "telemedicine" and "telehealth," with some opting to use both terms interchangeably. "Telehealth" is often employed to encompass a broader scope of services, while "telemedicine" may be reserved for describing the provision of clinical services. Moreover, there has been a growing trend in adopting terms prefixed with "tele," such as "telepractice" or "teletherapy" for physical and occupational therapy, behavioral therapy, and speech-language pathology, as well as "teledentistry" for dental services. When referring specifically to psychiatry services, "telepsychiatry" is commonly used as an alternative term. The range of terms continues to grow, with Puerto Rico recently introducing the term "cybertherapy" as a way to refer to a patient-therapist interaction using technological communication tools. Additionally, following the onset of the pandemic, though not yet widespread, a few Medicaid policies and programs have introduced the term "virtual care." The utilization of these various terms can potentially lead to confusion for providers, especially when they are accompanied by distinct and separate definitions and reimbursement requirements.

In the past, the most common restriction on the term telemedicine/telehealth was the exclusion of email, phone, and/or fax from the definition. However, due to the increased allowance of the telephone modality since COVID-19, some states have amended their definitions to either remove the explicit exclusion of telephone or explicitly include audio-only services in their telehealth/telemedicine definitions.

In some instances, CCHP found that a state Medicaid program provided a definition of telehealth or telemedicine that is inclusive of modalities such as store-and-forward, remote patient monitoring and/or audio-only but did not provide further explicit guidance on whether or not those modalities are individually reimbursed in their Medicaid program.

Medicaid Reimbursement

All 50 states, the District of Columbia and Puerto Rico have some form of Medicaid reimbursement for telehealth in their public program. CCHP was unable to locate any permanent telehealth reimbursement policy in the Virgin Islands' Medicaid program. Reimbursement policies for telehealth services varies across states, with some jurisdictions providing more comprehensive guidance than others.

While most states now consolidate their telehealth policies into a single, accessible location some have only recently streamlined their guidelines by updating their Medicaid manuals to include comprehensive and distinct sections on telehealth services. For instance, Delaware's Division of Medicaid and Medical Services recently updated its Practitioner Manual to add a dedicated section on their Telehealth Services Policies, and New York

released a specific Telehealth Provider Manual for fee-for-service providers. In addition, some states may not include telehealth reimbursement information in Medicaid manuals at all, but instead in Medicaid bulletins and/or dedicated Medicaid telehealth websites, such as Connecticut. Lastly, CCHP does not explicitly track Medicaid payment parity since, by default, Medicaid programs are required to reimburse telehealth services at the same rate as in-person services unless they seek an exception from the Centers for Medicare and Medicaid Services (CMS). However, we do include mentions of explicit payment parity policies in our policy finder that apply to Medicaid when we come across them.

State Example:

SOUTH DAKOTA, which already had a centralized telehealth policy, was able to streamline significant updates to enhance clarity and service eligibility by making adjustments in a single document. South Dakota's updates included expanding the list of eligible distant site providers, adding limitations for certain services, and adjusting billing requirements such as the use of the GT modifier for telemedicine services.

Live Video

The most common form of telehealth reimbursement, live video, enjoys widespread coverage across every state, the District of Columbia and Puerto Rico in their Medicaid programs. The Virgin Islands is the only jurisdiciton without explicit reimbursement, as previously mentioned. However, the criteria pertaining to live video reimbursement varies considerably from state to state. Generally, Medicaid programs typically impose limitations on live video telehealth (and other modalities) in three key areas:

- The **qualified healthcare providers who can receive reimbursement**, including physicians, nurses, physician assistants, and more, as well as the location of the provider, known as the distant site.
- The **eligible services for reimbursement**, such as office visits or inpatient consultations, or services only related to behavioral health.
- The **location of the patient**, known as the originating site.

Given the long-standing presence of extensive live video policies, there haven't been as many groundbreaking developments in this domain in the past year. Nevertheless, states continue to make gradual adjustments to their Medicaid programs, often offering further clarification on covered modalities, eligible providers, and billing requirements (which will be discussed further in subsequent sections).

Eligible Providers

While specific guidance regarding telehealth services may be absent in some state Medicaid programs, others have implemented restrictions regarding which providers are allowed to deliver telehealth services. It's worth noting that there has been a notable expansion in the types of eligible providers in many Medicaid programs in recent years, with most states now allowing a diverse array of providers to offer telehealth services without limiting the location in which they provide such services. For instance, Wisconsin, which already places no limitations on the type of provider that may be reimburse for telehealth services, clarified in a recent update that qualified treatment trainees (QTTs) could provide services via telehealth, provided they meet the necessary supervision and policy requirements. Utah also passed Senate Bill 24, adding physician assistants to the list of

professionals who can bill for telepsychiatric consultations. Additionally, FQHCs and RHCs have sometimes been explicitly added as distant site providers in recent years, a trend that is addressed more extensively in a subsequent section.

In the past year, states are continuing to develop policies to address the enrollment of out-of-state providers in Medicaid programs in an effort to ensure compliance with state-specific requirements. States identified last year that addressed this included Wisconsin, Indiana, Kentucky and Virginia. For example, Indiana introduced a telehealth-only provider enrollment option following the passage of House Bill 1352, allowing providers with no physical patient site to deliver services via telehealth if they meet Indiana's licensure and other special requirements. Similarly, Michigan Medicaid clarified that out-of-state providers are eligible for reimbursement as long as they are enrolled in Michigan Medicaid and licensed in the state where the patient resides, with additional instructions for virtual-only providers and those licensed under the telepsychology compacts. North Dakota has also adjusted its Medicaid policies, specifying that out-of-state telehealth providers serving North Dakota residents do not need to request out-of-state care authorization, as long as they are enrolled in North Dakota Medicaid. Utah adopted similar measures, allowing non-resident providers to offer telehealth services to Utah Medicaid members, provided they meet licensing and enrollment requirements. Likewise, California's Department of Health Care Services established exemptions from certain Medi-Cal provider enrollment requirements for remote services providers who offer mental health services exclusively through telehealth modalities.

