



Center for Connected
Health Policy

THE NATIONAL
TELEHEALTH POLICY
RESOURCE CENTER

State Telehealth Laws and Medicaid Program Policies

FALL 2022

SUMMARY REPORT:

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

The Center for Connected Health Policy's (CCHP) Fall 2022 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. CCHP provides 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. 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 July and early September 2022.

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Amy Durbin, Policy Advisor or Christine Calouro, Senior Policy Associate at info@cchpca.org. A special thank you to CCHP Policy Associate Veronica Collins for her invaluable contributions to this report. For further information, visit cchpca.org.

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

Mei Wa Kwong, JD

Executive Director

October 2022

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Introduction



The Center for Connected Health Policy's (CCHP) Fall 2022 analysis and summary of telehealth policies are based on information contained in its online [Policy Finder](#). This Summary Report provides highlights on certain aspects of telehealth policy and the changes that have taken place between now and the previous edition, Spring 2022. The research for this edition of the summary was conducted between July and early September 2022. 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 many states continue to keep their temporary telehealth COVID-19 emergency policies siloed from their permanent telehealth policies. These temporary policies are not included in this 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 July and early September 2022. 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. Those changes will be reviewed and catalogued in the upcoming Spring 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). For this edition, CCHP received additional funding from the National Association of Community Health Centers (NACHC) to create an FQHC specific section on Medicaid fee-for-service policies. 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.

State Telehealth Laws and Reimbursement Policies

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

In our first report ever published on state telehealth laws and Medicaid policies back in 2013, CCHP stated that no two states are alike in how telehealth is defined or regulated. We have made that statement in every report published since, and it continues to be true now more than ever. As states have adopted more robust telehealth policies, pushed by the rapid rise in utilization of telehealth due to COVID-19, each state has continued to be unique in how telehealth is treated by Medicaid programs, private payer laws, and professional requirements.

State Medicaid policies, specifically, are one of the areas where we see the most nuances in policies between states. While CCHP may generalize and list the states in the proceeding sections of this report that reimburse for live video, store-and-forward, remote patient monitoring and audio-only modalities, there are stark differences in the requirements associated with each modality in each state. Some states may allow any appropriately delivered Medicaid covered service to be delivered via telehealth, while other states may limit it to certain services, or have a list of explicitly excluded services from telehealth delivery. Due to the impact of COVID-19, over the past few years, many states have expanded their permanent telehealth Medicaid reimbursement policies, but with measured and incremental approaches. For example, in this Fall 2022 update, CCHP noted that Washington Medicaid now provides reimbursement for speech language pathology under Applied Behavioral Analysis, Maryland passed a law requiring Medicaid cover doula services delivered via telehealth, and Missouri Medicaid now covers teledentistry for specific codes. All of these states previously provided reimbursement for live video telehealth, however not explicitly for these services. These seemingly minor modifications to state telehealth Medicaid policies may be small, but make a big impact for certain patients/healthcare professions. Over time, as states continue to adjust their policies and add additional eligible services, providers and sites of service, they have a major impact as a whole.



One of the most common changes CCHP saw in Medicaid programs across states in the research for this edition was additions of the new Place of Service (POS) coding and telehealth modifiers recently adopted in the Medicare program. Under the new coding, POS 02 indicates telehealth services provided at sites other than the patient's home, and POS 10 indicates telehealth provided in the patient's home. The modifier FQ was also adopted in Medicare to denote telehealth services furnished using real-time audio-only communication technology. Louisiana and Rhode Island, for example, are now both utilizing POS 10, and Alaska started allowing modifier FQ in March. In some cases, the Medicaid program's adoption of POS 10 and FQ modifier were the first pieces of evidence CCHP has found that a Medicaid program is reimbursing services to the home or via the audio-only modality.

