SB

74

(FILE 6)

<TARGET><BILL>SB 74</BILL><SUBJECT>SB 74 (FILE 6)</SUBJECT><COMM>HFIN29</COMM></TARGET>

3/30/16

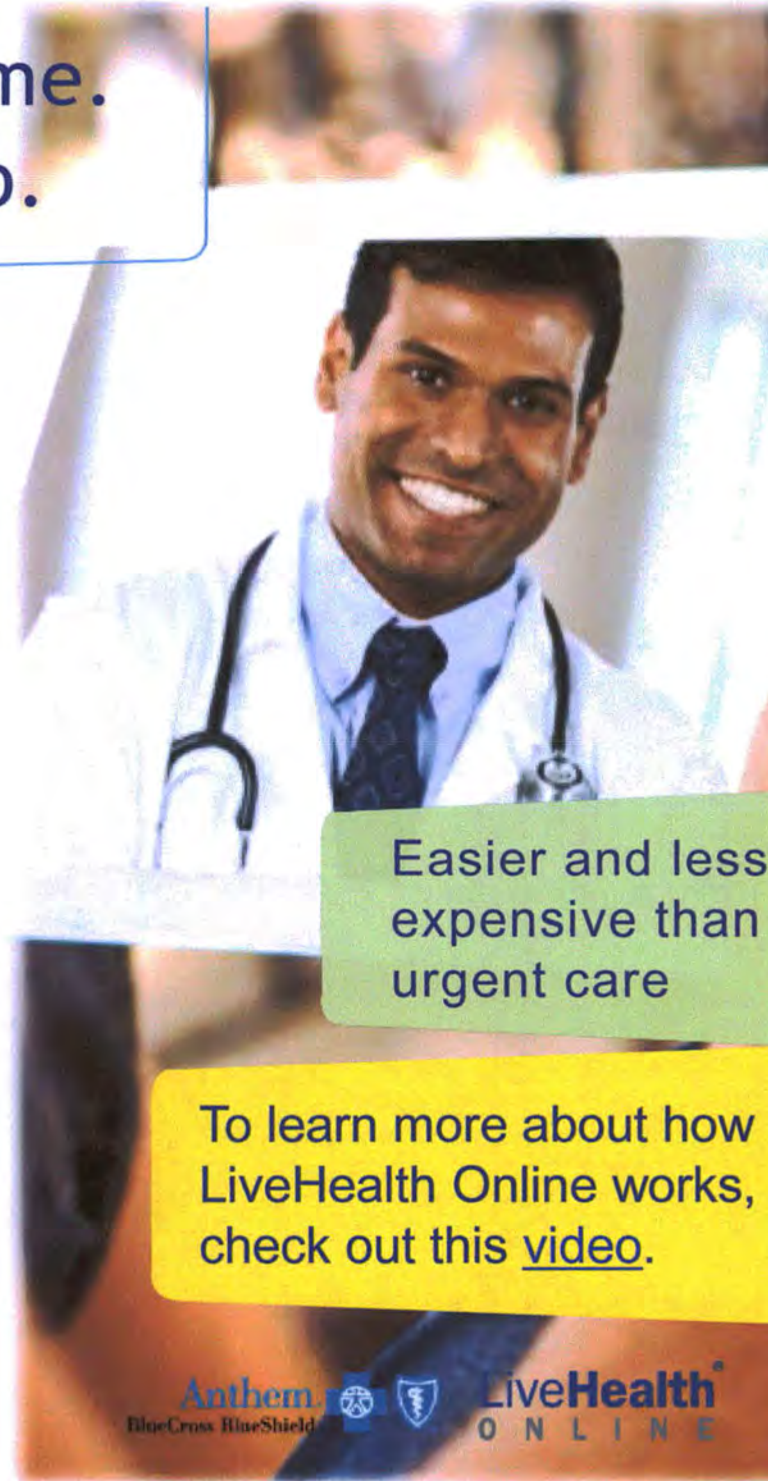
Introducing LiveHealth Online

LiveHealth
ONLINE

Doctor's care at the speed of life.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Visit with a doctor online, anytime. From work, at home or on the go.



LiveHealth Online:

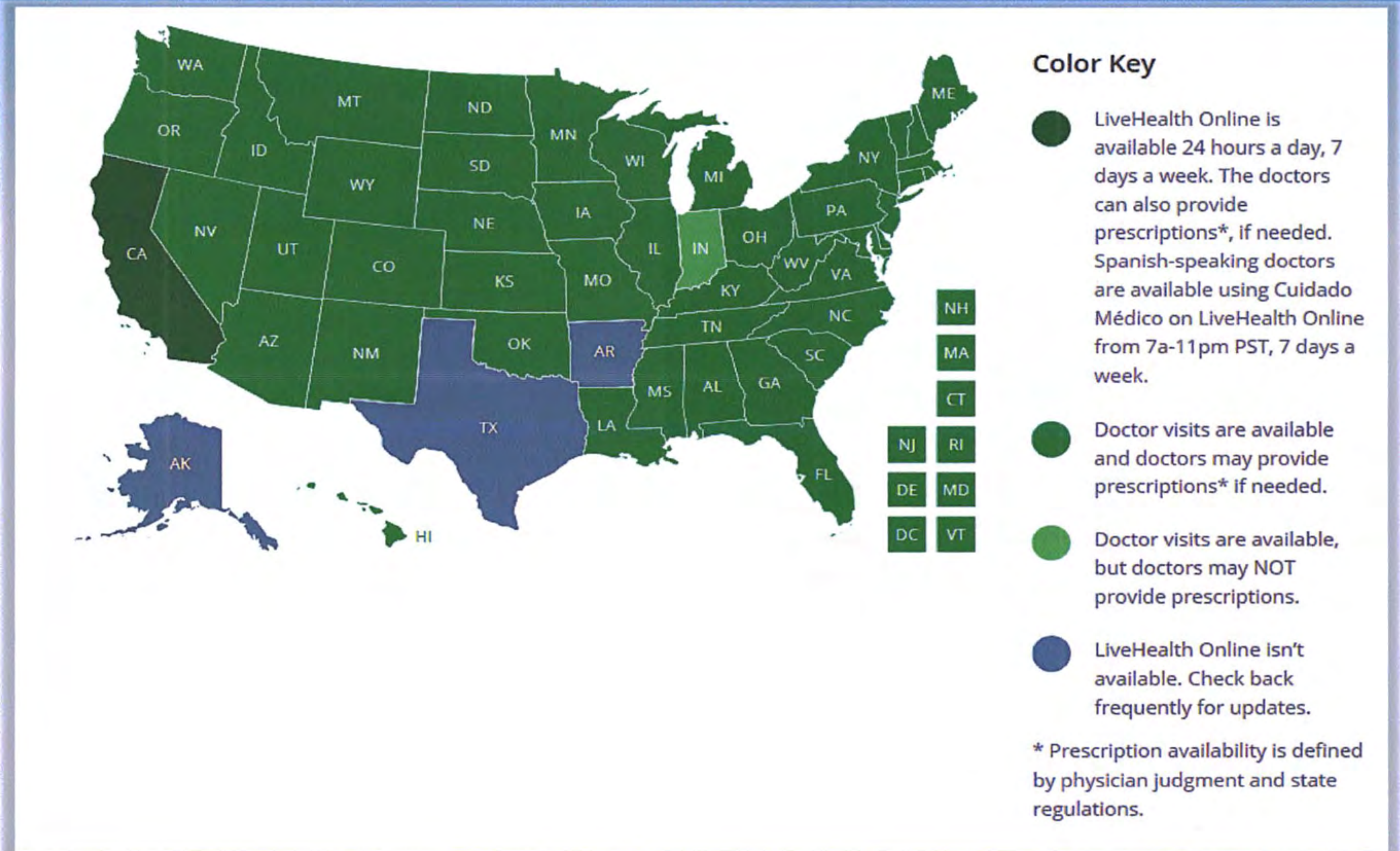
- Is available in most states, including D.C.*
- Is available 24 hours a day, 7 days a week, 365 days a year
- Is available anywhere you have a computer or mobile device with Internet access (at home, in the office or on the go)
- Provides access to in-network, board-certified doctors and licensed behavioral health professionals
- Allows doctors to ePrescribe** utilizing local pharmacies (where applicable)
- Takes member payments via Visa, MasterCard, American Express and Discover
- Is secure, convenient and easy to use

*LHO is available in 46 states and DC as of 09/14/2015

**In certain states, prescriptions cannot be issued as a result of an online interaction with a doctor. For state telehealth availability, check the map on LiveHealth.com.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Available in 47 states & DC



LiveHealth Online is the trade name of Health Management Corporation.

Two Distinct Telehealth Solutions

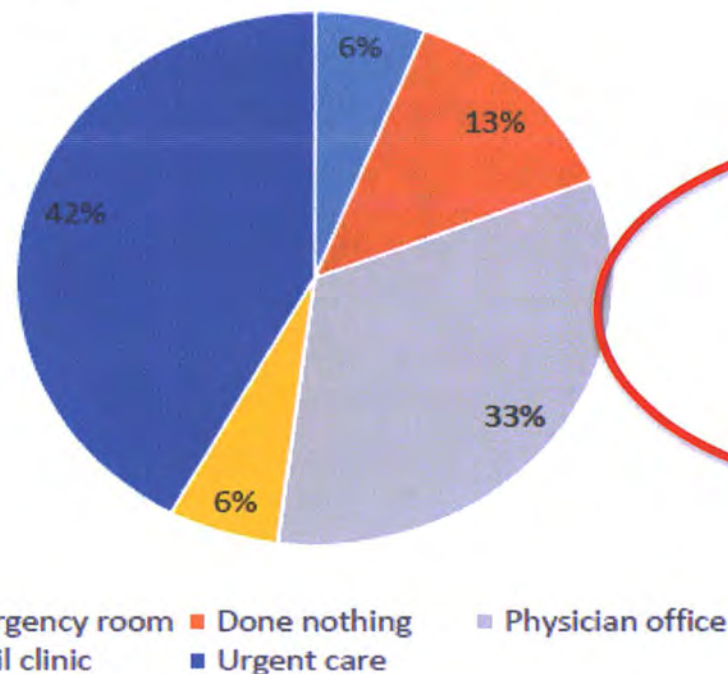
For Consumers	For Physicians
LiveHealth Online	**LiveHealth Online Practice Edition**
24 x 7 "urgent care in the cloud": When your doctor is not available or there is no primary care relationship	Practice defined telehealth for your patients in a convenient, private, secure setting

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

HealthCore study results are promising

Cost-savings (Medical + Pharmacy Episode Cost)

Patients reported they would have used the following, if not LHO:



For the 11 conditions of interest, on average:

RHC is 1.14x as expensive as LHO
UCC is 1.45x as expensive as LHO
ED is 6.35x as expensive as LHO
PCP is 1.60x as expensive as LHO

Therefore, Anthem and members save an average of **$202*** per episode (including follow-up) for the 11 conditions of interest

*This assumes that patients who do nothing would not eventually need additional care, that patients would use the care they say they would, and that care would follow patterns described previously.

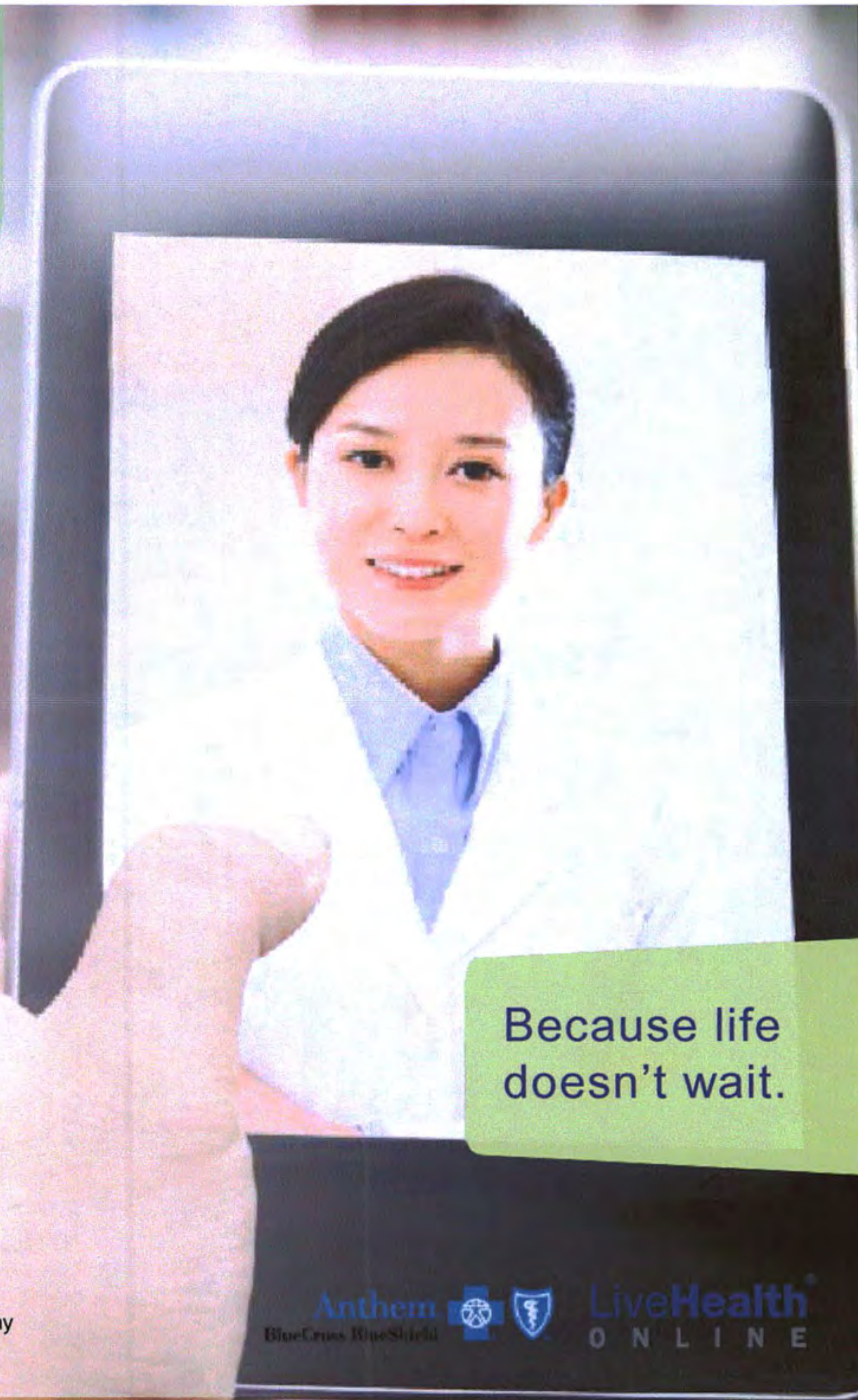
Employer benefits

LiveHealth Online adds value to your existing employee benefits packages without additional costs.

SAVINGS
Employees make fewer visits to higher-priced sites of care.

INCREASED PRODUCTIVITY
Employees spend less time traveling to and waiting at the doctor's office or urgent care centers.

EMPLOYEE SATISFACTION
Employees have access to doctors when they need it.



LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

A great consumer experience

Say "Ahhhh."

90%

patient satisfaction

"I am very impressed and will continue to recommend this service to friends, family and co-workers."

85%

completely resolve their medical issue

"I was able to get things taken care of in less than 10 minutes."

90%

saved time

"I will definitely use it again. I saved at least three hours by not going in to the doctor—and a ton of cash!"

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem. BlueCross BlueShield

LiveHealth® ONLINE

LiveHealth Online is changing healthcare

PC Magazine recently named Live Health Online as one of the ***10 Apps That Are Changing Healthcare****

"Telemedicine and telehealth apps are dramatically making healthcare **more convenient, less expensive, more preventative, and in many cases downright better**."

"These apps and sites—and others like them—are truly **revolutionizing healthcare**."

"One key differentiator with LiveHealth Online is that the service accepts some insurance plans, so you may owe the same co-pay as if you went into the doctor's office. Each consultation is a flat $49 if you have no coverage, if your plan doesn't cover online visits or if you haven't met your plan's deductible. **No matter whether your virtual visit is covered, you'll always see your cost before the appointment**."

*http://www.pcmag.com/article2/0,2817,2476623,00.asp

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

3/30/16

Better Care.
Lower Costs.

Impacts and Outcomes of Telehealth in Alaska

ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

Stewart Ferguson, PhD
Chief Technology Officer (CTO)
Alaska Native Tribal Health Consortium

"***Telemedicine*** is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."