State Example:

During this round of updates, **MISSISSIPPI** updated its Medicaid regulations to include licensed marriage and family therapists (LMFTs) and health clinics under the State Department of Health as eligible distant site providers. The state now has a total of 14 eligible provider types, including physicians, psychologists, physical, occupational and speech therapists and FQHCs and RHCs, among others.

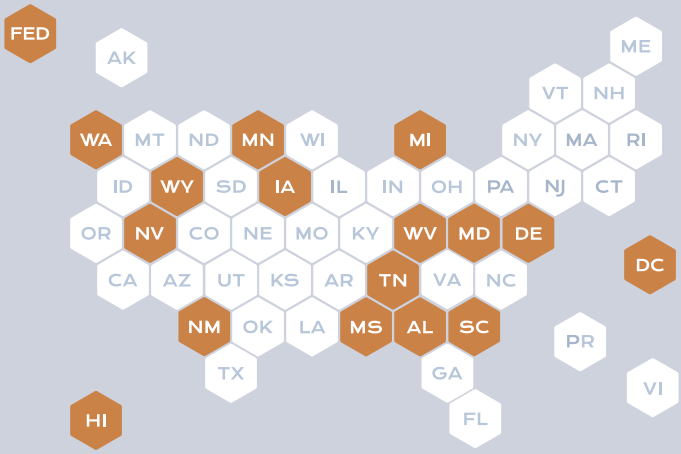
Eligible Services

In addition to expanding provider types, some Medicaid programs have introduced new services that are now eligible for telehealth reimbursement since CCHP's previous Fall 2023 edition. Arkansas and West Virginia, for example, made significant updates to their Medicaid programs by allowing ambulance services to utilize telemedicine for triage and transport to alternative destinations or in cases of treat-in-place scenarios. Meanwhile, California retroactively approved preventive medicine counseling codes for telehealth reimbursement under its Medicaid program (within the Local Education Agency Billing Option), and Colorado passed legislation requiring reimbursement of substance use disorder treatment via telehealth and added telehealth to the definition of school-based healthcare, allowing school-linked healthcare services to be delivered via telehealth. Meanwhile, both New York Medicaid and Minnesota Medicaid updated their Medicaid policies to specify that doula services could be provided via telehealth under certain circumstances.

Facility Originating Site Restrictions Map

MAP KEY:

- ○ No specific originating site list or restriction
- ● Has billable originating site list or restriction



Geographic & Facility Originating Site Restrictions

The approach of restricting reimbursable telehealth services exclusively to rural or underserved areas, as seen in Medicare's permanent policy, has significantly waned on the state level. Only three states (Hawaii, Montana and Maryland) currently have these types of restrictions. For Hawaii and Maryland, these geographic restrictions are present in the states' regulations while contradictory policy exists in the states' statute, indicating the states have likely not yet updated administrative policies to be consistent with changes in law. For example, enacted legislation in Maryland requires that Medicaid not distinguish between rural and urban locations, however as of CCHP's last review of the state in May 2024, language related to telehealth mental health services requiring beneficiaries reside in one of the designated rural geographic areas or have a situation that makes person-to-person psychiatric services unavailable was still in their administrative code. Likewise, despite Hawaii enacting a law that bars geographic limitations on telehealth within their Medicaid program, such language continues to persist in their Medicaid regulations.

Instead of implementing geographical constraints, state Medicaid programs typically favor an approach that limits the types of facilities eligible to function as originating sites for telehealth services. Currently fifteen states and DC have a specific list of sites that can serve as an originating site for a telehealth encounter. In many states, originating

State Example:

The geographic restriction CCHP has found for **MONTANA** Medicaid dictates that the originating site and distant providers must not be located within the same facility or community, with no definition of the term 'community' leaving it open for interpretation.

State Example:

NEBRASKA Medicaid updated their provider manual to specify that distant sites must bill an appropriate code from a specific list with place of service (02) designating a telemedicine service provided in a place other than in the patient's home OR place of service (10) designating a telemedicine service provided in the patient's home. Services delivered via telemedicine will be reimbursed at the same rate as a face-to-face (in the same physical location) service. Documentation requirements are the same as an in-person service.

site lists have evolved to encompass non-traditional settings like patients' homes and schools, resulting in broader eligibility criteria despite the presence of an initial list.

Forty-seven states and D.C. Medicaid programs explicitly allow the home to serve as an originating site, although it's often tied to additional restrictions, and a facility fee would not be billable. This number does not include states that make broad statements that any patient location is covered without explicitly referencing the home or patient's residence. Often states are counted as allowing the home due to inclusion of place of service (POS) code 10 to indicate the service took place at the patient's home (along with any appropriate modifiers). Since Fall 2024, two state Medicaid programs (Arizona and Kansas) explicitly added the home as an eligible site.

States are also increasingly allowing schools to serve as an originating site, with thirty-seven states and DC explicitly allowing schools to be originating sites for telehealth-delivered services, although, as is the case with the home, restrictions often apply. Services allowed via telehealth in schools vary from state to state but the most common services allowed are therapy services, such as mental health therapy as well as speech, occupational and physical therapy.