Modifications to existing private payer laws is less common for states, as this requires legislation, rather than the administrative changes often used in Medicaid programs. However, a few significant changes that occurred included New York requiring payment parity for commercial and Medicaid services via telehealth, although this will expire in April 2024. Connecticut also extended their private payer telehealth reimbursement law until June 2024 (previously it was set to expire in June 2023). Finally, Louisiana enacted a payment parity mandate for telehealth services for physical therapy services only.

As noted in previous editions by CCHP, an increasing number of state professional boards continue to adopt telehealth practice standards that include requirements related to providing the same standard of care when utilizing telehealth, consent requirements, prescribing rules, and documentation and privacy specifications. This includes professions not previously thought of as requiring telehealth standards but as telehealth modalities become more ubiquitous more professions are seeing the need to provide regulations, such as the New Jersey Board of Polysomnography.

Finally, more states than ever before have adopted cross state licensure exceptions, registrations or licenses specific to telehealth since CCHP's Spring 2022 report edition, with ten states adding such policies. Most of these policies are not broad allowances to practice within the state if providers hold licenses in other states, but rather targeted

exceptions for specific cases. For example, Illinois now has a licensing exception for social work delivered via telehealth for nonresidents of the state for not more than 5 days in any one month or 15 days in a calendar year, that have a previous established relationship with the person. For states that have enacted broader registrations in recent years for out-of-state providers, such as Florida, most entail an application process similar to full licensure and require a fee payment. Licensing Compacts also continue to be on the rise with seven out of nine compacts that CCHP tracks increasing membership since Spring 2022 and the Counseling Compact seeing the fastest growth, expanding to seventeen members (previously ten).

Note that in this round of updates, CCHP added the jurisdictions of Virgin Islands and Puerto Rico to its tracking, conducting the full search on laws, regulations, and Medicaid policies for those new jurisdictions. Both jurisdictions lack permanent Medicaid reimbursement policy for telehealth, concentrating laws instead on professional licensure, prescribing, and in Virgin Island's case a private payer law. Additionally, as mentioned previously, CCHP also added an entire new category for each state for Medicaid telehealth fee-for-service policy specifically as it applies to federally qualified health centers (FQHCs). This portion of the report is funded by the National Association of Community Health Centers (NACHC), and seeks to help FQHC staff understand how broader telehealth policies impact their work. Among the topics include whether or not a FQHC can serve as distant or originating sites, whether telehealth meets their state's definition of a visit and whether or not they can be reimbursed its usual rate. Further details on CCHP's findings from this new category can be found in CCHP's FQHC Fall 2022 Factsheet.

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, as mentioned above.
- **Twenty-five state Medicaid programs** reimburse for store-and-forward. However, two states (NC and OH) solely reimburse store-and-forward as a part of Communications Technology Based Services (CTBS), which is limited to specific codes and reimbursement amounts.
- **Thirty-four state Medicaid programs** provide reimbursement for remote patient monitoring (RPM). Hawaii, Kentucky, Massachusetts, and West Virginia are the states to add RPM since Spring 2022.
- **Thirty-four states and DC Medicaid programs** reimburse for audio-only telephone in some capacity; however, often with limitations. Audio-only was the modality that again (similar to the Spring 2022 edition) had the largest increase in states reimbursing for it, increasing by five since Spring 2022.
- **Seventeen state Medicaid programs** including Alaska, Arizona, California, Kentucky, Maine, Massachusetts, Maryland, Michigan, Minnesota, Missouri, North Carolina, New York, Ohio, Oregon, Texas, Virginia, Washington, 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.

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](#). What follows are summarized key findings in each category as of early September 2022.

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. In this update, Alaska and Arkansas were noted as adding definitions for telehealth (they previously had only definitions for telemedicine). Indiana was noted for eliminating their definition of telemedicine, and Pennsylvania for dropping its definition of telehealth.

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

The most common restriction some states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. However, due to the allowance for telephone in many COVID-19 temporary policies, some states are beginning to amend their definitions to either remove the explicit exclusion of telephone or explicitly include audio-only services in their telehealth/telemedicine definitions.

