HEALTH

Increasing Access to Health Care Through Telehealth

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- Promote policy innovation and communication among state legislatures
- Ensure state legislatures a strong, cohesive voice in the federal system

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As state spending on health care continues to increase, policymakers look for ways to ensure access to care in a cost-effective manner that improves health for their constituents. Enhancing and increasing access to health care services through telehealth is widely viewed as one strategy to help address workforce shortages and reach patients in rural and underserved areas.

The Health Resources and Services Administration defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."

Telehealth is a tool—a means—that capitalizes on technology to provide health care and other health-related services remotely. This includes communication and education between providers as well as between patients and providers. Though it does not increase the size of the provider workforce, it can help increase efficiency and extend the reach of existing providers. Telehealth is not a service itself, rather a mechanism for delivering health care services.

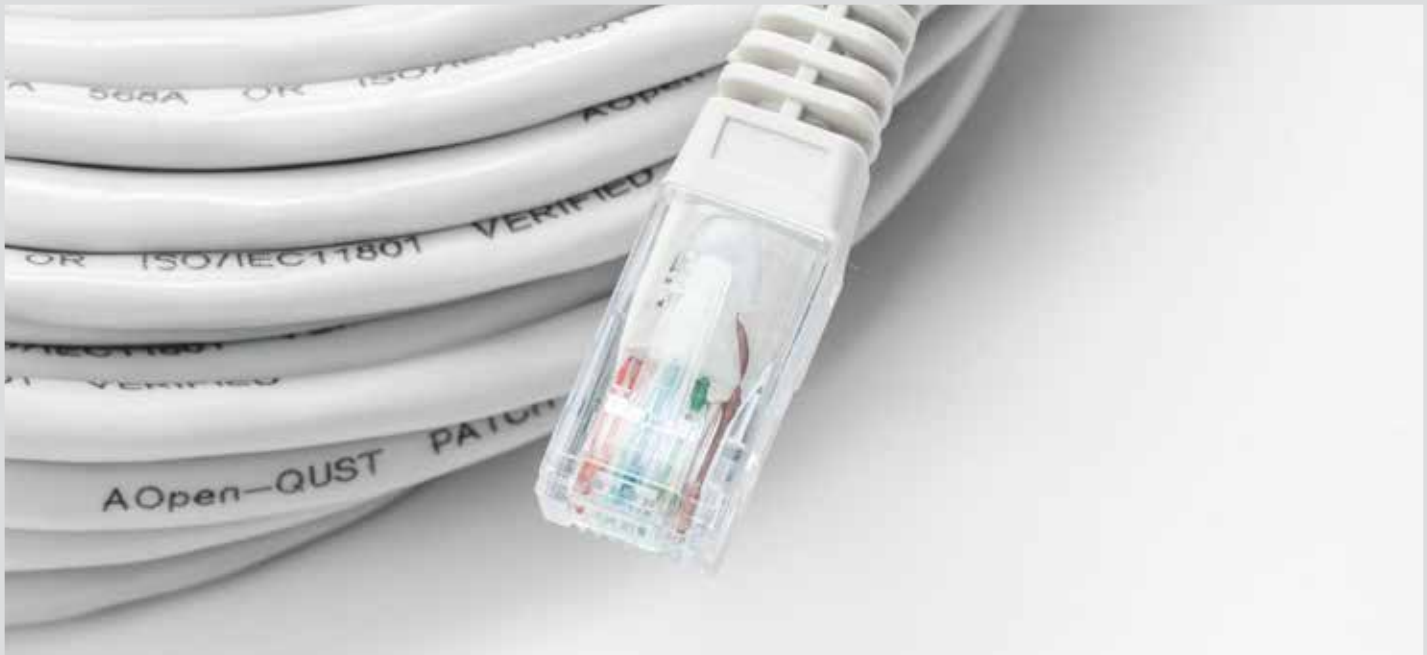
With its potential to overcome workforce and access barriers, telehealth can reduce[1] health disparities for aging and underserved populations, as well as reduce patients' costs and burdens associated with lost work time, transportation and child care. Telehealth gives patients living in rural areas access to more providers and allows them to receive care in their own communities, instead of traveling long distances. For example, patients can engage in live video visits with providers for both acute and chronic issues.

Telehealth Modalities

The three primary methods of telehealth are real-time communication, store-and-forward and remote patient monitoring. Mobile health is still an emerging modality.