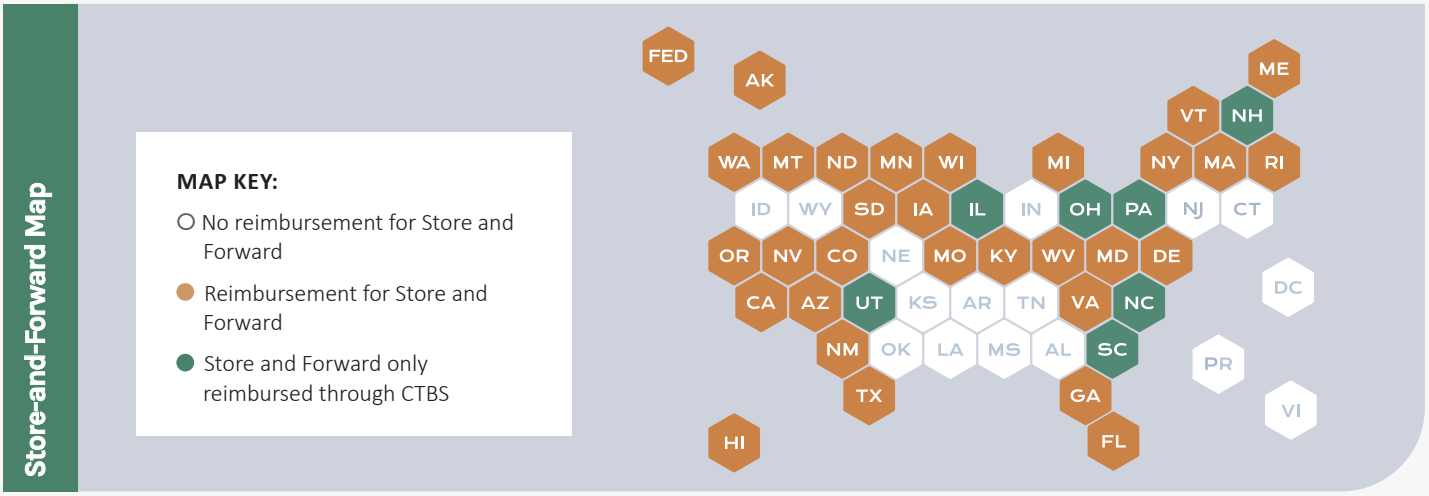
Federally Qualified Health Centers & Rural Health Clinics

Considering that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) seek reimbursement as organizational entities rather than individual providers, they are occasionally overlooked on telehealth eligible provider lists. Notably, Medicare has excluded these clinics from billing as distant site providers for telehealth services in their permanent policy (though they are currently eligible under COVID waivers until Dec. 31, 2024). However, it's important to note that they may still be eligible for reimbursement for facility fees associated with originating site services and for mental health consultations conducted through interactive telecommunication systems. Thirty-nine states and DC have specifically addressed this issue for FQHCs, RHCs or both, allowing them to serve as distant site providers. Some states have also begun addressing the reimbursement amount in their policy, clarifying whether or not FQHCs and RHCs will receive the same amount they typically receive under the prospective payment system (PPS) or all-inclusive rate (AIR). Since CCHP's Fall 2024 edition, Hawaii, for example, updated its Medicaid dental manual to allow FQHCs to submit telehealth claims under the Prospective Payment System (PPS), provided that both the patient and dentist are located at separate eligible FQHC or RHC sites. Missouri, meanwhile, provided billing clarifications for FQHCs and RHCs, ensuring that telehealth visits can count as eligible threshold encounters and providing guidance on facility fee billing. Finally, Pennsylvania expanded its definition of an FQHC/RHC encounter to include telehealth, telemedicine and teledentistry.

State Example:

TEXAS updated their Medicaid Telecommunications Services Handbook to clarify that distant site providers do include FQHCs and RHCs. The manual also provides clarification on how a FQHC and RHC would collect the facility fee, Q3014. It requires RHCs and FQHCs to obtain a signed letter from the client's treating healthcare provider at the FQHC/RHC, documenting that the client suffered an injury requiring additional diagnosis or treatment by a distant site provider. This documentation is necessary to receive additional facility fee payments for the same client on the same date of service.

Store-and-Forward Map



Store-and-Forward

Store-and-forward services are defined and reimbursed by thirty-seven Medicaid Programs. Colorado, Delaware, New Hampshire, and Pennsylvania are the states which added reimbursement for store-and-forward since the Fall 2023 update. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered 'telehealth'). In certain states, the definition of telemedicine and/or telehealth explicitly requires services to be conducted in "real-time" or to be "interactive," effectively excluding store-and-forward as a component of telemedicine and/or telehealth within those states. Among the states that do provide reimbursement for store-and-forward services, some impose restrictions on the type of services or professions that qualify for reimbursement. For example, North Carolina Medicaid focused in on dentistry specifically, clarifying that coverage is available for certain asynchronous dental service codes. Additionally, legislation requiring Medicaid reimbursement of remote ultrasounds and remote fetal nonstress tests passed in Maryland, Tennessee and Virginia.

State Example:

NEW HAMPSHIRE Medicaid Administrative Rules specify that they will only reimburse store-and-forward (and remote patient monitoring) if funding and resources within the current state fiscal year are available.

Three additional states (Connecticut, Mississippi, and New Jersey) have laws requiring Medicaid reimbursement for store-and-forward services, but CCHP has not been able to locate any official Medicaid policy indicating that they are in fact reimbursing. In some cases, although a definition of telehealth or telemedicine applicable to their Medicaid program included store-and-forward, there was no further indication of the modality being reimbursed, or the only specialty referenced was teleradiology which CCHP does not count as store-and-forward reimbursement for purposes of this list.

