



# State Telehealth Medicaid Fee-For-Service Policy

**A HISTORICAL ANALYSIS OF TELEHEALTH : 2013 - 2019**

January 2020





## EXECUTIVE SUMMARY

Since its initial publication in 2013, the Center for Connected Health Policy (CCHP) has released fourteen editions of the “State Telehealth Laws and Reimbursement Policies” report. The report is a compendium of state telehealth Medicaid fee-for-service policies, laws and regulations. This historical analysis utilizes the data gathered in CCHP’s seven years (14 editions) of publishing this report, to assess trends in Medicaid fee-for-service, identify changes and progress in specific areas, and provide context to the current telehealth policy landscape.

Telehealth is “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.”<sup>1</sup> Each state’s Medicaid fee-for-service program is unique and reimbursement for the three telehealth modalities of live video, store-and-forward, and remote patient monitoring vary across programs. While many states provide reimbursement for the same modalities, those services are not always available for the same medical specialties, provider types, or facilities.

Researchers for this report evaluated fourteen editions of CCHP’s “State Telehealth Laws and Reimbursement Policies” report, applying the tracking and research methodology developed across the past seven years. Evidence that a Medicaid program implemented a change in policy, such as changes to a Medicaid provider manual, departmental bulletins, provider letters or other governmental transmittals were used to establish consistent data. The specific subject areas evaluated include:

- Definitions of the term telemedicine/telehealth
- Medicaid reimbursement for live video
- Medicaid reimbursement for store-and-forward
- Medicaid reimbursement for remote patient monitoring
- Consent issues
- Medicaid geographic restrictions
- Medicaid facility originating sites



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1) Health Resources and Services Administration (HRSA). Telehealth Programs. Accessed Jan. 2020, <https://www.hrsa.gov/rural-health/telehealth>

## EXECUTIVE SUMMARY (cont)

States have refined and expanded their Medicaid fee-for-service telehealth policies over the past seven years. Many policies have been enacted to provide reimbursement for live video, store-and-forward, and remote patient monitoring across a wide array of provider types and services. Live video is currently reimbursed by all states and D.C. Medicaid fee-for-service. Over time, however, many states have adopted specific requirements on what services and providers are eligible. Store-and-forward reimbursement has been adopted more slowly and states have tended to place specific limitations for reimbursement. Remote patient monitoring has tripled in the number of states providing reimbursement, although it is often limited to home health services or telemonitoring for specific conditions.

States have also expanded their use of telehealth or telemedicine definitions, with most states having adopted one of these definitions into their Medicaid program. These definitions also grew more comprehensive and specific as states adopted more expanded reimbursement policies. The number of states with consent requirements has also tripled.

The Medicaid fee-for-service telehealth policy landscape has changed greatly over the past seven years as more states are reimbursing for each modality. Each area of policy tracked in this report showed only progressive adoption across the years, with a small number of states enacting policy changes each year. Additionally, many policies have changed over time. More states are providing reimbursement for live video and store-

and-forward only for specific specialties or services. However, some states, including California, have enacted policies to allow reimbursement for all covered services by both modalities. Remote patient monitoring policies have not changed as greatly and are often limited to home health services or telemonitoring for specific chronic conditions.

The use of geographic limitations, such as requiring a patient to be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA), has greatly declined since 2013. States with originating site restrictions have increased, however, as more states have enacted lists of facilities, such as hospitals, clinics, behavioral health centers, and others, that are eligible for reimbursement. Recently states have begun including the patient's home in these lists.

Telehealth reimbursement in Medicaid fee-for-service programs has increased greatly since 2013. As other programs, including Medicare, adopt new policies with reimbursement to new specialties, eligible originating sites, and fewer restrictions, it can be expected that many Medicaid programs will continue doing the same.

CCHP anticipates these changes to continue as programs potentially follow some of the more progressive policies adopted by states like California, which allow a provider to decide what service is appropriate for delivery via live video or store-and-forward.

## INTRODUCTION

Since 2013 when it was first published, the Center for Connected Health Policy (CCHP) has catalogued and researched state telehealth Medicaid fee-for-service policies, laws and regulations and published a compendium of that information in its “State Telehealth Laws and Reimbursement Policies” report. Through this report, CCHP has been uniquely able to track the evolution of telehealth policy in both statute and Medicaid policies. While CCHP has also tracked private payer policy development, this historical analysis focuses on the Medicaid fee-for-service information collected over the past seven years to examine the evolution of telehealth policy trends in Medicaid programs, identify notable changes and progress in specific policy areas, and provide context to the current telehealth policy landscape. This report only focuses on Medicaid fee-for-service and not Medicaid managed care.

Telehealth is defined by the U.S. Health Resources and Services Administration as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.”<sup>1</sup> Telehealth also includes three modalities. Live video is the use of a secure, real-time video between a patient and a provider. Store-and-forward, sometimes referred to as asynchronous telehealth, allows patients and providers to electronically share data, images and videos followed by a subsequent interpretation or response to the information, such as a medical/surgical consultation. Remote patient monitoring is the continuous monitoring of a patient for a period of time with the provider in a different location. Individual state and Medicaid program definitions may vary, with some states including specific restrictions on the use of telehealth within their definitions. While the term “telemedicine” is sometimes used, for this analysis, the term “telehealth” will include telemedicine.



## Key Findings

### A few significant findings include:

- More states have enacted telehealth/telemedicine definitions into their Medicaid programs and these definitions have grown more comprehensive over time as states expand reimbursement to more modalities and specialties.
- Live video is now reimbursed by all states and D.C. and many states have included additional medical specialties and services eligible for reimbursement.
- The number of states reimbursing for store-and-forward has increased slowly, some with specific restrictions on the allowable types of specialties and reimbursable services.
- The number of states reimbursing for remote patient monitoring has tripled, however policy language has changed little, even among newly included states, and reimbursement is often limited to home health services or telemonitoring for specific chronic conditions.
- The number of states with consent requirements has tripled over the past seven years.
- The number of Medicaid programs with geographic limitations has declined.
- More Medicaid programs are providing lists of eligible originating sites and many states now include the patient’s home in these lists.

1) Health Resources and Services Administration (HRSA). Telehealth Programs. Accessed Jan. 2020, <https://www.hrsa.gov/rural-health/telehealth>

## INTRODUCTION (cont)

Each state's Medicaid fee-for-service program is unique regarding how, where, and when telehealth can be provided. Early adopted Medicaid policies were also not as expansive as policies existing today. Some states will only reimburse for live video, while a few provide reimbursement for all modalities. Additionally, while many states provide reimbursement for the same modality, this does not mean that payment is available for the same medical specialties, provider types, or that they can be provided from the same facilities. As more states have incorporated telehealth into their Medicaid programs, many policies have been enacted to remove geographic or location-based restrictions, provide specific limitations on what provider types may deliver services through telehealth, and what types of services may be reimbursed.

The report was conducted by examining the previous fourteen "State Telehealth Laws and Reimbursement Policies" reports using CCHP's current coding system and noting changes in each state's Medicaid programs. Through this analysis, CCHP identified policy trends over the past seven years and highlighted a few of the most significant changes to telehealth reimbursement in state Medicaid policies. These findings show trends in Medicaid programs' adoption of telehealth policy and how those policies have expanded or become more restrictive over time. This report is intended to serve as an examination of these developments over time to show the overall evolution of telehealth policy across state Medicaid programs.

## METHODOLOGY

This historical analysis is built upon seven years of state Medicaid policy tracking by CCHP in the biannual "State Telehealth Laws and Reimbursement Policies" report. Through fourteen editions, CCHP has refined and developed its tracking and research methodology to accommodate the ever-evolving telehealth policy landscape. Though information in earlier editions of the 50 State Report was gathered in a very similar fashion in later editions, the methodology was not exactly the same. Therefore, researchers for this report culled through each of the previous fourteen reports with the same methodology currently applied in order to ensure consistent data to evaluate. In order for a state Medicaid program to be counted as having a specific type of policy, there must be evidence that the Medicaid program has implemented such a change. The evidence can be in the form of a Medicaid provider manual, departmental bulletins, provider letters or some other official governmental transmittal that such a policy change has been implemented in the program. The passage of legislation alone, absent any action from Medicaid, would not be enough for CCHP to change the way a

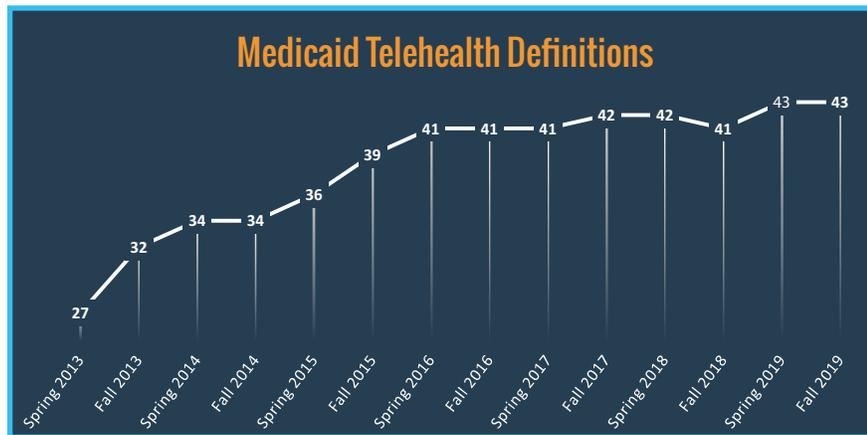
state is coded by current standards. After examining information from all 14 editions through this lens, CCHP compared the findings to data in the executive summary of each report and noted slight discrepancies when comparing the new data set with the original data. Each discrepancy was flagged for review by a second researcher to confirm accuracy and ensure the new data set represents accurate changes to Medicaid policy.

