NATIONAL GOVERNORS ASSOCIATION

M E M O R A N D U M

March 20, 2020

To: Governors
From: Bill McBride, Executive Director
Re: Gubernatorial Strategies for Telehealth

As COVID-19 continues to rapidly spread throughout the nation, states are taking sweeping actions to restrict individuals from congregating and encouraging self-quarantine to flatten the curve of the virus. One of the key strategies in this effort is telemedicine – allowing individuals to receive virtual care – which can reduce the spread of the virus and expand health care capacity by keeping potentially ill individuals in their homes, reducing exposure of health care workers and reducing the number of people needing care in facilities.

Many states will need to take swift action to ensure that the providers in their states are ready and able to provide telemedicine in a manner that best addresses COVID-19. States may use a variety of vehicles to achieve this goal depending on existing authorities and flexibilities, including gubernatorial authority, regulation, and legislation (where necessary) in order to limit unnecessary interactions and reduce the number of new infections.

To date, the federal government and many states have already taken steps to increase access to telehealth services by increasing the types of reimbursable covered services, reducing consumer costs, reducing participation requirements and barriers for providers, and increasing the modalities through which services may be offered via telehealth. However, there are many variations across states ranging from how Medicaid and private health insurance reimburses telehealth services, to what type of provider and what setting may be authorized for these services.

Governors seeking to improve coverage and access to telehealth services may consider:

Ensuring that individuals have coverage of telehealth services with limited or no cost sharing for those services. There is significant variability across states regarding what telehealth services are reimbursable under Medicaid and private health insurance as well as cost-sharing for consumers. As part of the COVID-19 response, some states have decided to eliminate cost sharing for all medically necessary telehealth services, in an effort to incentivize telehealth options and make them more accessible during a potential economic downturn. Other states have expanded Medicaid coverage of telehealth services to testing and treatment services related to COVID-19 to ensure all relevant services will be covered.

Examples of executive actions taken during the COVID-19 response include:

- Colorado's Department of Insurance issued a policy directive for commercial insurance calling for outreach and education to enrollees about telehealth service availability and coverage of COVID-19 related services provided in network without cost sharing, including co-pays, deductibles, and coinsurance that might otherwise apply.

- Iowa Governor Reynolds issued a proclamation of disaster emergency temporarily suspended preconditions, limitations, or restrictions on telemedicine to enhance telehealth delivery including lifting restrictions on residential and outpatient substance use disorder treatment and for face-to-face visitations.

- Massachusetts Governor Baker issued an executive order expanding access to telehealth services is covering clinically appropriate medically necessary covered services via telehealth for the Medicaid population at the same rate as in person services as set forth in this bulletin, which was issued by the Assistant Secretary for MassHealth, Massachusetts' Medicaid program. The state also is requiring the state's group insurance commission and all carriers regulated by the Division of Insurance to cover clinically appropriate medically necessary covered services via telehealth per executive order.

- New York's Department of Health State Medicaid Program issued a Special Addition Newsletter pursuant to the current state of emergency exempting all telehealth services from Medicaid copayments regardless of whether services are related to COVID-19.

Waiving state specific professional licensure requirements or granting temporary licenses to enable cross-state in-person or telehealth services in states that have declared a state of emergency and activating the Emergency Management Assistance Compact (EMAC). Currently, in most states, health care providers must maintain licenses in each state in which they render services to patients. Some states participate in interstate compacts for certain professionals, which has varying benefits. For physicians, interstate compacts ease the application process for licensure but does not eliminate the need for a license in each state where the provider renders services (the nurse compact however does provide reciprocity in all participating states). However, there are opportunities for states to allow temporary waivers or licenses so that providers can practice across state lines via telehealth or in person. That said, states each have different requirements they must consider around scope of practice and facilities have varying credentialing requirements.

Another option is for states to activate EMAC, which is a multi-disciplinary mutual aid compact whereby, upon gubernatorial activation, states may receive assistance from other states. According to the EMAC website, "The EMAC legislation solves the problems of liability and responsibilities of cost and allows for credentials, licenses, and certifications to be honored across state lines." Upon activating EMAC, states may consider including language that waives their own state specific limitations regarding telehealth practitioners and instead recognize the authorities of the state in which the practitioner is licensed.

A number of states have taken significant steps to address licensure and reciprocity for COVID-19. For example:

- California Governor Newsom activated EMAC via Executive Order which specifies that "Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparation for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code section 179.5, with respect to licensing and certification…" where 179.5 refers to EMAC.

- Florida's Surgeon General Rivkees issued an Emergency Order that allows certain out-of-state health care providers to render telehealth services to individuals in Florida "to respond to or mitigate the effects of COVID-19." The Order also allows certain physicians to use telehealth services instead of in-person examinations to prescribe controlled substances and medical marijuana. Although Florida passed a law in 2019 that allowed out-of-state health care providers to provide telehealth services based on certain eligibility requirements, the Emergency Order allows providers to act more quickly with fewer administrative and regulatory requirements.