- **Real-time communication** allows patients to connect synchronously with providers via video conference.
- **Store-and-forward** refers to transmission of data, images, sound or video from one care site to another for evaluation.
- **Remote patient monitoring** involves collecting a patient's vital signs or other health data while the patient is at home or another site and transferring the data to a remote provider for monitoring and response as needed.
- **Mobile health** (mhealth) is an emerging field that includes health education, information or other services via a mobile device. Mhealth references are much less common in state policy, with Hawaii as the only state with mobile health defined in statute.

Sources: Health Resources and Services Administration, NCSL, 2015



Broadband

To support telehealth and health information exchange, access to broadband services is key. Many rural areas do not currently have access to fast internet connections that allow data to be transmitted effectively and efficiently. The Federal Communications Commission's Rural Health Care Program receives $400 million annually to provide funding to rural health care providers to improve and expand their online connectivity. Providers apply to the program and if accepted they receive funds to improve their broadband networks. Additionally, states may take action. For example, through the Georgia Rural Development Council, the Georgia General Assembly recently approved a new tax on video streaming, digital books and downloaded music. The tax would raise money for rural internet subsidies to fund high-speed internet service in rural areas of the state.

Sources: Federal Communications Commission, 2019; Georgia House of Representatives, 2019

Teledentristry

At least eight states have adopted policies related to teledentistry—offering oral health services remotely. The policies are wide-ranging and can cover services such as face-to-face consultation via video conference, sharing images and records among providers, and monitoring patients remotely. Teledentistry can also act as an educational tool for dental professionals. For example, Montana enacted teledentistry legislation in 2018 that requires insurers to cover teledentistry services if that same service would be covered during an in-person visit. The language ensures that teledentistry services are subject to the same deductible, coinsurance and copayment provisions as the corresponding in-person service. The law also includes data privacy requirements and technology considerations.

Sources: Center for Connected Health Policy, 2019; Oral Health Workforce Research Center, 2016; Montana Code, 2017.

Telestroke

One specialty area of telehealth is stroke telemedicine or telestroke. Many rural hospitals do not have a doctor specializing in stroke care on-site so various providers work together as a team, including emergency room doctors at the originating site (the patient's location) and neurosurgeons and radiologists at the distant site (location of the provider) to ensure that patients receive fast diagnoses and appropriate treatment. This allows patients to remain in their communities while receiving care. Avera Health, located in Sioux Falls, S.D., ensures rural communities across the country have access to emergency services, among other specialties. Since Avera eCARE Emergency's inception in 2009, its providers have delivered immediate care to emergency departments at 137 hospitals. In 2018, Avera eCARE Emergency was attributed with $3.5 million in cost savings, avoiding over 700 potential patient transfers and providing more than 7,700 video encounters.

Sources: Mayo Clinic, 2019; Avera Health, 2019.

By improving access to lower-cost primary and specialty care, telehealth can provide timely, accessible care in lower-cost environments and help reduce expensive emergency room (ER) visits. Aside from primary care settings, telehealth is also used in a variety of specialty areas such as behavioral and oral health.

Telehealth also allows for consultation between providers, which can build capacity among practitioners in rural areas, where recruiting and retaining providers remains challenging. It also can allow providers to offer care in various settings, using the full extent of their education and training within their scopes of practice, with remote supervision or other support.

All states have a definition for telehealth or telemedicine, or both. States vary on whether the definition is by law, regulation or Medicaid program rules. Generally, "telemedicine" tends to focus on clinical services and "telehealth" tends to include other health care services. These definitions can be important as they can drive the basis for reimbursement and other policy issues.

Telehealth is widely cited as providing patient care and outcomes that are comparable to traditional care delivery. However, much of the research[2] on telehealth's effectiveness is still evolving. While many studies have found positive clinical outcomes and/or cost savings, it is challenging to make generalized statements about telehealth overall. One study[3] of randomized controlled trials concluded that the effectiveness of telehealth may depend on different factors, including patient population, the modality used, and the health care providers or systems involved in delivering telehealth.

Improved access can bring increased use of health care services. Most agree that the services provided using telehealth would be more appropriate and less costly (e.g., primary care visits are less expensive than emergency room care). A RAND study[4] of direct-to-consumer telehealth found that it may increase access to care for some and may also increase use of services and health care spending. While telehealth can provide initial remote access, there is some discussion that many patients require in-person follow-up care and can still face challenges in accessing that care.

Data on outcomes and cost-effectiveness are vital to policymakers seeking to invest state resources wisely. Relevant data may include service, cost and health information found in claims data, pharmacy records and patient medical records. Even data from remote patient monitoring or wearable electronics (such as activity trackers) may provide valuable information. State reforms, including alternative payment and delivery models, will also likely have implications for the use, outcomes and costs associated with telehealth. Policymakers may wish to consider the roles of telehealth, along with availability and integration of data, when examining system reforms.