The following subject areas were re-evaluated in each of the fourteen reports from the last seven years. These areas all focus on Medicaid policy:

- Definition of the term telemedicine/telehealth
- Medicaid reimbursement for live video
- Medicaid reimbursement for store-and-forward
- Medicaid reimbursement for remote patient monitoring (RPM)
- Consent issues
- Medicaid geographic restrictions
- Medicaid facility originating sites

## HISTORICAL TRENDS

### Definitions of the Term Telemedicine/Telehealth



States alternate between using the term “telemedicine” or “telehealth” while some states define both terms, using each to refer to specific services. For example, Arizona defines “telehealth” to include the use of telephones, facsimile machines, electronic mail, and remote monitoring devices, but defines “telemedicine” to refer specifically to health care delivery, diagnosis, and consultation delivered through live video or store-and-forward. Variations of these terms are also used to refer to the use of telehealth in a specific medical specialty, such as the term “telepractice” which is frequently used in physical and occupational therapy, behavioral therapy, and speech language pathology. Only the use of the terms “telemedicine” and “telehealth” as found in state Medicaid policies are tracked here.

In the Spring of 2013, twenty-seven states had a definition for telemedicine or telehealth in their Medicaid policy and by the end of 2013 the number rose to thirty-two states. Currently, forty-three state Medicaid programs include one of these definitions. This number only includes definitions found in materials (regulations & other official documents) issued by Medicaid programs, and does not

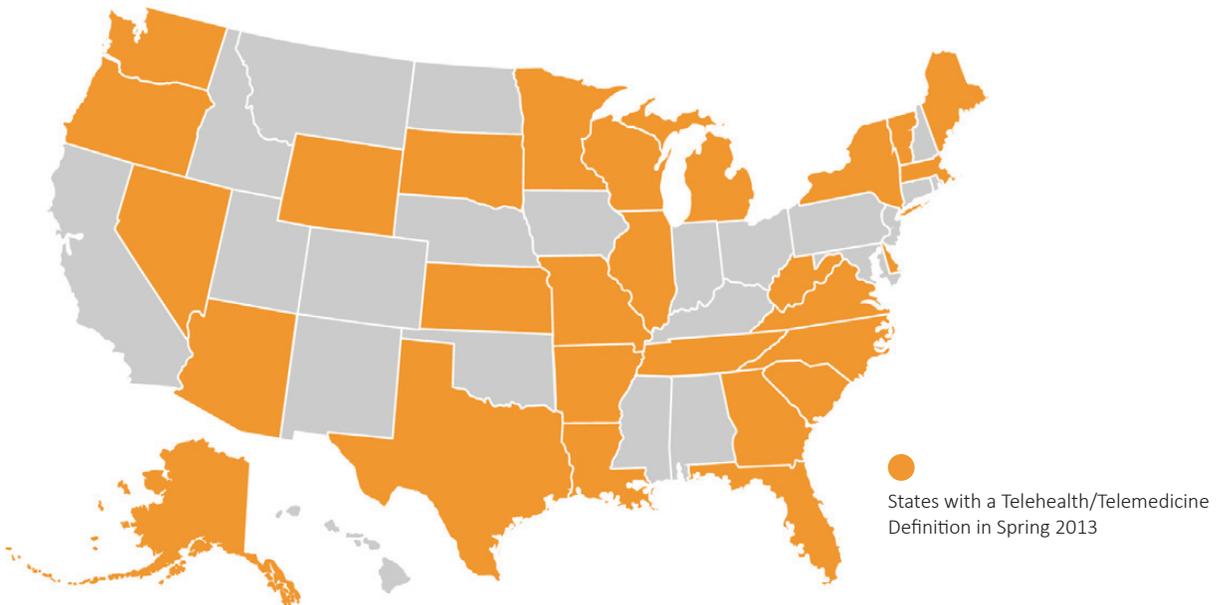
include statutory definitions. Only eight states still lack a definition in their Medicaid program and include Alabama, Connecticut, Hawaii, Iowa, Maryland, New Hampshire, New Jersey and Rhode Island. Alabama is also the only state lacking a definition in both its Medicaid program and state laws and regulations.

The language used in telehealth definitions in Medicaid programs sometimes puts additional limitations on what modalities can be used. Some states define telehealth as occurring in “real-time,” therefore excluding reimbursement for store-and-forward and remote patient monitoring. In 2013 and 2014, eighteen out of twenty-seven Medicaid programs defined telehealth as occurring in real-time. Many states, including Delaware, Georgia, Kansas, Kentucky, and Louisiana continue to define telehealth as occurring in real-time. More recently, other states, such as Alaska, Arizona, Arkansas, California, and Illinois have specifically included store-and-forward in their definitions either by listing “asynchronous” transmission under the definition of telehealth or by creating a separate definition for the modality.

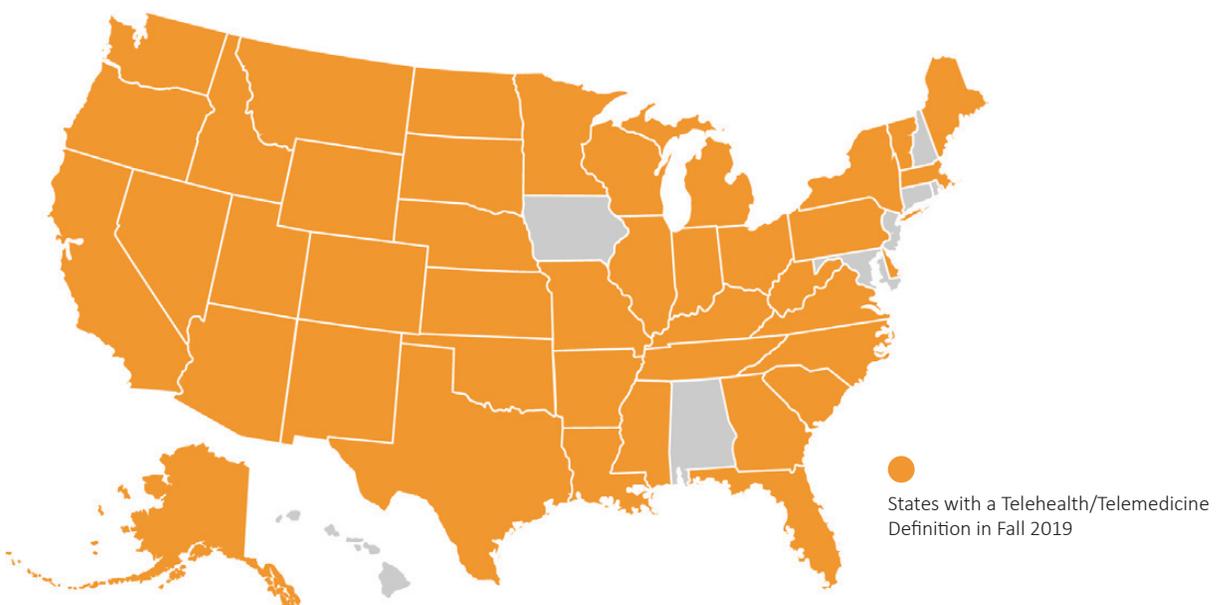
### HISTORICAL TRENDS

#### Definitions of the Term Telemedicine/Telehealth (cont)

State Telehealth/Telemedicine Medicaid Definitions Map in 2013

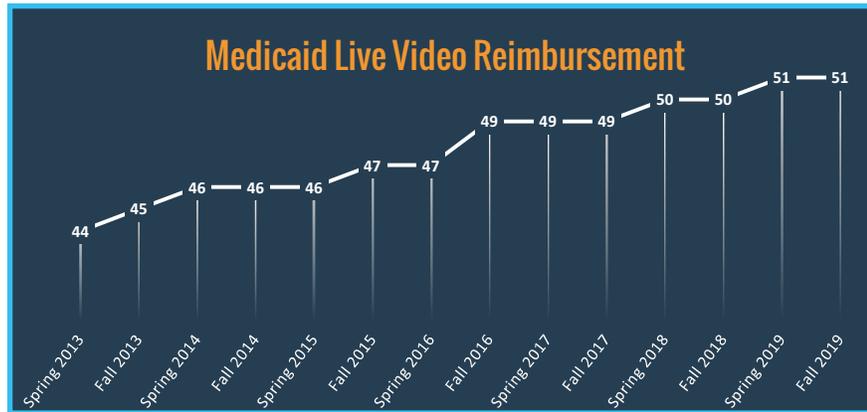


State Telehealth/Telemedicine Medicaid Definitions Map in 2019



## HISTORICAL TRENDS

### Reimbursement for Live Video



Since 2013, a total of six states and D.C. have added reimbursement for live video in their Medicaid policy in addition to the forty-four programs that were already providing reimbursement. With only one to two states adding live video reimbursement per year, adoption into Medicaid policy has been slow but consistent. With the addition of Massachusetts in early 2019, now all 50 states and D.C. provide reimbursement for this modality in their Medicaid programs.