- Mississippi's state board of medical licensure issued a proclamation pursuant to Governor Reeves' declaration of a state of emergency, allowing all out of state physicians to use telemedicine without securing a Mississippi license so long as the individual holds an unrestricted license to practice in their home state and is not the subject of an investigation or disciplinary proceeding.

- Texas' Medical Board is allowing physicians from other states to obtain a limited emergency license or hospital-to-hospital credentialing on a limited basis pursuant to Texas Administrative code governing physician as well as other health care providers practice and limited license for disasters and. Texas is also fast-tracking temporary licenses for out-of-state nurses and allowing nurses to practice telehealth in accordance with the state's Nurse Practice Act and Board Rules.

We note that on March 18, Vice President Mike Pence announced that the Department of Health and Human Services is issuing a regulation to permit doctors to practice across state lines. Once this regulation is released, we will provide an analysis of its impact on telehealth and broader practice across state borders.

Coordinating with health systems and hospitals to ensure capacity and capabilities to deliver telehealth services. While coverage and reimbursement policies are critical to the delivery of telehealth, as part of broader coordination, states should ensure that major health systems and hospitals have the infrastructure, capacity, and clarity around policies needed to provide telehealth services. This will help states identify gaps where states need to identify alternative solutions to address the care of their residents.

Streamlining and simplifying provider participation in telehealth. In responding to COVID-19, states need to take steps to ensure that a broader group of providers will be able to provide telehealth services including those who have not offered telehealth previously. Some providers who may have previously not been interested in telehealth may now be limited in their capacity to serve clients in person due to state restrictions, self-imposed social distancing, or because of their personal vulnerable health status. In addition, some states have historically limited the types of providers considered eligible for reimbursement via telehealth, such as requiring that patients have a face-to-face encounter with a provider before moving to a telehealth arrangement. As part of the COVID-19 response, some states have already taken action to eliminate barriers for entry for providers and to allow virtual establishment of provider-patient relationships. For example:

- New York's Office of Mental Health issued guidance that began allowing for self-attestation to allow delivery of tele-mental health services during the COVID-19 disaster declaration and to expand modality, professionals who can deliver services, and types of services.

- The Texas medical board is implementing procedures, under the direction and assistance from the governor's office, following Governor Abbott's state disaster declaration allowing for establishment of physician-patient relationship via telephone as well as for diagnosis, treatment, ordering of tests and prescribing for all conditions.

Expanding how and where telemedicine can be delivered and still qualify for reimbursement. As part of a COVID-19 response, in order to expand the number of providers who can engage in telehealth services and ensure that individuals can remain at home and receive services, states will need to take certain steps to address regulatory barriers. Specifically, a number of states now reimburse for services delivered by telephone, as well as other modalities such as live video technology and the electronic sharing of images, pathology results or other medical history. In addition, historically many states, as well as some federal programs, required that the patient must be within a provider's office, hospital, or other health care facility- known as the originating site- to receive telehealth services. In the context of COVID-19, however, the goal is to reduce the level of interaction between people and avoid unnecessary use of health care services. As a result, some federal programs state Medicaid, and state's regulating private insurance programs are allowing use of the home as an originating site for patients.

- The District of Columbia's Office of the Senior Deputy Director/Medicaid Director Byrd issued a transmittal making telehealth services provided within the home as the originating site reimbursable under Medicaid.

- Massachusetts Governor Baker issued an executive order requiring that the state's group insurance commission and carriers may not impose limitations or specific requirements regarding the type of technology uses for telehealth, thereby allowing audio-only services. The order specifies that the GIC and carriers must establish reasonable requirements for telehealth that may not be more restrictive than requirements for the state's Medicaid program as outlined in a bulletin issued by the Assistant Secretary for MassHealth Tsai.

- New York's Department of Health State Medicaid Program issued a Special Addition Newsletter pursuant to the current state of emergency specifying that New York Medicaid is covering telephonic evaluation and management services as part of broader telehealth policy to reduce congregation of individuals where COVID-19 might spread for all appropriate services where an established provider-patient relationships exists.

- More than 35 states reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) as distant site providers for purposes of telehealth services. Remaining states may benefit from lifting restrictions requiring FQHCs and RHCs to serve as both originating and distant sites so that patients can receive telehealth services in the home and at health centers.

- In 2019, the California legislature passed a law allowing Medicaid reimbursement for telephonic services that are normally provided via other modalities with flexibility in the originating site under the condition of federal authority and matching funds when services are rendered by community health centers. This legislation pre-dates COVID-19,

but the flexibilities persist. States may consider establishing authority that automatically lifts some restrictions to expand remote access upon declaration of an emergency.