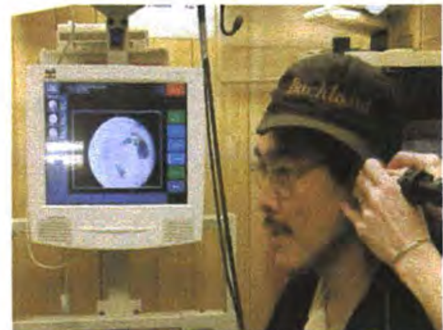
Source: The American Telemedicine Association (ATA)

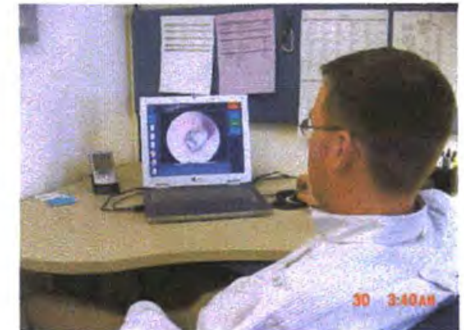
*The ATA treats **telemedicine** and **telehealth** as synonyms and uses the terms interchangeably.*

Types of Telemedicine

Video-Teleconferencing (VTC)
Synchronous Telemedicine
Video-Based
Live

Store-and-Forward (S&F)
Asynchronous Telemedicine

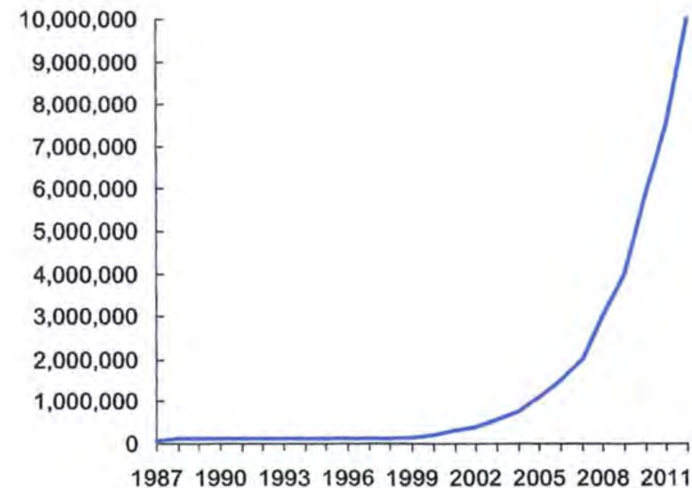




Home Telehealth (HTM)
Remote Patient Monitoring (RPM)
May be Live or S&F or both

How Typical is Telemedicine?

- Currently about 200 telemedicine networks in U.S.
- 3,500 service sites in the U.S.
- Over half of all U.S. hospitals now use some form of telemedicine.



Patients Served by Telemedicine in North America

Source: The American Telemedicine Association (ATA)

Alaska Tribal Health System

Medical Care Service Levels

- Alaska Native Medical Center tertiary care
  - Referrals to private medical providers and other states for complex care
- 6 regional hospitals
- 4 multi-physician health centers
- 25 subregional mid-level care centers
- 180 small community primary care centers

AFHCAN "Store and Forward" Usage

FY15

- **43,000** Telehealth Cases
- **1,500** Providers
- **26,000** Patients

2001-2015

- **265,000** Telehealth Cases
- **4,300** Providers
- **99,000** Patients

Specialty Healthcare Clinics available by VideoTeleconference

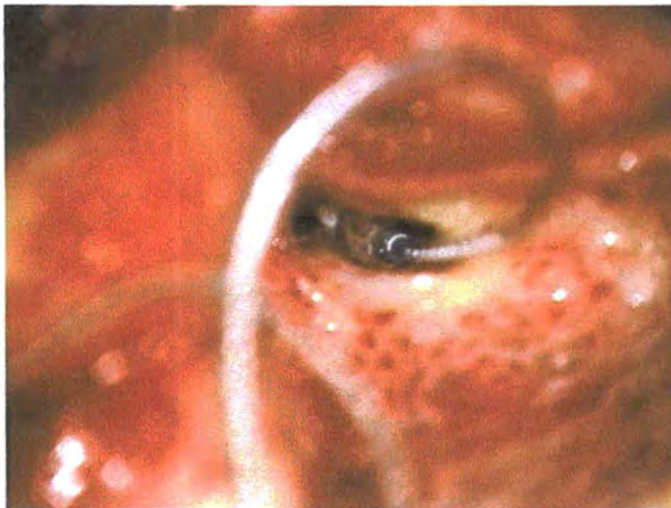
- Oncology
- Cardiology
- Pediatric Endocrinology
- Pediatric Speech Language Pathology
- Adolescent Medicine (care delivered by Seattle Childrens Hospital)
- Breast Cancer Screening (care delivered by Mayo Clinic)
- Endocrinology
- Pulmonology
- HIV/Early Intervention Services
- General Internal Medicine
- Infectious Disease
- Neurology
- Dermatology
- Emergency Department Services
- Gastroenterology
- Hepatitis
- Nephrology
- Diabetes
- Rheumatology
- ENT
- OB/GYN
- Primary Care

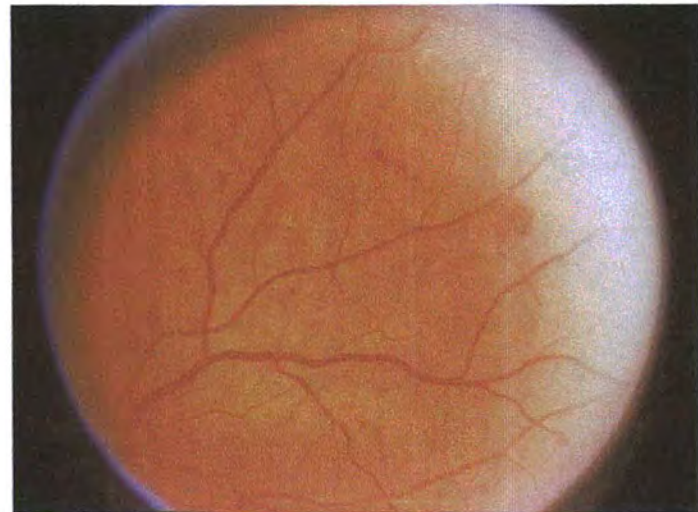
Many others are in development

Provider Reviews

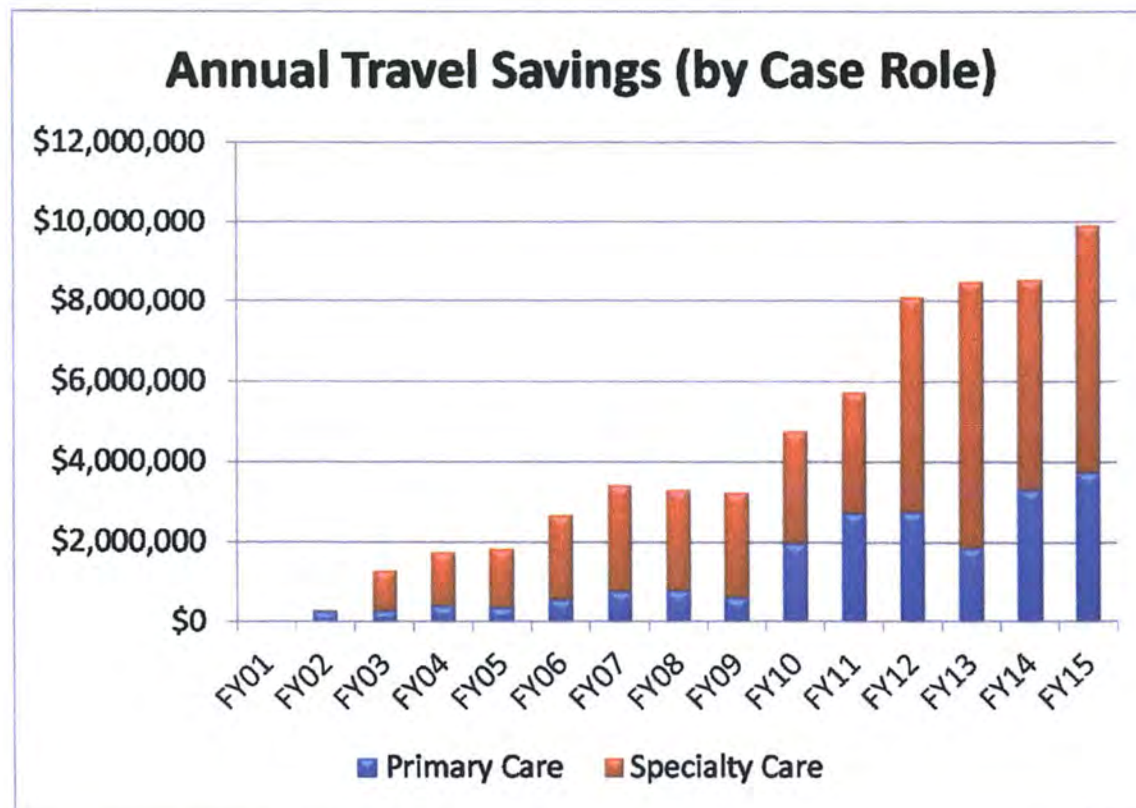
76% of encounters are rated as improving the quality of care for the patient (n=11,490).

67% of encounters are rated as improving patient satisfaction (n=11,477).





Estimated Travel Savings from Telehealth for **ALL** Patients



Medicaid now saves an estimated $10 to $11 for every $1 spent on specialty telehealth consultations

Estimated annual savings from telehealth for all patients amounts to about $10m with a total savings of $63.4m since 2003.

Telehealth Impact on Extended Waiting Times (> 4 months)

ORIGINAL RESEARCH

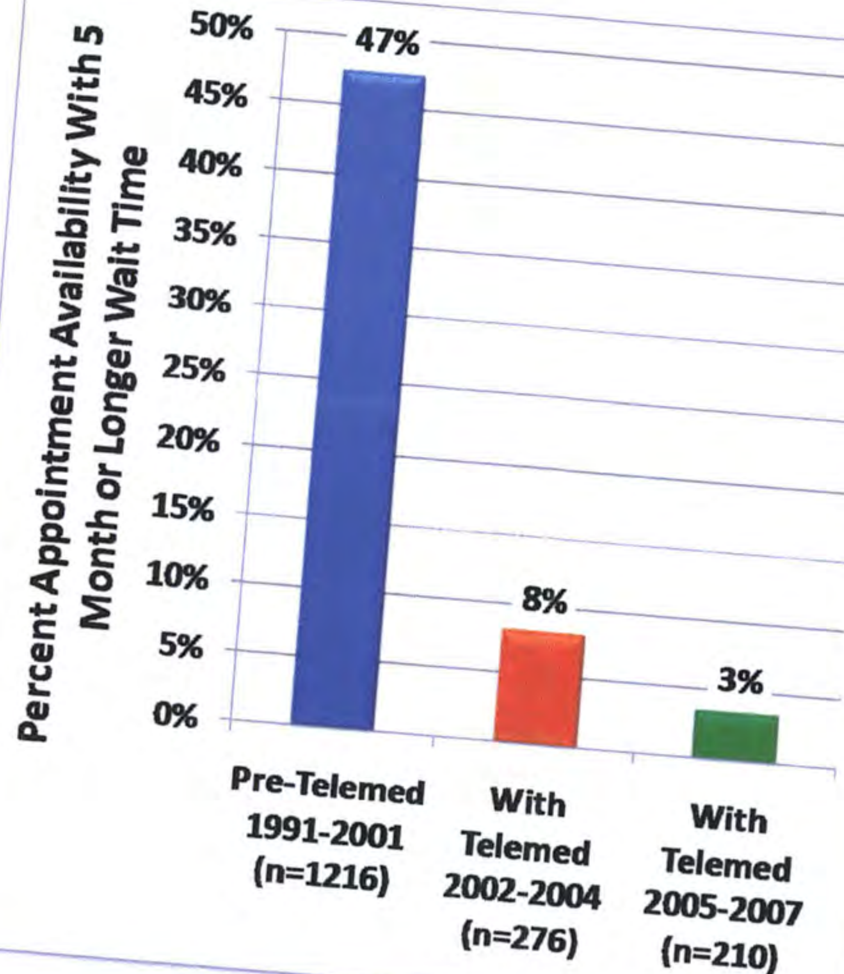
The Impact of Telehealth on Wait Time for ENT Specialty Care

Philip J. Hofstetter, Au.D.,[1] John Kokesh, M.D.,[2]
A. Stewart Ferguson, Ph.D.,[3] and Linda J. Hood, Ph.D.[4]

[1]Audiology Department, Norton Sound Health Corporation, Nome, Alaska.
[2]Department of Otolaryngology, Alaska Native Medical Center, Anchorage, Alaska.
[3]AFHCAN Telehealth Program, Alaska Native Tribal Health Consortium, Anchorage, Alaska.
[4]Department of Hearing and Speech Sciences, Vanderbilt University, Nashville, Tennessee.

Abstract

Introduction



Data courtesy of Phil Hofstetter

Alaska Native Tribal Health Consortium

ANMC Turnaround Time

25% of cases are turned around in **60 minutes**

60% of cases are turned around in **the same day**

Segment Care Management Models Based on Patient Care Needs

Segment	Share of patients	Goal
High-Risk Patients	**5%** of patients. Usually with complex disease(s), comorbidities.	Shift from high-cost services to lower-cost management.
Rising-Risk Patients	**15% - 35%** of patients. May have conditions not under control.	Avoid unnecessary higher-acuity, higher-cost spending.
Low-Risk Patients	**60% - 80%** of patients. Any minor conditions are easily managed.	Keep patient healthy

Source: Playbook for Population Health, © The Advisory Board Company 2013

Supports Provider Collaboration and Team-Based Care

Maniilaq Association

- Expanding services for Developmentally Disabled
- Piloting elderly care project – 100% Telehealth

Medicaid Tribally Targeted Case Management

- Approved demo projects with complex diabetes patients, cardiac patients, infant learning.

Virtual Field Clinics

- Rheumatology (Provider in Germany)
- ENT

The use of telehealth will play an essential component as part of broad efforts to increase care coordination and integrate behavioral health and primary care.

Supports Provider Collaboration and Team-Based Care: Virtual Field Clinic

Patient Health Aide

Gambell, Alaska

Patient Health Aide

Savoonga, Alaska

PCMH

Case Manager

Norton Sound Regional Hospital
Nome, Alaska

ENT Specialist
ENT Case Manager

Alaska Native Medical Center
Anchorage, Alaska

Caring for Our Most Expensive – and Most Vulnerable – Infant Population

Year 1 Costs Post-Discharge (NICU)

$200,000
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0

Average Cost (during Year 1 post-discharge)

0 50 100 150 200 250 300

Patients (with 1 full year of post-discharge data)

70% Total Cost

100% Total Cost

Respiratory System

Congenital Anomalies

Congenital + Respiratory

Some of these Primary Diagnosis Groups include patients that account for 70% - 100% of all costs for NICU patients in Year 1 post-discharge

Care Coordination for the Most Vulnerable Population

We estimate we would save 37% on the cost for care of these patients by:

- ✓ Reducing emergency visits and associated costs by 60%
- ✓ Reducing inpatient hospital admissions and associated costs by 50%
- ✓ Decreasing emergent travel and associated costs by 60%
- ✓ decreasing non-emergent travel and associated costs by 20%

Most importantly – this will improve access to care and improve the overall health of these children

Contributions to Health System Performance

Rural

Access

Delivers are over distance

Improves access to scarce and mal-distributed care

Increases efficiency of providers through e-consultation

Supports provider collaboration and team-based care

Enables chronic disease self-management

Enables new and system-wide care models

Urban

Quality & Cost

Questions

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907-229-3685

Federation of
STATE
MEDICAL
BOARDS

Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

April 2014

Federation of STATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:

An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.

A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

REFERENCES

American Accreditation HealthCare Commission. *Health Web Site Standards*. July 2001.

AMA. Council on Ethical and Judicial Affairs. *Code of Medical Ethics*. 2000-2001.

AMA. *Report of the Council on Medical Service*. Medical Care Online. 4-A-01 (June 2001).

College of Physicians and Surgeons of Alberta. *Policy Statement. Physician/Patient Relationships* (February 2000).

Colorado Board of Medical Examiners. *Policy Statement Concerning the Physician-Patient Relationship*.

The Department of Health and Human Services, HIPPA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. *A Model Act to Regulate the Practice of Medicine Across State Lines*. April 1996.

Health Ethics Initiative 2000. eHealth Code of Ethics. May 2000.

Health on the Net Foundation. *Code of Medical Conduct for Medical and Health Web Sites*. January 2000.

La. Admin. Code tit. 46, pt. XLV, § 7501-7521.

New York Board for Professional Medical Conduct. Statements on Telemedicine (draft document). October 2000.

North Carolina Medical Board. Position Statement. Documentation of the Physician-Patient Relationship. May 1, 1996.

Oklahoma Board of Medical Licensure. Policy on Internet Prescribing. November 2, 2000.

South Carolina Board of Medical Examiners. Policy Statement. Internet Prescribing. July 17, 2000.

Texas State Board of Medical Examiners. Internet Prescribing Policy. December 11, 1999.

Washington Board of Osteopathic Medicine and Surgery. Policy Statement. Prescribing Medication without Physician/ Patient Relationship. June 2, 2000.