Many states have placed limits on the type of services for which reimbursement can be provided when delivered through live video. Early on, many states specified that reimbursement could only occur for services including evaluation and management, medication management, psychiatric and behavioral health services, and consultations. Other states, such as California, Delaware, and Hawaii, stated that reimbursement would be provided broadly for “services,” suggesting fewer restrictions. Few states limited reimbursement only towards specific services. Florida had originally only reimbursed for live video when delivering child dental care services under the child protective services team program and Tennessee restricted reimbursement only towards emergency care. Recently, these states have expanded their policy to include additional specialties. For example, Florida Medicaid now reimburses for behavioral health services delivered through live video while Tennessee now includes mental health and substance abuse services within their Medicaid program. Some states have provided reimbursement for a much

more expansive list of services. One example of this is Arizona, which has provided reimbursement for live video through their fee-for-service program for eighteen specialties for the past seven years.

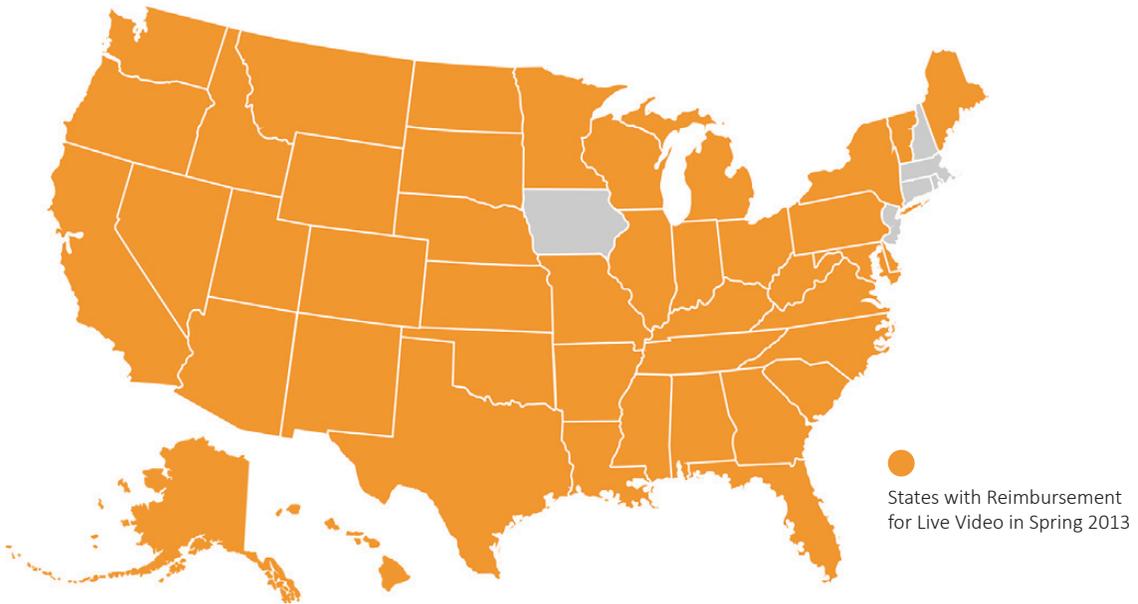
The following is a list of states that were not actively reimbursing for live video during the time of each report:

REPORT		STATES THAT DID NOT REIMBURSE FOR LIVE VIDEO
2013	Spring	Connecticut, D.C., Iowa, Massachusetts, New Hampshire, New Jersey, Rhode Island
	Fall	D.C., Iowa, Massachusetts, New Hampshire, New Jersey, Rhode Island
2014	Spring	D.C., Iowa, Massachusetts, New Hampshire, Rhode Island
	Fall	D.C., Iowa, Massachusetts, New Hampshire, Rhode Island
2015	Spring	D.C., Iowa, Massachusetts, New Hampshire, Rhode Island
	Fall	D.C., Iowa, Massachusetts, Rhode Island
2016	Spring	D.C., Massachusetts, Rhode Island, Utah
	Fall	Massachusetts, Rhode Island
2017	Spring	Massachusetts, Rhode Island
	Fall	Massachusetts, Rhode Island
2018	Spring	Massachusetts
	Fall	Massachusetts
2019	Spring	-
	Fall	-

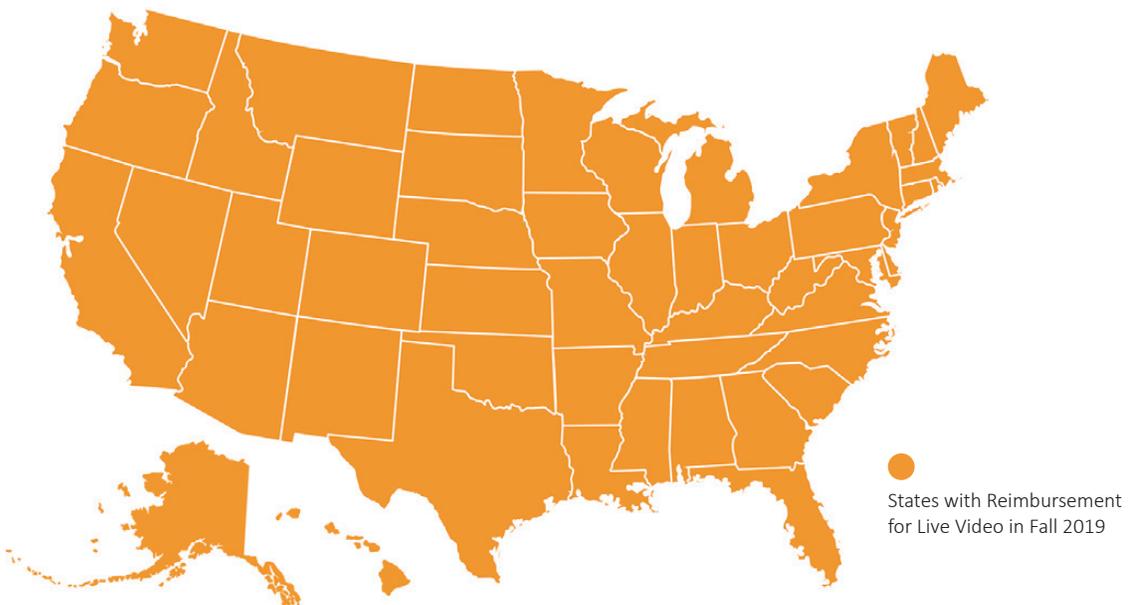
## HISTORICAL TRENDS

### Reimbursement for Live Video (cont)

Live Video Medicaid Reimbursement Map in 2013

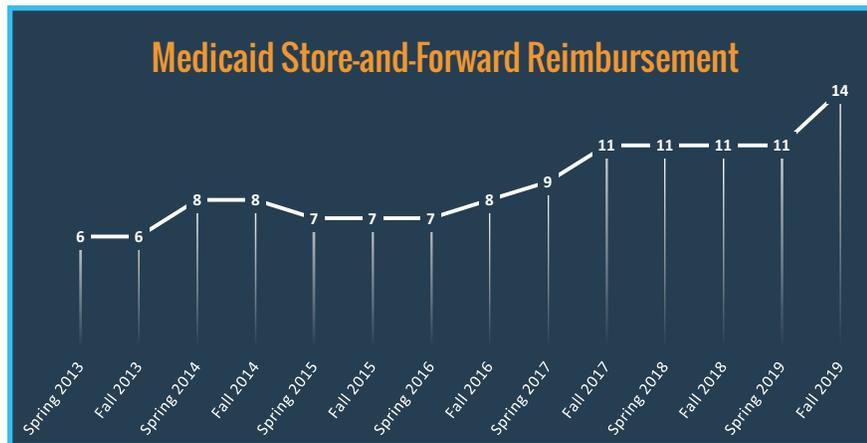


Live Video Medicaid Reimbursement Map in 2019



## HISTORICAL TRENDS

### Reimbursement for Store-and-Forward



Reimbursement for store-and-forward has fluctuated over the past seven years however there are currently fourteen state Medicaid programs providing some reimbursement for the modality. Since 2013, this has doubled from only seven states. Additionally, reimbursement for store-and-forward has increased the slowest when compared to live video and remote patient monitoring and is currently the least commonly reimbursed modality among state Medicaid programs.