Several more states have authorized store-and-forward reimbursement due to their reimbursement of Communication Technology Based Services (CTBS), some of which explicitly incorporate the store-and-forward modality within their descriptions. CTBS is discussed further in a subsequent section, but it's important to understand that seven (Illinois, North Carolina, New Hampshire, Ohio, Pennsylvania, South Carolina, and Utah) out of the 37 states that reimburse for store-and-forward do so through these CTBS codes.

A growing trend in telehealth is the adoption of electronic consultations (eConsults), which allow primary care providers to seek advice from specialists without requiring direct patient interaction. This trend may be partly due to recent CMS guidance clarifying that state Medicaid programs are permitted to reimburse for eConsults.

eConsults are commonly done through a store-and-forward modality, though it can also be conducted through live video or telephone as well. State Medicaid programs that added reimbursement for eConsults since Fall 2023 include Colorado, Maine, Michigan, Missouri, New York, North Dakota and Pennsylvania. However, some of the policies are limited. For example, Maine's policy change allows medication-management providers specifically to bill for interprofessional consultations. On the other hand, Pennsylvania's reimbursement of eConsult requires that the communication must be real-time and interactive, effectively excluding the store-and-forward modality. Asynchronous communications and applications, such as store-and-forward, may only be utilized as part of the synchronous consultation, but by itself does not meet the requirements for interprofessional consultations.

Remote Patient Monitoring (RPM)

Forty-two states have some form of reimbursement for RPM in their Medicaid programs. Since Fall 2023, Delaware, New Hampshire, New Jersey, Pennsylvania and South Dakota added reimbursement for RPM, though some additional Medicaid programs did make modifications or expand their RPM reimbursement to additional conditions. Five of the states reimburse only for specific remote patient monitoring CTBS codes, including California, Hawaii, Massachusetts, New Hampshire, and West Virginia. Reimbursement of RPM doesn't always mean reimbursement of the same remote physiologic monitoring codes that Medicare reimburses. Several states in the past year have implemented or expanded their reimbursement of continuous glucose monitors (CGMs) for patients with diabetes, including Georgia, Missouri and South Carolina. CGM services are typically reimbursed under their own unique CPT codes. It should also be noted that while Alaska Medicaid is included as covering RPM due to listing self-monitoring as a covered service in their Medicaid manual, CCHP has received anecdotal reports that the service is not actually being covered in Alaska.

State Example:

NEW HAMPSHIRE Medicaid now covers remote patient monitoring telehealth services (as required due to the passage of SB 258). Codes include:

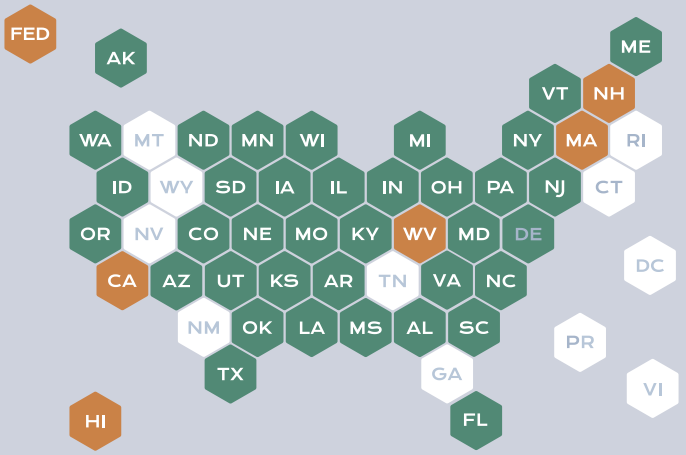
- **99453, 99454**– Remote monitoring of physiologic parameters
- **99457, 99458** – Remote monitoring treatment management services
- **99091** – Collection and interpretation of physiologic data digitally stored and/or transmitted

Many of the states that offer RPM reimbursement also have a multitude of restrictions associated with its use. South Dakota Medicaid, for example, recently updated their billing and policy manual to add permanent coverage of remote patient monitoring of physiologic functions when medically necessary for recipients with acute or chronic

Remote Patient Monitoring (RPM) Map

MAP KEY:

- ○ No reimbursement for Remote Patient Monitoring
- ● Remote Patient Monitoring only reimbursed through CTBS
- ● Reimbursement for Remote Patient Monitoring



conditions when ordered and billed by providers who are eligible to bill Medicaid for evaluation and management codes. Likewise, Colorado also passed SB 24-168 which mandates reimbursement for remote monitoring for outpatient clinical services specifically. The most common restrictions include only offering reimbursement to home health agencies, restricting the clinical conditions for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected. Connecticut Medicaid has a law requiring Medicaid reimbursement for RPM but at the time each state was reviewed for this report, they did not have any official Medicaid policy regarding RPM reimbursement. Note that CCHP's methodology does not include searches through Medicaid fee schedules. Therefore, if a state was reimbursing for specific CTBS codes (including RPM or RTM codes) but it is not mentioned in their telehealth policy, it would not be captured in this report.

Audio-Only

Audio-only, which has seen huge growth in Medicaid reimbursement since 2020, also made gains in several states in the past year. Forty-five state Medicaid programs and D.C. now allow for telephone reimbursement in some way. Since Fall 2023, two states added or extended reimbursement for audio-only telephone, including Delaware and West Virginia. Sometimes states will only reimburse specific specialties such as mental health, or specific services such as case management. Nevada, for example, expanded its use of audio-only services beyond behavioral health crisis intervention specifically, but still limits it to behavioral health providers, who can now use audio-only when they deem it clinically appropriate. Several states took Medicare's approach to audio-only, introducing (or updating) a list of certain current procedural terminology (CPT) codes which are allowable to be delivered via audio-only. Examples of states with this approach include Vermont, Virginia, and Washington. Many of the policies also specify that providers are to use the modifier 93 in their billing documents to signify the service was conducted via audio-only.