Facilitating continued access for individuals receiving medication-assisted treatment (MAT) by ensuring that addiction treatment providers are aware of the Drug Enforcement Agency (DEA) guidance described below, which allows DEA-registered practitioners to issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation. Under Substance Abuse and Mental Health Administration (SAMHSA) guidelines, counseling is required component of MAT administration for Opioid Treatment Programs (OTPs). In addition, State Opioid Treatment Authorities (SOTAs), state boards of medicine or pharmacy, or Medicaid programs may require counseling services for patients receiving buprenorphine through Office-Based Opioid Treatment (OBOTs). As the SAMHSA, Centers for Medicare & Medicaid Services, and DEA continue to issue updated guidance to promote access to MAT services during the COVID-19 crisis, states can take steps to ensure that none of their state or state Medicaid counseling and ancillary service requirements for patients receiving MAT at OTPs or OBOTs is more stringent than applicable federal requirements. State Medicaid programs may also work with providers to clarify that delivering these counseling and ancillary services telephonically is an allowable and reimbursable service.

Congressional and Administrative Actions Related to Telehealth
As part of its COVID-19 response, the federal government has published guidance on telehealth that may inform state actions on certain issues. Below is a summary of and links to recent guidance.

The Families First Coronavirus Response Act (H.R. 6201) – The Act requires group health plans (including self-insured ERISA plans) and health insurance issuers in the individual and group markets to cover COVID-19 testing and related services without cost sharing and without prior authorization or other medical management requirements during a telehealth visit. The Act also permits coverage of telehealth services for a beneficiary who had been seen by a provider (or a member of the provider's practice) within the past three years and had received a service that could have been paid for by Medicare if the person had been enrolled in Medicare.

Centers for Medicare & Medicaid Service (CMS) – Medicaid Guidance: On March 17, CMS published guidance and FAQs that address state options and flexibilities related to paying Medicaid providers for delivery of telehealth services through state plan fee-for-service payments, including examples. In accordance with previous guidance, it specifies that states do not have to submit a state plan amendment (SPA) to CMS for Medicaid coverage or reimbursement unless they are seeking to reimburse for telemedicine services differently from face-to-face visits.

Centers for Medicare & Medicaid Service (CMS) – Medicare Guidance: On March 17, CMS published guidance that expands coverage of telehealth services for Medicare beneficiaries, expanding options for originating sites to health care facilities and homes, increasing types of providers who can offer services, and waiving cost-sharing for telehealth visits, among other things. The guidance has a retroactive effective date of March 6.

HHS Office of the Inspector General (OIG): On March 17, the OIG issued a complementary policy statement to the Medicaid and Medicare guidance indicating that health care practitioners "will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services furnished consistent with the then applicable coverage and payment rules" during the time period covered by the Secretary's declaration of a public health emergency.

HHS Office of Civil Rights (OCR): OCR Guidance published on March 17, 2020 clarifies that OCR will waive enforcement penalties for health care providers providing telehealth in good faith during the COVID-19 nationwide public health emergency.

U.S. Drug Enforcement Agency (DEA): In response to the Secretary of HHS declaring a public health emergency, DEA issued guidance on March 17, 2020, that clarifies that DEA-registered providers are allowed to prescribe controlled substances for patients for whom they have not had an in-person consultation as long as the provider is prescribing in alignment with their normal professional practice, the telemedicine visit occurs over a live (real time), audio visual two-way interactive communication system, and the provider is adhering to state and federal laws throughout the remainder of the public health emergency declaration.

Substance Abuse and Mental Health Administration (SAMHSA): On March 19, 2020, SAMHSA released guidance regarding 42 CFR Part 2, which governs the protection and disclosure of substance use disorder information by providers participating in federally assisted substance use disorder programs (Part 2 providers). The guidance clarifies that because Part 2 providers may not be able to obtain written consent for disclosure of information because they are providing services via telehealth technology that such disclosure to medical personnel is not prohibited if a bona fide medical emergency exists. Under this exception, providers must use their own judgment regarding the whether a bona fide medical emergency exists.

Other Resources

There are a number of other resources that may be helpful to states in considering how to leverage telehealth as part of their COVID-19 response. Below are some examples of these resources:

The Center for Connected Health Policy is continuously updating a summary of telehealth coverage policies at the federal and state level which they are updating on an ongoing basis accessible via their website under "What's New."

The American Telemedicine Association has a new resources webpage including news/press releases, tools/resources, webinars, and policy updates.

MIT professors and chairs of the COVID-19 Policy Alliance, a team of experts from medicine, hospitals, telehealth, logistics, and cloud computing worked together to develop a state coordinated telehealth platform concept described in a paper to implement testing and treatment via telehealth without spreading the virus.

The Northeast Telehealth Resource Center has compiled the Telehealth Webliography for COVID-19 Pandemic, which has an extensive list of resources regarding telehealth.

The Alliance for Connected Care is tracking all federal health related actions and has prepared a summary of all state actions related to telehealth and related licensing issues.

For questions or concerns related to the contents of this memo, please contact NGA staff:

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