Some states counted as reimbursing during one report may be removed at a later date due to a lack of clarity or the removal or specific verbiage from their policy. In the Spring of 2015, South Dakota became the only state to be removed from the list due to the exclusion of store-and-forward from their Medicaid manual.

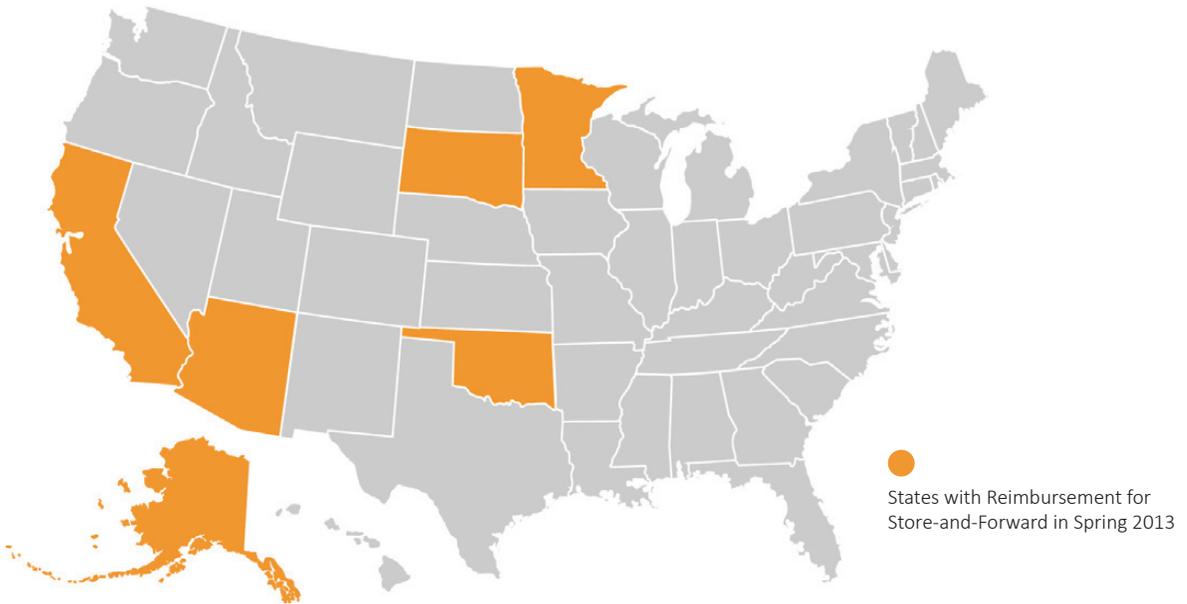
Medicaid programs now often place specific limitations on the specialties and services for which store-and-forward is eligible for reimbursement. Many states did not specify these limitations between 2013 and 2016, with few exceptions. California has reimbursed for store-and-forward in dermatology and ophthalmology since 2013 and added dentistry in 2015. Virginia also limited

store-and-forward to diabetic retinopathy screening and dermatology in 2015. In 2016 and 2017, when additional states began reimbursing for store-and-forward, more states limited reimbursement to specific services such as dentistry and dermatology. The current landscape of store-and-forward is more complex, with states such as Connecticut reimbursing only for provider-to-provider communications and Alaska reimbursing for services including office visits, consultations to confirm a diagnosis, psychiatric assessment, and medication management. Additionally, California recently adopted one of the most expansive store-and-forward policies in Medicaid. California Medicaid now provides reimbursement for all Medicaid services delivered through store-and-forward, as long as the same standard of care that would apply to in-person services is met.

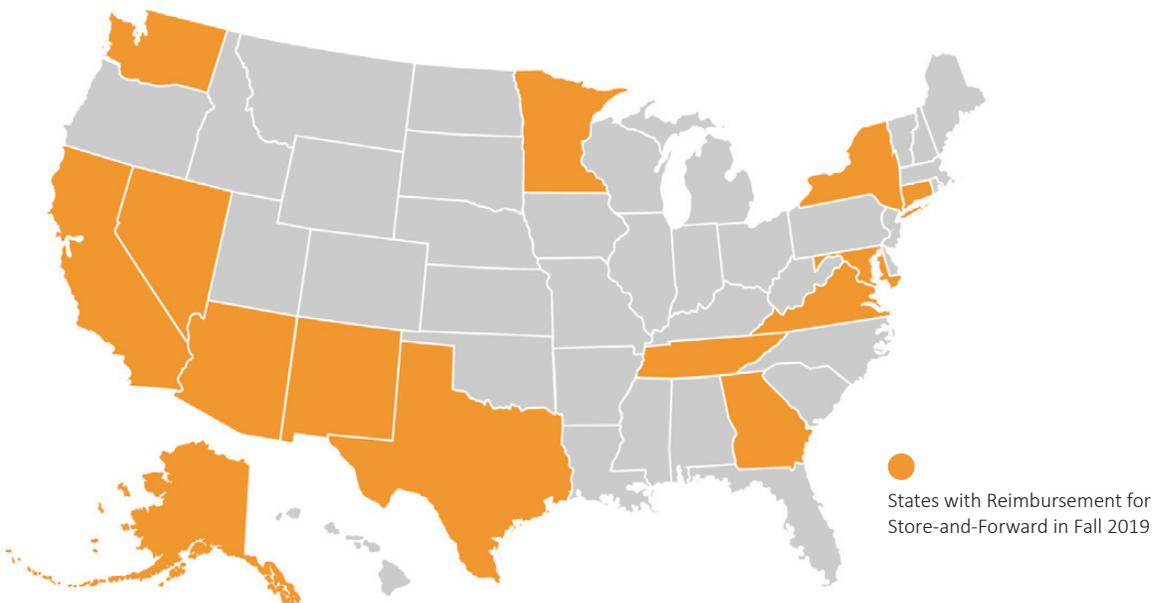
## HISTORICAL TRENDS

### Reimbursement for Store-and-Forward (cont)

Store-and-Forward Medicaid Reimbursement Map in 2013

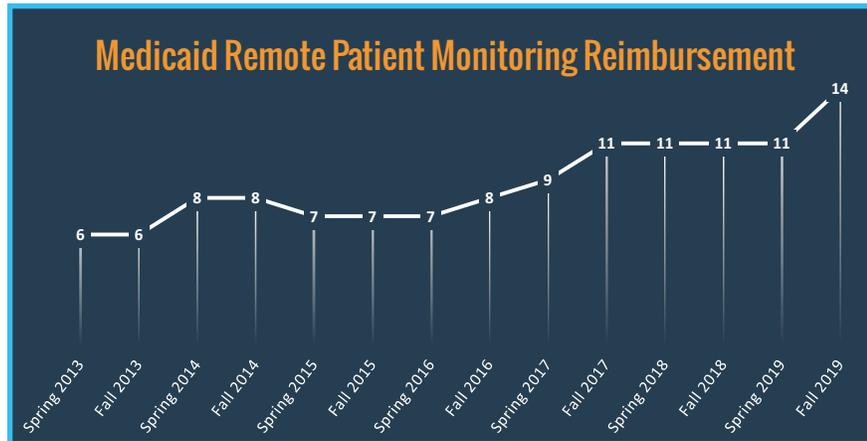


Store-and-Forward Medicaid Reimbursement Map in 2019



## HISTORICAL TRENDS

### Reimbursement for Remote Patient Monitoring (RPM)



RPM has followed a fairly consistent upward trend over the past seven years. In Spring of 2013, six states were reimbursing for remote patient monitoring in some form and that number has increased to twenty-two as seen in the most recent report. RPM has become the second most common modality of telehealth reimbursed by state Medicaid fee-for-service programs. While each state that provided reimbursement for RPM in 2013 continues to provide reimbursement in 2019, some of these policies have changed over the past seven years although most of the new policies place similar restrictions as other states and do not introduce reimbursement for new services or conditions. For example, Washington has removed its list of ineligible services and introduced reimbursement for additional home health services through telemedicine including prescription drug monitoring.