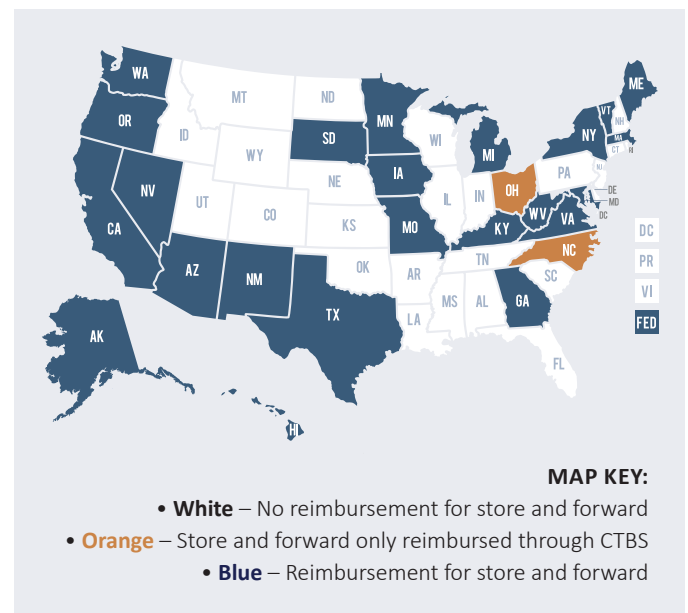
In some instances, CCHP found that a state Medicaid program provided a definition of telehealth or telemedicine that is inclusive of modalities such as store-and-forward, remote patient monitoring and/or audio-only but did not provide further explicit guidance on whether or not those modalities are reimbursed.

The restrictions and requirements around live video reimbursement, however vary 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.

Due to the significant amount of live video policy that has always existed, there has not been as many new developments around live video, though states are continuing to make small incremental modifications to their Medicaid programs, in many cases providing additional clarification on which modalities and providers are covered. Most new modality policy developments have been focused on the other ways services can be delivered via technology.

Store-and-Forward



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

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”. The extent of reimbursement for telehealth delivered services is less clear in some states than others.

Live Video

The most widely reimbursed form of telehealth modality is live video, with every state and D.C. offering some reimbursement in their Medicaid program. CCHP did not find official documentation indicating permanent Medicaid reimbursement for live video in Puerto Rico and the Virgin Islands.

State Example:

OHIO Medicaid provides a specific list of CPT codes that will be reimbursed if provided via telehealth. In contrast, **CALIFORNIA** Medicaid reimburses for all covered benefits or services as long as appropriate and meeting procedure code definition and confidentiality and patient rights requirements.

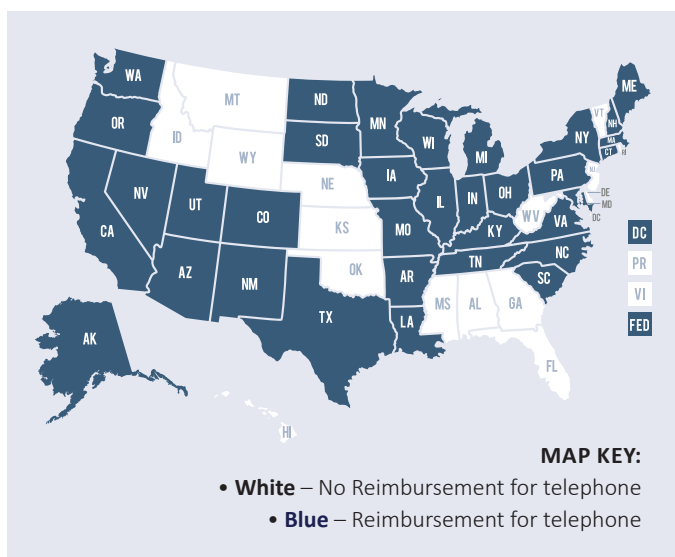
KENTUCKY, one of the most recent states to add reimbursement for RPM, for example only reimburses for patients with certain types of conditions, and the monitoring must be provided by a specific type of provider, though the list is long and includes physicians, physician assistants, psychiatrists, hospitals, FQHCs, and RHCs among others. They also require the device to meet the requirements of HIPAA.