State Example:

UTAH Medicaid updated their provider manual, specifying that audio-only synchronous care is limited to these services:

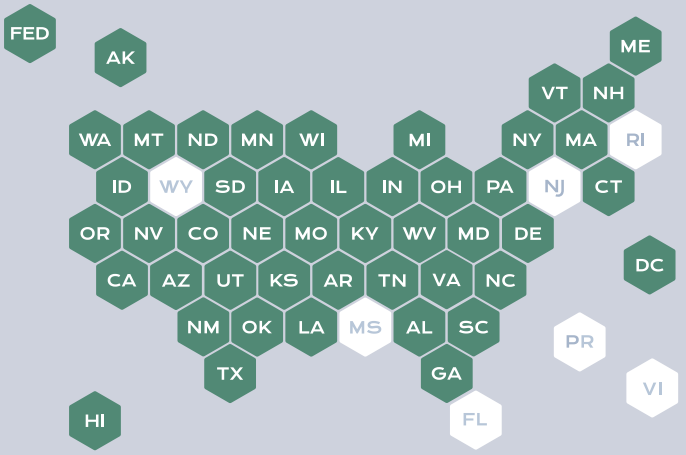
- Behavioral health, including substance use disorders (SUD)
- Diabetic self-management
- Speech and hearing
- Nutritional counselling
- Tobacco cessation
- Education for chronic kidney disease
- Advanced care planning

Audio-Only Map

MAP KEY:

○ No reimbursement for telephone

● Reimbursement for telephone



Communication Technology Based Services (CTBS)

States continue to utilize the CTBS codes established by CMS. CTBS includes the virtual check-in (G2012) and remote evaluation of pre-recorded information (G2010), audio-only service codes, e-visits, interprofessional consultations and remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM) codes. Examples of states that reimburse these codes include California, Illinois, Massachusetts, North Carolina, New Hampshire, Ohio, Pennsylvania, South Carolina, Utah, and West Virginia. Those codes were originally reimbursed in Medicare as an alternative to traditional telehealth. In cases where specific codes for modalities such as store-and-forward, telephone, and RPM are added but no other reimbursement provisions for these modalities exist, coverage will be limited to only the specific codes established by the state.

State Example:

NORTH CAROLINA Medicaid dedicates a section in their provider manual to Virtual Communications and lists CTBS codes that are eligible for reimbursement under the following categories:

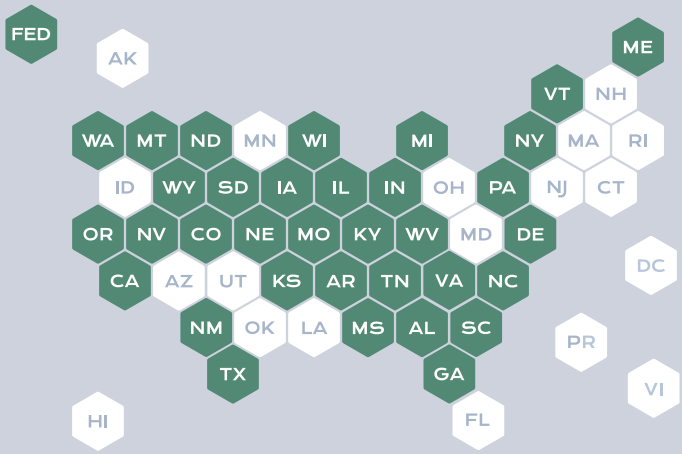
- online digital evaluation and management codes;
- telephonic evaluation and management;
- telephonic evaluation and management and virtual communication codes; and
- interprofessional assessment and management codes.

States have adopted a variety of strategies when it comes to integrating these codes into their healthcare systems. It has been observed that Medicaid programs often integrate CTBS codes within their telehealth infrastructure while making use of Medicare's coding system for identification and reimbursement purposes. New York, for example, added reimbursement for eVisits (a patient initiated virtual check-in which occurs through asynchronous communication) this year, with Medicaid issuing a Telehealth Policy Manual Update to announce the policy. Additionally, our previous research indicates that some states choose to include these codes in their fee schedules, keeping them distinct from their telehealth policies. For the purpose of CCHP's policy finder and the subsequent summary report, we have exclusively included CTBS codes that have been incorporated into state telehealth policies. It's worth noting that we did not examine state Medicaid fee schedules as a source for this summary. In CCHP's Summary Chart, states that solely reimburse a modality through the CTBS codes have been identified by adding an asterisk (*).

Transmission/Facility Fee Map

MAP KEY:

- ○ Does not reimburse
- ● Transmission / facility fee reimbursed



Transmission/Facility Fee

A total of thirty-four state Medicaid programs reimburse for either a transmission or facility fee, with the facility fee being far more common. These policies typically outline a defined list of eligible facilities that may receive the facility fee, and specify that when the patient's home or other non-medical sites serve as the originating site, the facility fee would not be applicable.

Additional Medicaid Restrictions

As telehealth becomes more widespread, some states are implementing guardrails and restrictions targeting patient rights and service quality. For instance, in California, the Medicaid program updated its Telehealth Provider manual to include two significant requirements:

(1) Medi-Cal recipients must be allowed to choose between synchronous audio/visual or audio-only telehealth modalities and can change their choice at any time.

(2) Providers must either offer in-person services or have a documented process for referring patients to in-person care within a reasonable time.

