



State Telehealth Laws and Medicaid Program Policies

SPRING 2023

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) Spring 2023 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 given these new updates. Historically CCHP has provided these bi-annual summary reports in the Spring and Fall each year to provide a snapshot of the progress made in the past six months. Beginning in Fall 2023, the summary report will transition to being released once per year in the Fall only, with three separate rounds of updates being made to each jurisdiction in the Policy Finder in the interim. 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 March 2023.**

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) Spring 2023 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 now and the previous edition, Fall 2022. The research for this edition of the Summary was conducted between January and March 2023. This summary offers the reader 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, the District of Columbia, Puerto Rico and the Virgin Islands.

Please note that although many states have moved towards making their COVID-19 emergency policies permanent, some are still siloed from their permanent telehealth policies. These temporary policies are not included in this 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 March 2023. 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 the upcoming Fall 2023 edition. 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 of future editions of CCHP's summary report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming implementation.

The information is organized on the policy finder into four major categories where state telehealth policy is found: Medicaid reimbursement, private payer laws, professional requirements and federally qualified health centers (FQHCs). Last year, CCHP received funding from the National Association of Community Health Centers (NACHC) to create an FQHC specific section on Medicaid fee-for-service policies, and have since maintained that category within our policy finder. COVID-19 is also included as a category in CCHP's 50 State policy tool, however as mentioned previously, COVID policies are not included as part of this report.



Within each category, information is organized into various topic and subtopic areas within CCHP's policy finder. 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

- **FQHC:**

- o Definition of Visit
- o Modalities Allowed
- o Same Day Encounters
- o Eligible Originating Sites
- o Eligible Distant Sites
- o Facility Fee
- o PPS Rate
- o Home Eligible
- o Patient-Provider Relationship

- **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

Key Findings

While movement in telehealth policy may seem slow and incremental, CCHP continues to observe states pushing the boundaries of their permanent telehealth policies. Likely as a result of the impact of the COVID-19 public health emergency, in this update CCHP found many state Medicaid programs are expanding the modalities of telehealth that are reimbursed beyond just live video, and broadening policies for audio-only, such as allowing for additional providers and services. We continue to emphasize that no two states are alike when it comes to defining or regulating telehealth. Each state has its unique approach to telehealth including how it is treated by Medicaid programs, and the accompanying professional requirements and private payer laws.

As foreshadowed in the previous paragraph, the most notable shift observed in this Spring 2023 edition was the expanded inclusion of additional telehealth modalities for specific use cases in many Medicaid programs. In most cases states already reimbursed for these modalities in a limited capacity, but we saw the policies broaden or were refined in this Spring 2023 update. For example, Nebraska Medicaid announced coverage for continuous glucose monitoring (CGM) for eligible beneficiaries with diabetes beginning January 1, 2023. While coverage was already available in the state for telemonitoring, this is the first time CGM specifically has been available through Nebraska Medicaid. Similarly, Alabama Medicaid published a new manual devoted solely to remote patient monitoring (RPM) and added new conditions that qualify for RPM services such as gestational diabetes and pediatric asthma.

The addition of audio-only reimbursement in Medicaid has been trending for the past two years. While it started out as temporary policy tied to the COVID-19 emergency, in many states it has already become incorporated into Medicaid permanent reimbursement policy, often through the addition of the 93 modifier to signify the audio-only modality was used. Georgia is an example of a state that recently made this change with an update to their telemedicine guidance.



Likewise, Nevada Medicaid issued an announcement that allows audio-only to be used for telehealth visits outside of the COVID-19 PHE for certain telephone evaluation and management codes.

Medicaid programs continue to refine and add detail to their policies, often providing additional instructions to help providers navigate nuances associated with specific billing scenarios and situations. For example, Indiana Medicaid updated their Telehealth and Virtual Services Manual, among other changes, adding new sub-sections to address issues around FQHC and RHC billing, intensive outpatient treatment, remote patient monitoring billing, services that require electronic visit verification and out-of-state telehealth providers. This coincides with enhanced requirements around documentation. For example, Louisiana Medicaid is now specifying that providers include in the enrollee's clinical record documentation that the service was provided through the use of telemedicine/telehealth specifically.

One interesting development can be observed in the Texas Medicaid Telecommunication Manual, where it is now mandated that clients cannot be compelled to receive services via telehealth, unless a formal declaration of a disaster is in place. This echoes a similar requirement in California's Medicaid consent policy, which stipulates that providers must disclose to patients their right to an in-person visit. Such policies likely stem from a concern that patients may be pushed into telehealth encounters for the sake of provider convenience, and seek to safeguard the availability of in-person care for patients.