Telehealth Modifier

Medicare providers use a modifier on their billing codes when submitting reimbursement claims to indicate that the service was delivered via telehealth. A specific reimbursement code, called a GT modifier, is used for live video services, and in 2017, the Centers for Medicare and Medicaid Services (CMS) allowed providers to submit their claims using a place of service (POS) modifier when a service is provided using telehealth. A GQ modifier is used for store-and-forward services in Alaska and Hawaii. More recently, in 2018, CMS added new reimbursement codes for services, including virtual check-ins and remote evaluations of prerecorded patient information. Using a modifier when submitting telehealth claims collects better data on the number and types of services provided via telehealth.

Sources: Centers for Medicare and Medicaid Services, 2019; Center for Connected Health Policy, 2018

As state leaders seek to capitalize on the potential for telehealth to support the health care workforce and improve access to care, a number of state policy issues arise. Reimbursement, licensure and provider practice standards are among the key topics being addressed in state legislatures.

Reimbursement

Public and private payment for telehealth services varies across the nation, which can affect its adoption. Although states occasionally use similar language in their policies, no two states are exactly alike in how telehealth is defined and regulated.

Medicaid

Medicaid policies include those that provide some type of reimbursement for telehealth, but the scope of these policies varies among states. All states and the District of Columbia reimburse for live video services in their Medicaid programs. Only six states stipulate Medicaid coverage and reimbursement for all three common telehealth modalities (live video, store-and-forward and remote patient monitoring). The types of providers, services and locations eligible for reimbursement also vary within state Medicaid programs[5].

For all modalities, states may restrict[6] the types of services, specialties and providers or the patient locations that are eligible for reimbursement. For example, all states allow coverage for mental or behavioral health services provided via live video, while 29 states reimburse for telehealth under their home health services. In addition, 16 states allow fewer than nine provider types to receive reimbursement for telehealth, while 19 states and the District of Columbia do not specify the type of provider. Generally, states have been expanding these categories to allow greater reimbursement for a growing number of services, providers and modalities[7].

According to the Center for Connected Health Policy and NCSL research, laws and regulations in 23 states and the District of Columbia allow for reimbursement of store-and-forward services. In some states, as with other modalities and services, there may be limitations on what will be reimbursed. For example, Maryland only reimburses for teledermatology, teleophthalmology and radiology.

Additionally, laws and regulations in at least 27 states allow for reimbursement for remote patient monitoring (RPM). As with the other modalities, states also place restrictions on the use of RPM. For example, Colorado requires patients receiving RPM services to have a diagnosis of at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma or diabetes. RPM may be reimbursed through other state agencies. South Dakota reimburses remote patient monitoring through its Department of Aging Services[8].

Medicare

Medicare limits telehealth reimbursement more than the states. Medicare primarily reimburses only live-video telehealth services, and only in certain instances—usually pertaining to locations, providers and services offered. The originating site must be a rural location, which is defined as a Health Professional Shortage Area (HPSA) or in a county that is outside of a Metropolitan Statistical Area (MSA) unless the patient is receiving services for end-stage renal disease or acute stroke symptoms. The geographic limitation does not apply to existing telehealth originating sites when a patient is receiving treatment for a substance use disorder or co-occurring mental health disorder. The originating site can be a medical facility—which includes hospitals, provider offices, critical access hospitals, rural health clinics and federally qualified health centers, among others—or a patient's home. Store-and-forward methods are only covered in Alaska and Hawaii.