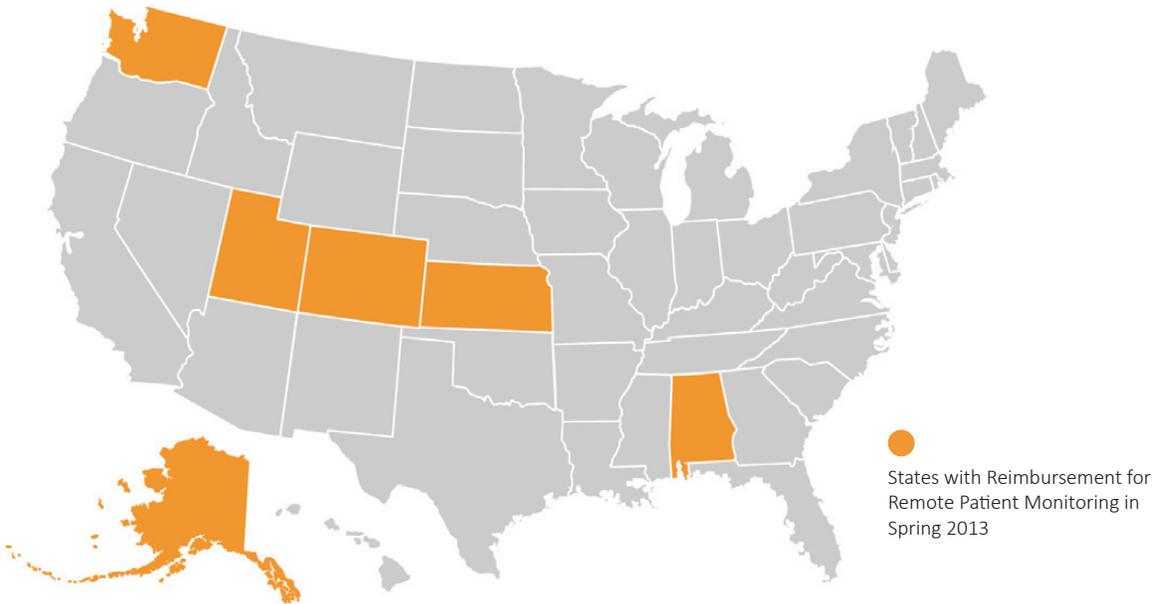
State Medicaid programs place strict limitations on reimbursement for RPM services. Many states only reimburse for home monitoring services for patients with chronic conditions such as diabetes, hypertension, congestive heart failure, or chronic obstructive pulmonary disease. States such as Alabama, Colorado, Kansas, and Utah have provided reimbursement for RPM since

2013, but have limited it to the treatment of these chronic conditions and continue to do so into 2019. Other states, including Indiana and Louisiana, provided reimbursement for RPM as early as 2014 but limited that reimbursement to home health agency services and health status monitoring. As of 2019, most states reimbursing for RPM services do so for telemonitoring with the requirement that the patient is diagnosed with a chronic condition that is eligible under the state's Medicaid policy. For example, Missouri reimburses telemonitoring for conditions including pregnancy, diabetes, heart disease, cancer, hypertension, asthma, and stroke. The specific conditions eligible for the service vary by state.

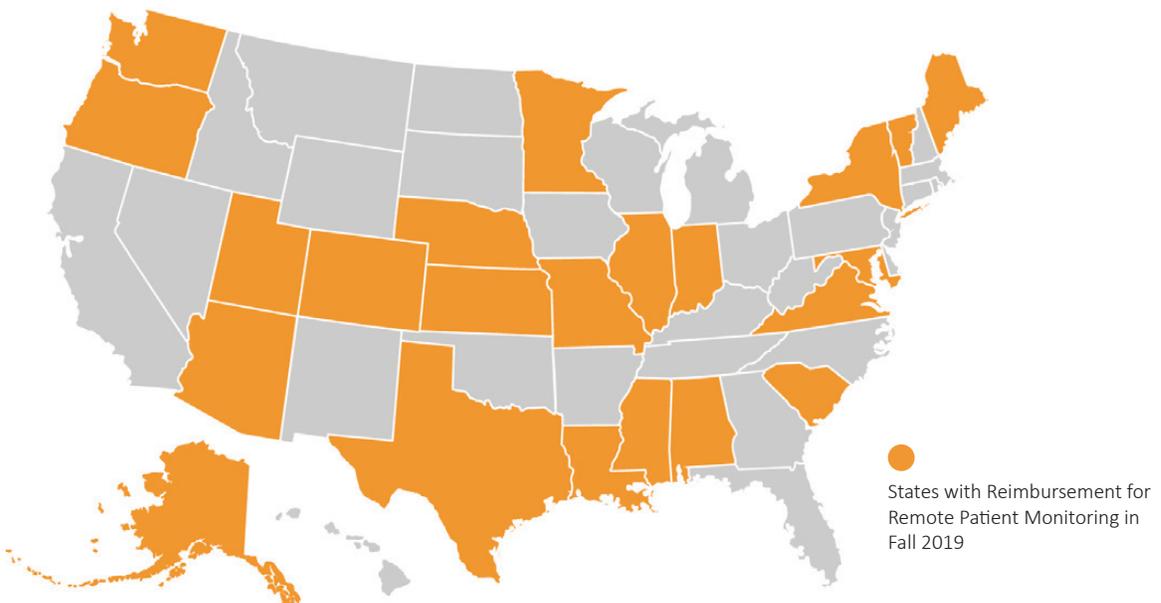
### HISTORICAL TRENDS

#### Reimbursement for Remote Patient Monitoring (RPM) (cont)

Remote Patient Monitoring Medicaid Reimbursement Map in 2013

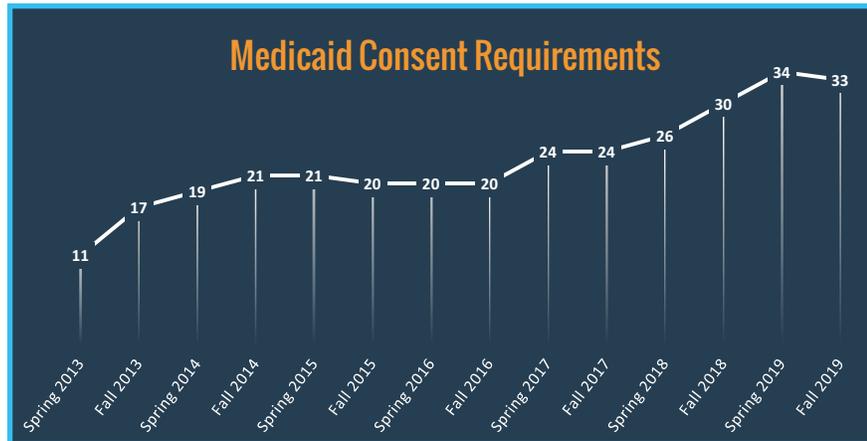


Remote Patient Monitoring Medicaid Reimbursement Map in 2019



## HISTORICAL TRENDS

### Consent Requirements



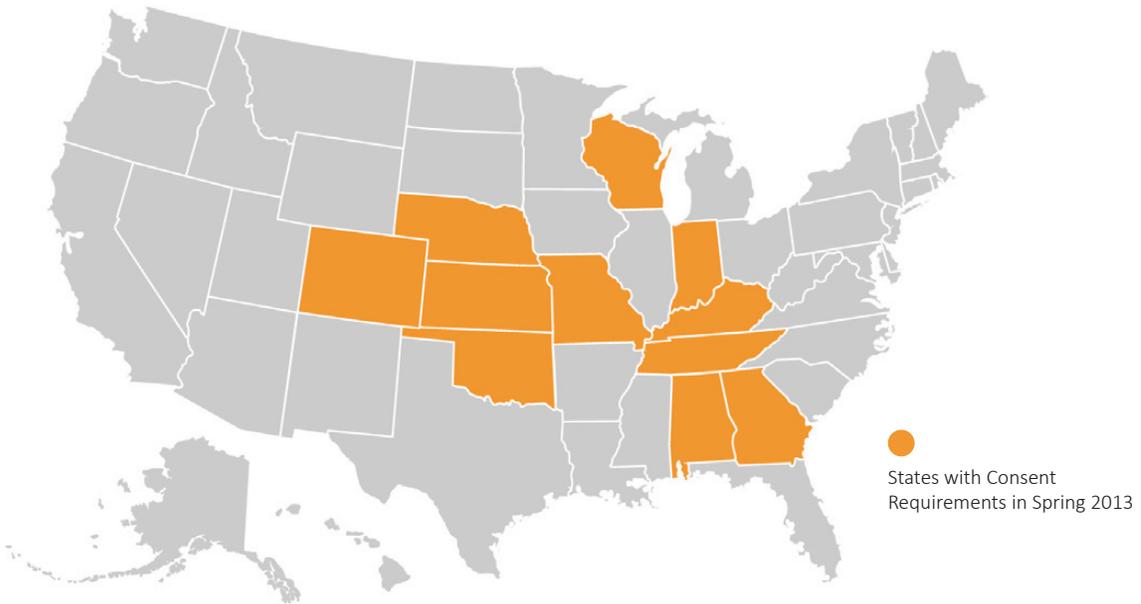
Many Medicaid programs have specific consent requirements for services delivered through telehealth. Consent policies have more than tripled in prevalence over the past seven years. Only eleven state Medicaid programs explicitly included telehealth consent requirements in the Spring of 2013. As of the Fall of 2019, thirty-three Medicaid programs have enacted consent requirements. Many Medicaid programs require that consent be obtained prior to the delivery of services through telehealth and sometimes place additional requirements on what information must be provided to the patient at the time of establishing consent. In 2013, Kentucky and Nebraska required providers to inform patients of alternatives to telehealth and that the