Since telehealth started becoming more commonplace, more state professional boards have adopted regulations related to telehealth. Recently, professions that are not typically associated with telehealth delivery of care have been adopting such regulations as professionals find use cases within their profession for the technology. In the Spring 2023 Update, for example, the Maine Board of Dental Practice adopted a new rule on practice requirements for teledentistry. Among many requirements, the rule requires a dentist, denturist or a dental hygienist to take reasonable steps to verify the patient's physical location, deliver teledentistry services at the same standard of care and professional ethics as in-person and provide informed consent to the patient for public display and in writing. A recent Oregon rule which previously forbid pharmacists from issuing a prescription solely based on a questionnaire or internet-based relationship was amended to delete this requirement and instead specify that prescriptions must be issued pursuant to a valid patient-practitioner relationship. This change had been made previously through an emergency temporary rule but is now permanent.



“With telephone becoming more ubiquitous, boards have also had to contend with how relationships solely established via telephone factor in to forming a patient-provider relationship.”

With telephone becoming more ubiquitous, boards have also had to contend with how relationships solely established via telephone factor in to forming a patient-provider relationship. The Arkansas Medical Board recently modified their regulations to allow for telephone to establish such a relationship when it is clinically appropriate under certain circumstances, while at the same time clarifying that a relationship cannot be established through internet questionnaire, email message, patient generated medical history, text messages, facsimile or any combination of those items.

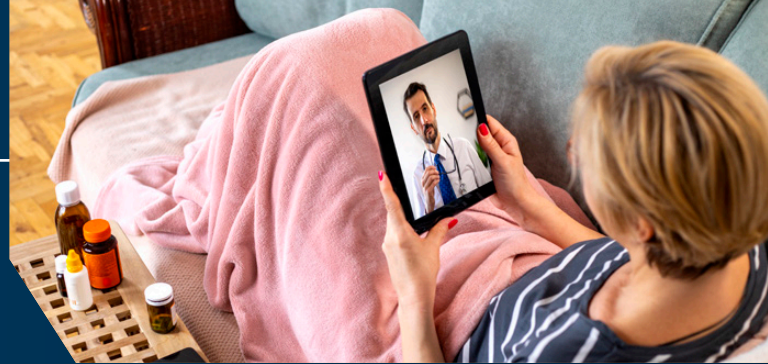
Interstate licensure compacts continue to be the most popular way to address cross-state licensing issues. While new states joining compacts appear to be slowing, CCHP noted that the Audiology and Speech Language Pathology Compact, Interjurisdictional Psychology Compact, Counseling Compact and Occupational Therapy Compact, all had new member states join since Fall 2022. Additionally, three new compacts, the Advanced Practice Registered Nurse Compact, the Social Work Compact and the Physician Assistant Compact have all had legislation in various states introduced with the language, though very few states have joined thus far and are therefore not yet operational.

Unlike in the Fall 2022 findings when more states than ever before adopted cross state licensure exceptions, registrations or licenses specific to telehealth, in the Spring 2023 update CCHP only found the state of Washington provided for a new very specific allowance to its in-state licensing requirements (see the cross-state licensing section below for further details). In contrast, Mississippi adopted a new regulation listing requirements for a licensed professional counselor providing services through means of distance professional services. Some of the requirements of the Mississippi regulation include holding a license in good standing in both the location the services are provided and the location of the recipient. It is uncommon for states to require providers to hold licensure in the state where they are physically located, when the patient being treated is not located in that state. This practice may be perceived as an overreach on the part of the state, as it assumes the authority to regulate providers physically located in another state.

Similarly, CCHP did not find any states with significant changes to their private payer laws in this Spring 2023 reporting period. In previous updates, CCHP had noted modifications to private payer laws incorporating payment parity requirements, and a prohibition against limiting reimbursement to specific telehealth vendors. This lack of changes to both private payer laws and cross-state licensing laws may potentially be attributed to the fact that the review of states transpired prior to the culmination of the legislative session in many states, with the majority of bills yet to be enacted. More activity on these topics may occur later in the year and will be noted in our Fall 2023 edition of our report.

Additional findings include:

- **Fifty states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service.** Both the jurisdictions of Puerto Rico and Virgin Islands do not explicitly indicate they reimburse for live video in their permanent Medicaid policies.
- **Twenty-eight state Medicaid programs reimburse for store-and-forward.** Wisconsin, Rhode Island and Illinois are the states which added reimbursement for store-and-forward, although each in a limited capacity.
- **Thirty-four state Medicaid programs provide reimbursement for remote patient monitoring (RPM).** No states have added RPM reimbursement since Fall 2022, though some states did add additional eligible services, and conditions to their existing RPM reimbursement.
- **Thirty-six states and DC Medicaid programs reimburse for audio-only telephone in some capacity;** however, often with limitations. Hawaii and Georgia are the two states that added reimbursement in some capacity for audio-only telehealth since Fall 2022.
- **Twenty state Medicaid programs including Alaska, Arizona, California, Hawaii, Illinois, Kentucky, Maine, Massachusetts, Maryland, Michigan, Minnesota, Missouri, North Carolina, New York, Ohio, Oregon, Texas, Virginia, Washington, and Wisconsin reimburse for all four modalities** (live video, store-and-forward, remote patient monitoring and audio-only), although certain limitations may apply.
- **Forty-three states, the District of Columbia and Virgin Islands have a private payer law that addresses telehealth reimbursement.** Not all of these laws require reimbursement or payment parity. Twenty-four states have explicit payment parity. There has been no movement in private payer laws since Fall 2022.



