State Telehealth Laws and Medicaid Program Policies

Spring 2022

EXECUTIVE SUMMARY:

A Comprehensive Scan of 50 States and D.C. Findings & Highlights

The Center for Connected Health Policy (CCHP) is releasing its Spring 2022 Summary Report of the state telehealth laws and Medicaid program policies catalogued in CCHP's online Policy Finder tool. Prior to Spring 2021, this same information was released at least twice a year in the form of a 500+ page PDF report titled, "the State Telehealth Laws and Reimbursement Report" since 2012. With the transition to the online Policy Finder, users are able to navigate each state's updated information as soon as CCHP makes it available. Additionally, the information from the online tool can be exported for each state into a PDF document using the most current information available on CCHP's website. CCHP plans to continue to produce these bi-annual summary reports of the status of telehealth policies across the United States in the Spring and Fall each year to provide a snapshot of the progress made in the past six months. CCHP is committed to providing timely policy information that is easy for users to navigate and understand through our Policy Finder. **The information for this summary report covers updates in state telehealth policy made between January and mid-April 2022.**

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, Policy Associate at info@cchpca.org. A special thank you to CCHP Policy Associate Veronica Collins for her invaluable contributions to this report. For further information, visit cchpca.org.

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

Mei Wa Kwong, JD
Executive Director
May 2022

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INTRODUCTION

The Center for Connected Health Policy's (CCHP) Spring 2022 analysis and summary of telehealth policies is based on its online Policy Finder. It highlights the changes that have taken place in state telehealth policy between the Fall 2021 Summary Report, and Spring 2022. The research for this Spring 2022 executive summary was conducted between January and April 2022. This summary offers policymakers, health advocates, and other interested health care professionals an overview of telehealth policy trends throughout the nation. For detailed information by state, see CCHP's telehealth Policy Finder which breaks down policy for all 50 states and the District of Columbia.

Please note that many states continue to keep their temporary telehealth COVID-19 emergency policies siloed from their permanent telehealth policies. These temporary policies are not included in this executive summary, although they are listed under each state in the online Policy Finder under the COVID-19 category. In instances where the state has made policies permanent, or extended policies for multiple years, CCHP has incorporated those policies into this report.

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, transmittals or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in the database tool specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources.

Every effort was made to capture the most recent policy language in each state at the time it was reviewed between the months of January and April 2022. Note that in some cases, after a state was reviewed (especially states reviewed in January and February), it is possible that the state may have passed a significant piece of legislation or implemented an administrative policy change that CCHP may not have captured. Those changes will be reviewed and catalogued in the upcoming Fall 2022 edition of CCHP's Summary Report. Additionally, even if a state has enacted telehealth policies in statute, these policies may not have been incorporated into its Medicaid program. For purposes of this summary, 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 implemented a policy or statute. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP's summary report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming implementation.

This survey focused on three primary areas for telehealth policy including Medicaid reimbursement, private payer laws and professional requirements. COVID is also included as a category in CCHP's online policy tool, however as mentioned previously, COVID policies are not examined as part of this report. Within each category, information is organized into various topic and subtopic areas. These topic areas include:

- **Medicaid Reimbursement:**
  - o Definition of the term telemedicine/telehealth
  - o Reimbursement for live video
  - o Reimbursement for store-and-forward
  - o Reimbursement for remote patient monitoring (RPM)
  - o Reimbursement for email/phone/fax
  - o Consent issues
  - o Out-of-state providers

- **Private payer laws:**
  - o Definitions
  - o Requirements
  - o Parity (service and payment)

- **Professional Requirements:**
  - o Definitions
  - o Consent
  - o Online Prescribing
  - o Cross-State Licensing
  - o Licensure Compacts
  - o Professional Board Standards

As noted earlier, COVID policies have been separated out into specific sections for each state.

KEY FINDINGS

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. The main areas where changes were made over the past five months fall in the three buckets that CCHP uses to categorize information within its Policy Finder: Medicaid policy, private payer policy, and regulation of health professionals.