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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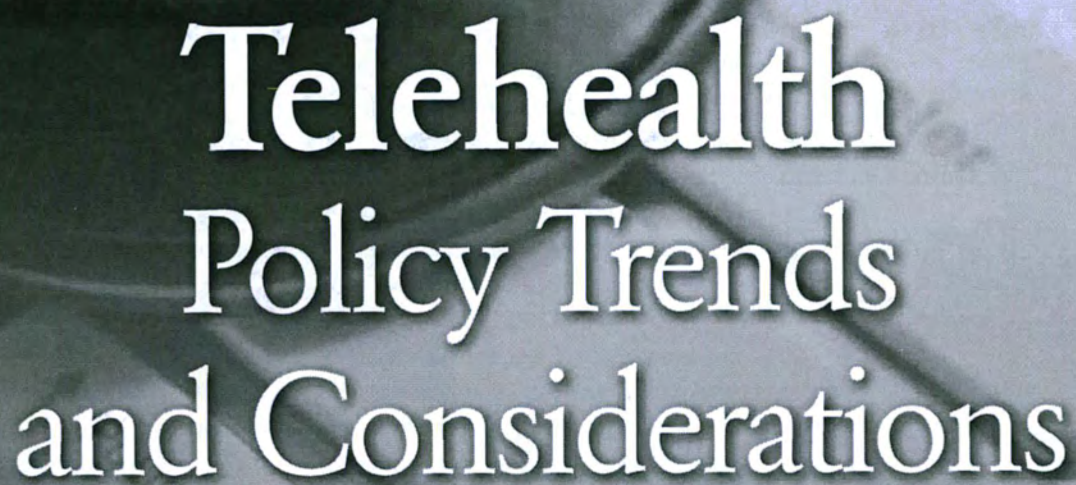

NATIONAL CONFERENCE *of* STATE LEGISLATURES

NCSL Partnership Project on Telehealth

In December 2014, NCSL brought together state legislators, legislative staff and private industry representatives to discuss telehealth adoption and barriers. The group met for one year and focused its attention on three policy areas: reimbursement of telehealth encounters, licensure for telehealth providers, and patient privacy, safety and security. This white paper represents the outcome of those discussions and provides options for state policymakers in those three areas.

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Telehealth presents one strategy to help achieve the triple aim of better health care, improved health outcomes and lower costs. It is widely acknowledged for its potential to ameliorate health care workforce issues by creating efficiencies and extending the reach of existing providers. With the potential to overcome access barriers, telehealth is also viewed as a means to reduce health disparities for aging and underserved populations, as well as reduce costs and burdens for patients.

Telehealth is a tool that capitalizes on technology to remotely provide health services. The federal Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration." It encompasses health-related services, including patient education, provider consultation and training, and remote care and home monitoring.

The adoption and expansion of telehealth across the nation poses various challenges, some of which present policy questions for state leaders. This report focuses on the following three primary policy issues related to telehealth.

- **Coverage and Reimbursement:** Differences in payment and coverage for telehealth services in the public and private sector, as well as different policies across states, remain a barrier for widespread telehealth use. States have enacted various policies related to Medicaid, and in many cases, private payers. State policy typically determines what constitutes telehealth; the types of technologies, services and providers that are eligible for reimbursement; where telehealth is covered and how; and other guidelines.

- **Licensure:** With technology's ability to span state borders, provider licensure portability is a key issue that states are examining to expand access and improve efficiency in the existing workforce. Policymakers are addressing practice across state lines through various mechanisms, including reciprocity with other states and interstate compacts.

- **Safety and Security:** Ensuring safe telehealth encounters for patients, as well as privacy and data security, has become an increasingly important issue as telehealth has grown. Some states are ensuring patient safety by defining which services are appropriate to be delivered remotely, creating guidelines for establishing a patient-provider relationship and mandating certain informed consent requirements.

Policymakers are working to craft frameworks that capitalize on the benefits of telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and health outcomes.

Legislators can ask questions to learn more about benefits, opportunities and challenges related to telehealth in their states. Leaders can guide policy discussions that center on telehealth as a way to extend existing health care services.

In considering telehealth policies, legislators may want to convene a variety of stakeholders from all sectors and perspectives. Policymakers modifying or creating policies may consider the level of oversight needed to ensure that services are effective in terms of costs and outcomes, and balance those needs with potential unintended consequences or future hurdles as telehealth continues to develop. Reimbursement, licensure and patient safety—along with new challenges and opportunities—will continue to be issues for state leaders to consider.

POLICY CHECKLIST

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

- ☐ **Examine existing policies** related to telehealth reimbursement and coverage in your state. Ask questions such as: Which providers can be reimbursed? For which services and telehealth modalities? Where must a provider or patient be located to ensure payment or coverage? What other policies affect coverage and reimbursement?

- ☐ **Consider existing definitions** of telehealth, and to what extent they may enable or constrain telehealth. Explore other states' definitions; weigh benefits and obstacles to promoting consistent language across states to help standardize telehealth.

- ☐ **Look at Medicaid and state employee reimbursement policies** and, if appropriate, consider expanding covered services.

- ☐ **Evaluate the benefits of telehealth expansion** within the context of other state needs. Consult with stakeholders and/or consider studying the potential initial costs associated with increased service utilization versus other state budget needs and the potential to save money in the future.

- ☐ **Work with private carriers** to determine if private payer requirements would help promote telehealth in your state. If so, consider the level and requirements of parity.

- ☐ **Consider the role for legislation** related to licensure and workforce issues in telehealth. Consult with stakeholders, including provider boards, providers, payers (who are responsible for creating adequate networks) and consumers. Consider language in legislation to help provide appropriate guidance to boards.

- ☐ **Look at current workforce or access gaps** and consider ways to facilitate coverage through telehealth. Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.

- ☐ **Assess the role of licensure** in existing or new payment and delivery reforms. If applicable to your state, examine ways to streamline licensure.

- ☐ **When creating legislation, consider language** that includes or can apply to all provider types, including those who may provide telehealth services in the future.

- ☐ **Study existing statutes** to see whether and where clarity might be needed to help guide safe telehealth policies and practices. For example, look at definitions of patient-provider relationships or examinations, and consult with stakeholders about changes or considerations.

- ☐ **In looking at existing or new legislation, balance the constraints** being placed on telehealth with the need to safeguard patient safety and security.

- ☐ **Examine how data are collected** on health care services delivered by telehealth. Data collection that includes a telehealth-specific identifier helps in evaluating programs and in monitoring for fraud and abuse.

DEFINING TELEHEALTH

Telehealth is defined differently by nearly all states and even by different entities within the federal government. The federal Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration."[1] Telemedicine typically refers to clinical services, whereas telehealth encompasses health-related services more broadly, including patient education, provider consultation and training, and remote care or home monitoring. However, telehealth and telemedicine are often used interchangeably.

Definitions of telehealth affect the services covered and reimbursed in each state. Some states limit telehealth definitions to certain types of technologies, while others allow more flexibility through broad definitions. In addition, most states exclude—or do not specify inclusion of—email, telephone and fax in their definitions of telehealth.

- **Georgia** Code Annotated § 33-24-56.4: "'Telemedicine' means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone,

OVERVIEW

Telehealth offers one potential strategy to help achieve the triple aim of better health care, improved health outcomes and lower costs. States spend a significant portion of their dollars on health care, and despite a recent slowdown, new projections estimate that health care spending in the United States will increase by an average of 5.8 percent per year from 2014 to 2024.[2] While examining cost drivers, state leaders are looking to leverage resources in a cost effective manner that improves health for the population.

Telehealth is a tool—or means—of delivering care that capitalizes on technology to remotely provide health care and other health services. It brings the services directly to the patient, changing the way patients and their families can interact with providers and the health care system.

With this mechanism for care delivery on the rise, many advocates and experts believe telehealth will continue to grow and gain acceptance. Use of telehealth services is expected to grow from 250,000 patients in 2013 to 3.2 million patients in 2018.[3] This trend is playing out in state legislatures, as more than 200 telehealth-related bills were introduced in 42 states in 2015.[4] State leaders are grappling with how to leverage the potential of telehealth while also ensuring appropriate use, health outcomes and safety. This report describes some of the trends and issues in state telehealth policies, and key considerations for lawmakers.

The roots of telehealth have been linked to innovative ideas from the late 1800s and early 1900s, as evidenced in an 1879 Lancet article that cited using the telephone to reduce unneeded office visits.[5] Over the past few decades, telehealth has been largely viewed as a means to reach rural communities, which typically face additional barriers to accessing care, such as fewer providers and greater travel distances. However, telehealth is increasingly being viewed more broadly as a way to reach multiple populations in different settings and to address various health care issues.

Telehealth is widely acknowledged for the po-

facsimile transmissions, unsecured email, or a combination thereof do not constitute telemedicine services."

- **Minnesota** Statute § 62A.671: "'Telemedicine' means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, email, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care."

- **Nevada** AB 292 (2015): "'Telehealth' means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail."

Sources: Center for Connected Health Policy; NCSL

tential to ameliorate health care workforce shortages and maldistributions. Though it does not increase the size of the provider workforce, it can help better distribute providers by creating efficiencies and extending the reach of existing providers. With its potential to overcome workforce and access barriers, telehealth is also viewed as a means to reduce health disparities for aging and underserved populations, as well as reduce costs and burdens for patients associated with lost work time, transportation and child care.

Telehealth can increase health care access in other ways, including, for example, the ability to reach care outside typical provider office hours or in different settings such as homes, long-term care facilities, schools, workplaces or prisons. By improving access to lower-cost primary and necessary specialty care, telehealth could provide timely, accessible care in lower-cost environments and help reduce expensive emergency room (ER) visits. For older people, telehealth may assist family caregivers, support aging in place and reduce institutional care. And certain telehealth modalities may be especially helpful in managing chronic conditions at home, thereby reducing ER and hospital readmissions.

The possibility to improve health,[6] along with consumer demand for convenience, is also a driving factor for many health leaders and providers to invest in telehealth programs. For example, 74 percent of consumers reported that they were likely to use online services.[7]

EFFECTIVENESS AND VALUE

Telehealth can help achieve the goals of the triple aim—improving care, bettering health and lowering costs—by improving access to appropriate, lower-cost services, such as timely primary or specialty care, or through lower-cost settings, including clinics, homes or workplaces. The Centers for Medicare and Medicaid Services (CMS) notes that telehealth is viewed as a cost-effective alternative to traditional service delivery.[8] For example, it is viewed as a beneficial tool to support patients and family caregivers in home health care for older Americans,

TELEHEALTH APPLICATIONS

Four modes, or modalities, are typically included in the definition of telehealth. The first three are most often seen in states' policies, whereas mobile health is less common in policies, but is a rapidly growing field.

■ **Real-time or Live Video:** Real-time or synchronous audio and video communication between a patient (and/or family member) and provider; e.g., visiting with a specialty care provider in real time over video.

■ **Store and Forward:** Transmission of data, images, sound or video from one care site to another; e.g., teleradiology or teledermatology, where images are sent to specialists for evaluation.

■ **Remote Patient Monitoring:** Services in which a patient's vital signs and other data are collected at home or outside a clinic and transferred to a provider for monitoring and response, if needed; e.g., at-home monitoring of patients with diabetes for blood glucose levels and other vital signs.

■ **mHealth (mobile health):** Health education, information or public health services provided by a mobile device; e.g., health education applications (apps) on cell phones, wearable devices or reminders to take medications. This area is much broader than the prior three modalities, and is still developing.

Telehealth is often associated with increasing access to primary care services.

However, it includes, but is not limited to, numerous other applications such as:

- Acute care, such as trauma, telestroke and tele-ICU programs
- Chronic care management
- Behavioral health care, such as telepsychiatry
- Long-term services and supports
- Home health care
- Dental care
- Specialty medical services, such as dermatology and radiology

For more information on specific uses of telehealth, please see resources such as the American Telemedicine Association's case studies.

who are a growing population and account for about 75 percent of health care costs.

Telehealth is often cited as effective for providing comparable—or no difference in—patient care and outcomes compared to traditional care delivery. The American Telemedicine Association, a telehealth advocacy organization, suggests that much of the research has found care provided through telehealth to be comparable to in-person care without differences in the ability to obtain necessary information, make a diagnosis or develop a treatment plan.[9] A recent review of 93 randomized control trials—the gold standard of research—found similar or better outcomes through telehealth alone or telehealth with usual care, as compared to usual care alone, for patients with a variety of health issues.[10] The findings were primarily related to patients with heart failure and diabetes, but some evidence supported comparable outcomes in areas such as mental health and dermatology.

In terms of clinical outcomes and cost effectiveness, many note that more research is needed. The review of randomized control trials concluded that effectiveness of telehealth may depend on different factors, including patient population (e.g., disease or condition), how telehealth is used (e.g., clinical visit, remote monitoring), and the health care providers or systems involved in delivering telehealth. The review noted that limited data were available on patient and provider satisfaction, as well as costs. Similarly, a stakeholder group convened by the Center for Connected Health Policy concluded that "larger, longer, more rigorously designed controlled studies" were needed to better evaluate telehealth.[11]

Many of the peer-reviewed, rigorous studies of telehealth cost effectiveness are only recently emerging,[12] and there are multiple challenges associated with measuring and making generalized conclusions about cost effectiveness. The studies in this field are each limited to different telehealth modalities, settings, diseases or conditions, or patient groups.[13] This makes it difficult to make a broad statement about cost effectiveness in telehealth as a whole. The rapid pace of technological change in the field,[14] as modalities and use change, also create challenges to keeping the research relevant.

Researchers, states and other groups are trying to measure the effects of telehealth on costs. For example, among 12 peer-reviewed studies published since 2007, most of the research found cost savings or no difference in telehealth compared to traditional care delivery (see box on page 10 for examples).[15] In addition, in a report required by legislation, Maryland's Department of Health and Hygiene found that Medicaid expenditures using a "hub and spoke" telemedicine model could increase costs for the state between $500,000 and $700,000 through increased service use. The report also suggested the projected increases were relatively small and would likely be offset by reductions in ER visits and transportation costs. In a different context, an analysis of various private payer data found cost savings of approximately $126 for each commercial telehealth visit, compared to in-person acute care.[16] It also estimated that Medicare could save around $45 per telehealth visit.

Data on outcomes and cost effectiveness are vital to policymakers seeking to invest state resources wisely and will continue to be important moving forward. State leaders can support collecting and measuring data on telehealth services to help strengthen the evidence base. Relevant data may include service, cost and health information found in claims data, pharmacy records and patient medical records. Even data from remote patient monitoring or wearable electronics (such as activity trackers) may provide valuable information. Data analytics, including a comprehensive strategy for collecting and using data among multiple health care stakeholders, is increasingly important to understand cost drivers and manage the population's health. State reforms, including alternative payment and delivery models, will also likely have implications for the use, outcomes and costs associated with telehealth. Policymakers may wish to consider the roles of telehealth, along with availability and integration of data, when examining system reforms.

EMERGING COST-EFFECTIVENESS RESEARCH

Some newer studies related to cost effectiveness in telehealth have found comparable costs or cost savings compared to traditional care delivery.

A study of a private nursing home chain that switched from on-call physicians to telemedicine physician coverage during off-hours looked at hospitalizations and the level to which nursing homes were engaged in telehealth service.[17] Among other things, the researchers found that facilities that used telehealth to a greater extent realized a significant decline in hospitalizations. They found the average savings to Medicare would be $151,000 per nursing home per year for the more engaged facilities. The authors also acknowledge that Medicare better incentivizes reducing hospitalizations, while nursing homes may have a financial disincentive to invest in telehealth to prevent hospitalizations for long-term Medicaid patients. This is because, instead of Medicaid payments, the facility will often receive a higher skilled-nursing benefit from Medicare when patients return post-hospitalization.

An analysis of a Veterans Health Administration chronic disease management program that included care coordination with home telehealth monitoring devices to help veterans age in place and prevent nursing home admissions found positive results.[18] The findings included that the care coordination home telehealth group, in comparison to the usual care group, had significantly lower health care costs and smaller increases in Medicare costs. The group also had a greater increase in pharmacy costs attributed to better medication management and adherence. These findings built on a 2008 study, which found a 25 percent reduction in numbers of "bed days," a 19 percent reduction in hospital admissions, and a cost of $1,600 per patient per year, substantially less than other non-institutional care programs and nursing home care.[19]

An evaluation of the Hospital at Home model to serve aging Medicaid and Medicare patients with chronic diseases also found benefits for the telehealth group.[20] The Hospital at Home group had a telehealth unit in the home and a remote telehealth nurse to monitor conditions, as well as more extensive services such as physician and nurse visits. The study found 19 percent cost savings, similar outcomes and higher patient satisfaction in Hospital at Home, compared to similar inpatients.

POLICY ISSUES

Telehealth adoption and expansion across the nation bring various challenges, some of which present policy questions for state leaders. For example, lack of broadband and cellular connectivity, and availability and affordability of devices for consumers and providers can hinder telehealth. The telehealth field is changing rapidly, and in some cases, technology may be getting ahead of policy. Policymakers are working to craft frameworks that capitalize on the advancements and potential for telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and their constituents' health outcomes.

