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Covering and Reimbursing Telehealth Services

By Kate Blackman

Policymakers who are striving to achieve better health care, improved health outcomes and lower costs are considering new strategies and technologies. Telehealth is a tool that uses technology to provide health services remotely, and state leaders are looking to it now more than ever as a way to address workforce gaps and reach underserved patients. Among the challenges facing state lawmakers who are working to introduce or expand telehealth is how to handle covering patients and reimbursing providers.

Federal Action

Medicare—the federal insurance program for people ages 65 and older, and younger people with disabilities or certain conditions—began covering telehealth in 1997. While the program has since expanded its coverage, Medicare limits telehealth reimbursement to certain modalities, services and locations, including geography. States have the ability through the Affordable Care Act (ACA) to use telehealth to integrate coverage for the dually eligible under both Medicare and Medicaid. For example, 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.

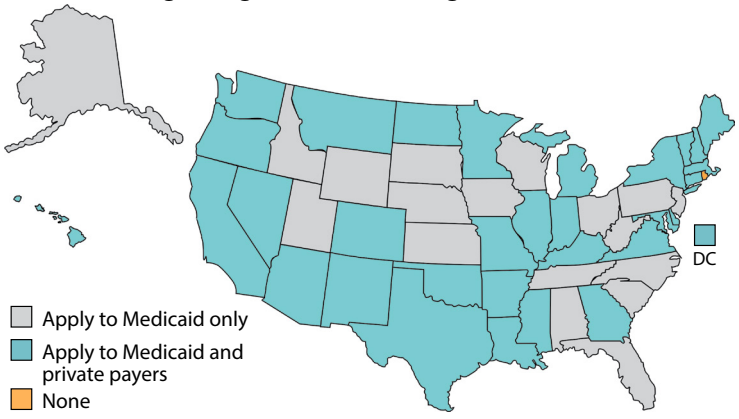
Did You Know?

- 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.
- Use of telehealth services is expected to grow from 250,000 patients in 2013 to 3.2 million patients in 2018.
- Most states are making telehealth coverage and reimbursement comparable to that provided for in-person health care services.

State Action

More than 200 telehealth-related bills were introduced in 42 states in 2015, according to the Center for Connected Health Policy. 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. States' definitions of telehealth are important because they can determine whether and which services are covered and reimbursed under public and private insurance. State policymakers are tackling coverage and reimbursement issues as they relate to Medicare, Medicaid, private payers and state employees.

Policies Regulating Telehealth Coverage and Reimbursement



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

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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."

While Medicaid coverage and reimbursement differ among states, almost all states (49) and the District of Columbia have some coverage for telehealth. Nearly all states reimburse for live video telehealth, while significantly fewer reimburse for electronically transmitted health information via store-and-forward services (nine states) or remote patient monitoring (17 states). Most states specifically exclude—or do not specify inclusion of—email, phone and fax in their definitions of telehealth services that can be reimbursed.

Coverage for telehealth in state Medicaid programs varies in terms of services, providers and settings.

- Almost all states (48) provide some coverage for mental or behavioral health services delivered via live video.
- Eight states reimburse for telehealth under their home health services.
- Nineteen 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.
- Twenty-four states and the District of Columbia do not specify a patient setting or location as a condition of payment.

Most states do not require that patients be located in rural settings like Medicare does. Nevada, Michigan and Missouri removed their geographic restrictions in recent years, and Colorado removed its requirement during the 2015 legislative session.

Private Payers. Currently, 32 states and the District of Columbia have telehealth private payer laws, some of which go into effect in 2016 or 2017. 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, meaning reimbursement could take into account differing facility and administrative fees. 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.

State Employee Groups. All states provide health insurance coverage for their employees, collectively paying about $25 billion in 2013. Twenty-four states allow some type of coverage for telehealth in state employee plans, with 21 extending the coverage through their parity laws.

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NCSL, Telehealth: Policy Trends and Considerations