Communication Technology Based Services (CTBS)

States continue to utilize the CTBS codes established by CMS, although CCHP has only noticed an increase of the codes for remote patient monitoring specific codes in this edition. CTBS includes the virtual check-in (G2020) and remote evaluation of pre-recorded information (G2012), audio-only service codes, and remote physiological monitoring (RPM) codes. Examples of states that reimburse these codes include California, Hawaii, Massachusetts, North Carolina, and West Virginia. In cases where those codes were added and the state has no other form of reimbursement for the modalities (i.e. store-and-forward, telephone and RPM), it should be noted that coverage is extremely limited. Those codes were originally reimbursed in Medicare as an alternative to traditional telehealth, as CMS considers telehealth to replace a service typically delivered in-person.

States have taken various approaches to adopting these codes. We have found that often Medicaid programs allow CTBS codes to fall under the umbrella of telehealth but utilize Medicare’s same coding system to identify and reimburse for them. From previous research, some states also take the approach of adding the codes into their fee schedules and keeping them completely separate from their telehealth policies. For purposes of CCHP’s database and this summary report, only CTBS codes that have been incorporated into states telehealth policies are included, as state Medicaid fee schedules were not examined as a source for this summary. In CCHP’s Summary Chart, states that solely reimburse a modality through the CTBS codes have been identified by adding an asterisk (*).

Email & Audio-Only

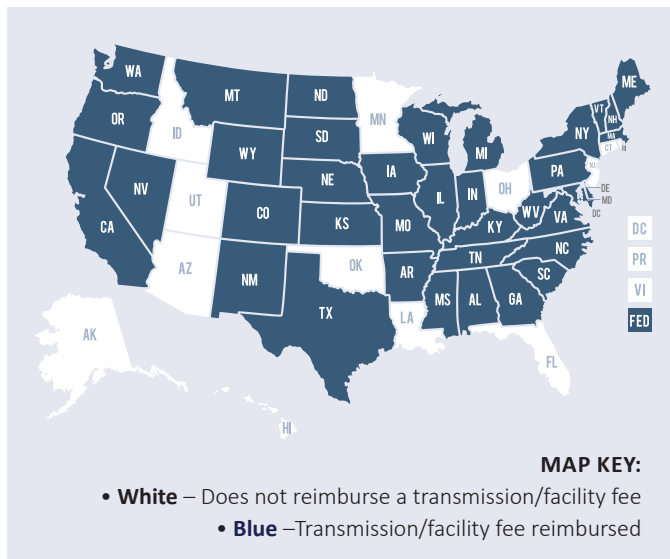


Due to pressures exerted by COVID-19 and the need for patients to access providers even without strong internet connections, telephone or audio-only service delivery has quickly gone from the least likely modality to be reimbursed to the second most commonly reimbursed modality (just behind live video) over the last several years. That trend has continued with this Fall 2022 Update, with thirty-four state Medicaid programs and D.C. now allowing for telephone reimbursement in some way, representing the telehealth modality with the most significant increase since Spring 2022 with five states being added and more than doubling since Spring 2021. Sometimes states will only reimburse specific specialties such as mental health, or for specific services such as case management.

State Example:

MISSOURI, a new state to add audio-only reimbursement in Medicaid on a permanent basis has done so for mental health services using the FQ modifier to signify services rendered using the audio-only modality.

Transmission/Facility Fee



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

Eligible Providers

While some state Medicaid programs are silent, other states limit the types of providers that can provide services at the distant site through telehealth. These eligible provider lists have broadened over the past few years, and most states now allow a wide variety of provider types to deliver telehealth services. For example, Ohio has a list of over 40 provider types including occupational and physical therapists,

pharmacists, and Medicaid school programs just to name a few. The states that don't have a provider list at all, simply state that any Medicaid enrolled provider can be reimbursed for delivering services via telehealth.