A significant number of administrative changes centered around broadening Medicaid reimbursement policies were made. In many cases, this was influenced by the COVID-19 pandemic and the expiration of temporary expansions in telehealth reimbursement that have been in place for the past two years, and which providers and patients have become accustomed. Some state Medicaid programs have explicitly referenced their COVID policies in their permanent expansions. For example, the Department of Medical Assistance Services (DMAS) in Virginia has made reimbursement for remote patient monitoring a covered service and audio-only a covered modality beyond the COVID-19 public health emergency (PHE), and clarified guidance on select behavioral health codes eligible for telemedicine delivery in anticipation of the federal PHE soon expiring. Massachusetts Medicaid is another state that references aligning their permanent policy with their COVID-era policies, although they note that their policies may change after Dec. 31, 2022 upon further evaluation. Often these states are expanding their permanent telehealth policies to be closer in line with their COVID policies, but may also add more restrictions than were in place during COVID. For example, Massachusetts clarifies that any type of service is allowed via telehealth if certain conditions are met, with some exceptions, including the exclusion of some services such as chiropractic and ambulance services. Changes in Medicaid programs have also recently included the addition of instructions on proper billing for audio-only telehealth, audio-video telehealth and asynchronous telehealth, so differentiating the modalities in the billing paperwork is possible.

Other Medicaid changes included adding services reimbursed, more covered professionals, coverage of the audio-only modality, and the home explicitly being referenced as an eligible location for a patient at the time of services. Pennsylvania, for example, expanded reimbursement in their Medicaid program to include any covered service that is within the provider's scope of practice and clinically appropriate. Arkansas, on the other hand, added telehealth coverage to the Occupational Therapy, Physical Therapy and Speech-Language Pathology section of their manual. South Dakota also did an update allowing federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be both distant and originating site providers. The addition of audio-only coverage is one of the starkest differences between trends prior to the COVID emergency and afterward. State Medicaid programs, such as Arkansas, Wisconsin, District of Columbia, South Dakota and New Mexico continue to expand their definitions of telehealth/telemedicine to include audio-only service delivery and/or explicitly allow for its reimbursement within their reimbursement policy. Often, audio-only reimbursement is associated with specific codes and requirements such as no alternative for audio-video communication. A few states that didn't previously define an eligible place of service as the patient's home, such as New Mexico, Rhode Island and Pennsylvania are now doing so. Finally, some states are making more unique moves with their telehealth policies. For example, Arkansas Medicaid now includes requirements for patient-provider professional relationship establishment in their telehealth policy. Typically, those type of standards are confined to professional regulation of the health professions, rather

than Medicaid policy. They also require that providers who elect to deliver care through telehealth make available interpretation services, including sign language interpretation for individuals being served.

While no new states passed private payer laws since Fall 2021, states did make amendments to existing laws, usually to add more detail or strengthen the law in some way. For example, Oklahoma passed a law clarifying that insurers are prohibited from limiting reimbursement to a specific vendor and adding payment parity but also clarifying that insurers can limit telehealth to coding and clinical standards established by the American Medical Association or the Centers for Medicare and Medicaid Services (CMS). New Jersey also added detail clarifying that their telehealth law also applies to Medicaid, and restricts insurers from limiting the ability of providers to any electronic technologic platform (including audio-only and store-and-forward), while requiring coverage of remote patient monitoring.

On the professional regulation side, licensing compacts continue to grow in popularity among states. We saw the largest jump in participation in the Occupational Therapy Compact and the Professional Counseling Compact during this edition. The states offering their own exceptions for providers utilizing telemedicine in their state, often through a registration or telemedicine license, is also slowly growing. For example, Georgia Medical Board recently issued regulations outlining qualifications for a telemedicine license for out-of-state providers. As was the case in Fall 2021, state boards are continuing to adopt telehealth practice standards at a faster pace than they did pre-COVID. Alaska, for example, adopted new physical, occupational therapy and nursing telehealth practice standards, and Iowa adopted new standards for physician assistants, psychologists and speech therapists. New Jersey also adopted practice standards for a large portion of their health professions in the state.