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 March 2023.

Definitions

How a term is defined may determine the expansiveness of a state’s telehealth policy. For example, some states put specific restrictions within the definition of telehealth/telemedicine such as using the term “live” or “interactive,” excluding store-and-forward and RPM from the definition and subsequently from reimbursement. All fifty states, the District of Columbia (DC), Puerto Rico and the Virgin Islands have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both.

States alternate between using the term “telemedicine” or “telehealth” while some use both terms. “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 have become 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. Additionally, since the pandemic, while not widespread at this point, we have seen a few Medicaid policies/programs use the term “virtual care”. The use of these different terms may cause confusion for providers, particularly if they are given separate and distinct definitions.



In this update, Massachusetts was noted for adding a definition for telemedicine (previously only having a definition for telehealth), and Maine was noted for dropping their telemedicine definition, continuing with only a ‘telehealth’ definition. 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 the telephone modality since COVID-19 policies were put in place, 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 reimbursed.

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. CCHP was unable to locate any permanent telehealth reimbursement policy in Puerto Rico and the Virgin Islands’ Medicaid programs, though they may have had definitions available for the modalities or the term “telehealth/telemedicine”. Reimbursement policies for telehealth services varies across states, with some jurisdictions providing more comprehensive guidance than others.

› LIVE VIDEO

The most widely reimbursed form of telehealth is live video, with every state and D.C. offering some reimbursement in their Medicaid program, with the exception of Puerto Rico and Virgin Islands (as noted above). The restrictions and requirements around live video reimbursement, however differ widely between states. 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.

State Example:



MICHIGAN Medicaid provides a specific list of procedure codes and modifier information in the form of a Telemedicine Services Database for providers to access to determine whether or not a service is reimbursed.

Meanwhile, **FLORIDA** takes a different approach, simply stating they will reimburse a practitioner who is providing an evaluation, diagnosis or treatment recommendation at a site other than where the recipient is located.



> STORE-AND-FORWARD

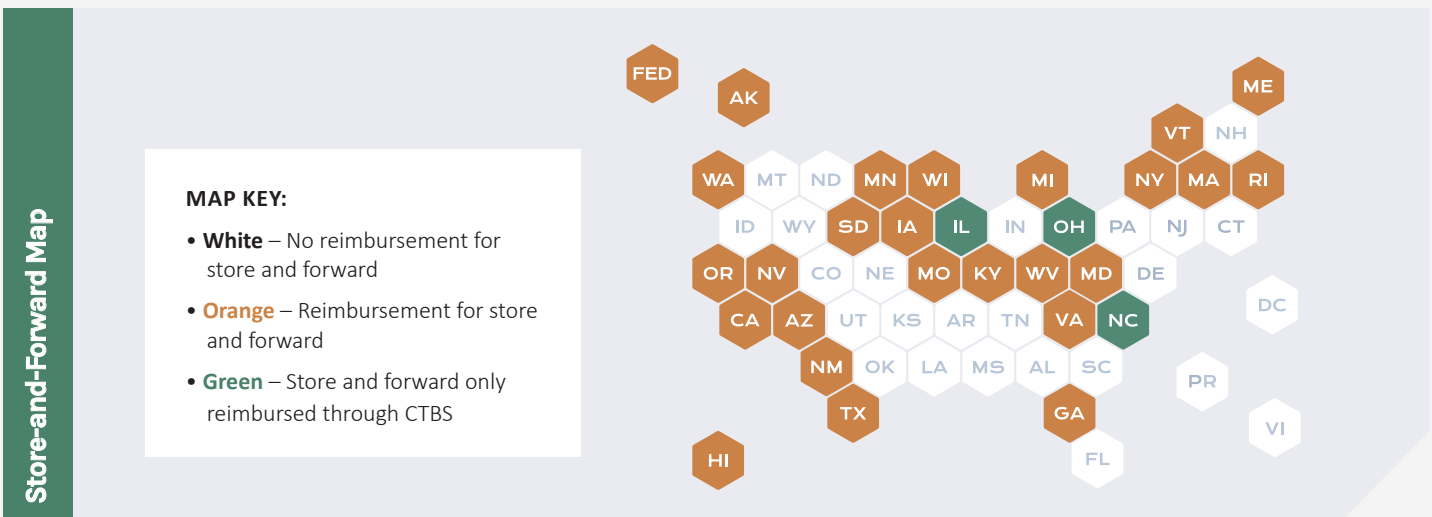
Store-and-forward services are only defined and reimbursed by twenty-eight Medicaid Programs. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered ‘telehealth’). In some states, the definition of telemedicine and/or telehealth 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.

Five additional states (Colorado, Connecticut, Mississippi, New Hampshire, 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.

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 allow for the reimbursement of a teledentistry code that specifically includes in its description the asynchronous review of information by a dentist. Additional states have allowed for store-and-forward reimbursement as a result of reimbursement for Communication Technology Based Services (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 three (Illinois, Ohio and North Carolina) out of the 28 states that reimburse for store-and-forward do so through these CTBS codes.