Federally Qualified Health Centers & Rural Health Clinics

Because FQHCs and RHCs bill as entities rather than as providers, telehealth eligible provider lists may exclude them or do not have an explicit mention of these entities. Medicare has also excluded these clinics from billing for telehealth delivered services as distant site providers (although they do qualify for the originating site facility fee, and reimbursement for a mental health visit delivered through interactive telecommunication systems). Thirty-eight states 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). The District of Columbia, for example, has addressed it for FQHCs specifically and even specified that it will be in accordance with the district's prospective payment system, alternate payment methodology, or fee for service rate. Virginia specifies that FQHCs and RHCs will be paid under their 'encounter rate'. Nebraska, on the other hand, also clarifies that FQHCs and RHCs are paid at the rate for a comparable in-person service, however telehealth is not covered under the encounter rate. Starting with this edition, you will see on CCHP's Policy Finder that FQHC Medicaid fee-for-service telehealth policies have been separated out into its own section. More details regarding trends and findings in state FQHC policies can be found in CCHP's FQHC Telehealth Policy Factsheet.

State Example:

MISSISSIPPI MEDICAID has a list of twelve eligible providers who may provide telehealth services at the distant site. These providers include physicians, physician assistants, social workers, counselors, FQHCs, RHCs, and physical, occupational and speech therapists, among others.

New Mexico is one state that includes in its eligible site list school-based health centers and the patient's home (in various situations including when an interactive audio and video telecommunication system is used).

Geographic & Facility Originating Site Restrictions

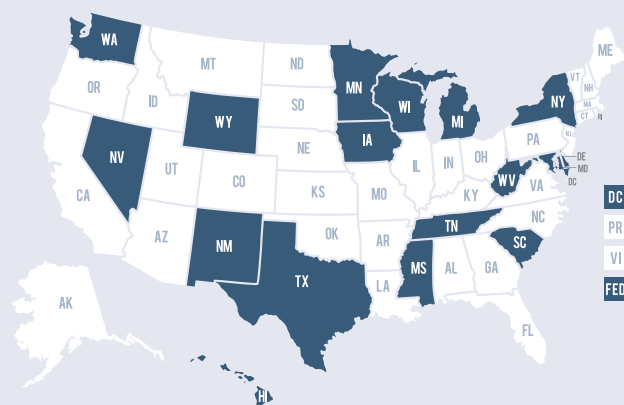
The practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is becoming increasingly rare. Only three states (Hawaii, Montana and Maryland) currently have these types of restrictions. For Hawaii and Maryland, these geographic restrictions 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, recently passed legislation in Maryland requires that Medicaid not distinguish between rural and urban locations, however as of CCHP's last review of the state in August 2022, language requiring beneficiaries reside in rural geographic areas for telehealth mental health services was still in their administrative code. Although Hawaii passed a law prohibiting a geographic limitation for telehealth in their Medicaid program, such language is still present in their Medicaid regulations as well.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site. Currently seventeen states and DC have a specific list of sites that can serve as an originating site for a telehealth encounter. Even though a state may have an originating site list, they can still be quite expansive as many states now include non-traditional sites on their

State Example:

MONTANA MEDICAID stipulates the originating site and distant providers may not be within the same facility or community.

Geographic & Facility Originating Site Restrictions



MAP KEY:

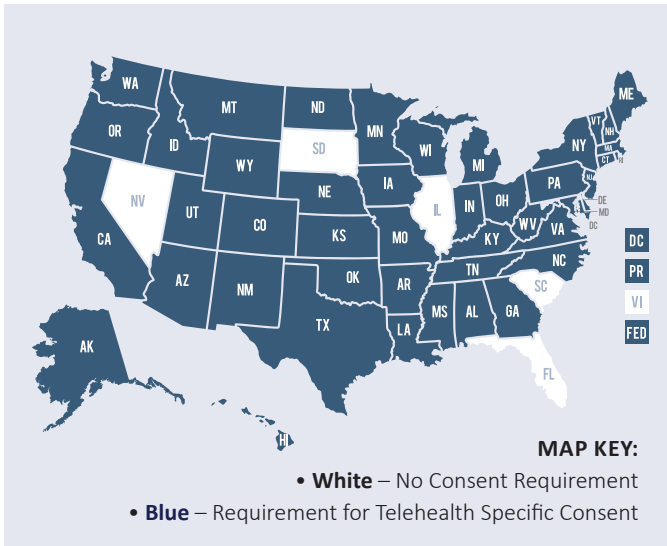
- **White** – No specific originating site list or restriction
- **Blue** – Has a billable originating site list or restriction

lists, such as the patient's home and school. New Mexico is one state that includes in its eligible site list school-based health centers and the patient's home (in various situations including when an interactive audio and video telecommunication system is used).

Thirty-six 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 has jumped by four states in recent months, often due to clarification that the Medicaid program provides reimbursement for POS 10 which indicates services are delivered via telehealth to the home. 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.

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

Consent



Forty-five states, DC, and Puerto Rico include some sort of consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. For example, New Hampshire's consent policy specifically applies to the delivery of medication assisted treatment via telehealth, while in contrast California's requirement for verbal consent applies to all telehealth interactions in the state. California recently passed a law that would create additional consent requirements for Medicaid telehealth interactions as well.

Licensure

Twenty-five 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. This number increased by eleven states since CCHP's Spring report, representing the most significant change in policy for this edition. Most of these states, however, are not allowing for broad cross-state practice. The majority of the new states are adding licensure exceptions 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. For example, Virginia's Medical board created the exception for the specific scenario of patients who have a prior practitioner-patient relationship with the provider and have been seen in-person within the previous 12 months. Alaska, Colorado, Delaware, Idaho, Illinois, Kentucky, Maryland, New Hampshire, South Carolina, Virginia and Vermont all added telemedicine licenses or new licensing exceptions since Fall 2021. Minnesota's provision is a licensing exception allowing physicians licensed in other states to provide telehealth services to patients in Minnesota if they agree not to open an office, not meet with patients in Minnesota or receive calls in Minnesota from patients, and they annually register with the state's board.

Another common licensing policy is the adoption of interstate compacts which allow specific providers to practice in states they are not licensed in as long as they hold a license in good standing in their home state. CCHP is currently tracking nine Compacts, each with their own unique requirements to participate. For example, the interstate medical licensure compact allows for an expedited licensure process, where physicians still need to apply for a license in individual states.

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

State Example:

ARIZONA allows out-of-state providers to provide services within their borders if they register with the state's applicable health care board, pay a registration fee, annually submits to the board their total number and type of encounters, and follows other requirements listed in their regulations.

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. **Interstate Medical Licensure Compact:**
37 states, DC and the territory of Guam.
2. **Nurses Licensure Compact:** 37 state members and the territory of Guam and Virgin Islands
3. **Physical Therapy Compact:** 33 state members and DC.
4. **Psychology Interjurisdictional Compact:**
32 state members and DC.
5. **Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC):**
23 state members.
6. **Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA):**
22 state members.
7. **Occupational Therapy Compact:**
22 state members.
8. **Counseling Compact:** 17 state members.
9. **Advanced Practice Registered Nurse Compact:**
3 state members.

Online Prescribing

There are a number of nuances and differences across the states related to the use of technology and prescribing. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. Most states don't require an in-person examination prior to a prescription, but often do require that if telehealth is used, the exam meets the standard of care that would be expected during an in-person exam. CCHP notes that in the past year a few states that had been silent previously in regards to whether or not a telehealth interaction could establish a provider/patient relationship clarified that it could, and established parameters and requirements for it. Kentucky, for example, requires that prior to prescribing in response to any communication transmitted or received by computer or other electronic means, the physician must establish a proper physician-patient relationship by taking certain steps such as verifying the person, establishing a documented diagnosis, and maintaining the medical record. 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 addressed this during this latest update is Alabama, which now explicitly allows the prescribing of controlled substances only if the prescription is based on a live video examination, there was at least one in-person visit in the preceding 12 months and it was for a legitimate purpose established within the previous 12 months. It should be noted that federal law also limits the prescribing of controlled substances via telehealth, except in very limited circumstances. Providers would be required to comply with both the federal and state law to be in compliance.