ADDITIONAL FINDINGS INCLUDE:

- **Fifty states and Washington DC** provide reimbursement for some form of live video in Medicaid fee-for-service.
- **Twenty-five state Medicaid programs** reimburse for store-and-forward. However, two states (NC, OH) solely reimburse store-and-forward as a part of Communications Technology Based Services (CTBS), which is limited to specific codes and reimbursement amounts. Iowa, Massachusetts and South Dakota were all states that added store-and-forward since Fall 2021. Additionally, three jurisdictions (MS, NH, and NJ) have laws requiring Medicaid reimbursement for store-and-forward but as of the creation of this edition, don't have any official Medicaid policy indicating this is occurring.
- **Thirty state Medicaid programs** provide reimbursement for RPM. Wisconsin is the only state to add RPM since Fall 2021. As is the case for store-and-forward, three Medicaid programs (NH, HI and NJ) have laws requiring Medicaid reimbursement for RPM but at the time this report was written, did not have any official Medicaid policy.
- **Twenty-nine states and DC Medicaid programs** reimburse for audio-only telephone in some capacity; however, often with limitations. For example, Michigan only reimburses for it when used for provider-to-provider electronic consultations.
- **Thirteen state Medicaid programs** including Arizona, California, Maine, Michigan, Minnesota, North Carolina, New York, Ohio, Oregon, South Carolina, Texas, Virginia, Washington, reimburse for all four modalities (live video, store-and-forward, remote patient monitoring and audio-only), although certain limitations apply.
- **43 states and DC have a private payer law that addresses telehealth reimbursement.** Not all of these laws require reimbursement or payment parity. Twenty-one states have explicit payment parity.

While this Executive Summary 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 utilizing CCHP's telehealth Policy Finder. Below are summarized key findings in each category area contained in the Policy Finder as of April 2022.

Definitions

States alternate between using the term "telemedicine" or "telehealth". In some states both terms are explicitly defined in law and/or policy and regulations. "Telehealth" is sometimes used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" prefix are also becoming more prevalent. For example, the term "telepractice" is used frequently as it relates to physical and occupational therapy, behavioral therapy, and speech language pathology, and "teledentistry" for dental services. "Telepsychiatry" is also a term commonly used as an alternative when referring specifically to psychiatry services.

Some states put specific restrictions within the definitions, which often limit the term to "live" or "interactive", excluding store-and-forward and RPM from the definition and subsequently from reimbursement. The most common restriction some states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. However, due to the allowance for telephone in many COVID-19 temporary policies, some states are beginning to amend their definitions to either remove the explicit exclusion of telephone or explicitly include audio-only services in their telehealth/telemedicine definitions. All fifty states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both.

Medicaid Reimbursement

Modalities: Live Video, Store-and-Forward, Remote Patient Monitoring (RPM), Email/Phone/Fax

All 50 states and the District of Columbia have some form of Medicaid reimbursement for telehealth in their public program. However, the extent of reimbursement for telehealth delivered services is less clear in some states than others.

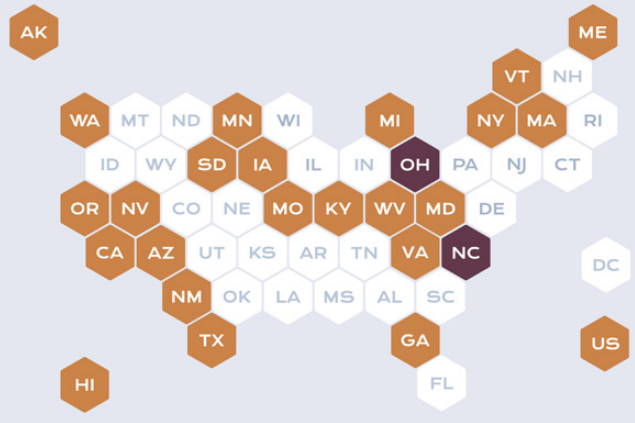
Live Video

The most widely reimbursed form of telehealth modality is live video, with every state offering some type of live video reimbursement in their Medicaid program. However, what and how it is reimbursed varies. Some Medicaid programs, for example limit reimbursable services to a specific list of CPT codes, such as Ohio, while other states, such as California, leave it open ended, reimbursing for all covered benefits or services as long as appropriate, and meeting procedure code definition and confidentiality and patient rights requirements. In general, the main restrictions Medicaid programs typically place on live video telehealth include:

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

Since Fall 2021, most of the state policy changes in Medicaid have focused on other areas of Medicaid policy, such as allowing for audio-only services, however Pennsylvania did expand reimbursement in their Medicaid program in their most recent update to include any covered service that is within a provider's scope of practice and is clinically appropriate. Additionally, South Dakota added coverage for Applied Behavioral Analysis services and therapy services delivered via telehealth into their permanent policy manual, but still specify that the allowance is tied to the COVID-19 emergency.