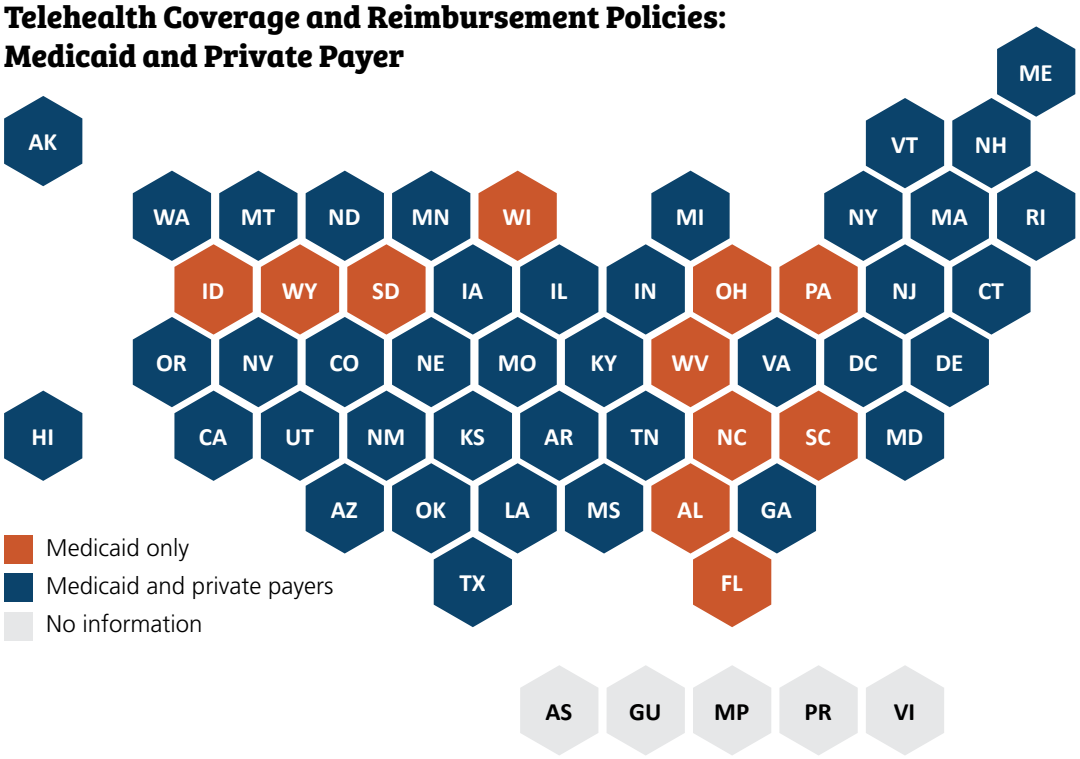
Sources: Center for Connected Health Policy, 2019; Centers for Medicare and Medicaid Services, 2019

Private Payers

Many states have adopted coverage and reimbursement policies related to private payers to increase broader access to telehealth services. Currently, 39 states[9] and the District of Columbia have some type of private payer policy. Typically, these policies require coverage and/or reimbursement that is comparable to what is covered and/or reimbursed for in-person visits—however, not all these policies mandate coverage or reimbursement. State laws governing private payers vary. Some stipulate certain criteria if payers choose to cover telehealth; some require coverage of telehealth for certain services, certain populations or all patients; and others require certain coverage and payment for telehealth.

Full parity—which exists in at least 12 states[10]—is when both coverage and reimbursement are comparable to in-person services. Many states with parity laws stipulate that telehealth services are subject to the terms and conditions of the contract, or similar language.

Telehealth Coverage and Reimbursement Policies: Medicaid and Private Payer



Source: Center for Connected Health Policy, 2019

Licensure

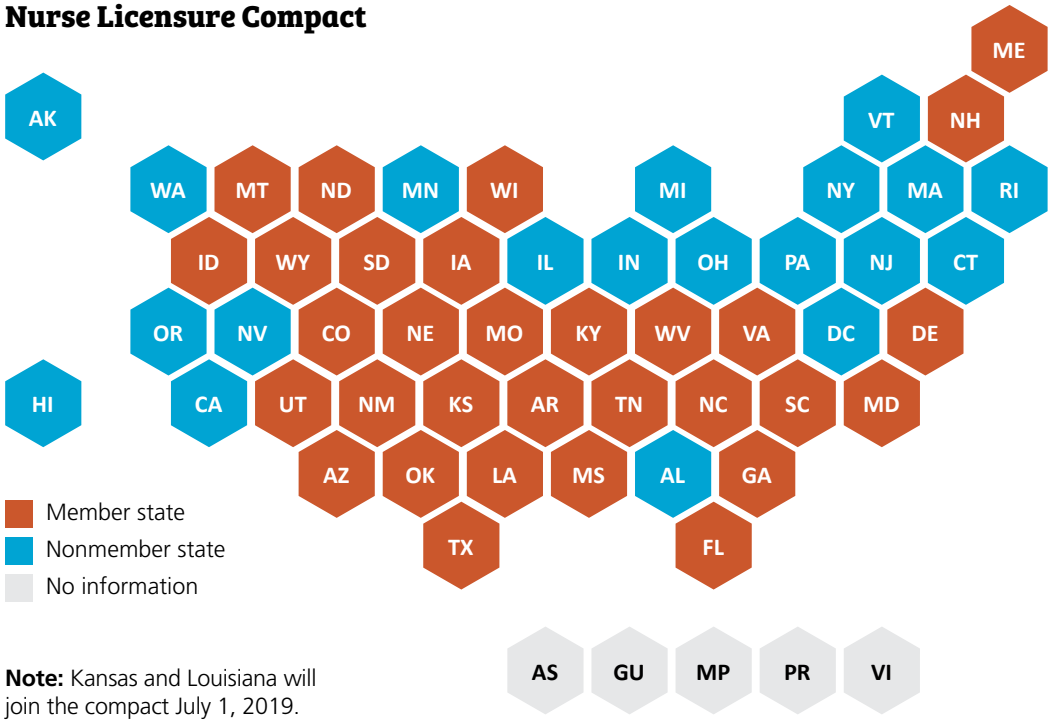
Because technology crosses borders, licensure of providers becomes an issue when considering telehealth as a solution to workforce shortages. Generally, health care providers must be licensed in the state where the patient is receiving care, and states retain oversight of providers within their borders. This may pose challenges for providers and states seeking to expand access across state lines, particularly through telehealth. Some policymakers have considered options to allow out-of-state providers to offer services in their states.