service could be ended at any time by the patient with no repercussions. As of 2019, Nebraska Medicaid still requires this consent and only New Jersey, West Virginia, and Wyoming have adopted similar policies. Most states with consent requirements for telehealth have not placed these additional requirements on providers, only stating that consent must be obtained.

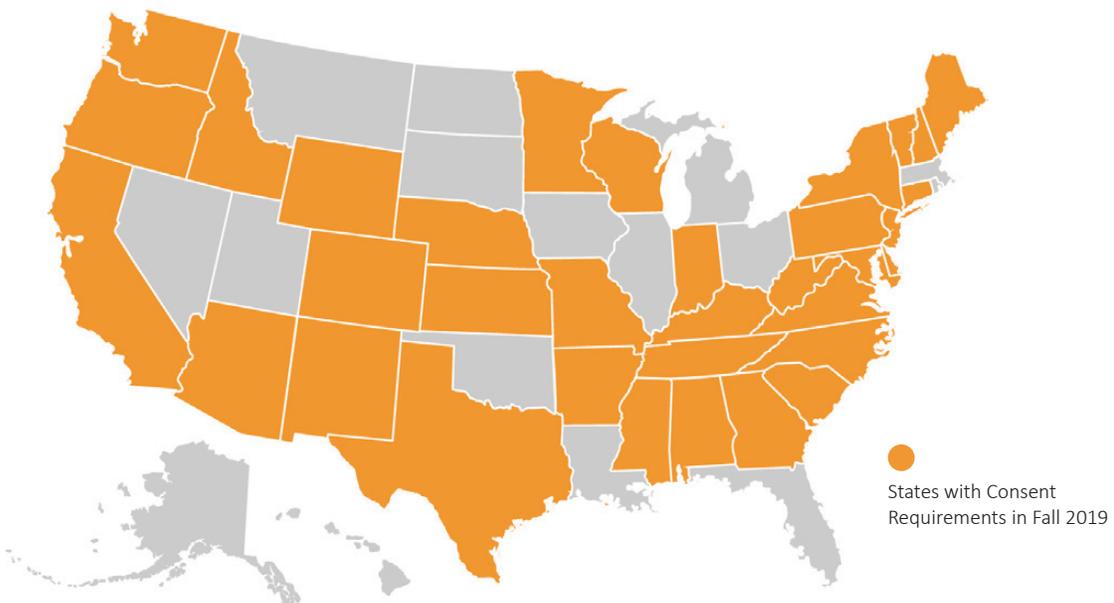
## HISTORICAL TRENDS

### Consent Requirements (cont)

Medicaid Consent Requirements Map in 2013

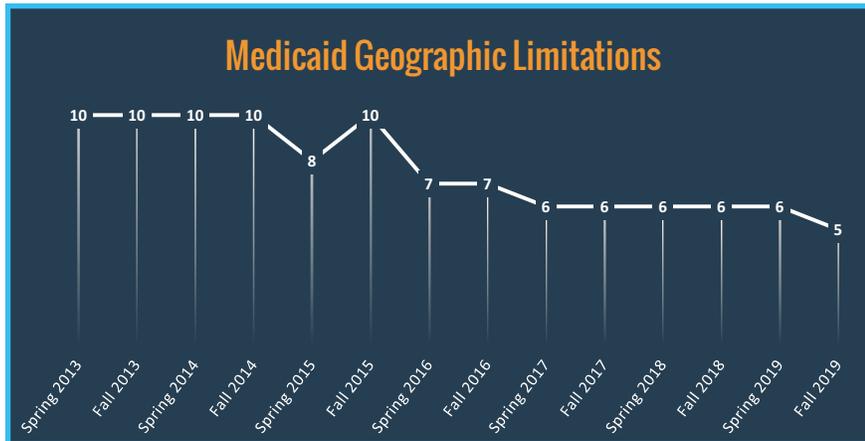


Medicaid Consent Requirements Map in 2019



## HISTORICAL TRENDS

### Geographic Restrictions



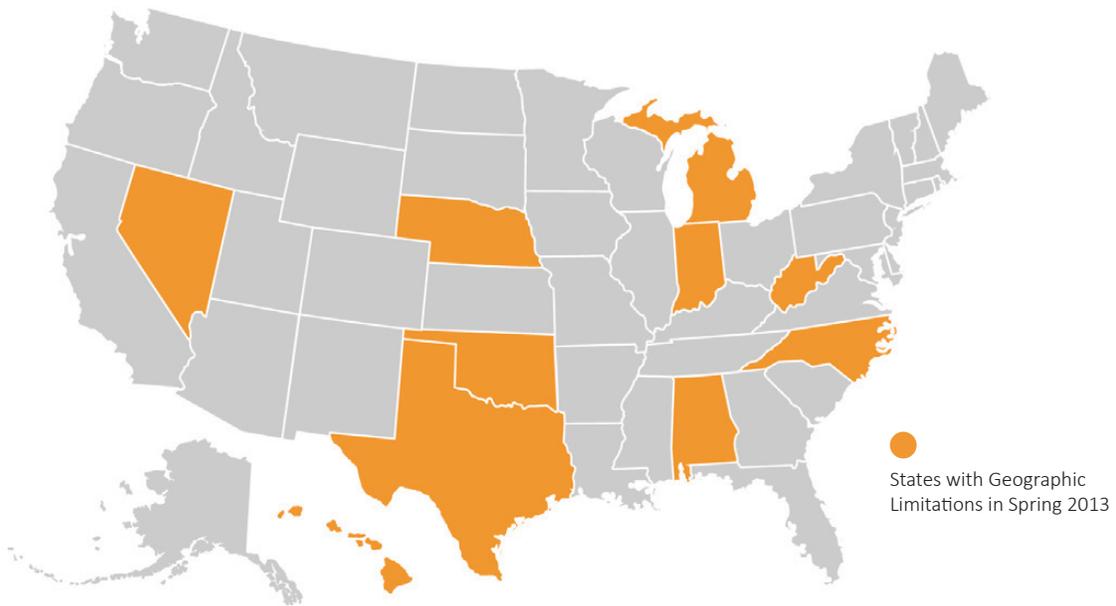
Geographic restrictions are one of the most significant barriers to telehealth adoption. Over the past seven years, many states have removed these restrictions from their Medicaid policies, however other states have adopted new restrictions, resulting in a fluctuating list of states with this barrier. These restrictions may vary by state, however one of the most common is to deny reimbursement for telehealth services when the originating and distant sites are within a specified distance from each other (typically five miles). In recent years, some states have taken a different approach. Montana and South Dakota both have policies that deny reimbursement when both the originating and distant sites are located in the same community. At the peak, ten

states had geographic restrictions for telehealth within their Medicaid policies. Although Nevada and South Carolina removed their geographic restrictions in the Spring of 2015, Maryland, New Hampshire, and Ohio each added new restrictions to their policies during the same year. Beginning with the Spring 2016 report, the number of states with geographic restrictions began to decline to its lowest point of four states.