This report focuses on the following three primary policy issues related to telehealth often cited by advocates, providers and lawmakers.

- **Coverage and Reimbursement:** Differences in payment and coverage for telehealth services in the public and private sector, as well as different policies across states, remain a barrier for widespread telehealth use.
- **Licensure:** With technology's ability to span state borders, provider licensure portability is a key issue that states are examining to expand access and improve efficiency in the existing workforce.
- **Safety and Security:** Ensuring safe telehealth encounters for patients, as well as privacy and data security, has become an increasingly important issue as telehealth has grown.

COVERAGE AND REIMBURSEMENT

Coverage and payment are important pieces for all parties involved in telehealth. Health care professionals may be concerned about adequate payment for providing services remotely, and lack of payment could affect their ability to invest in telehealth technologies.[21] Similarly, differences in coverage may leave some patients without access to services that could be delivered via

telehealth. Federal policies have consequences for telehealth under the Medicare program, but states have a great deal of flexibility in other areas. States have taken different paths in reimbursement policies for Medicaid programs and, in some cases, for private carriers.

Medicare

Medicare, the federal insurance program for people age 65 and older and younger people with disabilities or certain conditions, began covering telehealth on a limited basis in 1997.[22] Though Medicare is a federal program, it affects what states can do for vulnerable populations, including those dually eligible under Medicare and Medicaid. Over time, the program has expanded its scope in terms of telehealth, but many limitations remain in place.

Medicare specifies reimbursement only for certain telehealth modalities, services and locations, including geography. It limits coverage to live-video (real-time audio and video technology) telehealth for office visits, office psychiatry services and provider consultations.[23] Store and forward methods are only covered in Alaska and Hawaii, the two exceptions to the live video policy, and remote patient monitoring is not covered at all.

Reimbursement for telehealth under Medicare is also dependent on the location of the beneficiary, or patient, receiving the services. The site of the patient—also known as the originating site—must be a rural location, which is defined as a Health Professional Shortage Area (HPSA) or in a county that is outside of a Metropolitan Statistical Area (MSA).[24] In addition, while the provider can be remote, the originating site must be a medical facility, which includes certain settings such as hospitals, provider offices, critical access hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities and community mental health centers.[25] This restriction excludes settings such as patients' homes.

States have the ability, through the Affordable Care Act (ACA), to use telehealth in integrating coverage for the dually eligible under both Medicare and Medicaid. Currently, Georgia, New York and Virginia cover telehealth services for their dually eligible populations through the Centers for Medicare and Medicaid Services (CMS) Capitated Financial Alignment Model for Medicare-Medicaid Enrollees.[26] And under CMS approval, Virginia has waived some of the Medicare barriers to telehealth. For example, Virginia allows plans to use and reimburse for telehealth in rural and urban settings, including store and forward and remote patient monitoring services.

At least two pending congressional bills would affect telehealth practices for Medicare. The Medicare Telehealth Parity Act (HR 2948), one of several proposed federal pieces of legislation, would expand telehealth under the Medicare program. Among other things, it would amend the definition of an originating site and direct the Government Accountability Office to study the effectiveness and savings of certain telehealth services. The Telehealth Enhancement Act (HR 2066) also seeks to expand telehealth under Medicare, including by expanding originating sites and authorizing accountable care organizations to include telehealth and remote patient monitoring as supplemental health care benefits, as well as in a national pilot on payment bundling. Both bills were introduced in 2015 and remain under consideration at time of publication.

Many state policymakers and telehealth stakeholders view the Medicare policies as burdensome barriers to telehealth growth. Because of the restrictions, many states are now leading the way with innovative policies for programs that fall under their purview.

Medicaid

States have significant control and flexibility in their Medicaid programs, unlike in Medicare, including the ability to decide Medicaid coverage and reimbursement for telehealth. According to CMS, "states are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology."[27] State policy typically determines what constitutes telehealth; the types of technologies, services and providers that are

CONNECTIVITY INFRASTRUCTURE

Broadband, cellular networks and availability of smartphones and devices—which allow users to connect to the Internet at high speeds—are important when considering how patients can access the growing availability of telehealth services. Smartphone use among Americans is at about two-thirds and around 70 percent have broadband access at home. Yet there are disparities. The broadband numbers dip when looking at older adults and those with lower education levels, limited incomes, chronic health conditions or disabilities, or who live in rural areas. And some—around 20 percent in 2013—have neither a smartphone nor broadband. Even access to smartphones or broadband does not necessarily guarantee access to services because of speed or data limitations.

Providers, especially rural or smaller clinics or practices, may also face challenges in connectivity. This is particularly important for those who want or need to connect to larger or other health care systems. Nearly all states have enacted legislation to support broadband in some way, including promotion, coordination or funding. The federal government is also involved in expanding broadband. The Health Care Connect Fund, for example, provides support to expand access to broadband services for health care providers, particularly in rural areas, and encourages the formation of state and regional broadband networks. This may be one avenue for states and providers to leverage in order to expand provider connectivity. The Federal Communications Commission created a National Broadband Plan, which also cited the need to expand broadband to enable health-related technologies, including in rural areas.

Sources: Pew Research Center's Internet Project; NCSL

eligible for reimbursement; where telehealth is covered and how; and other guidelines.

Based on analysis from the Center for Connected Health Policy, the American Telemedicine Association and NCSL research, telehealth coverage and reimbursement in state Medicaid programs vary considerably:[28]

- Almost all states (49) and the District of Columbia have some coverage for telehealth.
- Nearly all reimburse for live video telehealth.
- Nine states—Alaska, Arizona, California, Illinois, Minnesota, Mississippi, New Mexico, Oklahoma and Virginia—reimburse for store and forward services.
- At least 17 states have some reimbursement for remote patient monitoring (RPM) in Medicaid: Alabama, Alaska, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, New York, South Carolina, Texas, Utah, Vermont and Washington, plus Pennsylvania and South Dakota, who reimburse for RPM through their departments of aging.
- Most states specifically exclude—or do not specify inclusion of—email, phone and fax in their definitions of telehealth services that can be reimbursed.

Within these reimbursement structures, there are many nuances among states. For all modalities, states may restrict the types of services and specialties, the types of providers and the location of the patient in order to be eligible for reimbursement.[29] For example, 48 states have some coverage for mental or behavioral health services provided via live video, whereas eight states reimburse for telehealth under their home health services.[30] In addition, 19 states allow fewer than nine provider types to receive reimbursement for telehealth (including four states that allow reimbursement only for physicians), while 15 states and the District of Columbia do not specify the type of provider.[31]

Though some states created geographic limits similar to Medicare, requiring that patients be located in rural settings, the trend increasingly is for states to remove these restrictions: The majority of states do not currently have rural requirements. For example, Nevada, Michigan

and Missouri removed their geographic restrictions in recent years, and Colorado (HB 1029) removed its requirement during the 2015 legislative session.

States may also require other conditions for Medicaid reimbursement for telehealth. They include, for example, the type of site that can be an originating site (where the patient is located) or distant site (where the provider is located), and whether another provider must be present with the patient as a "telepresenter." Currently, states are relatively split in regard to these requirements. Twenty-four states and the District of Columbia do not specify a patient setting or patient location as a condition of payment.[32] Half of all states allow a patient's home to serve as an originating site, and 16 recognize schools or school-based health centers.[33] And 28 states and D.C. do not require a telepresenter during the telehealth encounter or on the premises during the service.[34]

As states continue to transform the ways they deliver and pay for care, telehealth is one tool that may be deployed within state reforms. For example, 24 states allow telehealth services under Medicaid managed care.[35] In some respects, alternative models such as Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs) that typically have capitated payments (e.g., per member, per month) or global payments for patient care have greater ability to cover telehealth. These approaches often emphasize care coordination, and the payment models share risk while providing incentives for positive outcomes and value of care over volume of services. These models may offer more flexibility and incentive to provide services via telehealth. In fact, some argue that the fee-for-service model is a barrier to telehealth.[36] The global payment structure in MCOs and ACOs may allow hospitals, clinics and other providers the ability to invest some resources in telehealth, and realize the benefits and cost savings in the future.[37]

States can experiment with some of these alternative approaches through Medicaid state plan amendments, waivers and grants. Alabama, Iowa, Maine, New York, Ohio and West Virginia have used state plan amendments that include telehealth in their health home proposals. Kansas, Pennsylvania and South Carolina have

MEDICAID AND PRIVATE PAYER COVERAGE AND REIMBURSEMENT POLICIES

Note: Not all private payer laws require coverage of telehealth.

Sources: American Telemedicine Association; Center for Connected Health Policy; NCSL

used waivers to cover remote patient monitoring for long-term care services.[38] In addition, components of Vermont and Oregon's State Innovation Model (SIM) grants from the Center for Medicare and Medicaid Innovation (CMMI) included telehealth pilots. Massachusetts uses SIM funds to support behavioral health integration in primary care, including through telehealth. Hawaii also received support from CMMI for its State Innovation plan, which included expanding telehealth services, and Arkansas similarly included telehealth as a tool to increase availability and access to services. As lawmakers examine telehealth, they may consider it within the context and goals of any of these experiments, or within other state delivery or payment system reforms. Telehealth policies around reimbursement in particular may need to be examined or developed to promote reform goals—aligned with the triple aim—of containing costs and/or better coordinating care to improve health.

Private Payers and State Employees

Many states have adopted policies related to private payers, including coverage and reimbursement of telehealth in order to facilitate wider access and adoption. State laws governing private payers vary: Some stipulate certain criteria if payers choose to cover telehealth; some require coverage of telehealth for certain services, certain populations or all beneficiaries; and others require certain payment for telehealth.

In states that mandate reimbursement, some require that reimbursement is "equivalent to" or at the same rate as in-person services. Others—such as Colorado, Missouri and Virginia—require payment "on the same basis," as in-person services, which some argue may better take into account cost differences that could be achieved through telehealth, such as lower facility and administrative fees. Currently, 32 states and the District of Columbia have telehealth private payer laws, some of which will go into effect in 2016 or 2017.[39] Full parity—which exists in at least 23 states and the District of Columbia, according to the American Telemedicine Association—is considered when both coverage and reimbursement are comparable to in-person services.[40] Many states with parity laws stipulate that telehealth services are subject to the terms and conditions of the contract, or similar language.

CENTER FOR TELEHEALTH AT THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

The University of Mississippi developed a telehealth program with rural hospitals and clinics in 2003 in order to increase access to health care and specialty services throughout the state, particularly for rural Mississippians. The Center for Telehealth at the University of Mississippi Medical Center uses telehealth video technology to provide remote medical care—including more than 30 different specialties—as well as health education and public health services to 200 clinical sites in three-quarters of Mississippi's counties. The center has served more than 500,000 rural residents. It keeps patients in their home communities and helps improve rural facilities' workforce and bottom line. In addition, projections of savings for Medicaid from the use of UMMC's remote monitoring program for chronic disease management is estimated to be in excess of $189 million per year. Mississippi's program can serve as a model for other states and rural hospitals with specialty care shortages.

Source: The Center for Telehealth at the University of Mississippi Medical Center

Regardless of parity laws, some private insurers choose to cover telehealth services for all or a select segment of their members. For example, through Live Health Online, Anthem offers online live video telehealth visits with providers as a covered benefit for members in most of their commercial markets. These services are also available for a fee to non-members.

All states provide health insurance coverage for their employees. While there is significant variation between individual states, states collectively paid about $25 billion in 2013 to insure their employees.[41] State employee health coverage is a significant portion of state health spending, second only to Medicaid.[42] Twenty-four states allow some type of coverage for telehealth in state employee plans, with 21 extending the coverage through their parity laws.[43]

For states considering health care reforms, including telehealth implementation, employee plans can provide a model for other employers[44] or serve as a demonstration for potential new policies and services. North Dakota, for example, recently enacted legislation (HB 1038) to pilot telehealth in its employee health program.

Coverage and Reimbursement Policy Checklist

- Examine existing policies related to telehealth reimbursement and coverage in your state. Ask questions such as: Which providers can be reimbursed? For which services and telehealth modalities? Where must a provider or patient be located to ensure payment or coverage? What other policies affect coverage and reimbursement?
- Consider existing definitions of telehealth, and to what extent they may enable or constrain telehealth. Explore other states' definitions; weigh benefits and obstacles to promoting consistent language across states to help standardize telehealth.
- Look at Medicaid and state employee reimbursement policies and, if appropriate, consider expanding covered services.
- Evaluate the benefits of telehealth expansion within the context of other state needs. Consult with stakeholders and/or consider studying the potential initial costs associated with increased service utilization versus other state budget needs and the potential to save money in the future.
- Work with private carriers to determine if coverage requirements would help promote growth of telehealth in your state. If so, consider the level and requirements of parity.

LICENSURE

Licensure, and license portability, is an important issue for states looking at expanding provider networks beyond their borders through telehealth or other means. Licensing policies can also help address existing workforce shortages and the greater provider workloads resulting from more insured patients through the ACA.

Licensure is the responsibility of each state, which determines the qualifications to be licensed providers within its borders and the services and circumstances for health care practice. Through licensing, states have the authority to protect patients located in their borders and hold health care providers accountable to their practice, patient safety and liability laws. Telehealth can be delivered under current state licensure laws. Licensure is based on the location of the patient—providers abide by laws and requirements in the state where the patient receives services—which poses challenges for providers and states seeking to expand access across state lines, particularly through telehealth.

Licensing Options

Most providers are licensed in the state in which they practice health care, and providers wishing to practice in other states can apply for full licenses in those states. Credentialing, which is discussed on page 19, is another issue in telehealth related to licensure.

In order to provide services via telehealth across state lines, some states grant temporary licenses, telehealth-specific licenses or have reciprocity with neighboring states. Wyoming, for example, offers a temporary, expedited license for telehealth for physicians and physician assistants. Nine states—Alabama, Louisiana, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Tennessee and Texas—have special licenses related to telehealth.[45] These allow physicians to provide services remotely across state lines, and typically include certain terms, such as agreeing not to set up a physical office in the state. Other vehicles for out-of-state practice, though used less often, include reciprocity and endorsement. Some states, such as Alabama and Pennsylvania, have agreements with other states to grant licenses to out-of-state physicians that reciprocally accept the home-state license. Endorsement, as in Connecticut, simply allows an out-of-state physician to obtain an in-state license based on his or her home-state standards.[46]

Interstate compacts are another avenue for cross-state licensing that may promote and expand telehealth. Compacts are formed when a certain number of states enact the same legislation, with specific language that must be adopted. Joining a compact is voluntary on the part of the provider in compact states. States maintain their authority to monitor and discipline providers in their states, and both the home and other compact states have jurisdiction to do so over the health care professionals providing care within their borders. Compacts have the ability to expand provider networks, facilitate expedited help from out-of-state providers in the wake of disasters, and allow states to share information about bad actors. On the other hand, some parties may resist compacts for fear of losing authority, and others are concerned about costs for the state or providers related to implementing compacts.

Licensure compacts have been created for providers such as physicians, nurses and advanced practice registered nurses. The Federation of State Medical Boards' (FSMB) Interstate Medical Licensure Compact for physicians was first introduced in 2015. This compact creates an expedited process for eligible physicians to apply for licensure in compact states. It is intended to allow for a less onerous and time-consuming process for physicians seeking licenses in multiple states. Though the compact enables full licensure not specific to telehealth, one of the goals was to increase access to care through telehealth. Twelve states (Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, Wisconsin and Wyoming)—more than the minimum number of seven required to put the compact into effect—passed the medical licensure compact language in 2015, all by large margins in their legislatures. Two representatives from each

state that approves the compact sit on the Interstate Commission, which will provide the administration and oversight, including developing and enforcing rules.[47] The commission met for the first time in October 2015.