State Example:

WISCONSIN Medicaid released an update that announces the addition of asynchronous telehealth services if they are ‘functionally equivalent’ to in-person services. Must be billed with the GQ modifier and includes, but is not limited to, teleophthalmology, teledermatology, and teleradiology.



➤ REMOTE PATIENT MONITORING (RPM)

Thirty-four states have some form of reimbursement for RPM in their Medicaid programs. Since Fall 2022, no new states added reimbursement for RPM, though some did make modifications or expand their RPM reimbursement to additional conditions. Four of the states reimburse only for specific remote patient monitoring CTBS codes, including California, Massachusetts, Hawaii, and West Virginia. While the other states reimburse for CMS' remote physiologic monitoring codes, West Virginia reimburses for remote therapeutic monitoring codes that were adopted by Medicare in the finalized 2022 physician fee schedule in order to account for the management of patients using medical devices that collect non-physiologic data. It should also be noted that while Alaska Medicaid is included as covering RPM, CCHP has received reports that they are currently only covering the device and not the service.

State Example:

Remote patient monitoring can sometimes be for very specific situations. For example, **NEW YORK** Medicaid recently expanded coverage for remote patient monitoring during pregnancy and up to 84 days postpartum to further improve and expand access to prenatal and postpartum care. The expansion includes an additional monthly fee to cover the cost of the RPM devices/equipment.

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. Connecticut, New Hampshire, 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. 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.

Remote Patient Monitoring (RPM) Map



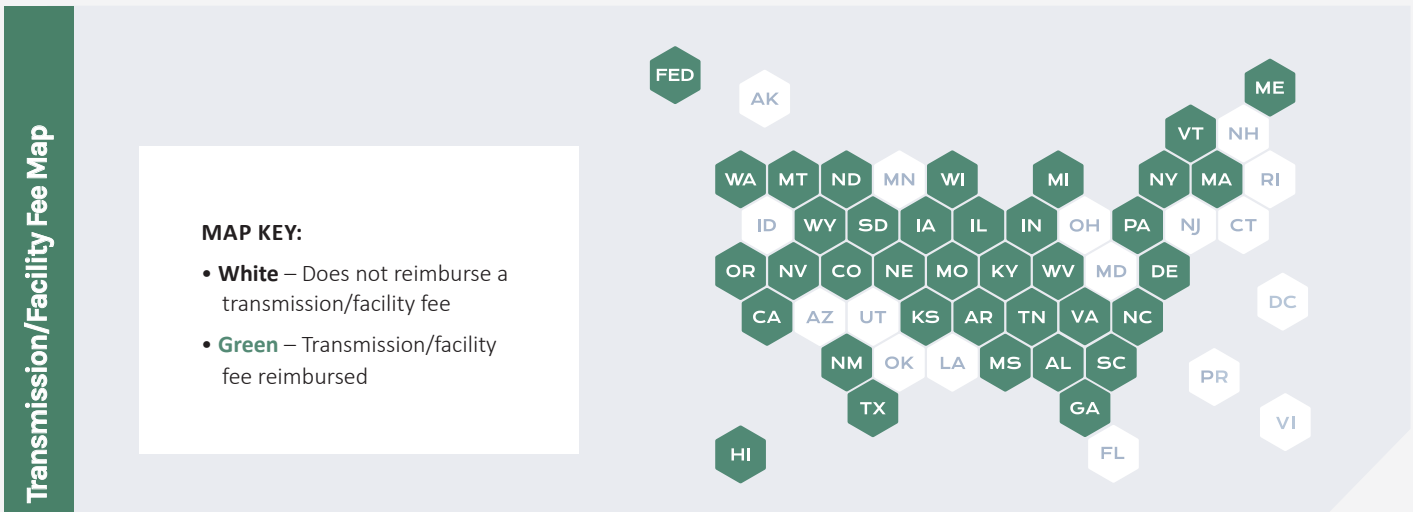
States have embraced diverse methodologies in integrating these codes into their healthcare systems. We have found that Medicaid programs often incorporate CTBS codes within the telehealth framework, while leveraging Medicare’s coding system for their identification and reimbursement purposes. From previous 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 policy finder 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 (*).

State Example:

NEW YORK Medicaid adopted a new rule expanding telehealth reimbursable services to include electronic consultations, virtual check-in, and even virtual patient education. The provider must meet certain billing requirements, as determined and specified by the Commissioner in administrative guidance.

► TRANSMISSION/FACILITY FEE

A total of thirty-six state Medicaid programs reimburse for either a transmission or facility fee, with the latter being the prevailing choice. 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.



➤ **ELIGIBLE PROVIDERS**

While certain state Medicaid programs lack explicit guidelines, other states impose restrictions on the types of providers authorized to render telehealth services at the distant site. Notably, in many Medicaid programs the roster of eligible provider types has expanded significantly in recent years, with the majority of states now permitting a diverse range of providers to offer telehealth services. Medicaid programs may also vary their lists of eligible providers depending on the types of services being provided. For example, while Michigan Medicaid allows all health care professionals licensed or registered in the state to furnish telehealth services, a specific list of behavioral health therapy providers is provided for telepractice services specifically. States that do not maintain a provider list often state that any Medicaid-enrolled provider is eligible for reimbursement when delivering services through telehealth.