Store-and-Forward



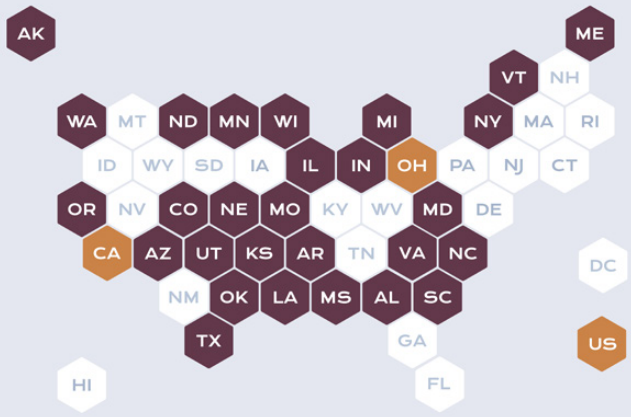
MAP KEY:

- **White** – No reimbursement for store and forward
- **Orange** – Reimbursement for store and forward
- **Purple** – Store and forward only reimbursed through CTBS

Store-and-forward services are only defined and reimbursed by twenty-five Medicaid Programs. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered 'telehealth'). In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in "real-time," automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether in those states. Of those states that do reimburse for store-and-forward services, some have limitations on what will be reimbursed or if they do not reimburse for the modality, they carve out special exceptions. For example, Maryland's Medicaid program specifies that while they don't reimburse for store-and-forward, they do not consider use of the technology in dermatology, ophthalmology and radiology to fit into the definition of store-and-forward.

Three additional states (MS, NH and NJ) 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. Store-and-forward is slowly being introduced in some states through specific CPT codes that include store-and-forward in its description. For example, Hawaii and Iowa recently allowed for the reimbursement of a teledentistry code that specifically allows for asynchronous review of information by a dentist. Massachusetts is a recent addition to states reimbursing for store-and-forward due to a bulletin indicating MassHealth (MA Medicaid) will reimburse for the GQ modifier when rendering asynchronous telehealth, although further details were not provided. Additional states have allowed for store-and-forward reimbursement as a result of reimbursement for CTBS, some of which include the store-and-forward modality in its description. CTBS is discussed further in a subsequent section, but it's important to understand that two (OH and NC) out of the 25 states that reimburse for store-and-forward do it through these CTBS codes.

Remote Patient Monitoring (RPM)

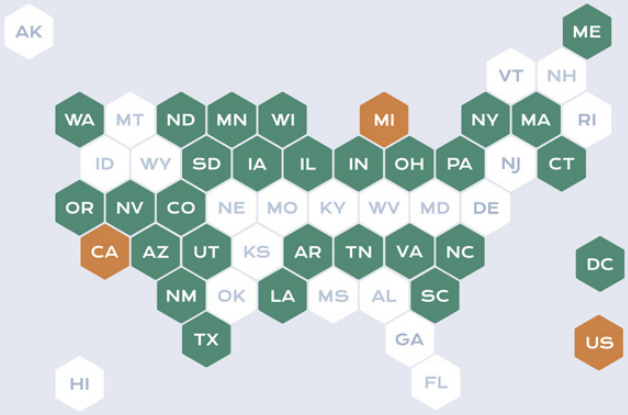


MAP KEY:
- **White** – No reimbursement for RPM
- **Orange** – RPM only reimbursed through CTBS
- **Purple** – Reimbursement for RPM

Thirty states have some form of reimbursement for RPM in their Medicaid programs. Since Fall 2021, only Wisconsin added reimbursement for remote patient monitoring. Two states (OH and CA) reimburse only for specific remote physiologic monitoring codes modeled after CMS reimbursement. In California, CCHP found that five remote monitoring codes are listed as reimbursable in the Medi-Cal (California Medicaid) Rate Fee Schedule for the same codes Medicare reimburses for remote physiological monitoring (99091, 99453, 99454, 99457 and 99458). Therefore, CCHP has counted CA as reimbursing with the caveat that it's only those CTBS codes. Many of the states that offer RPM reimbursement also have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical conditions for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected. Wisconsin, the most recent addition, for example only reimburses for patients with certain types of conditions, and the monitoring must be provided by a physician, nurse practitioner or physician assistant. They also require the device used must meet the Food and Drug Administration (FDA) definition of a medical device and for physiologic

data to be wirelessly synced. Transmission can be synchronous or asynchronous. Hawaii and New Jersey Medicaid have laws requiring Medicaid reimbursement for RPM but at the time this report was written, did not have any official Medicaid policy regarding RPM reimbursement.