Other providers also have interstate compacts, which allow practice—including telehealth—across state borders. The Nurse Licensure Compact preceded FSMB's physician compact; it has been in existence for about 15 years with 25 states participating. The Nurse Compact creates a multi-state license similar to a driver's license, where the license is recognized in the home state and other compact member states.[48] This is different from the medical licensure compact that has an expedited approval process but still requires physicians to obtain licenses from each state where they practice. The model language for this compact was recently revised, and beginning in 2016, existing states and those wishing to join will need to pass the new language. Many of the modifications to the language were made based on feedback from states. The compact will go into effect after 26 states join or by Dec. 31, 2018, whichever occurs first. Similar to the Nurse Licensure Compact, an Advanced Practice Registered Nurse Compact will also

PROJECT ECHO

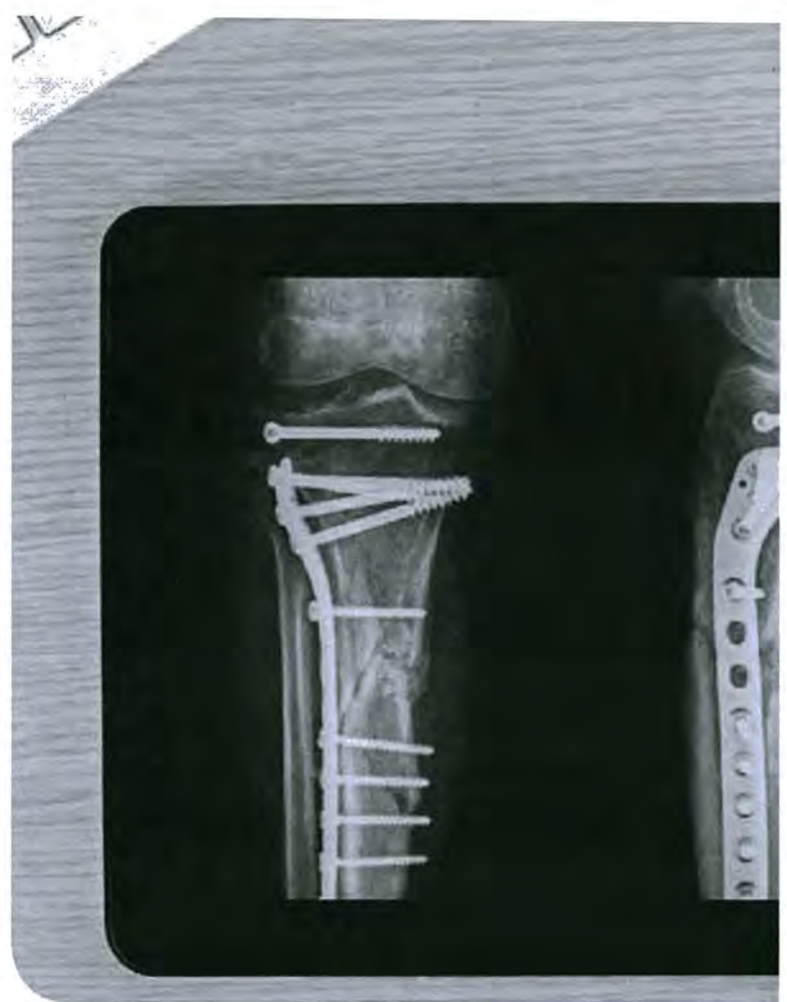
In some cases, providers can consult with each other across state lines without running into licensure issues. Project ECHO (Extension for Community Healthcare Outcomes) is an example of a provider consultation model using telehealth. The project began in New Mexico as a way to build capacity among primary care providers based in rural, underserved areas. Through weekly teleECHO (telemedicine) clinics, primary care clinicians receive support and advice from a specialty care team. In addition to building primary care providers' knowledge and efficacy in certain diseases, the model reduces the isolation of rural providers, increases their satisfaction, expands patient access, and has been shown to achieve care comparable to that delivered in a specialty clinic. There are now 39 ECHO hubs operating in 22 states. For example, during the 2015 legislative session, Missouri appropriated funds to support ECHO clinics.

Source: University of New Mexico School of Medicine, Project ECHO

be new in the 2016 sessions. Other examples of interstate compacts include EMS personnel, which was introduced in 2015 in seven states, and pending compacts for psychologists and physical therapists.

Federal Efforts

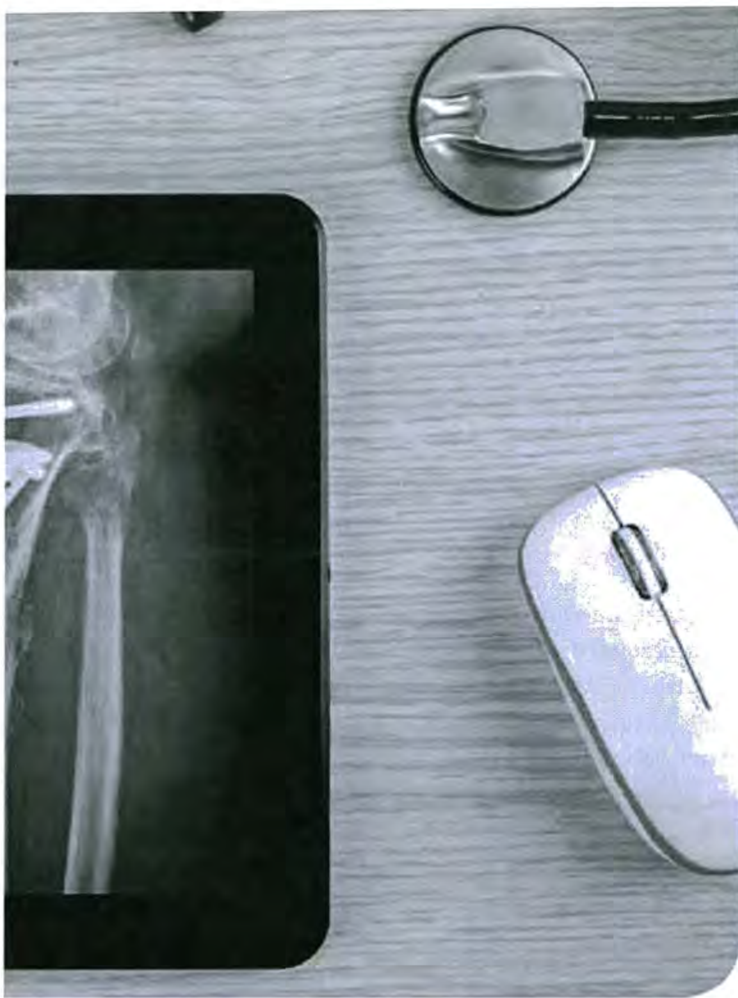
Two pieces of legislation that would affect licensure in Medicare and the Veterans Administration (VA) have also been introduced in Congress. These acts would supersede state requirements around licensure, laws and regulations, and essentially create one license (similar to the driver's license model) in the Medicare and VA programs. The TELE-MED Act (TELEmedicine for MEDicare Act of 2015; SB 1778 and HB 3081) would allow some Medicare providers to offer telehealth services to other Medicare beneficiaries across state lines. The jurisdiction would lie with the licensing or authorizing state. The Veterans E-Health & Telemedicine Support Act of 2015 would allow a health care professional authorized to provide care through the Department of Veterans Affairs and licensed in any state to provide services via telehealth, regardless of where the provider or patient is located.



Related Issues

Outside the licensure realm, several other issues may be of interest to legislators. Some of these issues may be contentious and, according to an Institute of Medicine (IOM) report, "practice standards, scopes of practice and other regulatory issues are increasingly polarizing stakeholders."[49] In many cases, state lawmakers may wish to stay informed about these issues, and in a handful of cases, states are taking action in these areas.

- **Liability:** Most providers may be covered for telehealth under existing liability coverage; however, much of this area is still unsettled and could be a barrier to telehealth. In fact, some of the unresolved issues (described later) involving patient-provider relationships, informed consent and practice standards relate to liability.[50] For example, state requirements around informed consent for telehealth can have liability implications. State policies on liability also differ and can create issues around interstate practice. Legal issues related to liability also include policy coverage for care via telehealth and for patients in other states; applicable state and federal privacy and security laws; and record retention policies. Lawmakers may want to be aware of existing legal considerations and differences in the application of telehealth, as well as new liability considerations that may arise.
- **Scope of Practice:** Scope of practice describes what a health professional can and cannot do to or for a patient. A professional's scope of practice is often based on the education, training and experience typical for that profession. Scope of practice is defined by state professional regulatory boards, often with guidance from state legislatures, and therefore regulations vary by state. Telehealth laws do not change a provider's existing scope



Licensure Policy Checklist

- Consider the role for legislation related to licensure and workforce issues in telehealth. Consult with stakeholders, including provider boards, providers, payers (who are responsible for creating adequate networks) and consumers. Consider language in legislation to help provide appropriate guidance to boards.
- Look at current workforce or access gaps and consider ways to facilitate coverage through telehealth. Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.
- Assess the role of licensure in existing or new payment and delivery reforms. If applicable to your state, examine ways to streamline licensure.
- When creating legislation, consider language that includes or can apply to all provider types, including those who may provide telehealth services in the future.

of practice; telehealth can be practiced with a state's existing scope of practice for all provider types. Providers may need to be aware of applicable standards of care and laws on supervision and collaboration through telehealth. While separate from licensure, some states may need to look at scope of practice for some disciplines as they address out-of-state providers, workforce shortages (especially behavioral health) and interstate compacts because of differences in state laws.

- **Credentialing and Privileging:** Credentialing and privileging are undertaken by health care facilities to verify providers' proficiency and expertise through data collection.[51] This can be an issue in telehealth when a provider needs credentialing and privileging at each health care facility at which he or she is treating patients via telehealth. Facilities in some cases can allow credentialing and privileging by proxy, relying on the decisions of the other facility. This issue is often being handled by facilities themselves, but some states have gotten involved to help facilitate telehealth. Oregon, for example, enacted legislation in 2013 requiring the Oregon Health Authority to adopt uniform documentation requirements for credentialing providers using telehealth.
- **Provider Training and Education:** Many assert that to improve telehealth adoption and use, students and providers in health care professions need to be trained in telehealth modalities. While telehealth training may occur in pockets, some stakeholders argue that it is not keeping up with the pace of telehealth. Incorporating training into education could help more students leave with the knowledge and skills to work effectively with patients remotely. Providers already delivering care may also need support to understand and implement new technologies. State policymakers may want to consider ways to encourage state-sponsored education that includes telehealth or examine mechanisms to support ongoing provider training.

SAFETY AND SECURITY

Telehealth is widely used in a number of contexts and for a number of services. In some cases it may ensure or improve patient safety by providing high-quality care that is more timely, accessible or appropriate. Remote patient monitoring, for instance, may be especially beneficial for seniors by keeping them safe and healthy in their homes. Live video counseling with a provider, or even an avatar (an image that represents another person), can help some patients with mental health disorders feel more comfortable. New technologies can also improve care, as in new pill bottles, for example, that can help remind patients about taking medication and allow providers to monitor adherence from a distance.

With excitement about the potential for telehealth has also come concerns for ensuring that services provided remotely are as safe and comprehensive as in-person care. Some argue that this concern needs to be addressed without holding telehealth to a stricter standard than traditional health care delivery. Many policymakers are balancing the rapid acceleration of technology and telehealth and its potential benefits with the responsibility to ensure safe, quality care for their constituents.

The standard of care—what another similarly trained and equipped provider would do in a similar situation—applies to health care providers regardless of the means of service delivery. Therefore, the standard of care and best practices for each health care profession should similarly govern safety in telehealth. In other words, because telehealth is simply a modality of delivering care, the standard of care for each type of service still applies. Some assert there is little or no need for other additional safeguards because the standard of care, as well as best practices and malpractice contingencies, will rein in any outliers in telehealth. As it is further employed, the standard of care of telehealth is likely to evolve.

Best practices and practice guidelines are also, according to the IOM, the "key to the future of telehealth"[52] and will similarly grow as evidence and use advances. Some state regulatory boards have adopted guidelines around standards for providing care via telehealth. In addition, several organizations—including the American Medical Association (AMA), the American Telemedicine Association (ATA) and the Federation of State Medical Boards (FSMB)—have also put forward best practice guidelines for safe use of telehealth. For example, the AMA developed model state legislation, which provides guidance on establishing a provider-patient relationship. The ATA has a set of practice guidelines that cover different health care services in telehealth. FSMB's guidelines provide guidance for state medical boards.

Some states are also getting involved in ensuring patient safety by defining which services are appropriate to be delivered through telehealth (as described in the reimbursement section), creating guidelines establishing a patient-provider relationship, and mandating certain informed consent requirements.

Patient-Provider Relationships and Prescribing

In telehealth, as with other modes of care, patients should trust that providers will offer necessary information for patients to make decisions about care. They should also expect competent care, assurance of privacy and confidentiality, and continuity of care. Providers' ethical responsibilities remain the same with telehealth, but differences in possible patient-provider interactions in telehealth have brought accountability and the patient-provider relationship to the forefront in discussions about telehealth safety. Some states are examining specific guidelines for those relationships. In many cases, these requirements seek to ensure that providers have adequate information about a patient prior to treatment. As an avenue for service delivery, telehealth ideally would be integrated into regular, coordinated care and services. However, there is some concern about fragmented care from different providers or duplication of services. With that is concern that certain providers could deliver care without the proper medical history or information, which could endanger patients and also jeopardize the growing tele-

KAISER PERMANENTE NORTHERN CALIFORNIA

Kaiser Permanente Northern California implemented new technology and telehealth tools in 2008, including Internet and video communication. Kaiser offered secure email services and phone appointments with providers, both of which were rated highly by patients—more than 80 percent of members in surveys reported that the communication with providers using these technologies was very good or excellent at meeting their needs. Kaiser also used video visits for some services, including after-hours medical care. Providers could refer patients to in-person emergency care as needed, but largely these visits helped avoid more costly ER visits. Physicians also reported that the online tools helped them provide better care. From 2008 to 2013, the number of virtual visits grew by more than 6 million.

Source: R. Pearl, "Kaiser Permanente Northern California: Current Experiences With Internet, Mobile, And Video Technologies," Health Affairs 33, no. 2 (2014): 251-257.

health field. On the other hand, there remains unease about creating higher standards for telehealth that can inhibit access to care.

At the crux of the patient safety issue are questions about whether and how a patient-provider relationship can be established via telehealth. The majority of states allow a patient-provider relationship to be established via telehealth. Some states have laws requiring an initial "face-to-face" visit or an exam; however statutes are not always clear whether "face-to-face" means in-person or via live telehealth interaction. In these cases, it is often up to provider boards to interpret and set policies. A few states specifically require an in-person visit or exam. Arkansas, for example, enacted legislation in 2015 (SB 133) that designates specific requirements for determining a professional relationship, such as conducting a prior in-person exam or "personally [knowing]" the patient.* Alabama, Georgia and Texas also require an in-person follow-up after a telehealth visit.[53] Many stakeholders are wary of requiring in-person visits because of the additional burden placed on the patient to seek in-person care, which could help recreate some of the barriers telehealth seeks to remove.

The patient-provider relationship also comes into play in prescribing medication. Federal law—the Ryan Haight Act—governs controlled substance prescribing via telehealth. State laws also govern a provider's authority to prescribe, including provider board rules and regulations that set the standard of care for prescribing. State pharmacy practice acts also regulate the standard of care for pharmacists. The accepted standard of care is for a provider to conduct a medical exam prior to prescribing a medication.[54] As with telehealth in general, some states allow the exam through telehealth. However, almost all states specifically do not allow an online questionnaire alone to count as an exam, because it relies solely on patients to provide their medical history and other applicable information for a provider, which is not keeping with the standard of care.[55] For example, Idaho's 2015 legislation (HB 189) that defined professional relationships included a clause that treatment based solely on an online questionnaire does not constitute an acceptable standard of care. Most stakeholders agree that if providers can prescribe and dispense medications via traditional means, they should be able to do so via telehealth as well, provided they can establish a relationship and gather the necessary information.

** At the time of publication, the Arkansas State Medical Board had a proposed rule pending that would allow establishment of the patient-physician relationship via telehealth in certain circumstances.*

CARE AND DATA COORDINATION

Information and data from telehealth visits, along with integration with a patient's medical record, present additional considerations for continuity of care, patient safety and health. Many hope that telehealth is integrated in a patient's regular care and coordinated with primary care and other providers. On the other hand, as with services like urgent care, there are some concerns about patients accessing services and/or prescriptions online without their primary care providers' knowledge, which could have implications for the patients' usual care. In either instance, questions remain about whether the responsibility to share data among multiple providers rests with the provider or patient.

Connecticut (SB 467) passed legislation in 2015, for example, requiring providers to ask patients to consent to disclose records from the telehealth interactions with their primary care provider, and if consent is granted, to do so in a timely manner. Alternatively, Anthem's Live Health Online offers the patient a record from the visit that he or she can give to his or her primary provider. Other data challenges include creating policies around data storage and retention, ensuring that data are interoperable between platforms and providers, and managing large volumes of data created from modalities like remote patient monitoring and wearable devices.

Informed Consent

Informed consent is a process by which a patient is made aware of any benefits and risks associated with a particular service or treatment, as well as any alternative courses of action. Many consider this type of knowledge to be good practice regardless of the service delivery mechanism. Informed consent also relates to providers' liability and legal exposure. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks and understand that a condition or treatment may require a provider to defer to in-person services. In terms of informed consent, some states are creating policies specifically related to telehealth.

Currently, 29 states have some type of informed consent policies.[56] This requirement may apply to different arenas—e.g., all providers or just the Medicaid program, or even specific services, depending on the origination (statute, administrative code, Medicaid policy) and intent of the policy.[57] States that require informed consent also vary in whether they require written or verbal consent. Less than 10 states require some type of written consent.[58]

Informed consent also provides patients the option to decline a service or treatment. In Colorado, for example, the law requires providers using telehealth to give patients a written statement of informed consent that includes their right to refuse services delivered by telehealth at any time without losing or withdrawing treatment.

