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As state spending on health care continues to increase, policymakers look for ways to ensure access to cost-effective care that improves health for their constituents. Enhancing and increasing access to health care services via telehealth is widely viewed as one strategy to help patients in rural and underserved areas access care.

Telehealth is a tool—a means—that capitalizes on technology to provide health care and other health-related services remotely. This includes communication and education between providers as well as between patients and providers. Though it does not increase the size of the provider workforce, telehealth can help increase efficiency and extend the reach of existing providers.

With its potential to overcome workforce and access barriers, telehealth can reduce health disparities for aging and underserved populations. It can also reduce patients’ costs and burdens associated with lost work time, transportation and child care. By improving access to lower-cost primary and behavioral health care, telehealth can provide timely, accessible care in lower-cost environments and help reduce expensive emergency room visits.

As state leaders seek to capitalize on the potential for telehealth to support the health care workforce and improve access to care, a number of policy issues arise. Prescribing practices, reimbursement and licensure are among key topics being addressed in state legislatures and Congress.

**State Action**

Although states occasionally use similar language in their policies, no two states are exactly alike in...
how they define and regulate telehealth. Public and private payment for telehealth services varies across the nation, which can affect its adoption. All states and the District of Columbia allow reimbursement for some form of live-video services in their Medicaid programs, 23 states allow reimbursement for store-and-forward services (sharing information electronically) and 27 states allow reimbursement for remote patient monitoring.

Mobile health (mHealth) is an emerging modality. It includes health education, information or other services via a mobile device. mHealth references are much less common in state policy—Hawaii is the only state to define mobile health in statute.

For all methods of telehealth, states may restrict the types of services, specialties and providers, as well as a patient’s location, that are eligible for reimbursement. For example, 29 states reimburse for telehealth under their home health services.

Sixteen states allow fewer than nine provider types to receive reimbursement for telehealth, while 19 states and the District of Columbia do not specify the type of provider. Generally, states have been expanding these categories to allow greater reimbursement for a growing number of services, providers and modalities.

Many states have adopted coverage and reimbursement policies related to private payers to broaden access to telehealth services. Currently, 40 states and the District of Columbia have some type of private payer policy. Typically, these policies require coverage and/or reimbursement that is comparable to what is covered and/or reimbursed for in-person visits. However, not all these policies mandate coverage or reimbursement. Florida is the most recent state to allow, but not require, private payers to reimburse for telehealth services.

Because technology crosses borders, licensure of providers becomes an issue when considering telehealth as a solution to workforce shortages. Generally, health care providers must be licensed in the state where the patient is receiving care and states retain oversight of providers within their borders. This may pose challenges for providers and states seeking to expand access across state lines.

Licensure compacts for various providers have been gaining traction as a way to allow interstate practice, particularly with an eye toward promoting telehealth. Compacts are formed and become active when a certain number of states enact the same legislation, with specific required language or by a certain date, whichever occurs first. However, joining the compact is voluntary on the part of the provider.

**Federal Action**

In addition to addressing overall gaps in health services, state and federal policymakers increasingly consider telehealth as a way to increase access to essential behavioral health services. The federal SUPPORT for Patients and Communities Act, enacted in 2018, expands telehealth access for patients with substance use disorders (SUD). The law removes previous geographic restrictions in Medicare for telehealth services for treating a person with a SUD diagnosis. The law also includes funding to train to rural providers with Project ECHO, which can improve providers’ capacity to address SUD by consulting with other providers regularly through telehealth.

Additionally, the law allows the U.S. attorney general and the U.S. Department of Health and Human Services secretary to issue a special registration to providers to prescribe controlled substances via telehealth in emergency situations.

Telehealth has the potential to help states leverage a shrinking and maldistributed workforce, increase access to services and lower costs. As challenges persist, legislators will surely continue to consider innovative strategies like telehealth to improve individual, community and population health.