Telephone



MAP KEY:

- **Green** – Reimbursement for telephone
- **White** – No Reimbursement for telephone
- **Orange** – Telephone only reimbursed through CTBS

While telephone or audio-only service delivery has historically rarely been an acceptable modality, that is quickly changing with the advent of COVID-19, and the need to continue utilizing audio-only to reach people without access to high-speed broadband that allows for live video interaction. Twenty-nine state Medicaid programs and D.C. now allow for telephone reimbursement in some ways, representing the telehealth modality with the most significant increase since Fall 2021 with seven states and DC being added and doubling since this time last year. Sometimes states will only reimburse specific specialties such as mental health, or for specific services such as case management. Michigan is counted as reimbursing for telephone as a result of reimbursement for a CTBS code that allows for audio-only interaction. While Arizona's reimbursement of audio-only isn't restricted to CTBS codes specifically, they do maintain a list of codes that are eligible for audio-only delivery much like CMS does for Medicare. Illinois added reimbursement of audio-only instructing providers to use the new modifier 93 to indicate audio-only telecommunication systems were used. They also note that the communication during the audio-only service must be of an amount or nature that meets the same key components and/or requirements of face-to-face interaction. Finally, Pennsylvania is now allowing audio-only services in situations where the beneficiary does not possess or have access to video technology and when clinically appropriate. Last year, Oregon became one of the first states to pass a law requiring Medicaid to reimburse 'any permissible telemedicine application or technology' which includes telephone, at the same rate as in-person.

Communication Technology Based Services (CTBS)

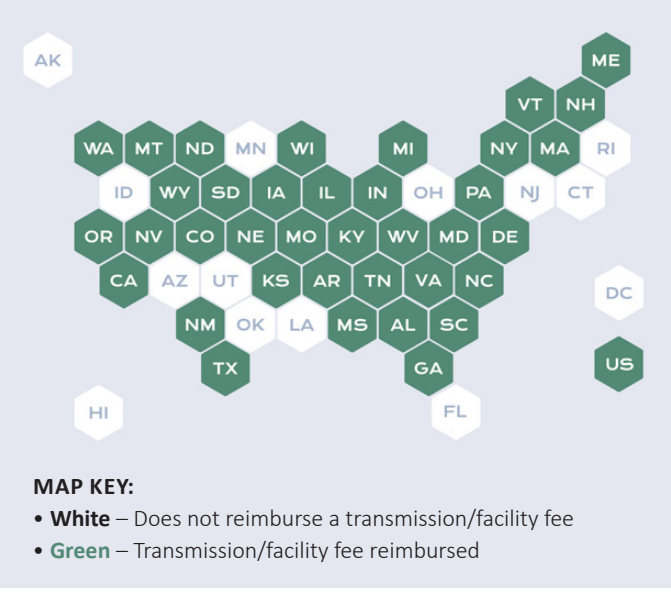
States continue to utilize the CTBS codes established by CMS, although CCHP has noticed a net-decrease in the states solely offering reimbursement of CTBS codes within a specific modality in this edition. Often, states have kept their reimbursement of CTBS but added additional services to a modality. CTBS includes the virtual check-in (G2020) and remote evaluation of pre-recorded information (G2012), audio-only service codes, and remote physiological monitoring (RPM) codes. Examples of states that reimburse these codes include California (for RPM), North Carolina, and Ohio. In cases where those codes were added and the state has no other form of reimbursement for the modalities (i.e. store-and-forward, telephone and RPM), it should be noted that coverage is extremely limited. Those codes were originally reimbursed in Medicare as an alternative to traditional telehealth as CMS considers telehealth to replace a service typically delivered in-person. CTBS are services that would not normally occur in-person, but due to the advancements of technology, can now be provided effectively. Thus, CMS created CTBS codes as a way to allow for greater use of technology to deliver services, but would not have the telehealth restrictions apply.

States have taken various approaches to adopting these codes even though they are not met by the same restrictions Medicare is in federal law. We have found that often Medicaid programs allow CTBS codes to fall under the umbrella of telehealth but utilize Medicare's same coding system to identify and reimburse for them. From previous research, some states also take the approach of adding the codes into their fee schedules and keeping them completely separate from their telehealth policies.