As cross-state telehealth has become more prevalent, a new area for Medicaid programs to address is how to handle out-of-state providers operating in the state with a valid in-state license within the Medicaid program. While most states don't explicitly address this yet, a few states have taken this on. Colorado Medicaid is one of those states. They have created an Electronic Health Entity (eHealth Entity) within their Medicaid program, and out-of-state providers as well as corporate telehealth providers operating via telehealth exclusively are expected to enroll as such providers. There are limitations around eHealth Entities in Colorado including that they cannot be a primary care medical provider.

➤ **FEDERALLY QUALIFIED HEALTH CENTERS & RURAL HEALTH CLINICS**

Given that FQHCs and RHCs submit for reimbursement as entities rather than individual providers, telehealth eligible provider lists sometimes exclude them. Medicare has omitted these clinics from billing as distant site providers for telehealth services under their permanent policy (though they may qualify for reimbursement for the facility fee associated with originating site services and for mental health visits delivered through interactive telecommunication systems). Thirty-eight 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). For example, Michigan Medicaid released

State Example:



NORTH CAROLINA Medicaid specifies that to be eligible to bill for telehealth, providers must meet Medicaid qualifications for participation, be enrolled in the program and bill only procedure codes, products and services that are within their scope of practice. They also specify that a distant site provider can participate in a telemedicine interaction from any appropriate location.

State Example:



INDIANA Medicaid has a section dedicated to FQHC and RHC billing in their Telehealth and Virtual Services manual that provides details on the codes FQHCs/RHCs should bill depending on if they are the originating or distant site and provides details about when they will receive the PPS rate and documentation requirements.

a bulletin recently announcing FQHCs and RHCs would be eligible to be reimbursed the PPS rate for telemedicine services. During the Fall 2022 edition of CCHP's Policy Finder was enhanced to encompass a distinct category dedicated to FQHC Medicaid fee-for-service telehealth policies. For in-depth insights and comprehensive information on trends and findings in state FQHC policies, readers can refer to CCHP's FQHC Telehealth Policy Factsheet.

➤ **GEOGRAPHIC & FACILITY ORIGINATING SITE RESTRICTIONS**

The practice of confining reimbursable telehealth services solely to rural or underserved areas, an approach taken in Medicare permanent policy, has almost completely disappeared 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 January 2023, 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.

Rather than imposing geographical limitations, it is more customary for state Medicaid programs to adopt an approach that restricts the types of facilities eligible to serve as originating sites for telehealth services. Currently sixteen states and DC have a specific list of sites that can serve as an originating site for a telehealth encounter. In many states, originating 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.

Thirty-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. Since Fall 2022, only Massachusetts explicitly added the home as an eligible site 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).

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:

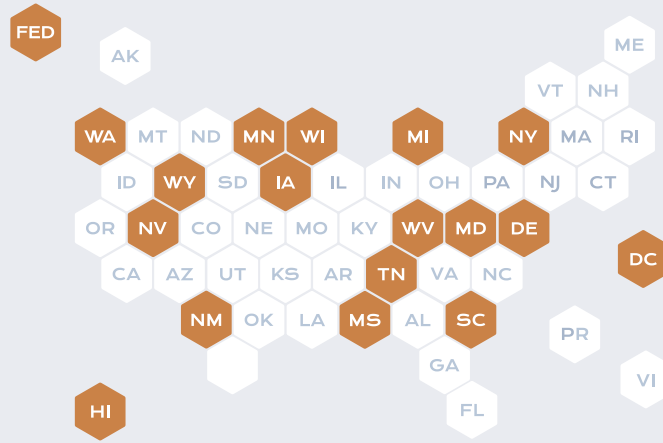


WASHINGTON is a state that includes in its originating site list both schools, and the beneficiary's home or "any location determined appropriate by the individual receiving the service."

Geographic & Facility Originating Site Restrictions Map

MAP KEY:

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



States are also increasingly allowing schools to serve as an originating site, with thirty-three 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.