Related Issues

Telehealth considerations often bring related issues such as fraud, abuse, data security and the federal Health Insurance Portability and Accountability Act (HIPAA) to the discussion. __
that privacy and security must be addressed to advance telehealth and ensure providers' and patients' trust in telehealth.[59]

Fraud and abuse of services delivered through telehealth can be monitored in the same ways as other health care services. The risk of provider abuse or fraud in telehealth may not necessarily be higher than any other mechanism of care. One provider who bills for a disproportionate amount of telehealth services may warrant an audit, for instance, just as it would be justified for a provider with outlying data in any service provided through traditional care. Including a unique identifier in the data can help stratify telehealth so it can be monitored separately. As telehealth expands, the implications of various

federal and state fraud and abuse laws could create more liability concerns for providers.[60]

Security of patient health data and compliance with HIPAA are also considerations. Patient privacy, confidentiality and data security need to be protected at all stages of a telehealth encounter, as it would be in traditional forms of care delivery. Telehealth services need appropriate protocols and measures to protect patient security and integrity of data at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who may be supporting the technology. Audio, video and all other data transmission should be secure through the use of encryption that meets recognized standards. Security features such as multi-factor authentication and the ability to remotely disable or erase personal health information are also examples of ways to protect mobile device use.

Some providers and others are paying particular attention to HIPAA compliance in telehealth technologies and electronic health records systems. However, using telehealth does not change existing security guidelines or responsibilities under HIPAA, and entities such as providers and insurers are subject to the same standards as in-person care.[61] Business associates, such as technology services that help deliver health information, are also defined under HIPAA and may need to be examined under telehealth protocols and policies. Whether, and the extent to which, state policy is needed is still emerging. However, some stakeholders also believe the federal law—which supersedes state law, except in the cases of more stringent state laws—provides enough guidance.

Safety and Security Policy Checklist

- Study existing statutes to see whether and where clarity might be needed to help guide safe telehealth policies and practices. For example, look at definitions of patient-provider relationships or examinations and consult with stakeholders about changes or considerations.
- In looking at existing or new legislation, balance the constraints being placed on telehealth with the need to safeguard patient privacy, safety and security.
- Examine how data are collected on health care services delivered by telehealth. Data collection that includes a telehealth identifier (as Medicare does) helps in evaluating programs and monitoring for fraud and abuse.

CONCLUSION

Telehealth is a rapidly growing field that has the potential to help states leverage a shrinking and maldistributed provider workforce, increase access to services, improve population health and lower costs. State leaders are grappling with how to capitalize on this potential while safeguarding state investments in telehealth and ensuring patient outcomes and safety. Reimbursement, licensure and patient safety will continue to be issues for state policymakers to consider, along with new challenges and opportunities, as telehealth grows and develops.

OVERALL FRAMEWORK FOR CONSIDERING TELEHEALTH

- Telehealth is a tool for delivering care. Help guide policy discussions that center on telehealth's ability to extend existing health and long-term care services with technology, versus describing telehealth as a new service.

- Conduct a needs assessment to find out where telehealth services are already being used and where investing in telehealth may be most effective. Identify model programs that may be replicable in your state (e.g., university, private hospital systems, etc.). Study existing laws and best practices that may also apply in telehealth (e.g., standard of care).

- Convene a variety of stakeholders from all sectors and perspectives to help ensure the best information is available when considering policy decisions. Consider all types of health care providers (e.g. physicians, nurse practitioners, physician's assistants, psychiatrists, etc.), state boards, community health centers, hospitals and payers, as well as consumers, patients and family caregivers.
- Telehealth is changing and growing rapidly. Consider the level of oversight needed to ensure that services are effective in terms of cost and outcomes, and balance those needs with potential unintended consequences or future hurdles as telehealth develops.

NOTES

1. Health Resources and Services Administration (HRSA), Telehealth, http://www.hrsa.gov/healthit/telehealth/, accessed Sept. 5, 2015.

2. Sean P. Keehan et al., "National Health Expenditure Projections, 2014–24: Spending Growth Faster Than Recent Trends," Health Affairs (2015), http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2015.0600.full.

3. Bruce Japsen, "ObamaCare, Doctor Shortage To Spur $2 Billion Telehealth Market," Forbes (2013), http://www.forbes.com/sites/brucejapsen/2013/12/22/%20obamacare-doctor-shortage-to-spur-2-billion-telehealth-market/.

4. Center for Connected Health Policy, State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia, (Sacramento, Calif.: CCHP, 2015), http://cchpca.org/sites/default/files/resources/STATE%20TELEHEALTH%20POLICIES%20AND%20REIMBURSEMENT%20REPORT%20FINAL%20JULY%202015.pdf.

5. IOM (Institute of Medicine), The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary (Washington, D.C.: The National Academies Press, 2012), http://iom.nationalacademies.org/Reports/2012/The-Role-of-Telehealth-in-an-Evolving-Health-Care-Environment.aspx.

6. Foley and Gardner LLP, 2014 Telemedicine Survey, (2014), http://www.foley.com/2014-telemedicine-survey-executive-summary/.

7. NTT Data, Trends in Telehealth, (2014), http://americas.nttdata.com/Industries/Industries/Healthcare/~/media/Documents/White-Papers/Trends-in-Telehealth-White-Paper.pdf

8. Centers for Medicare and Medicaid Services, Telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html, accessed Sept. 5, 2015.

9. American Telemedicine Association (ATA), Research Outcomes: Telemedicine's Impact on Healthcare Cost and Quality, (2015), http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine's-impact-on-healthcare-cost-and-quality.pdf.

10. Gerd Flogren et al., "Interactive Telemedicine: Effects on Professional Practice and Health Care Outcomes," Cochrane Database of Systematic Reviews 9 (2015), http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002098.pub2/abstract.

11. Center for Connected Health Policy, Recommendations for the CCHP Telehealth and the Triple Aim Project: Advancing Telehealth Knowledge and Practice, (Sacramento, Calif.: CCHP, 2014), http://cchpca.org/sites/default/files/resources/Telehealth%20%20Triple%20Aim%20Report%202.pdf.

12. ATA, Research Outcomes.

13. Richard Wootton, "Twenty years of telemedicine in chronic disease management – an evidence synthesis," Journal of Telemedicine and Telecare 18, no. 4 (2012): 211–220, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3366107/.

14. IOM, The Role of Telehealth.

15. Center for Connected Health Policy, Cost Effectiveness Research Catalogue, (2015), http://cchpca.org/sites/default/files/resources/Cost%20effective%20research%20catalogue%20final%20Sept.%202015.pdf.

16. Dale H. Yamamoto, Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services, (2014), http://www.connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf.

17. David C. Grabowski and A. James O'Malley, "Use Of Telemedicine Can Reduce Hospitalizations Of Nursing Home Residents And Generate Savings For Medicare," Health Affairs 33, no. 2: (2014): 244-250, http://content.healthaffairs.org/content/33/2/244.abstract.

18. Adam Darkins et al., "Reduced Cost and Mortality Using Home Telehealth to Promote Self-management of Complex Chronic Conditions: A Retrospective Matched Cohort Study of 4,999 Veteran Patients," Telemedicine and e-Health 21, no. 1 (2015): 70-76.

19. Adam Darkins et al., "Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions," Telemedicine and e-Health 14, no. 10: (2008): 1118-1126, http://www.ncbi.nlm.nih.gov/pubmed/19119835.

20. Lesley Cryer, Scott B. Shannon, Melanie Van Amsterdam, and Bruce Leff, "Costs For 'Hospital At Home' Patients Were 19 Percent Lower, With Equal Or Better Outcomes Compared To Similar Inpatients," Health Affairs 31, no. 6 (2012): 1237-1243, http://content.healthaffairs.org/content/31/6/1237.full.

21. American Hospital Association, Realizing the Promise of Telehealth: Understanding the Legal and Regulatory Challenges, (Trendwatch 2015), http://www.aha.org/research/reports/tw/15may-tw-telehealth.pdf.

22. HRSA, What are the reimbursement issues for telehealth?, http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/whatarethereimbursement.html, accessed Sept. 5, 2015.

23. Ibid.

24. Ibid.

25. Centers for Medicare and Medicaid Services, Telehealth Services: Rural Health Fact Sheet Series, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, accessed Sept. 5, 2015.

26. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage and Reimbursement, (Washington, D.C.: American Telemedicine Association, 2015), http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf.

27. Centers for Medicare and Medicaid Services, Telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html, accessed Sept. 5, 2015.

28. Center for Connected Health Policy, State Telehealth Laws and Medicaid Program Policies; Thomas, State Telemedicine Gaps Analysis: Coverage and Reimbursement.

29. Center for Connected Health Policy, State Telehealth Laws and Medicaid Program Policies.

30. Thomas, State Telemedicine Gaps Analysis: Coverage and Reimbursement.

31. Ibid.

32. Ibid.

33. Ibid.

34. Ibid.

35. Ibid.

36. Robert S. Rudin et al., "Paying for Telemedicine," American Journal of Managed Care 20, no. 12 (2014): 983-985.

37. IOM, The Role of Telehealth; Rudin, "Paying for Telemedicine."

38. Thomas, State Telemedicine Gaps Analysis: Coverage and Reimbursement.

39. Center for Connected Health Policy, State Telehealth Laws and Medicaid Program Policies.

40. Thomas, State Telemedicine Gaps Analysis: Coverage and Reimbursement.

41. The Pew Charitable Trusts and the MacArthur Foundation, State Employee Health Plan Spending (2014), http://www.pewtrusts.org/~/media/assets/2014/08/stateemployeehealthcarereportseptemberupdate.pdf.

42. Ibid.

43. Thomas, State Telemedicine Gaps Analysis: Coverage and Reimbursement.

44. Pew, State Employee Health Plan Spending.

45. Center for Connected Health Policy, State Telehealth Laws and Medicaid Program Policies.

46. American Hospital Association, Realizing the Promise of Telehealth.

47. Federation of State Medical Boards, Interstate Medical Licensure Compact, licenseportability.org, accessed Nov. 5, 2015.

48. National Council of State Boards of Nursing, Nurse Licensure Compact, https://www.ncsbn.org/nurse-licensure-compact.htm, accessed Nov. 5, 2015.

49. IOM, The Role of Telehealth, 27.

50. American Hospital Association, Realizing the Promise of Telehealth.

51. Ibid.

52. IOM, The Role of Telehealth.

53. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Physician Practice Standards and Licensure, (Washington, D.C.: American Telemedicine Association, 2015), http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis--physician-practice-standards-licensure.pdf.

54. Christa Natoli, Telemedicine: Prescribing and the Internet (Washington, D.C.: Center for Telehealth and e-Health Law, 2011), http://ctel.org/wp-content/uploads/2011/06/Telemedicine-Prescribing-and-the-Internet.pdf.

55. Ibid.

56. Center for Connected Health Policy, State Telehealth Laws and Medicaid Program Policies.

57. Ibid.

58. Ibid.

59. Joseph L. Hall and Deven McGraw, "For Telehealth to Succeed, Privacy and Security Risks Must Be Identified and Addressed," Health Affairs 33, no. 2 (2013): 216-221, http://content.healthaffairs.org/content/33/2/216.full.

60. American Hospital Association, Realizing the Promise of Telehealth.

61. Center for Connected Health Policy, HIPAA and Telehealth (Sacramento, Calif.: CCHP, n.d.), http://cchpca.org/sites/default/files/resources/HIPAA%20and%20Telehealth.pdf.

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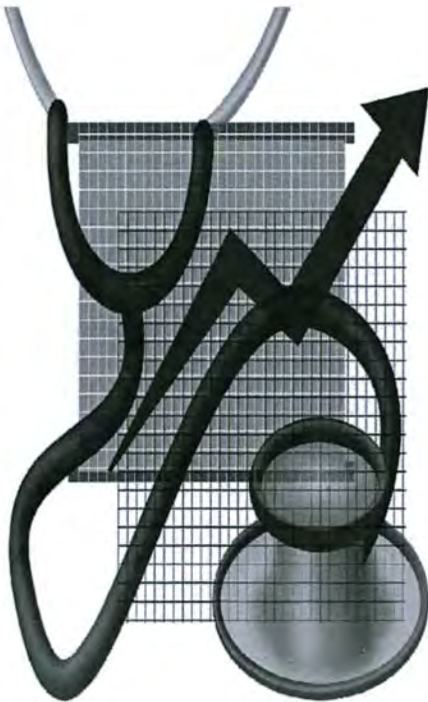
Improving Behavioral Health Access & Integration Using Telehealth & Teleconsultation: A Health Care System for the 21st Century

Charles Townley and Rachel Yalowich



This issue brief is intended to serve as a resource for state policymakers and other stakeholders as they build new or expand existing telehealth and teleconsultation programs. It offers strategies to address various regulatory and legal structures that present barriers to the diffusion of telehealth. It also offers strategies that may result in increased telehealth adoption and shares examples from five leading telehealth and teleconsultation programs in Alaska, Massachusetts, Mississippi, New Mexico, and Washington.

Introduction

Individuals with medical and behavioral health comorbidities often receive fragmented care, resulting in higher costs and poorer outcomes.[1] States, the federal government, and providers have all made significant investments to build and expand evidence-based integration models, such as the collaborative care model,[2] to reduce fragmentation and improve care. However, workforce shortages and limited resources may hinder the feasibility of these models, particularly in rural areas. Emerging evidence demonstrates that telehealth services and provider teleconsultation may be viable alternatives for individuals that are willing to participate and can deliver equal or better care when compared to traditional in-person care for individuals with behavioral health needs.[3,4,5] While telehealth is often framed as a way to improve access in rural settings, patients in urban settings may also benefit.[6]

While some individuals may prefer to continue to receive traditional in-person care, telehealth and teleconsultation offer opportunities for states to increase patient choice and expand the scope of services individuals can receive at their usual care site—including primary care clinics, mental health centers, and correctional facilities. These programs may also build the primary care systems' capacity to treat mild-to-moderate behavioral health conditions. More research is necessary to understand the full effect on service utilization and healthcare costs, but early findings demonstrate that telehealth and teleconsultation programs for behavioral health services may reduce state spending or produce overall cost savings:

- Wyoming Medicaid found a 1.82:1 return-on-investment, and a 42 percent reduction in the number of children aged five or younger using psychotropic medications after implementing a psychiatric teleconsultation program to support primary care physicians serving children with behavioral health needs in the state.[7]

Using technology to connect patients and providers is often referred to by many names, including, but not limited to: telehealth, telemedicine, telebehavioral health, and telemental health. For the purposes of this issue brief, we use the following definitions:

- Telehealth or Telemedicine: A system in which patients receive services from providers in a different location.
- Telebehavioral health or Telepsychiatry: A subset of telemedicine that remotely connects patients with behavioral health providers.
- Teleconsultation: A system in which providers remotely consult with other providers in a different location.

Depending on the policies of individual states, these programs may or may not require a local provider's presence or referral for an individual to receive remote services. It is also important to note that there are various modes of telehealth, including real-time communication, asynchronous store-and-forward, remote patient monitoring, and mobile health.[10] Unless otherwise noted, the scope of this paper is limited to real-time communication.

- Georgia is one of many states that have increased the use of telehealth to serve individuals in correctional facilities. The state reported savings of $500 per telehealth encounter ($9 million in fiscal year 2011), largely due to reduced transportation and staffing costs.[8]
- A study of 106 nursing homes residents in New York and Vermont found that a combined 278 telepsychiatry encounters resulted in estimated savings ranging from $33,739-$67,477 in reduced personnel costs and $84,347-$253,040 in avoided physician travel.[9]

Improving Patient Access Through Telehealth

When referrals to in-person services are not feasible, remotely connecting patients and providers through telehealth can be an effective way to increase the scope of services delivered at an individual's usual care site. Alaska and Mississippi are two leaders in this area, having built statewide telehealth programs that have expanded patient access to services and reduced costs (See Table 1).

Implementation

While many of the leading telehealth programs across the country are payer- or provider-driven initiatives, each state's unique policy environment has shaped how payers in the state treat telehealth services and provider adoption rates.[11] There are many important roles for states to play in supporting the development of new or enhancement of existing telehealth programs. As a purchaser, for example, the state can implement policies to provide reimbursement for telehealth services on behalf of the state employees or Medicaid and Children's Health Insurance Program (CHIP) enrollees. As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and telebehavioral health services.[12]

Beyond purchasing power, states can leverage their roles as lawmakers, regulators, and conveners to advance telehealth programs while also protecting consumers and payers. State officials may find the following strategies useful when determining how to leverage remote services to increase patient access to care:

1. Amend regulatory restrictions limiting reimbursement;
2. Foster or mandate multi-payer support;
3. Provide education and guidance on pertinent legal considerations; and
4. Leverage federal funds to develop broadband infrastructure in rural areas.