These rules seek to ensure patients maintain control over how they receive care while emphasizing the importance of access to in-person services when necessary. California isn't the only state implementing new telehealth related requirements specific to Medicaid. In Georgia, telemedicine practitioners are now required to carry professional liability insurance, with specific coverage amounts, while Washington's Medicaid program has also enhanced its telehealth best practices, requiring providers to ensure accessibility by checking if patients need assistive devices and designing telehealth services with equity in mind. These measures reflect a broader trend of states refining telehealth policies in an attempt to balance access, quality, and patient safety. Nevertheless, additional restrictions specific to Medicaid may make it more difficult for providers to ensure consistent compliance and access across various payers and patient populations.

Consent

Forty-seven states, DC, and Puerto Rico include some sort of telehealth consent requirement in their statutes, administrative code, and/or Medicaid policies. The application of the consent requirement can differ depending on the precise wording and extent of the policy, ranging from Medicaid programs to specific specialties or all telehealth encounters within a state. For example, Oregon has consent requirements for specific professions, such as physicians, physical therapy, occupational therapy and optometry. Meanwhile, they also have very detailed requirements for consent in their Medicaid program, requiring providers to obtain a member's written, oral, or recorded consent to receive services using a telemedicine or telehealth delivery method in a language that the member understands and must be documented in the member's health record. Consent must include an assessment of member readiness to access and participate in telemedicine or telehealth delivered services, including conveying all other options for receiving the health care service to the member. Consent for Oregon Medicaid must be updated at least annually thereafter. For members and their families with Limited English Proficiency (LEP) or hearing impairments, providers must use qualified or certified health care interpreters, when obtaining patient consent.

State Example:

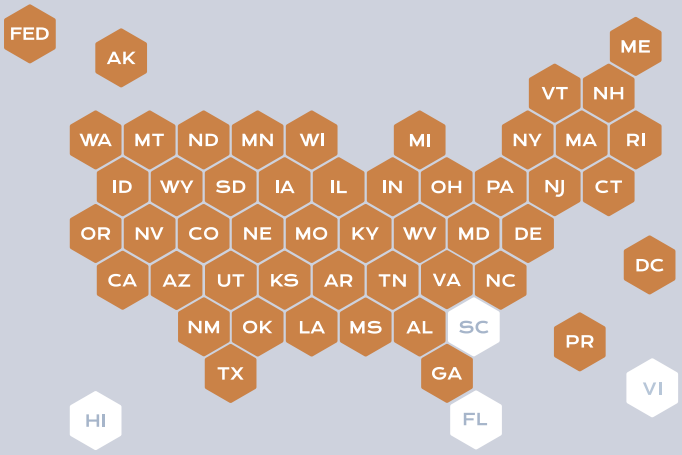
Multiple professional boards in **KENTUCKY** have consent requirements. Providers are required to inform the patient about:

- The limitations of using technology in the provision of telepractice;
- Potential risks to confidentiality of information due to technology in the provision of telepractice;
- Potential risks of disruption in the use of telepractice;
- When and how the licensee will respond to routine electronic messages;
- In what circumstances the licensee will use alternative communications for emergency purposes;
- Who else may have access to client communications with the licensee;
- How communications can be directed to a specific licensee;
- How the licensee stores electronic communications from the client; and
- That the licensee may elect to discontinue the provision of services through telehealth.

Consent Map

MAP KEY:

- ○ No Requirement for Telehealth Specifi Consent
- ● Requirement for Telehealth Specific Consent



Telehealth Practice Requirements

As states continue to refine Medicaid and private payer telehealth policies, many are also implementing telehealth practice requirements for various professions, particularly for those that may not have previously considered the use of telehealth. These professional standards are designed to ensure telehealth services are delivered with the same level of care and safety as in-person services. For example, Arkansas has updated regulations for dietitians, speech-language pathologists, and audiologists to include telehealth practice standards. In contrast, states may place restrictions on telehealth use for professions with hands-on requirements. For instance, West Virginia's regulatory boards for massage therapy and acupuncture have clarified that telehealth is not suitable for their practice due to the physical nature of the services. Some states are also expanding telehealth to more specialized fields. Colorado, for example, has passed telehealth regulations for veterinarians, while Michigan introduced telehealth standards for chiropractors. In Maine, optometrists are now permitted to use telehealth as long as they remain within their scope of practice. Meanwhile, states like Florida and South Carolina have implemented specific telehealth guidelines for dental and medical services, ensuring that telehealth practices adhere to the same standards of care and patient safety as in-person visits. These varying approaches demonstrate how states are tailoring telehealth policies to meet the unique needs and limitations of different professions.

Licensure

As telehealth use has grown, states are increasingly adopting exceptions to the traditional requirement that healthcare providers be licensed in the same state as their patient. CCHP found in our search that 38 states, as well as DC offer some type of exception to licensing requirements. Note that while CCHP's search of statute and regulations was confined to telehealth-related keywords, if we happened to come across a more general licensing exception, we did include it in our reporting, and in this number. Among these exceptions could include the allowance for out-of-state providers to consult or operate under the supervision of in-state providers when the responsibility for care remains with the in-state provider. Additionally, these exceptions are typically limited to specific situations. For instance, since Fall 2023, California enacted SB 233, which allows Arizona physicians to treat Arizona patients in California specifically for abortion care, but this exception only lasts until November 2024 and requires registration with the appropriate state board. Additionally, California has recently made allowances for out-of-state marriage and family therapists, clinical social workers, and clinical counselors, as well as physicians treating patients with life-threatening conditions, provided certain conditions are met. Other examples include the District of Columbia, which passed a law allowing out-of-state practitioners to provide services without a D.C. license if the patient is temporarily present in the District and the care does not exceed 120 days. Likewise, Oregon introduced more flexible regulations, allowing physicians and physician assistants to provide care to established patients temporarily in Oregon without requiring an Oregon license, for follow-up care. These trends demonstrate how states are cautiously expanding cross-state telehealth access for certain situations while maintaining regulatory oversight in most instances.