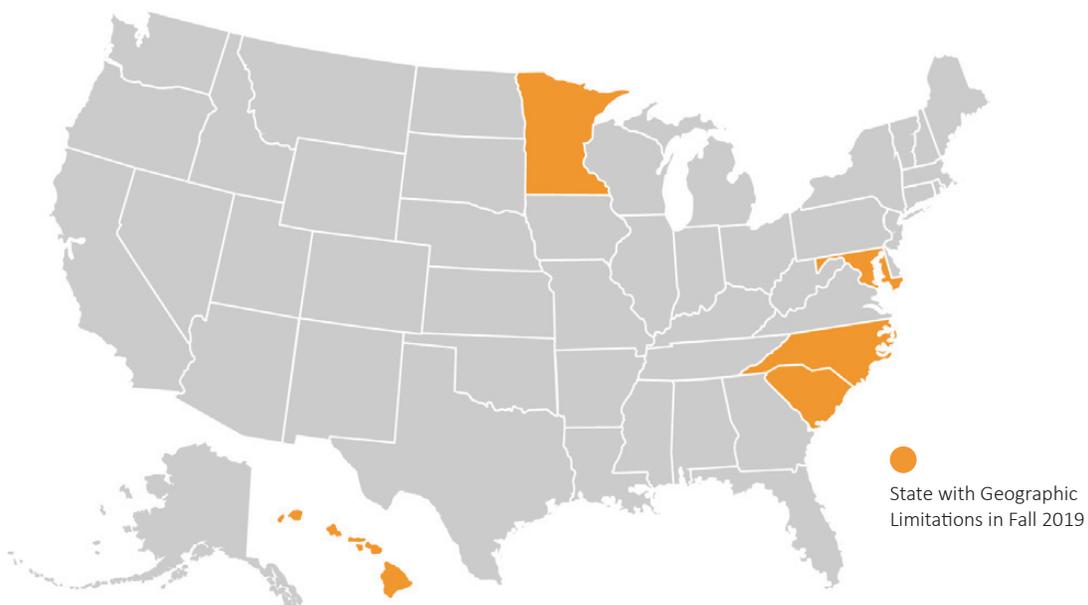
## HISTORICAL TRENDS

### Geographic Restrictions (cont)

Medicaid Geographic Limitations Map in 2013

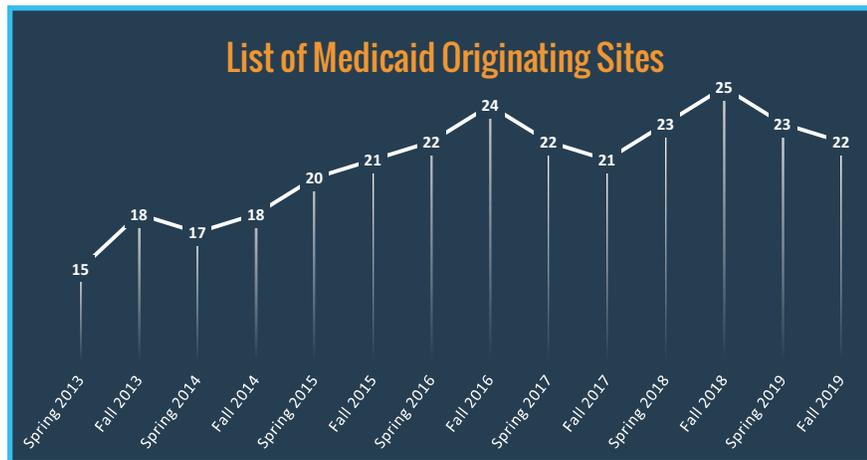


Medicaid Geographic Limitations Map in 2019



## HISTORICAL TRENDS

### Facility Originating Site Restrictions



A more common form of restriction is for state Medicaid programs to limit the type of facility that may be an originating site, thereby restricting reimbursement to only those sites. The originating site is considered the location where the patient is located during the delivery of services, while the distant site is the location of the provider delivering the service. Typically, originating site lists include locations such as physician offices, hospitals, and critical access hospitals. Some states also include rural health clinics and federally qualified health centers.

Recently, states have begun to include the Medicaid beneficiary's home as an eligible originating site. Seven states were permitting reimbursement for some services delivered to a beneficiary's home in 2013, however most of this reimbursement was only for home health services and other services delivered by home health agencies. Over the past two years, more Medicaid programs have begun reimbursing for live video services delivered to a

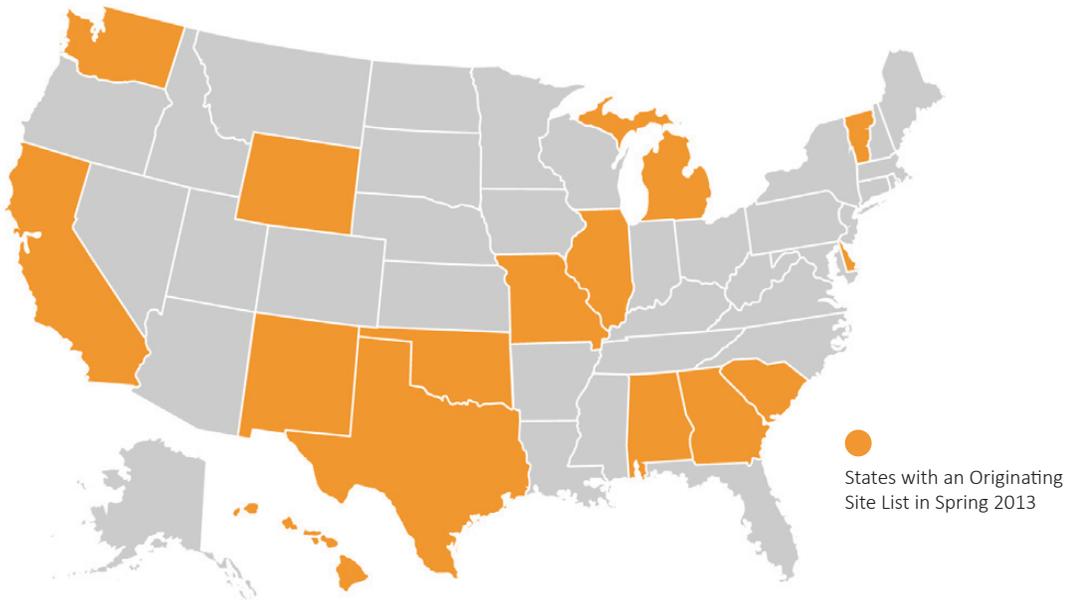
beneficiary's home by including it in their list of eligible originating sites. Currently, twenty-nine states indicate reimbursing for live video or home health services delivered to a beneficiary's home via a telehealth modality.

The amount of Medicaid programs that list eligible originating sites has increased since 2013. During that time, only fifteen states listed these sites. Although some states have removed their originating site lists over the past seven years, the number of states with these lists increased to a peak of twenty-five in the Fall of 2018. The most recent report has shown a slight decrease to twenty-two states in the Fall of 2019.