To provide services via telehealth across state lines, some states grant temporary licenses, telehealth-specific licenses or have reciprocity agreements with neighboring states. Texas, for example, offers an out-of-state telemedicine license. Physicians holding this license are limited to two services. They may provide follow-up care to a patient who received the majority of his or her care in another state, or they can interpret diagnostic tests, but must report the results to a licensed physician practicing in Texas.

Some states have reciprocity agreements with other, often neighboring, states, allowing practitioners to provide care to patients in other states without obtaining additional licenses. At least nine states[11] have created telehealth-specific licenses that allow out-of-state providers to offer services in the state, if they abide by certain requirements (e.g., not setting up a physical location in the state).

Licensure compacts for various providers have been gaining traction as a way to allow interstate practice, particularly with an eye toward promoting telehealth. Compacts are formed and become active when a certain number of states enact the same legislation, with specific required language, or by a certain date, whichever occurs first. However, joining the compact is voluntary on the part of the provider. The Nurse Licensure Compact, created nearly 25 years ago by the National Council of State Boards of Nursing, currently has 29 member states, with Kansas and Louisiana joining the compact on July 1, 2019.

Nurse Licensure Compact

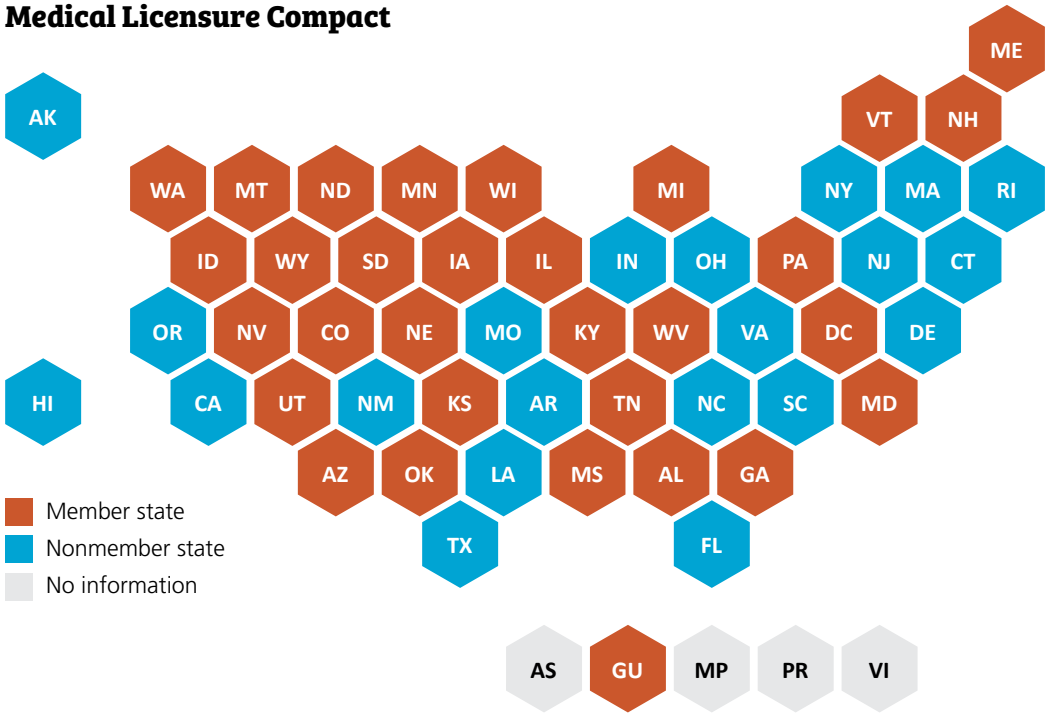


Note: Kansas and Louisiana will join the compact July 1, 2019.