In the Spring, CCHP noted that two states (Maine and Oklahoma) were the first states CCHP is aware of that have tied the issue of prescribing to private payers, prohibiting insurance carriers from placing restrictions on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that are more restrictive than requirements

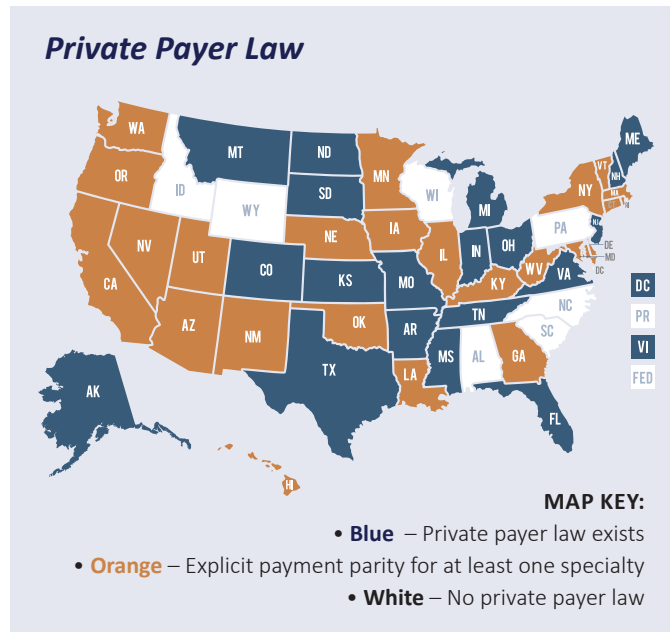




for in-person consultations. In this Fall Update, CCHP found Missouri Medicaid is now also addressing the issue of prescribing within its Medicaid regulations, adding practice standards and requirements around prescribing.

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 Spring 2022 (Virgin Islands was only added as a result of the addition of the jurisdiction to the report). Even modifications to existing private payer laws were relatively few during this Fall 2022 update. A few states did add payment parity for telehealth delivered services, but an interesting observation is the emergence of the practice of only applying the payment parity to certain specialties instead of being broadly applied as has been common for payment parity laws in the past. For example, Louisiana added a payment parity provision to their law that specifically applies to physical therapy only. Utah is another example of a state that has payment parity provision for only mental health services. Other states tied payment parity language in their laws to expiration dates. Such is the case for New York which added payment parity language to their law, as well as applying it to Medicaid, but noted that parity provisions would 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.



State Example:

MISSISSIPPI also amended their private payer telehealth law with an expanded definition of telemedicine to include any HIPAA compliant telecommunication system including remote patient monitoring and store-and-forward. It also stipulates that the Insurance Commissioner may adopt rules related to real time audio interaction, and makes a number of clarifications including that coverage must be provided to out of network providers, providers must use proper medical codes for telemedicine and that health plans shall not limit coverage to consultations only via telehealth. This section also has an expiration date of July 1, 2025.

Puerto Rico and the Virgin Islands

Beginning with this edition of the 50 State, CCHP has begun tracking information for Puerto Rico and the Virgin Islands. At this time, there is very little permanent and established Medicaid fee-for-service telehealth policy for either territory. Both do have existing telehealth statutory policies that impact issues such as licensure and consent and while Puerto Rico and the Virgin Islands did allow temporarily the broad use of telehealth in response to COVID-19, permanent Medicaid coverage policies could not be found at this time.

To learn more about state telehealth related legislation, visit CCHP's telehealth [policy finder tool](#).