Table 1. Telebehavioral Health Services in Alaska and Mississippi

	Alaska Psychiatric Institute's Telebehavioral Health Center	Center for Telehealth at the University of Mississippi Medical Center
Program Description	In 2003, Alaska began a telebehavioral health pilot. Today, the Frontline Remote Access Clinic, housed within the Alaska Psychiatric Institute (API), provides telebehavioral health services to individuals in approximately 26 towns and villages across the state—only four of which are connected to the state's road system.[13]	In 2003, the University of Mississippi Medical Center (UMMC) began their telehealth program for emergency medicine services in rural hospitals.[14] In 2008, telepsychiatry services were added to the program to serve mental health clinics and are available on an acute or scheduled basis. Today, UMMC's Center for Telehealth includes more than 30 different specialties and serves patients at more than 194 locations across the state (including primary care clinics, mental health clinics, local health departments, schools, and prisons), and is expanding telepsychiatry services to nursing homes in 2015.
Funding	As the state's psychiatric hospital, API is funded through legislative appropriations. The Frontline Remote Access Clinic within API bills remote sites at an hourly rate for their services. Grant funding also supports API's telebehavioral health work.	The Center has developed a sustainable business model with revenue from contracts and insurance reimbursement for telemedicine services. Mississippi law requires private and public payers, including Medicaid, to reimburse for telehealth services. Approximately 100,000 telehealth visits occur annually.
Outcomes	API's telebehavioral health services generated over $1 million in avoided hospitalization costs in state fiscal year (SFY) 2015, building on the $600,000 in avoided hospital costs in SFY2014. An additional $70,000 in patient travel costs was avoided over those years.[15]	Telepsychiatry is one of UMMC's most demanded services and is being delivered to mental health clinics, group homes, emergency departments, primary care clinics and to students in schools and colleges. Although outcomes data specific to telepsychiatry are not available, the model has generated positive outcomes for other services. For example, the Center's TelEmergency program reduced rural ED staffing costs by 25 percent and reduced unnecessary transfers to urban hospitals by 20 percent; patient outcomes in rural hospitals are equal to those at the academic medical center.[16]

1. Amend Regulatory Restrictions Limiting Reimbursement

Nearly all Medicaid programs reimburse for telemedicine and telebehavioral health services. The federal Medicaid statute does not define telemedicine as a distinct service,[17] and the Centers for Medicare & Medicaid Services (CMS) encourages states to "use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology."[18] As a result, states' reimbursement policies vary widely as to which services are reimbursable, which providers can bill, and what types of technology can be used.[19]

Common state regulations and reimbursement policies include provider eligibility requirements, licensure requirements for providers across state lines, and in-person evaluation requirements for remote services. While these policies may limit the development of telehealth programs, they have often been put in place by states to address potential quality and patient safety concerns. If states choose to amend their policies to advance telehealth, it will be important to incorporate consumer protections into these policies.

Eligible practice settings and technologies

Challenges: Many states place restrictions on where patients can be seen in order for providers to bill for remote services, such as limiting the types of providers who may provide remote services, limiting the setting in which remote services are billable, or establishing minimum mileage requirements between the patient and remote provider as a condition of payment.[20]

Strategies: Many states have telehealth laws that allow reimbursement in non-traditional care settings; for example, 16 states allow for remote services at schools or school-based health centers, and 25 states allow patients to receive telehealth services at home.[21] Furthermore, while most states have removed mileage requirements for reimbursement—Colorado expanded their law earlier this year[22]—exceptions may still apply.[23] In 2014, Indiana promulgated a regulation removing a mileage requirement for federally qualified health centers, rural health clinics, community mental health centers, and critical access hospitals, but maintained a minimum required distance of 20 miles when reimbursing other eligible providers.[24] Similarly some states place limitations on which technologies can be used for provider-to-patient communication (e.g., live communication, asynchronous communication); approximately half of states limit reimbursement to real-time communication.[25]

As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and telebehaviorial health services.
Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement (Washington, D.C.: American Telemedicine Association, May 2015). http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis—coverage-and-reimbursement.pdf.

Practicing telehealth across state lines

Challenges: When telehealth services are provided across state lines, cross-state licensure issues arise. The majority of state medical boards require physicians to hold active licenses in each state where patients receiving telehealth services legally reside,[26] although some states have exceptions to their licensure laws that allow physicians to provide infrequent services either directly to patients or in consultation with another physician without procuring a license from each state.[27]

Strategies: In September 2014, the Federation of State Medical Boards introduced model legislation for states interested in adopting the Interstate Medical Licensure Compact to reduce administrative burden of physicians applying for licenses in additional states.[28] Under the Compact, each state retains its authority to regulate the practice of medicine, and out-of-state physicians are subject to the laws and rules set forth by the legislatures and medical boards in the state where the patient is located. Within a span of a year, 11 states have enacted the Compact through legislation;[29] although some state medical boards have expressed concerns.[30] The Consortium of Telehealth Resource Centers has suggested other potential models to mitigate licensure barriers, including endorsement, mutual recognition, reciprocity, and limited licenses.[31]

In-person requirements for remote services

Challenges: Some state laws and regulations require an in-person visit before an individual can receive services remotely. For example, the Arkansas Medical Board requires an in-person evaluation prior to most remote services,[32] and the Texas Board of Medicine requires that patients receive an in-person evaluation annually after remote consultations.[33] These medical practice standards are particularly important for providers using telemedicine to remotely prescribe medication, as those are subject to various state and federal laws intended to ensure proper prescribing and use. This is an important consideration given the U.S. Government Accountability Office's findings that children in Medicaid are already prescribed psychotropic and antipsychotic medications at higher rates than privately insured children.[34] Although federal law provides some exemptions for prescribing controlled substances via telemedicine, the interpretation of these exemptions have been left to local Drug Enforcement Agency (DEA) branches, which has established procedures that require face-to-face office visits before providers can prescribe controlled substances in some telemedicine programs.[35]

Strategies: Some state legislatures agencies have passed legislation or released administrative guidance clarifying what is and is not acceptable when providing remote services under state law. For example, Alaska recently passed legislation stipulating a physician can prescribe, dispense, or administer prescriptions for controlled substances without a physical examination as long as: 1) the physician is licensed and physically located in the state and 2) the patient has access to follow-up care and agrees to have all medical records from remote encounters sent to his or her primary care provider. In addition to these requirements, a physician must either have a previously established relationship with the patient or have another appropriate licensed provider physically present with the patient to aid the prescribing physician with an examination and diagnosis.[36] Alaska's policy serves as a reminder that state officials should carefully consider when it is appropriate to require that a local provider be involved in the provision of remote services.

2. Foster or Mandate Multi-Payer Support

In addition to deciding which telehealth services are reimbursable, payers also need to decide how much to pay for those services. When determining sustainable payment rates, state policymakers may also find that multi-payer participation is an important component of long-term support and sustainability for telehealth programs.

Challenges: Limited access to behavioral health services and workforce shortages affect the entire health care system, not just Medicaid. Some commercial health plans may set restrictive telehealth policies, limiting providers' ability to meet the needs of commercial populations.

Strategies: As more payers reimburse for telehealth services, the proportion of a practice's panel eligible to receive telehealth services increases. This not only increases patients' access to remote services, but it also may reduce the administrative burden on providers. This may also help promote sustainability if payers are supporting the infrastructural and operational costs of the same program.

For example, in 2013, Mississippi enacted a telehealth parity law that required Medicaid, state employee health plans, and private insurers to provide coverage for telehealth services to the same extent that the services would be covered if they were provided in-person.[37] The legislation received broad support, including, most notably, support from Governor Phil Bryant.

The University of Mississippi Medical Center's Center for Telehealth cites multi-payer telehealth payments as a critical aspect of the enduring success of its program; furthermore, payment parity has allowed the telehealth program to be sustainable outside of grant funding.[38] Mississippi Medicaid has also worked to ensure that its payment policies encourage the use of telehealth, including new originating site facility fees effective July 1, 2015.[39] As of July 2015, 28 other states and the District of Columbia have passed parity laws for private insurers.[40] Medicare has also covered telehealth services since the Balanced Budget Act of 1997, although federal law limits reimbursement to individuals seen in specific rural care settings.[41]

3. Provide Education and Guidance on Pertinent Legal Considerations

When providers practice medicine remotely, they must meet the same legal standards that apply when serving patients in their offices. State agencies have an important role in helping providers understand how to meet these legal obligations by providing education and policy guidance as necessary and appropriate. One important area in which states can provide guidance is on privacy laws and data sharing.

Challenges: Federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), set national privacy and security standards for holding and sharing protected health information. 42 CFR Part 2 extends further privacy and security standards to patients' behavioral health data for most drug and alcohol treatment providers.[42] Some states have passed more stringent laws regulating protected health information.

Strategies: While privacy laws do not uniquely affect telehealth programs, they underscore the importance of secure data exchange to providing comprehensive care through telehealth. Telehealth services can be more effective when the remote provider can access and review patients' medical records. Regional and state health information exchanges can be an important tool to facilitate behavioral health information exchange across treating providers.[43] In the absence of a robust health information exchange, providers have entered into contractual arrangements to facilitate data exchange. For example, when providers in Alaska contract with the Frontline Remote Access Clinic housed within the Alaska Psychiatric Institute (API) for telebehavioral health services, API enters into a business associate agreement and memorandum of understanding that allows API's psychiatrists to access the other systems' electronic health records.[44,45]

4. Leverage Federal Funds to Develop Broadband Infratrsucture in Rural Areas

Access to secure, high-speed Internet service is critical to implementing telehealth programs. Providers in communities without access to affordable broadband service or computer equipment can leverage federal programs designed to promote the use of telemedicine.

Challenges: Despite significant investment over the past five years,[46] some rural and frontier providers still lack adequate access to high-speed Internet—and those that have access may find it prohibitively expensive.[47]

Strategies: A range of federal grant and loan guarantee programs are available to help rural providers, practices, or communities-at-large maximize their financial investments by defraying some infrastructure costs:

- The Federal Communication Commission's (FCC's) Rural Health Care Program (RHC Program) includes two programs that provide up to $400 million in funding annually:
  - o Eligible providers participating in the Healthcare Connect Fund receive a 65 percent discount on all eligible expenses, including broadband service and equipment.
  - o The Telecommunications Program subsidizes rural providers service costs, allowing rural providers to pay the same rates as urban providers.[48]
- The United States Department of Agriculture and Rural Development (USDA) administers various pertinent grant and loan guarantee programs:
  - o The Distance Learning and Telemedicine Grant Program provides competitive grants between $50,000 and $500,000 with a 15 percent match. The funds can be used to acquire necessary equipment and infrastructure as well as technical assistance to train staff in using the equipment.[49]
  - o The Community Connect Grant Program provides competitive grants between $100,000 and $3,000,000 with a 15 percent match. The funds can be used to build infrastructure in areas where broadband service is not available, as well as provide broadband service free-of-cost to critical community facilities (including hospitals and health care providers) for two years.[50]
  - o The Telecommunications Infrastructure and Farm Bill Broadband Loans & Loan Guarantee Program provide funding to construct, improve, or acquire facilities and equipment required to bring broadband service to eligible rural areas.[51,52]

Due in part to implementation delays, the FCC only disbursed a total of $327 million in the RCH Program's first 12 years, a combined total less than the program's $400 million annual cap.[53] Funding requests have risen sharply in recent years (an average of nearly $235 million annually across fiscal years 2013 and 2014), but as of September 30, 2015, less than $100 million has been requested for fiscal year 2015.[54] States and local government agencies are eligible applicants for all of the USDA grant and loan programs identified above; states may also be in a position to assist providers in participating in these programs if they can cover a portion of the required matching funds or help secure foundation or private payer support.

Increasing Provider Capacity Through Teleconsultation

Remotely connecting patients to specialty providers can alleviate access issues, but access to specialty providers is only half of the equation. By providing distance learning opportunities and supports, the primary care system becomes better equipped at managing individuals' behavioral health needs and referring out to specialty services as necessary. Two models in particular, the Massachusetts Child Psychiatry Access Project (MCPAP) and the University of New Mexico's Project ECHO, have gained national momentum over the past few years (See Table 2).[55]

Implementation

Comparatively, teleconsultation programs can be much easier to implement than telehealth programs. Many of the legal and regulatory issues discussed in the previous section are not applicable provided that the program does not create a new physician-patient relationship under state law (a legal standard that varies by state). Furthermore, only four states (Michigan, North Dakota, Pennsylvania, and South Dakota) do not have a law providing some exclusions to state licensure requirements for out-of-state providers when conducting physician-to-physician consultations.[56] Two key issues remain: provider buy-in and sustainability.

Table 2. Teleconsultation Services in Massachusetts and New Mexico

	The Massachusetts Child Psychiatry Access Project	University of New Mexico's Project ECHO
Program Description	First piloted in 2003, the Massachusetts Child Psychiatry Access Project (MCPAP) telephonically connects pediatricians across the state with one of six regional behavioral health teams. The teams consist of a child psychiatrist, a social worker, and a care coordinator; all of whom assist pediatricians to diagnose, treat, and manage children with behavioral health needs. The program can provide one-time face-to-face consultations with patients and facilitates referrals to in-person services as necessary and appropriate.	Launched in 2003, Project ECHO is a hub-and-spoke model that uses web-based video to connect primary care providers with specialist mentors. Providers have applied the model to nearly 40 health conditions, including an Integrated Addiction and Psychiatry (IAP) TeleECHO Clinic. Participating primary care teams take part in case-based learning that includes a mix of didactic presentations and reviewing actual cases using de-identified information.
Funding	MCPAP is funded through a Massachusetts Department of Mental Health line item ($3.1 million in FY2015) and, beginning in FY2015, commercial health plans pay a surcharge for their share of program costs. Budget shortfalls required the program to scale back in recent years, but it is currently being expanded through the state's State Innovation Model Test Award.	Funded through a mix of federal, state, and philanthropic dollars, including consultative service payments to providers by New Mexico's Medicaid managed care plans. In July 2015, the GE Foundation awarded a $14 million grant to Project ECHO and the Institute for Healthcare Improvement to extend the model to additional community health centers across the country.[57]
Outcomes	In 2012, 92 percent of practices in the state with more than 2,000 children used the service. After using the service, prescriber-level psychiatric care remained with the primary care provider 67 percent of the time. A survey of participating providers found that 64 percent either agreed or strongly agreed that they could "meet the needs of children with behavioral health problems," compared to 8 percent before enrollment.[58]	Although outcomes data specific to the IAP TeleECHO Clinic are not available, the model has generated positive outcomes for other conditions. Participating primary care providers were able to manage Hepatitis C treatment as effectively as an academic medical center with fewer reported serious adverse events.[59] When the IAP network was used to recruit participants for buprenorphine training, more New Mexico physicians from traditionally underserved areas chose to be trained, compared with physicians nationwide.[60]
Spread	Similar programs are underway in various stages of implementation in 30 states and the District of Columbia.[61]	Hubs currently operate in 22 states; some serve multiple states.

1. Provider Buy-in

A teleconsultation program's success depends on providers' willingness to participate. Provider outreach and engagement activities that make the case for participation to both specialty and primary care providers may have the greatest impact.

Challenges: Specialists may be resistant to sharing their expertise, particularly if it means fewer referrals. Primary care providers may also be hesitant to work with behavioral health providers with whom they do not have an established working relationship.

Strategies: Teleconsultation programs have benefitted from identifying and engaging specialty physicians who will champion the model.[62] Messaging can be critical, and it is important to remind stakeholders that the purpose of these types of programs is not to supplant specialty care, but rather ensure that patients receive appropriate care in the appropriate setting. Facilitating face-to-face introductions between the primary care providers and consulting physicians may increase the comfort levels of both participanting providers and risk managers, even if it's a one-time meeting.[63]

2. Sustainability

The physical infrastructure required for teleconsultation programs can cost significantly less compared to telehealth programs. For example, MCPAP requires nothing more than a telephone line and telephone. Sustaining teleconsultation programs may require significant funding commitments depending on the staffing model and whether participating providers are compensated for their time, but larger providers hosting or administering teleconsultation programs may be in a financial position to bear some of the associated costs.

Challenges: Grant funding and/or annual legislative appropriations is sometimes used to provide seed funding to launch or maintain teleconsultation programs; however, given the scarcity of state financial resources, relying on grants and appropriations creates uncertainty as to whether the program will be sustainable. Traditional fee-for-service billing may not be appropriate for programs that do not provide direct medical services to patients. Even if a direct billing mechanism is created, it does not necessarily mean the program will be sustainable. In other child psychiatry access programs, fee-for-service was not a sustainable payment methodology due to variable billing volume and cumbersome billing processes, as well as increased legal risk due to the fact that the payment created new physician-patient relationships.[64]

Strategies: Teleconsultation programs may be more sustainable when paid for using alternative, value-based payment models that promote team-based care and allow flexibility to cover services that may be non-billable, including physician consultation and care coordination. Furthermore, like other payment and delivery system reforms, sustainability may rest in multi-payer participation. This was a particularly important issue in Massachusetts, where more than half of the MCPAP encounters in FY2014 (58 percent) were for children covered by commercial insurance.[65] With legislative authority granted in the state's FY2015 budget, the Massachusetts Department of Public Health promulgated new regulations ensuring commercial plans would proportionally share in their cost to the program.[66]

Blending Telehealth and Teleconsultation

In addition to the telehealth and telepsychiatry services described earlier, the programs in Mississippi and Alaska also offer educational services that build provider capacity similar to Project ECHO. For example, the University of Mississippi Medical Center's Distance Learning Educational Series for Behavioral Health is available to all of the sites for which it provides telemedicine and telepsychiatry services.[67]

Simultaneously expanding direct access through telehealth and improving provider capacity through teleconsulting may have an additive effect. Representatives from both the University of Mississippi Medical Center's Center for Telehealth and Project ECHO discussed potential benefits of blending their programs.[68,69]

One Medicaid managed care plan in Washington found that telepsychiatry was most effective in a stepped-care model where primary care providers worked with a behavioral health coordinator and consulting psychiatrist before connecting patients with the psychiatrist through telepsychiatry (see Table 3); practices using telepsychiatry alone have had a harder time integrating remote services into their workflows.[70] As new initiatives are launched, program leaders may wish to explore how telehealth and teleconsultation services can be combined to achieve program goals.