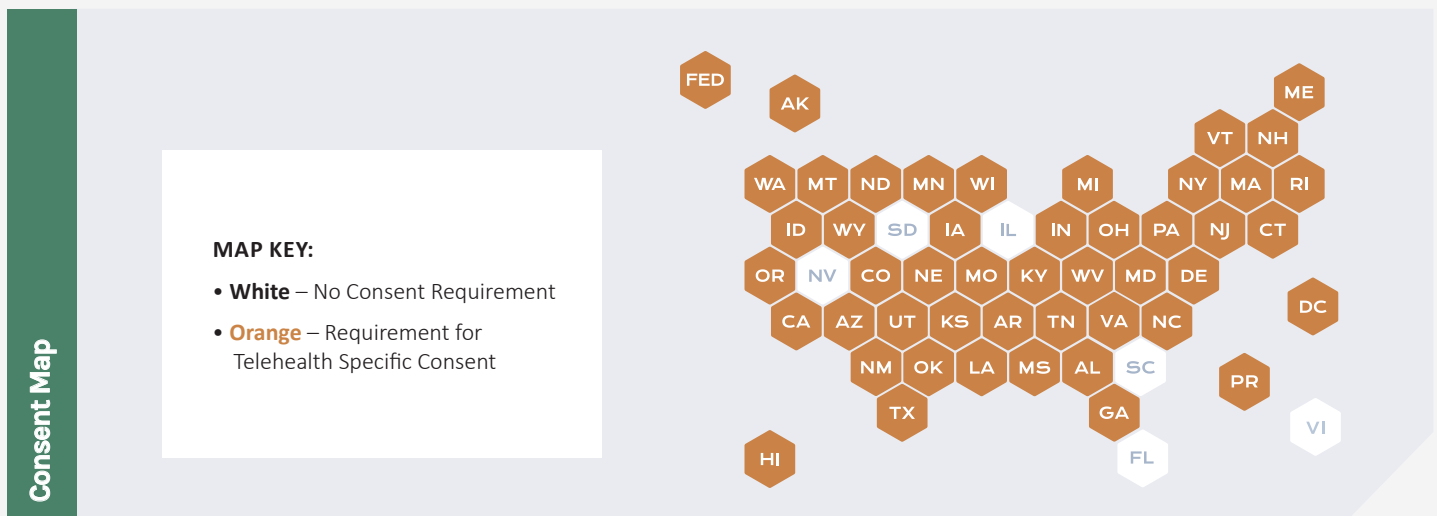
State Example:

In the Spring 2023 update, CCHP discovered **WYOMING** Medicaid released a School Based Services (SBS) Program Manual which contains a section devoted to the topic of telehealth. It specifies that all individual services covered under the SBS Program may be billed under participating Learning Education Agencies (LEAs) when performed via telehealth, except for services that preclude a telehealth modality, such as group services. It specifies that the place of service (POS) code for a school is 03, while telehealth is 02.

Consent

Forty-four states, DC, and Puerto Rico include some sort of consent requirement in their statutes, administrative code, and/or Medicaid policies. The setting in which the consent requirement applies may vary depending on the specific policy language and scope, ranging from Medicaid programs to specific specialties or all telehealth encounters within a state. For example, Oregon has telehealth informed consent requirements that apply to the professions of physical therapy, occupational therapy and optometry specifically. Meanwhile, Arizona consent requirements apply to all health care providers, with exemptions only if the telehealth interaction does not take place in the physical presence of the patient, in an emergency situation or it involves transmission of diagnostic images to a consulting provider.

Additionally, while some state policies have a vague requirement for consent, others include many details. For example, Idaho Medicaid provides a list of elements an appropriate informed consent should include, such as verification of the patient and provider’s identity, agreement that the provider will determine whether or not the condition being diagnosed is appropriate for telehealth, information on security measures and disclosure of potential information loss and technical failures. In California, all healthcare providers are required to obtain a general verbal consent for telehealth services. However, the state’s Medicaid consent policy provides a more comprehensive framework that outlines the essential elements of consent, including the patient’s entitlement to request an in-person service.



Licensure

Twenty-six states have professional boards that issue special licenses or certificates or have exceptions to licensing requirements related to telehealth that may include registering with an in-state board rather than obtaining full licensure. Only Washington has added a cross state licensing exception since Fall 2022. However, this may be due to 2023 state legislation not yet being enacted at the time states were reviewed. Most of these states are not allowing for broad cross-state practice. The majority of the states that have added licensure exceptions in the past two years are for specific types of healthcare professionals in specific situations where the patient has moved or is visiting a certain state and has a pre-existing relationship with a provider in their former state. This has become a common issue of concern for college students wanting to continue care with their established mental health professionals in their home state, or for those that may be traveling for a limited amount of time.

State Licensure Compacts CCHP Tracks:

** 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. Advanced Practice Registered Nurse Compact:**
3 state members (*Not yet active*)
- 2. Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC):**
25 state members.
- 3. Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA):**
22 state members.
- 4. Counseling Compact:** 20 state members.
- 5. Interstate Medical Licensure Compact:**
37 states, DC and the territory of Guam.
- 6. Nurses Licensure Compact:**
37 state members and the territory of Guam and Virgin Islands
- 7. Occupational Therapy Compact:**
25 state members.
- 8. Physical Therapy Compact:**
33 state members and DC.
- 9. Physician Assistant Compact:**
1 state member (*Not yet active*)
- 10. Psychology Interjurisdictional Compact:**
34 state members and DC.
- 11. Social Worker Compact:**
0 state members. Legislation pending in 9 states.
(*Not yet active*)

For example, Alabama's Board of Medical Examiner allows physicians licensed in other states to provide services in Alabama without a license on an irregular or infrequent basis, defined as less than ten days/ calendar year or ten patients/calendar year. In many cases, this may be enough to cover patients traveling in the state temporarily or attending school. Washington is the one new state CCHP found with a cross-licensing exception in this Spring 2023 update. The Washington Medical Commission created exemptions from licensing requirements through a telemedicine policy statement to accommodate patients seeking second opinions from out-of-state specialty providers such as cancer centers, or accessing providers in their home state while temporarily traveling within Washington for the purpose of continuity of care. In recent years, more states have also begun creating their own telehealth registration processes that allow out-of-state providers to operate in the state through telehealth by completing a registration with the Board, agreeing to certain terms and conditions, and paying a fee to the Board.