As some states have implemented targeted exceptions from licensing requirements for out-of-state telehealth providers since Fall 2023 (as discussed above), other states have implemented special registrations or licensure processes for out-of-state telehealth providers, allowing an alternative process to full in-state licensure to offer telehealth services within the state in certain instances and subject to specific requirements. Twenty-two states, as well as the Virgin Islands now offer special telehealth licenses, or registration processes for out-of-state providers. To be counted in this number, the licenses/registrations did need to specifically reference telehealth (or remote care) in some way. A recent state to implement this is Arizona, which introduced new regulations (implementing a previously passed law) that establishes a telehealth provider registration process for out-of-state providers, outlining practice standards such as consent and liability insurance requirements within it. In Washington, SB 5481 enacted the Uniform Telehealth Act, which in addition to adopting limited licensure exceptions for out-of-state providers, encourages a review of the Uniform Law Commission's proposal for an out-of-state provider registration process, signaling the state's interest in developing a more formalized approach. Delaware also adopted regulations that allow social workers practicing via interstate telehealth to bypass the need for a full Delaware license if they are registered under the state's telehealth registration system.

State Example:

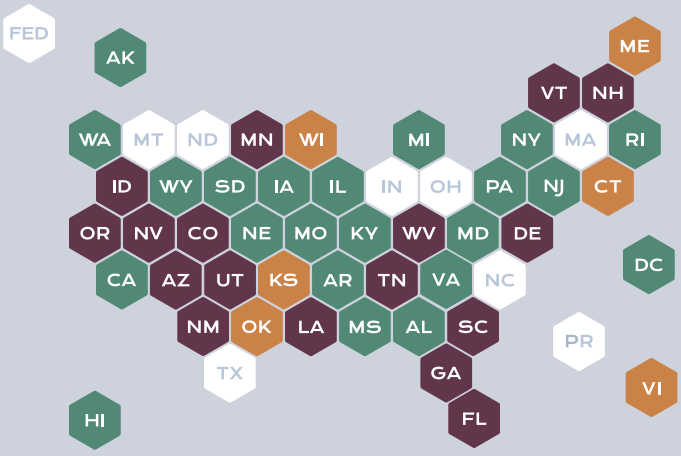
COLORADO passed SB 24-141 which permits (starting in 2026) healthcare providers licensed in other states to provide telehealth services to Colorado patients, as long as they register with the appropriate state regulatory body, meet certain requirements expected of health care professionals in the state and agree not to open a physical office in the state. In addition, the providers commit to:

- Provide the patient with guidance on appropriate follow-up care as required by the laws, rules, and standard of care for Colorado;
- In the event of an emergency, make a good faith effort to take certain steps to ensure the patient receives needed care.
- Maintain a written emergency protocol that is appropriate to the applicable standard of care in Colorado.
- Maintain a current list of hospitals, urgent care centers or clinics, and crisis providers, such as crisis stabilization units, and withdrawal management facilities, in the area where the patient resides.

Cross-State Licensing Exceptions & Telehealth Registration/License Map

MAP KEY:

- ○ No out-of-state licensing policies found (states may still participate in Compacts)
- ● Limited Licensure Exceptions
- ● Telehealth License/Registration Process
- ● Both Limited Licensure Exceptions AND Telehealth Licensure/ Registration Process



Although states have introduced specific provisions for out-of-state providers, interstate compacts remain the most common method for enabling out-of-state practitioners to work across multiple professions and states. These compacts typically allow specific healthcare providers to practice in states where they are not licensed, provided they hold a valid license in their home state, and possess a special 'compact' license. Currently, CCHP monitors twelve different Compacts, each with its own distinct eligibility criteria and process. For instance, the Interstate Medical Licensure Compact streamlines the licensure process, although physicians are still required to apply for licenses in individual states. We saw the largest jump in participation in the Social Work Compact, Counseling Compact and Physician Assistant Compact during this Fall 2024 edition of the report. Since last year, a new Compact was also added to CCHP's tracking, the Dietitian Compact. So far, only three states (Alabama, Nebraska and Tennessee) are member states. In addition, as some compacts are relatively new, not all are currently considered active and/or issuing licenses at this time.

State Licensure Compacts CCHP Tracks:

1. **Advanced Practice Registered Nurse Compact:** 4 state members *(Not yet active)*
2. **Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC):** 32 state members.
3. **Counseling Compact:** 35 state members.
4. **Dietitian Compact:** 3 state members. *(Not yet active)*
5. **Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA):** 24 state members.
6. **Interstate Medical Licensure Compact:** 40 states, DC and the territory of Guam.
7. **Nurses Licensure Compact:** 40 state members and the territory of Guam and the Virgin Islands
8. **Occupational Therapy Compact:** 30 state members.
9. **Physical Therapy Compact:** 35 state members and DC.
10. **Physician Assistant Compact:** 11 state members *(Not yet active)*
11. **Psychology Interjurisdictional Compact:** 40 state members and DC.
12. **Social Worker Compact:** 19 state members *(Not yet active. Expected to launch in 2025.)*

* Not all states listed above may be currently operating the compact as many just recently passed legislation and have not had the opportunity to start the issuing process.