Table 3. Washington State's Mental Health Integration Program

	Washington State Mental Health Integration Program (MHIP)
Program Description	Launched in 2008, Community Health Plan of Washington (CHPW), one of the state's Medicaid managed care plans, administers the Washington State Mental Health Integration Program (MHIP). Building on the Collaborative Care Model,[71] behavioral health coordinators embedded in over 100 community health centers across the state work closely with primary care teams and meet weekly with a remote consulting psychiatrist at the University of Washington Medical Center.[72] Primary care physicians can also consult directly with the psychiatrist as needed. Since launch, CHPW has introduced telepsychiatry services into MHIP, allowing patients to remotely meet with the consulting physician.
Funding	First supported through legislative appropriations, CHPW provides two payments: one to community health centers to hire the behavioral health coordinator; and a second to University of Washington Medical Center to pay for a portion the consulting psychiatrists' time. A unit-based caseload rate provides the necessary flexibility to cover the coordinators' time spent consulting with the primary care providers and psychiatrist, as well as entering data into a registry. It also provides flexibility for the psychiatrists, who allocate their time between working in the registry and consulting with the coordinator, primary care team, and patients. A 2015 law requires Washington's Medicaid managed care, state employee, and commercial health plans to begin reimbursing for telemedicine services no later than January 1, 2017.[73] CHPW is actively exploring how the new law impacts their payment model for direct telepsychiatry services, but the law does not provide reimbursement for remote consultation.
Outcomes	MHIP has decreased specialty referrals and increased primary care providers' ability to meet the behavioral health needs of their patients.[74] In the first 14 months, the program reports that it saved more than $11 million in avoided hospital costs; the program also created positive social outcomes, including fewer arrests and smaller increases in homelessness.[75]

Preparing for Future Innovations

Technology continues to change the way in which patients receive services. Mobile and home-based technologies that remotely connect patients with providers and their peers are shaping the future of the health care system. For example:

- Payers and providers across the country are beginning to partner with Big White Wall, an "anonymous clinically facilitated peer community" that connects individuals with credentialed therapists and peer supports online.[76]

- In June 2015, former executives from Facebook, Google, and other leading technology companies launched Lyra Health, a startup that plans to use web-based screening tools and data analytics to identify individuals with unmet behavioral health needs and connect them with providers that match their preferences.[77]

It remains to be seen how or if states will adopt these or similar initiatives in their public insurance programs. When deciding which new technologies to implement, states will need to weigh the costs of implementation with their fiscal climate and the potential for the technology to create a return on investment. Once a technology is selected for implementation, states will need to examine whether any state-level legal or regulatory barriers will make implementation challenging or restrict its effectiveness. Flexibility can be important when designing new state laws and regulations affecting telehealth policy because it is likely that technological innovations will outpace the laws and regulations.

Ultimately, it is in states' best interest to have a process in place to ensure that new technologies are cost-effective and safe. States' Medicaid advisory committees and similar oversight and evaluation committees are important partners for policymakers when determining which technologies to adopt and how to implement and pay for these technologies to ensure appropriate consumer protections, limit inappropriate utilization, and manage costs.

Conclusion

As the programs discussed in this issue brief show, telehealth and teleconsultation programs have the potential to improve access, increase provider and system capacity, and promote a health care system in which appropriate services are provided in the appropriate setting. Mild-to-moderate behavioral health conditions are prevalent in primary care, and primary care providers play an important role in addressing these conditions while simultaneously managing physical health comorbidities.[78] As primary care providers' capacity to treat mild-to-moderate conditions increases, specialty providers have more time to spend with complex, high-need individuals.

Additional Resources

State officials and other stakeholders interested in learning more are encouraged to visit the following organizations' websites:

- American Telemedicine Association: State Policy Resource Center
- Center for Connected Health Policy: Telehealth Medicaid & State Policy
- National Conference of State Legislatures: State Coverage for Telehealth Services
- Health Resources and Services Administration: Telehealth
- SAMSHA-HRSA Center for Integrated Health Solutions: Telebehavioral Health
- Consortium of Telehealth Resource Centers
- Center for Technology and Behavioral Health

Endnotes:

1. Benjamin G. Druss and Elizabeth Reisinger Walker, Mental Disorders and Medical Comorbidity (Princeton, NJ: Robert Wood Johnson Foundation, February 2011). http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1.

2. Janine Archer et al., Collaborative Care for Depression and Anxiety Problems. Cochrane Database of Systematic Reviews 2012, no. 10 (October 17, 2012).

3. Stacie Deslich et al., "Telepsychiatry in the 21st Century: Transforming Healthcare with Technology," Perspectives in Health Information Management / AHIMA, American Health Information Management Association 10, no. Summer (July 1, 2013).

4. Donald M. Hilty et al., "The Effectiveness of Telemental Health: A 2013 Review," Telemedicine Journal and e-Health 19, no. 6 (June 2013): 444–454.

5. John C. Fortney et al., "Practice Based Versus Telemedicine Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial," The American Journal of Psychiatry 170, no. 4 (April 1, 2013).

6. Laura Markwick, Kenneth McConnochie, and Nancy Wood, "Expanding Telemedicine to Include Primary Care for the Urban Adult," Journal of Health Care for the Poor and Underserved 26, no. 3 (2015): 771–776.

7. Robert J. Hilt et al., "A Statewide Child Telepsychiatry Consult System Yields Desired Health System Changes and Savings," Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association 21, no. 7 (July 2015): 533–537.

8. The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, Managing Prison Health Care Spending (Philadelphia, PA: The Pew Charitable Trusts, October 2013). http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/pctcorrectionshealthcarebrief050814pdf.pdf.

9. "What is Telehealth?" Center for Connected Health Policy. Accessed October 16, 2015. http://cchpca.org/what-is-telehealth.

10. Terry Rabinowitz et al., "Benefits of a Telepsychiatry Consultation Service for Rural Nursing Home Residents," Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association 16, no. 1 (February 2010): 34–40.

11. Julia Adler-Milstein, Joseph Kvedar, and David W. Bates, "Telehealth Among US Hospitals: Several Factors, Including State Reimbursement And Licensure Policies, Influence Adoption," Health Affairs 33, no. 2 (February 1, 2014): 207–215.

12. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement (Washington, D.C.: American Telemedicine Association, May 2015). http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf.

13. Mark Erickson, personal communication, September 25, 2015.

14. Richard L. Summers et al., "The Anniversary of TelEmergency," Journal of the Mississippi State Medical Association 54, no. 12 (December 2013): 340–341.

15. Cheryl Nino, personal communication, August 20, 2015.

16. Kristi Henderson, "Testimony Before the United States Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies," May 7, 2015. http://www.appropriations.senate.gov/sites/default/files/hearings/050715%20Henderson%20Testimony%20-%20LaborHHS.pdf.

17. National Advisory Committee on Rural Health and Human Services, Telehealth in Rural America (Rockville, MD: HRSA, March 2015). http://www.hrsa.gov/advisorycommittees/rural/publications/telehealthmarch2015.pdf.

18. "Telemedicine." Medicaid.gov. Accessed October 14, 2015. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html.

19. Ibid.

20. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement (Washington, D.C.: American Telemedicine Association, May 2015). http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf.

21. Ibid.

22. An Act Concerning Coverage Under a Health Benefit Plan for Health Care Services Delivered Through Telehealth in Any Area of the State, Chapter 38 of the Session Laws of Colorado 2015. http://tornado.state.co.us/gov_dir/leg_dir/olls/sl2015a/sl_38.htm.

23. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement.

24. "Telemedicine Services," 405 IAC 5-38. http://www.in.gov/legislative/iac/iac_title?iact=405&iaca=5.

25. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Coverage & Reimbursement.

26. Ibid.

27. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Physician Practice Standards & Licensure (Washington, D.C.: American Telemedicine Association, May 2015). http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis--physician-practice-standards-licensure.pdf.

28. Federation of State Medical Boards. "Interstate Medical Licensure Compact Ready For Consideration By States" September 5, 2014. Accessed October 26, 2015. http://www.licenseportability.org/assets/pdf/FSMB_statement_on_final_compact_09032014FINAL.pdf.

29. "Interstate Medical Licensure Compact." Federation of State Medical Boards. Accessed October 14, 2015. http://www.licenseportability.org/.

30. See, for example: State Medical Board of Ohio, July 8, 2015 Letter to Physicians Licensed in the State of Ohio. Accessed October 27, 2015. http://med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/Center-Panel/News-Folder/Interstate-Compact-Licensure-Letter-to-Physicians.pdf.

31. " Licensure and Scope of Practice." Telehealth Resource Centers. Accessed October 14, 2015. http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-practice.

32. "An Act to Encourage the use of Telemedicine." Chapter 887 of the 2015 Session Laws of Arkansas. http://www.arkleg.state.ar.us/assembly/2015/2015R/Acts/Act887.pdf.

33. "Telemedicine Medical Services Provided at Sites other than an Established Medical Site," 22 Tex. Admin. Code. §174.7. https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=9&ch=174&rl=7.

34. United States Government Accountability Office, Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care (Washington, D.C.: U.S. GAO, December 2012). http://www.gao.gov/assets/660/650716.pdf.

35. Association for Community Affiliated Plans, Safety Net Health Plans Delivery Better Care and Increase Access via Telemedicine (Washington, D.C.: ACAP, November 2014). http://communityplans.net/portals/0/fact%20sheets/acap%20telemedicine%20nov2014.pdf.

36. "An Act Relating to Prescription of Drugs by a Physician Without a Physical Examination," Chapter 115 of the 2014 Session Laws of Alaska. http://www.legis.state.ak.us/PDF/28/Bills/HB0281Z.PDF.

37. "An Act to Require Health Insurance Plans in this State to Provide Coverage for Telemedicine Services to the Same Extent that the Services Would Be Covered If They Were Provided Through In-Person Consultation," Chapter 478, Mississippi Laws of 2013. http://billstatus.ls.state.ms.us/documents/2013/pdf/SB/2200-2299/SB2209SG.pdf.

38. Kristi Henderson, personal communication, July 22, 2015.

39. "Telemedicine," 23 Miss. Admin. Code Pt. 225, https://www.medicaid.ms.gov/wp-content/uploads/2015/07/Admin-Code-Part-225.pdf.

40. American Telemedicine Association, "2015 State Telemedicine Legislation Tracking (as of 7/7/2015)" (ATA, 2015), http://www.americantelemed.org/docs/default-source/policy/2015-ata-state-legislation-matrix.pdf.

41. Centers for Medicare & Medicaid Services, Telehealth Services: Rural Health Fact Sheet Series (Baltimore, MD: CMS, December 2014), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

42. For more information on 42 CFR Pt 2, please see the following SAMHSA FAQ: http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs.

43. National eHealth Collaborative, The Current State of Sharing Behavioral Health Information in Health Information Exchanges (Washington, D.C.: SAMHSA-HRSA Center for Integrated Health Solutions, September 2014). http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf.

44. Mark Erickson, personal communication, August 20, 2015.

45. The contract can be accessed at: http://dhss.alaska.gov/dbh/Documents/api/Fee_for_Service_Form_TBH-6.pdf.

46. Office of Science and Technology Policy and The National Economic Council, Four Years of Broadband Growth (Washington, D.C.: The White House, June 2013). https://www.whitehouse.gov/sites/default/files/broadband_report_final.pdf.

47. Mohit Kaushal et al., "Closing The Rural Health Connectivity Gap: How Broadband Funding Can Better Improve Care," Closing The Rural Health Connectivity Gap: How Broadband Funding Can Better Improve Care, April 1, 2015. http://healthaffairs.org/blog/2015/04/01/closing-the-rural-health-connectivity-gap-how-broadband-funding-can-better-improve-care/.

48. "Rural Health Care Program." Federal Communications Commission. Accessed October 14, 2015. https://www.fcc.gov/encyclopedia/rural-health-care.

49. "Distance Learning & Telemedicine Grants." United States Department of Agriculture Rural Development. Accessed October 14, 2015. http://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants.

50. "Community Connect Grants." United States Department of Agriculture Rural Development. Accessed October 14, 2015. http://www.rd.usda.gov/programs-services/community-connect-grants.

51. "Telecommunications Infrastructure Loans & Loan Guarantees." United States Department of Agriculture Rural Development. Accessed October 14, 2015. http://www.rd.usda.gov/programs-services/telecommunications-infrastructure-loans-loan-guarantees.

52. "Farm Bill Broadband Loans & Loan Guarantees." United States Department of Agriculture Rural Development. Accessed October 14, 2015. http://www.rd.usda.gov/programs-services/farm-bill-broadband-loans-loan-guarantees.

53. United States Government Accountability Office, FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program (Washington, D.C.: U.S. GAO, November 2010). http://www.gao.gov/new.items/d1127.pdf.

54. "Funding Information." Universal Service Administrative Company. Accessed October 13, 2015. http://www.usac.org/rhc/healthcare-connect/funding-information/default.aspx.

55. Valarie Blake, "When Is a Patient-Physician Relationship Established?" Virtual Mentor 14, no. 5 (May 1, 2012): 403.

56. Latoya Thomas and Gary Capistrant, State Telemedicine Gaps Analysis: Physician Practice Standards & Licensure.

57. David Barash, "Project ECHO: Force Multiplier For Community Health Centers," Health Affairs Blog, July 20, 2015. http://healthaffairs.org/blog/2015/07/20/project-echo-force-multiplier-for-community-health-centers/.

58. John H. Straus and Barry Sarvet, "Behavioral Health Care For Children: The Massachusetts Child Psychiatry Access Project," Health Affairs 33, no. 12 (December 1, 2014): 2153–2161.

59. Sanjeev Arora et al., "Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers," New England Journal of Medicine 364, no. 23 (June 9, 2011): 2199–2207.

60. "Integrated Addiction and Psychiatry." University of New Mexico Project ECHO. Accessed October 14, 2015. http://echo.unm.edu/nm-teleecho-clinics/integrated-addiction-and-psychiatry-clinic/.

61. "Existing Programs: Member Organizations by Home State." The National Network of Child Psychiatry Access Programs. Accessed October 14, 2015. http://www.nncpap.org/existing-programs.html.

62. Miriam Komaromy, personal communication, July 2, 2015.

63. Erin Hafer, personal communication, July 30, 2015.

64. John H. Straus and Barry Sarvet, "Behavioral Health Care For Children: The Massachusetts Child Psychiatry Access Project," Health Affairs 33, no. 12 (December 1, 2014): 2153–2161.

65. Ibid.

66. "Massachusetts Child Psychiatry Access Program Assessment," 104 CMR 30.08(3). http://www.mass.gov/eohhs/docs/dmh/regs/reg-104cmr30.pdf.

67. Elizabeth Joseph, personal communication, September 30, 2015.

68. Kristi Henderson, personal communication, July 22, 2015.

69. Miriam Komaromy, personal communication, July 2, 2015.

70. Erin Hafer, personal communication, July 30, 2015.

71. "Collaborative Care." University of Washington AIMS Center. Accessed October 14, 2015. https://aims.uw.edu/collaborative-care

72. "Washington State's Mental Health Integration Program (MHIP)." University of Washington AIMS Center. Accessed October 14, 2015. https://aims.uw.edu/washington-states-mental-health-integration-program-mhip.

73. "An Act Relating to Telemedicine," Chapter 23 of the 2015 Session Laws of Washington. http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/Senate/5175-S.sl.pdf.

74. Association for Community Affiliated Plans, Safety Net Health Plans Delivery Better Care and Increase Access via Telemedicine.

75. Community Health Network of Washington and Washington Association of Community & Migrant Health Centers, Community Health Centers: Behavioral Health Integration (Seattle, WA: Community Health Network of Washington, December 2013). https://chpw.org/BriefingPaper - Behavioral_Health_Integration.pdf.

76. Jen Hyatt, "Big White Wall: Expanding Mental Health Access Through The Digital Sphere," Health Affairs Blog, June 1, 2015. http://healthaffairs.org/blog/2015/06/01/big-white-wall-expanding-mental-health-access-through-the-digital-sphere/.

77. "Lyra Health." Lyra Health. Accessed October 13, 2015. http://www.lyrahealth.com/.

78. Ruth Shim and George Rust, "Primary Care, Behavioral Health, and Public Health: Partners in Reducing Mental Health Stigma," American Journal of Public Health 103, no. 5 (May 2013): 774–776.

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