Note that the number of states with telehealth-related licensing exceptions or registrations does not include states that made allowances for out-of-state providers consulting or under the supervision of in-state providers when the responsibility for care remains with the in-state provider. For example, New York did add an out-of-state allowance, but only for Speech Language Pathologists and Audiologists and restricted visits to no more than thirty days in any calendar year and must be provided in conjunction with and/or under the supervision of a speech language pathologist or audiologist licensed in New York.

Another licensing policy commonly seen is the adoption of interstate compacts, which permit certain providers to practice in states where they do not hold a license (or they hold a special 'compact' license), as long as they maintain a valid license in good standing

in their home state. CCHP is currently tracking eleven 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.

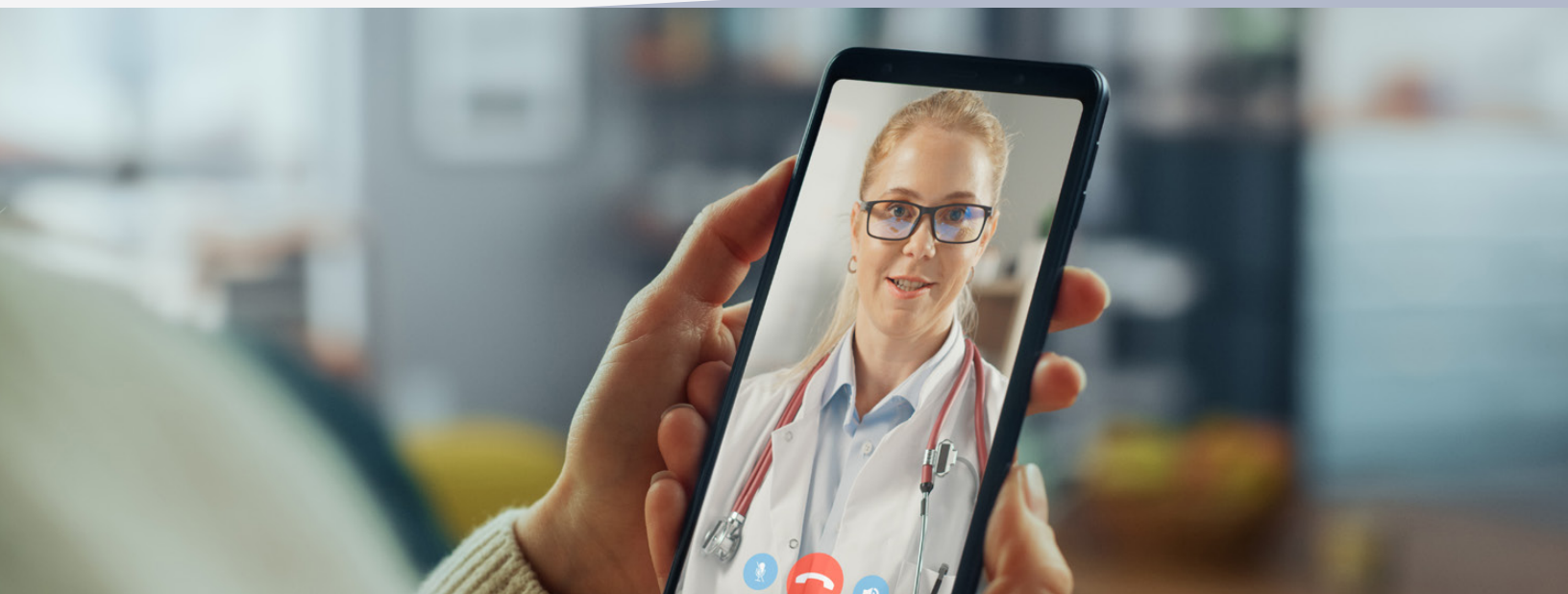
Some states have laws that do not explicitly cover telehealth or telemedicine licensing, but instead allow for practicing in neighboring states or grant temporary licenses under certain conditions that align with the licensing requirements of the specific state in question. Amid the COVID-19 pandemic, several states implemented temporary waivers of their licensing requirements, with most of them having expired by now, though a few may still be in effect. Those waivers are not tracked in this report, however the Federation of State Medical Boards is tracking those policies via their chart on [State COVID-19 Physician Licensing](#) and CCHP tracks it in the [COVID-19 Policies section](#) of our policy finder.