For purposes of CCHP's database and this summary report, only CTBS codes that have been incorporated into states telehealth policies are included, as state Medicaid fee schedules were not examined 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

Thirty-seven states will reimburse either a transmission or facility fee, with the facility fee being the most common. Policies often stipulate a specific list of facilities eligible to receive the facility fee, and specify that when the originating site is the patient's home (or other non-medical sites), the facility fee would not apply.



MAP KEY:

- **White** – Does not reimburse a transmission/facility fee
- **Green** – Transmission/facility fee reimbursed

Eligible Providers

While many state Medicaid programs are silent, some states limit the types of providers that can provide services at the distant site through telehealth. These eligible provider lists have broadened over the past few years, and most states now allow a wide variety of provider types to deliver telehealth services. For example, Ohio has a list of over 40 provider types including occupational and physical therapists, pharmacists, and Medicaid school programs just to name a few. Many states don't have a provider list at all and simply state that any Medicaid enrolled provider can be reimbursed for delivering services via telehealth. For example, Nevada states that telehealth may be used by any Nevada Medicaid provider working within their scope of practice. Since Fall 2021, Pennsylvania has expanded their reimbursement from a specific list to any enrolled provider in the Medicaid program (including out-of-state providers if they are PA licensed and enrolled), and Arkansas has added coverage for physical, occupational and speech therapy providers.

Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC)

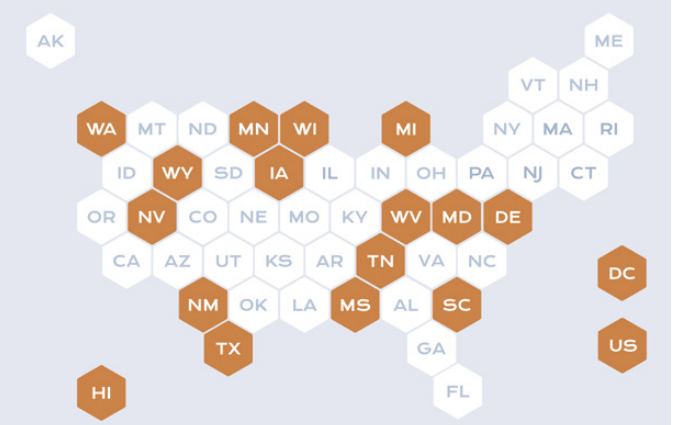
Because FQHCs and RHCs bill as entities rather than as providers, telehealth eligible provider lists often exclude them or do not have an explicit mention of these entities. Medicare has also excluded these clinics from billing for telehealth delivered services as distant site providers (although they do qualify for the originating site facility fee, and reimbursement for a mental health visit delivered through interactive telecommunication systems). Since Fall 2021, two states (ND, TX) have specifically addressed this issue for FQHCs, RHCs or both allowing them to serve as distant site providers. A few 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). The District of Columbia, for example, has addressed it for FQHCs specifically and even specified that it will be in accordance with the district's prospective payment system, alternate payment methodology, or fee for service rate. Virginia specifies that FQHCs and RHCs will be paid under the their 'encounter rate'. Nebraska, on the other hand, also clarifies that FQHCs and RHCs are paid at the rate for a comparable in-person service, however telehealth is not covered under the encounter rate.

Geographic & Facility Originating Site Restrictions

The practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is becoming increasingly rare. Only two states (HI and MD) currently have these types of restrictions. Both of 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 code to be consistent with changes in law. For example, recently passed legislation in Maryland requires that Medicaid not distinguish between rural and urban locations, however as of CCHP's last review of the state in January, language requiring beneficiaries reside

in rural geographic areas for telehealth mental health services was still in their administrative code. Although Hawaii passed a law prohibiting a geographic limitation for telehealth in their Medicaid program, such language is still present in their Medicaid regulation. Minnesota previously had a geographic requirement only applying to Medication Therapy Management Services, but it was removed in recent months prompting CCHP to eliminate the state from this list.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site. Currently sixteen states and DC have a specific list of sites that can serve as an originating site for a telehealth encounter. Even though a state may have an originating site list, they can still be quite expansive as many states now include non-traditional sites on their lists, such as the patient's home and school. New Mexico is one state that includes in its eligible site list school-based health centers and the patient's home (in various situations including when an interactive audio and video telecommunication system is used).