Source: National Council of State Boards of Nursing, 2019

The physicians' version—the Interstate Medical Licensure Compact—was created in 2015 with the help of the Federation of State Medical Boards. It has been enacted in 29 states, the District of Columbia and Guam. Key differences exist in the compacts. For example, the nurse compact operates like a driver's license, with one license for all participating compact states, while the physician compact provides an expedited path to a separate license in each participating state.

Medical Licensure Compact



Source: Interstate Medical License Compact Commission, 2019

Other Licensure Compacts

Three other licensure compacts exist for emergency medical providers, physical therapists and psychologists:

- The Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA) was activated in May 2017 and 16 states have signed the REPLICA legislation into law.
- The Physical Therapy Compact, activated in 2017, has 13 member states. An additional 12 states enacted the compact language but have yet to start issuing compact privileges.
- The Psychology Interjurisdictional Compact (PSYPACT) activated in 2019, has seven member states. Illinois will join the compact Jan. 1, 2020.

Sources: National Registry of Emergency Medical Technicians, 2019; PT Compact, 2019; Association of State and Provincial Psychology Boards, 2019.

Provider Practice Standards

In addition to differences in payment and licensure, providers delivering health care services through telehealth may encounter different state laws regarding practice standards. Policymakers across the country continuously balance the rapid acceleration of the benefits of technology and telehealth with the responsibility to ensure safe and high-quality care for their constituents. States ensure patient safety by creating guidelines establishing a patient-provider relationship and mandating certain informed consent requirements. For example, there is some concern about fragmented care from different providers and ensuring that patients' primary providers are aware of any services provided via telehealth. Ideally, telehealth is integrated into the health care delivery system and is coordinated with other providers. Other concerns about telehealth include ensuring that services provided remotely are as safe and as comprehensive as in-person care. Policies related to practice standards include applying the standard of care, establishing a patient-provider relationship and ensuring informed consent.

Standard of Care

The standard of care—what another similarly trained and equipped provider would do in a similar situation—applies to health care providers regardless of the method of service delivery and should similarly govern safety in telehealth. Some states, including Idaho, Louisiana, Missouri, New Jersey and Texas, have codified that the applicable standard of care that applies to in-person care also applies in telehealth. As it is further employed, the standard of care[12] of telehealth is likely to evolve.

Privacy, Confidentiality and HIPAA

Policymakers may discuss other considerations such as privacy, confidentiality, data security and the federal Health Insurance Portability and Accountability Act (HIPAA) when developing telehealth strategies. Since HIPAA does not have specific requirements related to telehealth, providers must meet the same HIPAA requirements as in-person services. Additional steps may need to be taken that would otherwise be unnecessary for in-person visits[13]. For example, a technology support person working on telehealth equipment could be more easily exposed to a patient's personal health information.

Policymakers need to ensure that laws permitting and/or promoting telehealth still maintain patient privacy protections, as required by HIPAA. Some argue[14] that privacy and security must be addressed to advance telehealth and ensure providers' and patients' trust in it.