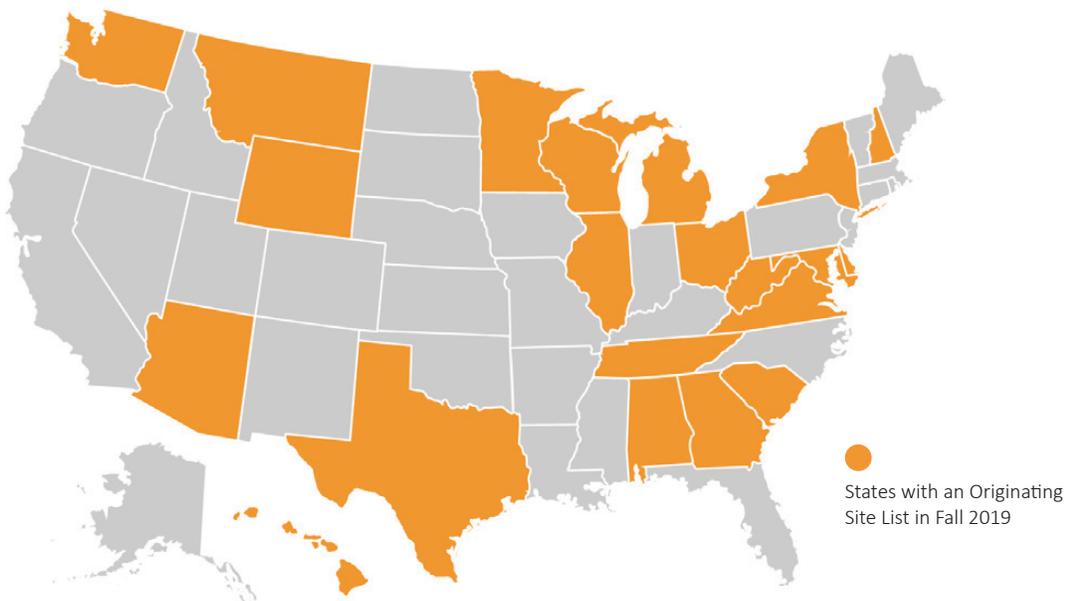
### HISTORICAL TRENDS

#### Facility Originating Site Restrictions (cont)

Medicaid Originating Site Lists Map in 2013



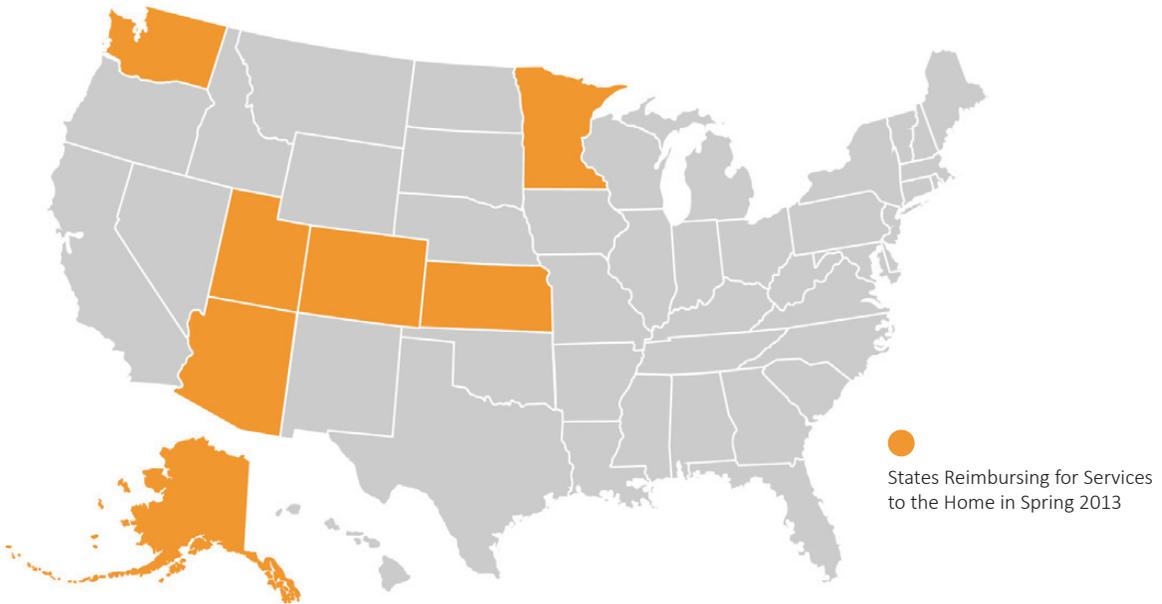
Medicaid Originating Site Lists Map in 2019



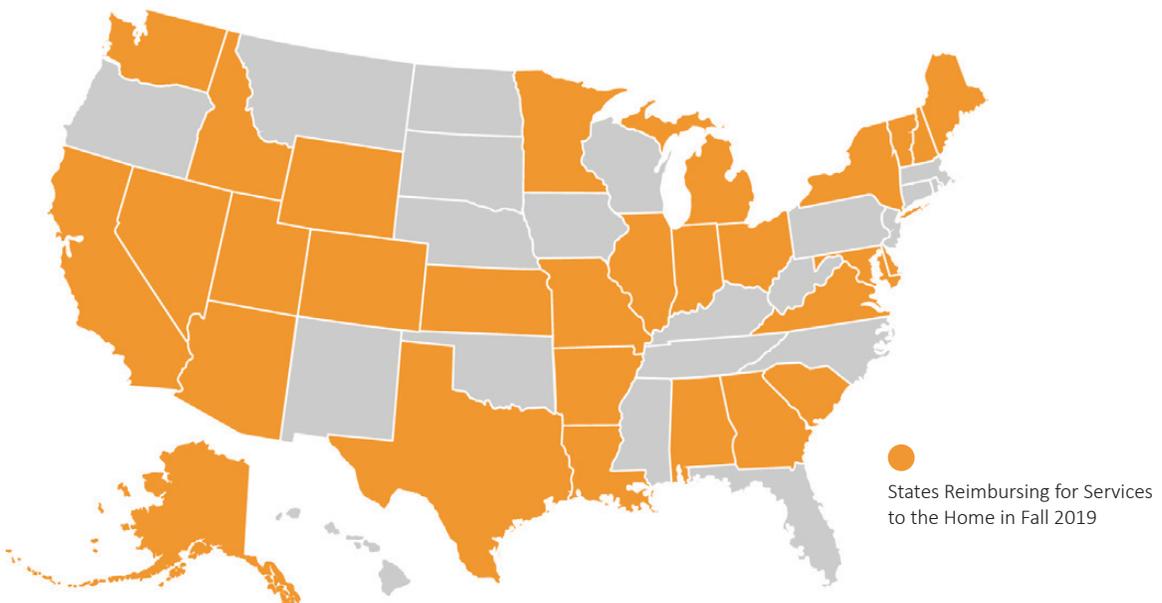
### HISTORICAL TRENDS

#### Facility Originating Site Restrictions (cont)

State Medicaid Programs Reimbursing for Services to the Home in 2013



State Medicaid Programs Reimbursing for Services to the Home in 2019



## DISCUSSION

Over the past seven years, the Medicaid telehealth policy landscape has changed drastically. There are currently more state Medicaid programs reimbursing for each telehealth modality compared to any time previously. The number of state Medicaid programs reimbursing for each modality of telehealth has increased overall, with each state and D.C. reimbursing for live video, fourteen states reimbursing for store-and-forward, and twenty-two states reimbursing for RPM as of the Fall 2019 report. Both live video and RPM reimbursement have increased incrementally since the initial report in the Spring of 2013. Each state reimbursing for these modalities in 2013 has continued to provide reimbursement as of the Fall of 2019.

No individual year stood out as showing significantly higher rates of adoption of reimbursement policies or any other area of Medicaid policy affecting telehealth. Each of the fourteen editions of the “State Telehealth Laws and Reimbursement Policies” report showed only incremental increases in the number of states adopting telehealth policies into their Medicaid programs. However, the individual policies have changed over time. Many states, such as Tennessee, that only provided live video reimbursement for specific specialties or services have expanded to incorporate additional specialties and services. The number of states providing reimbursement for remote patient monitoring has tripled over the past seven years, however many states did not make changes to the conditions and services considered reimbursable. States reimbursing for RPM often only provide reimbursement for home health services or telemonitoring for the specific chronic conditions listed in their policy. States have also been slow to adopt store-and-forward and those that do have tended to place additional restrictions on the types of services that can be delivered. Overall, there has been an expansion in telehealth policy across all modalities. One example of this is California, which implemented a policy that all Medicaid services are covered when delivered through live video or store-and-forward. However, in the case of store-and-forward, many states have favored restricting the services that can be delivered through the modality.

There has been a significant increase in the number of states with consent requirements and definitions listed in their Medicaid policies since 2013. Most states have a definition of telehealth or telemedicine in their Medicaid programs. Many states have expanded these definitions over time to be more inclusive of the various modalities of telehealth either by specifying that telehealth can occur in real-time and asynchronously or by enacting separate definitions for each modality. The number of states with consent requirements has tripled since 2013, however the specific information that is required to be provided for consent has not changed significantly in each state over time and most states have only said that consent must be obtained prior to the delivery of services through telehealth.

Geographic limitations and originating site restrictions have shown interesting trends over the last seven years. Geographic limitations have declined as states have removed distance and location restrictions for originating and distant sites. Before this decline, some states had geographic limitations similar to those found in Medicare, which require a patient to be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA). Only five states maintain geographic limitations which now often restrict the originating and distant sites from being in the same community or zip code. It has become increasingly common over the past seven years for states to place restrictions on what types of facilities can act as originating sites. Most of these lists include originating sites that are also eligible under Medicare, although often they are more expansive and include additional places of service such as behavioral health centers, schools, and the patient’s home.

## CONCLUSION

The use of telehealth has expanded greatly over the last seven years, with significantly more adoption of reimbursement policies for live video and RPM services. As other programs, including Medicare, continue to adopt new policies that expand reimbursement for telehealth services to include more specialties, eligible originating site locations, and fewer restrictions, it can be expected that many state Medicaid programs will continue to do the same.

Trends in Medicare may be especially important to the development of Medicaid policies. Historically, Medicare has shown significantly greater limitations to telehealth and reimbursement than many state Medicaid programs. As a result of the passage of the Bipartisan Budget Act of 2018, effective January 2020 CMS has removed many current coverage restrictions for telehealth in Medicare Advantage (if the plans choose to implement it), including the removal on the limitation on the types of services that can be provided and the limits on geographic location. Additionally, CMS has finalized payment for a number of communication technology-based services in the CY 2019 physician fee schedule. CMS does not consider such services to be telehealth and therefore typical restrictions on telehealth services do not apply. State Medicaid programs may follow a similar trend, adopting codes for services delivered through “communication technology-based services” and not specifically labeling a service as “telehealth.”

Overall, the trend over the past seven years has been an increased adoption of more expansive telehealth policies in Medicaid fee-for-service programs. We anticipate this to continue as programs potentially follow in the footsteps of some of the more progressive policies adopted by states like California that allow a provider to decide what service is appropriately delivered via live video or store-and-forward.



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