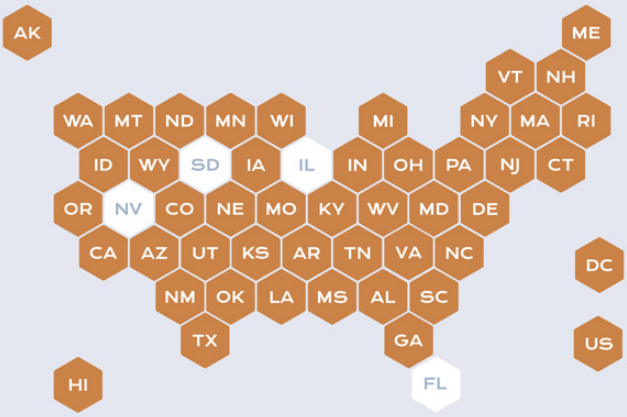


MAP KEY:
- **Orange** – Has a billable originating site list or restriction
- **White** – No specific originating site list or restriction

Thirty-three 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 does not include states that make broad statements that any patient location is covered without explicitly referencing the home or patient's residence.

More states are also allowing schools to serve as an originating site, with twenty-nine states and DC explicitly allowing schools to be originating sites for telehealth-delivered services, although, as is the case with the home environment, 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.

Consent



MAP KEY:
- **Orange** – Requirement for Telehealth Specific Consent
- **White** – No Consent Requirement

Forty-six states and DC include some sort of consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. For example, New Hampshire's consent policy specifically applies to the delivery of medication assisted treatment via telehealth.

Licensure

Fifteen states have professional boards that issue special licenses or certificates or have exceptions to licensing requirements related to telehealth, that may include simply registering with an in-state board rather than obtaining full licensure. Florida and Arizona, for example, are two states that have recently relaxed their

licensing requirements, requiring an out-of-state telehealth provider to only register with their applicable professional board within the state. Additional stipulations in Arizona apply, such as not opening an office within the state or providing in-person health care services. Minnesota, Georgia and Connecticut all added telemedicine licenses or new licensing exceptions since Fall 2021. Minnesota's provision is a licensing exception allowing physicians licensed in other states to provide telehealth services to patients in Minnesota if they agree not to open an office, not meet with patients in Minnesota or receive calls in Minnesota from patients and they annually register with the state's board. Georgia added a telemedicine license and regulations that provide criteria to qualify for such licensure.

A more common practice is the adoption of interstate compacts which in some cases allow specific providers to practice in states they are not licensed in as long as they hold a license in good standing in their home state. CCHP is currently tracking nine Compacts, each with their own unique requirements to participate. For example, the interstate medical licensure compact allows for an expedited licensure process, where physicians still need to apply for a license in individual states. Below we have listed the Compacts we are currently tracking along with the number of states each has participating. Not all states listed below may be currently operating the compact as many just recently passed legislation and have not had the opportunity to start the issuing process.

1. **The Interstate Medical Licensure Compact:** 34 states, DC and the territory of Guam.
2. **The Nurses Licensure Compact:** 37 state members and the territory of Guam.
3. **The Physical Therapy Compact:** 33 state members and DC.
4. **The Psychology Interjurisdictional Compact:** 30 state members and DC.
5. **The Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC):** 19 state members.
6. **The Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA):** 21 state members.
7. **The Occupational Therapy Compact:** 19 state members.
8. **The Counseling Compact:** 10 state members.
9. **The Advanced Practice Registered Nurse Compact:** 3 state members.

Still other states have laws that don't specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state's licensing conditions are met. During COVID-19 many states issued temporary waivers of their licensing requirements, some of which have now expired but others are still active. Those waivers are not tracked in this report, however the Federation of State Medical Boards is tracking some of those policies via their chart on State COVID-19 Physician Licensing and CCHP's COVID-19 Policies section.