Informed Consent

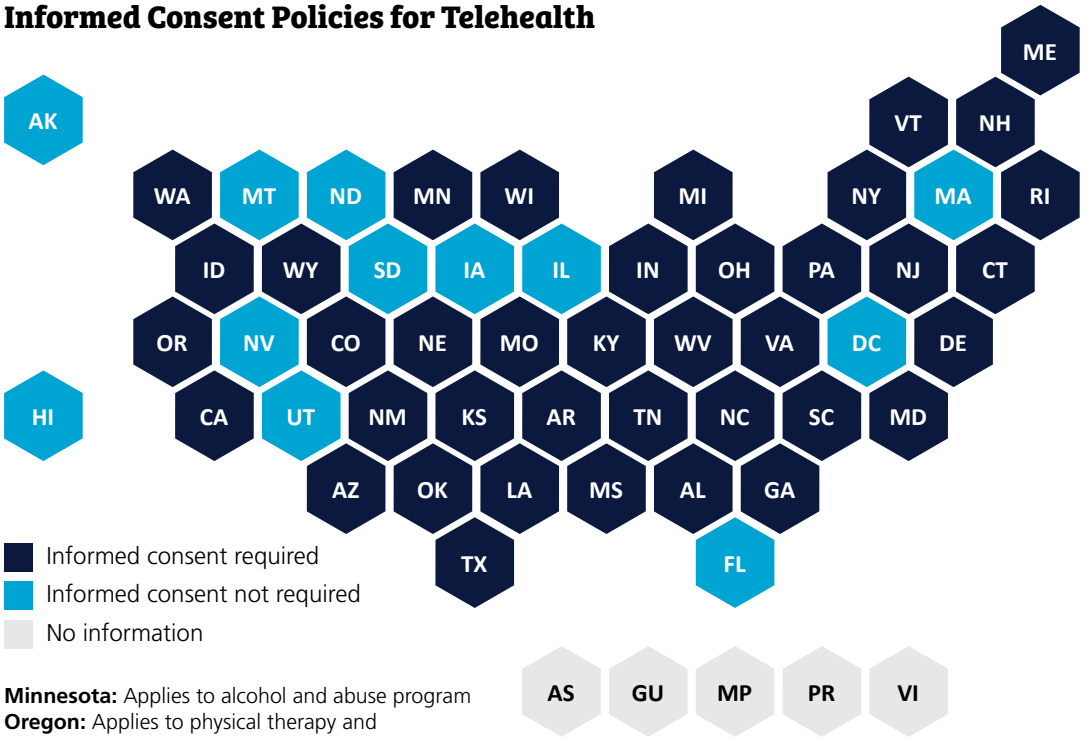
States may also consider informed consent policies—a process by which a patient is made aware of any benefits and risks associated with a particular service or treatment, as well as any alternative courses of action. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks and understand that a condition or treatment may require a provider to defer to in-person services.

Scope of Practice

Scope of practice, defined in state policy, describes what a health professional can and cannot do to or for a patient. A professional's scope of practice is often based on the education, training and experience typical for that profession. Telehealth laws do not change a provider's existing scope of practice but providers practicing across state lines must be aware of scope of practice laws in case the requirements differ from their home state. Providers may need to be aware of applicable standards of care and laws related to supervision and collaboration through telehealth.

Currently, 39 states and the District of Columbia have some type of informed consent policy for telehealth, which represents a growing trend. This requirement may apply to different arenas—e.g., all providers or just the Medicaid program, or even specific services, depending on the origination (statute, administrative code, Medicaid policy) and intent of the policy. States that require informed consent primarily require verbal consent but six states and the District of Columbia require written consent. Requiring written consent may create additional barriers to accessing telehealth because it can require an in-person encounter to sign a waiver prior to receiving telehealth treatment. Depending on the policy, this may lead to a paradox, where the potential benefits of telehealth are stifled by the requirements to receive it[15].

Informed Consent Policies for Telehealth



Minnesota: Applies to alcohol and abuse program
Oregon: Applies to physical therapy and community treatment
New Mexico: Applies to behavioral health services

Source: Center for Connected Health Policy, 2019

Patient-Provider Relationships

The relationship between a patient and health care practitioner, or the patient-provider relationship, is an important determinant of the quality of care a patient will receive. Establishing a high-quality patient-provider relationship will usually[16] lead to better outcomes and more trust between the patient and the physician. As with other modes of care, patients receiving[17] care through telehealth should expect to receive competent care, the assurance of privacy and confidentiality, and continuity of care. Differences in possible patient-provider interactions in telehealth have brought accountability and the patient-provider relationship to the forefront in discussions about telehealth safety.

As telehealth grew in popularity, many states initially required telehealth patient-provider relationships to be established in person. Requiring an initial in-person visit to a telehealth provider prior to treatment can create a barrier to access and perpetuates the problem that telehealth intends to solve. Patients who seek telehealth treatment because they are unable to access a health care facility may be disadvantaged by laws requiring patient-provider relationships to be established in person. However, as of 2017, all 50 states[18] allow a patient-provider relationship to be established remotely, representing the desire of states to facilitate telehealth. In 2017, Texas became the last state to allow physicians to treat telehealth patients without prior face-to-face interaction under SB 1107, a bipartisan bill.

Despite loosening regulations on establishing telehealth relationships, some states[19], such as Georgia and Alabama, maintain requirements for patients to receive follow-up care from telehealth providers in person. Proponents of telehealth are wary of requiring follow-up in-person visits because of the additional burden placed on the patient to seek in-person care, which could potentially recreate some of the barriers telehealth seeks to remove.