Online Prescribing

Variations in regulations governing the use of technology for prescribing are apparent when comparing different states. While many states do not mandate an in-person examination, telehealth consultations are frequently required to uphold the same standard of care as an in-person appointment. Since Fall 2023, several states have implemented new rules around prescribing via telehealth, especially for controlled substances, to ensure safe and compliant practices. Note that although there is a federal requirement for an in-person visit prior to prescribing via telehealth, that rule is currently waived until Dec. 31, 2024 (with the possibility of further exceptions in 2025 pending proposed regulations). Additionally, states can have stricter policies if they choose. In the past year, Alaska's nursing board revised regulations, repealing a provision that previously allowed buprenorphine to be prescribed without a healthcare provider physically present during a declared disaster. This change underscores a shift back to more traditional oversight in telehealth prescribing post-pandemic. Montana amended its rules for physicians and physician assistants, removing the requirement for an in-person examination before prescribing Schedule II controlled substances. Now, providers must comply with Drug Enforcement Agency (DEA) regulations, reflecting a more standardized approach aligned with federal guidelines. Other states, like Tennessee and New York, have taken steps to refine telehealth laws further. Tennessee's HB 2857 removed a provision that required an in-person encounter within 16 months prior to a telemedicine visit, allowing for greater flexibility in maintaining patient-provider relationships.

Additionally, states are increasingly addressing telehealth policies related to medical cannabis, with varying approaches. In Alabama, a new rule was implemented that prohibits physicians from using telemedicine to certify, recommend, or conduct any examinations related to medical cannabis. Conversely, the District of Columbia has embraced telehealth for medical cannabis, allowing practitioners to recommend its use through telehealth services, provided they comply with existing medical practice laws. Ohio has taken a middle-ground approach, updating its administrative code to allow the formation of a bona fide physician-patient relationship for prescribing medical marijuana through either in-person or telehealth exams, as long as ongoing care is provided. These differing policies reflect the range of perspectives on how telehealth can be integrated into healthcare, and in particular medical marijuana programs.

State Example:

WEST VIRGINIA statute states that a telehealth provider who provides health care to a patient solely through the use of telemedicine technologies is prohibited from prescribing a controlled substance listed in Schedule II of the Uniform Controlled Substance Act except under the following circumstances:

- The patient is an established patient of the prescribing telehealth provider's group practice;
- The provider submits an order to dispense a Schedule II controlled substance to a hospital patient, other than in the emergency department, for immediate administration in a hospital; or
- The telehealth provider is treating patients who are minors, or if 18 years of age or older, who are enrolled in a primary or secondary education program and are diagnosed with intellectual or developmental disabilities, neurological disease, Attention Deficit Disorder, Autism, or a traumatic brain injury in accordance with guidelines as set forth by organizations such as the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, or the American Academy of Pediatrics. The provider must maintain records supporting the diagnosis and the continued need of treatment.

Private Payers

Currently, forty-four states, DC, Puerto Rico, and the Virgin Islands have laws that govern private payer telehealth reimbursement policies. Both Puerto Rico and Pennsylvania are the two new states that have added private payer laws or policies since Fall 2023. Each law takes a different approach to reimbursement and payer requirements. Currently, 23 states and DC have explicit payment parity requirements in their law, which is the most common modification made to state laws. New York is an example of a state to have a temporary payment parity requirement initially tied to the COVID public health emergency. The state recently passed a law extending telehealth reimbursement parity for private payers to April 2026, ensuring that telehealth services continue to be reimbursed at the same rate as in-person care for the next two years. In addition, Connecticut recently made their COVID policy ensuring payment parity permanent. Meanwhile, Pennsylvania recently passed the state's first private payer telehealth law, requiring insurers to cover medically necessary services delivered via telemedicine and preventing the exclusion of services simply because they are provided remotely, a concept known as coverage or service parity, which is separate from reimbursement or payment parity policies. Pennsylvania's law also prohibits insurers from mandating the use of proprietary telemedicine platforms, giving providers more flexibility in delivering remote care.

Rather than going the statutory route, Puerto Rico took the unusual step of adopting new regulations that enable healthcare professionals to bill both private insurance and Medicaid for telehealth services, expanding access across different payers. These policies reflect a continued trend toward ensuring that telehealth remains a viable and accessible option for both patients and providers, with a focus on maintaining reimbursement parity and flexibility in service delivery.

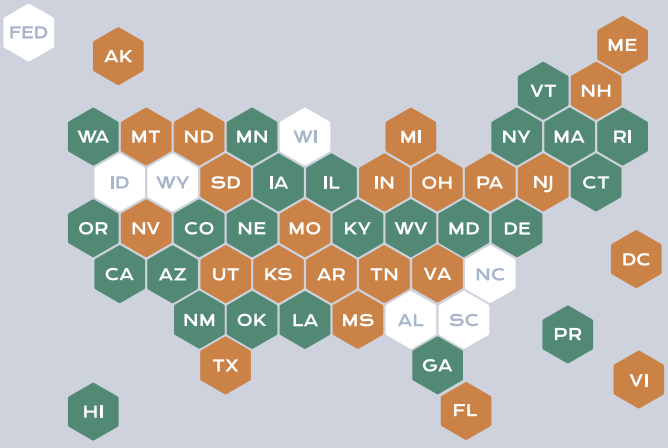
State Example:

MICHIGAN passed HB 4579 which amended the state's telehealth private payer law to specify that an insurer shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. It clarifies that telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. The law now further requires that if a service is provided through telemedicine, the insurer shall provide at least the same coverage for that service as if the service involved face-to-face contact between the health care professional and the patient. Telemedicine is defined to encompass electronic media that links patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act (HIPAA) compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store-and-forward online messaging.

Private Payers Map

MAP KEY:

- ○ Private payer law does not exist
- ● Explicit payment parity for at least one specialty
- ● Private payer law exists



To learn more about state telehealth related legislation, visit CCHP's telehealth policy finder tool.