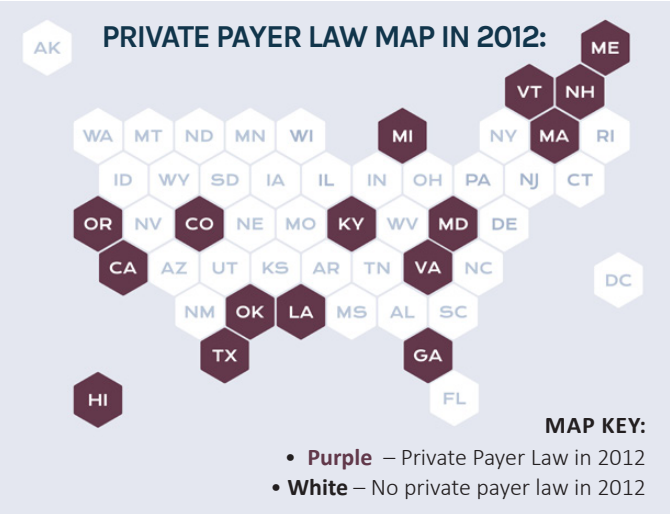
Online Prescribing

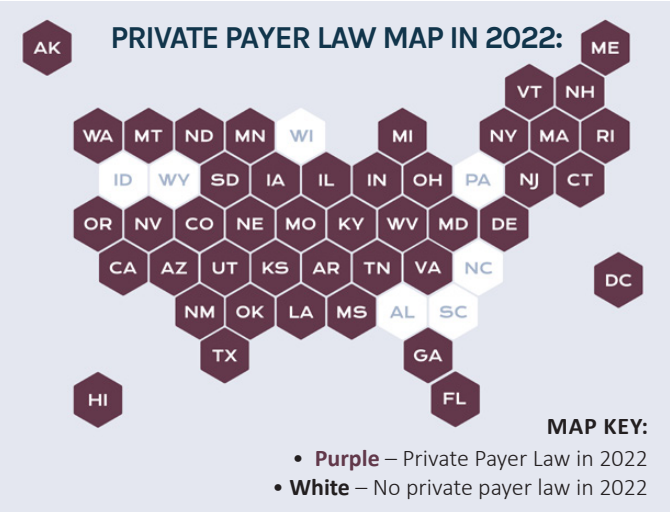
There are a number of nuances and differences across the states related to the use of technology and prescribing. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. States may also require that a physical exam be administered prior to a prescription being written, but most states don't require an in-person examination, and some specifically allow the use of telehealth to conduct the exam. CCHP notes that in the past year a few states that had been silent previously in regards to whether or not a telehealth interaction could establish a provider/patient relationship clarified that it could, and established parameters and requirements for it. West Virginia has gone as far as to specify a physician-patient relationship can be established through audio-only calls, although audio-visual communication is preferrable. States have also increasingly clarified whether or not controlled substances can be prescribed over telehealth, often creating two policies (one for non-controlled substances and the other for controlled substances). An example of this is in Virginia, where their Medical Board released guidance in Aug. 2021 differentiating between the two and tying stricter requirements to the prescribing of controlled substances. It should be noted that federal law also limits the prescribing of controlled substances via telehealth, except in very limited circumstances. Providers would be required to comply with both the federal and state law to be in compliance.

Maine and Oklahoma are the first states CCHP is aware of that have tied the issue of prescribing to private payers, prohibiting insurance carriers from placing restrictions on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that are more restrictive than requirements for in-person consultations.

Private Payers

Currently, forty-three states and DC have laws that govern private payer telehealth reimbursement policies. Although no new states added private payer laws since Fall 2021, a few states (OK, NJ and TN) made amendments to add detail or strengthen existing law. In Oklahoma's case, they added much more detail to their private payer law, and made sure to include Medicaid as an insurer that the law is applicable to. Additionally, they allow insurers to limit telehealth to coding and clinical standards set by the American Medical Association or CMS. The new law also adds payment parity and prohibits insurers from limiting reimbursement to specific vendors. New Jersey removes an exclusion of audio-only from the definition of telemedicine, prohibits insurers from denying coverage for remote patient monitoring and allows a provider-patient relationship to be formed over store-and-forward under certain circumstances. Tennessee's policy adjustments include modifying the definition of telemedicine to include audio-only conversations and eliminating an in-person encounter requirement during a state of emergency. As noted in previous editions of this report, Oregon is an example of a state with a previously robust private payer law, but has made significant additional adjustments. First, they made the law applicable not only to health benefit plans but also to dental-only plans. They also now require the plans to work to (1) ensure meaningful access to telehealth is achieved, (2) ensure access to auxiliary aids and services are provided when needed, (3) ensure telemedicine for enrollees who have limited English proficiency or who are deaf or hard of hearing and (4) ensure telemedicine services are culturally and linguistically appropriate and trauma informed. Finally, they also specify that payers are not allowed to reimburse an out-of-network provider at a rate for telemedicine health services that is different than the rate paid to out-of-network providers for in person services.





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