Prescribing Power

The federal Ryan Haight Act, passed in 2008, prohibited practitioners from prescribing controlled substances without an in-person exam or meeting one of the seven "practice of telemedicine exceptions." This act created barriers to treatment, particularly for individuals suffering from substance use disorders (SUDs), and restricted the use of telehealth to deliver medication-assisted treatment (MAT) to these patients.

As the opioid epidemic intensified, Congress responded by passing the SUPPORT for Patients and Communities Act in 2018. This act amended the Ryan Haight Act to require the Drug Enforcement Administration (DEA) to activate a special registration allowing physicians and nurse practitioners to prescribe controlled substances through telehealth and without a prior in-person exam, opening the door to MAT. While there are still barriers to providing MAT through telehealth, the passage of the SUPPORT Act is likely to bring changes at the state level.

Telebehavioral Health

Policymakers increasingly consider telebehavioral health as a way to reduce gaps and increase access to essential behavioral health services. The prevalence of mental health and substance use disorders, coupled with roadblocks to obtaining treatment, constitute what many consider to be a serious problem in the United States.

Telepsychiatry is a branch of telebehavioral health and covers care traditionally provided by psychiatrists, including prescribing psychiatric drugs. The American Psychiatric Association defines telepsychiatry as a subset of telemedicine involving psychiatric evaluations, therapy— including individual, group and family therapy—patient education and medication management. Telepsychiatry is a way to meet patients' needs for convenient, affordable and readily accessible mental health services.

The federal SUPPORT for Patients and Communities Act expands telehealth access for patients with substance use disorders (SUDs). The law removes the geographic restrictions in Medicare for telehealth services for treating an individual with a SUD diagnosis. The law also includes funding to train rural providers on Project ECHO, which allows providers to consult with each other regularly through telehealth. Additionally, the law allows the U.S. attorney general and the U.S. Department of Health and Human Services secretary to issue a special registration to providers to prescribe controlled substances via telehealth in emergency situations.

As telehealth services become more widely accepted, state legislators increasingly consider using it to bridge provider gaps and improve behavioral health. A 2017 report by the American Telemedicine Association found that all states have some form of coverage and reimbursement for mental health services provided via telehealth, although state policies vary widely in scope and specificity.

State laws also govern a provider's authority to prescribe medications, including provider board rules and regulations that set the standard of care for prescribing. Most states do not allow an online questionnaire to establish a patient-provider relationship, instead requiring real-time telehealth interactions before a provider can write prescriptions. Further, some states require an in-person exam before any prescription is written, eliminating the ability to use telehealth to prescribe medications. However, there are many exceptions to these policies, including MAT exceptions designed to address the opioid epidemic.

All states will need to adjust their prescriber policies related to telehealth to be in accordance with the SUPPORT Act. Most stakeholders agree that if providers can prescribe and dispense medications via traditional means, they should be able to do so via telehealth as well, provided they can gather the necessary information and maintain patient privacy rights.

Policy Options

Legislators may wish to explore these areas when examining telehealth policies:

- Look at reimbursement policies for Medicaid and private payers. Consider which providers and services are eligible for reimbursement and how that aligns with your state's needs. Examine the use of telehealth under public and private insurers and the potential barriers or constraints providers and patients face in using telehealth. If data on telehealth use are hard to access, consider a modifier for billing codes in Medicaid to track services.
- Examine current workforce or access gaps and consider ways to facilitate coverage through telehealth. Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.
- Examine current statutes and regulations to see if clarity is needed on telehealth policies. Consider informed consent, the patient-provider relationship and standard of care policies when looking to improve provider practice standards.
- Consider which policies might facilitate telehealth in a way that fits the needs and context of your state. Engage various stakeholders (e.g., providers, hospitals, payers, consumers) in this conversation.

Conclusion

Telehealth has the potential to help states leverage a shrinking and maldistributed workforce, increase access to services and lower costs. A number of strategies exist for state policymakers seeking to address telehealth needs in their state. Reimbursement, licensure and provider practice standards will continue to be issues for policymakers to consider. While no single solution will solve all the challenges, legislators have adopted many of these strategies to remove barriers and enhance access to health care in rural and underserved communities through telehealth. As challenges persist, legislators will surely continue to consider innovative strategies to improve individual, community and population health.

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This brief is an update to the NCSL's Telehealth Policy Trends and Considerations publication, released in 2015. We would like to recognize the work of the NCSL Partnership Project on Telehealth, a public-private partnership brought together to discuss telehealth adoption and barriers.

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