State Example:



FLORIDA has implemented an out-of-state Telehealth Provider Registration. To qualify for the registry, providers must:

- Submit an application
- Maintain an active license in a US state or territory
- Not be subject to any disciplinary action from another state board
- Designate a duly appointed registered agent for service of process in Florida
- Maintain liability coverage provided to patients in Florida
- Not open a Florida office or provide in-person services
- Only use a Florida-licensed pharmacy to dispense drugs.



Online Prescribing

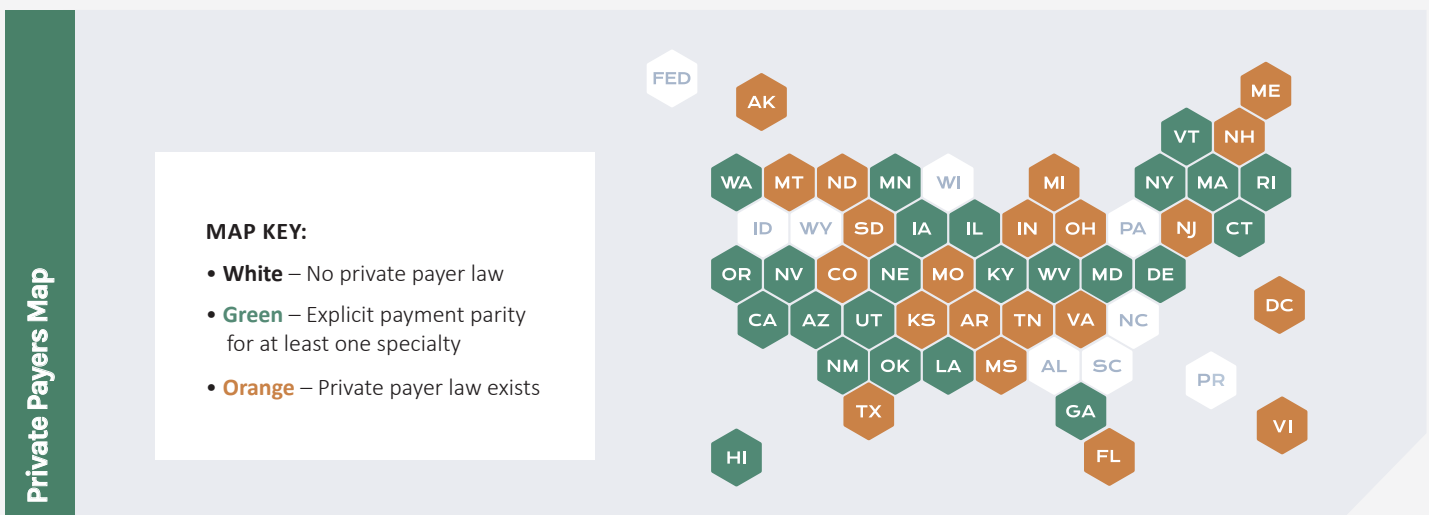
Across different states, the nuances and disparities in regulations around the utilization of technology for prescribing purposes are evident. Although an in-person examination may not be mandatory in many states, telehealth encounters are often expected to meet the same level of care as an in-person visit. Notably, in recent years, there has been an emergence of clarifications from states that were previously silent on the matter, affirming the potential of telehealth interactions to establish a provider/patient relationship while also establishing specific parameters and requirements for this mode of healthcare delivery. Tennessee, for example, allows a physician patient relationship to be established via telemedicine without the use of a facilitator as long as the patient utilizes adequate technology to enable verification of identity and location, the patient transmits all relevant health information via store-and-forward or secure video conferencing and the remote provider discloses his or her name, location, medical degree and specialty to the patient.

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). A state that addresses this is New Hampshire. Recent statutory changes make it unlawful for any person to prescribe by means of telemedicine a controlled drug classified in Schedule II through IV except substance use disorder treatment (SUD). For SUD controlled substances, only specific types of providers can prescribe those medications via telehealth in specific circumstances.

Last year, CCHP noted three states (Maine, Missouri and Oklahoma) 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. CCHP is aware of no new states having added such a requirement since Fall 2022.

Private Payers

Currently, forty-three states, DC and the Virgin Islands have laws that govern private payer telehealth reimbursement policies. No new states added private payer laws since Fall 2022. In fact, CCHP did not even find any new modifications to existing private payer laws in this Spring 2023 update. As mentioned previously, this may simply be because the majority of states were reviewed before the end of state’s 2023 legislative sessions.



Trends in private payer laws flagged in previous editions included adding requirements for payment parity. Although in some cases, they come with expiration dates. For example, New York has payment parity language in their law that will expire on April 1, 2024 leaving it uncertain whether or not payment parity will continue past that time. Similarly, Connecticut's payment parity language expires June 30, 2024. Over the years, some state private payer laws have had to specify insurers cannot limit reimbursement to certain telehealth vendor companies.

State Example:



OKLAHOMA specifies that insurers shall not restrict coverage of telemedicine to services provided by a particular vendor or other third party or platform. They also require that insurers not place restrictions on prescribing medications through telemedicine that are more restrictive than what is required in-person.

