



**Center for Connected
Health Policy**

THE NATIONAL
TELEHEALTH POLICY
RESOURCE CENTER

State Telehealth Policy: Summary and Findings from the Fall 2022 Webinar Series

Center for Connected Health Policy
January 2023

This report was made possible by Grant #U6743496 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

INTRODUCTION

As the COVID-19 pandemic moves towards its third year anniversary, some are seeing an eventual end to the public health emergency (PHE). In the Fall 2022, the Center for Connected Health Policy (CCHP) held two webinars in its popular state telehealth policy series that focused on what the telehealth policy landscape may look like in a post-PHE environment.

THE FALL SERIES

The Fall Series expanded the scope of subject matter as the sessions focused on federal issues, specifically what might be expected in a post PHE environment, and what providers needed to keep in mind when operating in multiple jurisdictions. The webinars were:

- Webinar #1: Crossing State Lines – October 21, 2022
- Webinar #2: Federal Policy & Telehealth: What to be Aware of Going Forward – October 28, 2022

The two webinars combined showed 2716 people registered and 1,199 attended. The majority of attendees represented state or federal offices, public health agencies, hospitals and providers' offices, safety net clinics, and non-profit policy and advocacy organizations. The diversity of topics reflected the variety of attendees.

WEBINAR #1 – CROSSING STATE LINES

The unique features of telehealth renders geographic barriers irrelevant and allows providers to cross state lines easily. However, while distance issues may be alleviated, but policy barriers in individual states still remain. This webinar focused on the various issues that providers may encounter when providing services in jurisdictions they are not physically located in.

Kimberly Horvath, JD, Senior Attorney, American Medical Association

Ms. Horvath focused on the issues related to licensure and practicing across state lines. Each state regulates their own licensure laws that impact health care professionals. Essentially, any physician (and most health care providers) will need to be licensed by the state in which the patient is located at the time they are receiving services. There are exceptions, but they are few and very specific. For example, some states allow for consultations or irregular or infrequent care to be provided without the physician needing to be licensed, but not all states have these exceptions. There were several paths in which to meet these licensure requirements by states. These avenues included the traditional path of applying for a license through the state medical board. Recently licensure compacts have gained a lot of popularity not just for physicians, but other health care professionals as well. There are also special telehealth licenses some states have or a registry that physicians can apply to be on. Ms. Horvath stressed that unless an interaction fell into one of the narrow exceptions most likely

health care providers will need to meet the licensure requirements of the state their patient is located in.

Jeremy Sherer, Esq, Partner, Digital Health Co-Chair, Hooper, Lundy, & Bookman, PC

Mr. Sherer provided the attendees with an overview of the different scope of practice and legal considerations they needed to make when practicing across state lines. His list included:

- Licensure
- Prescribing
- Corporate Practice
- Modalities
- ID Verification, Consent
- Reimbursement
- Credentialing, Supervision
- Malpractice Coverage

Mr. Sherer focused on the prescribing, consent and malpractice coverage issues as the other speakers presented on the other topics. He noted for corporate practice that providers needed to be certain that their arrangements/contracts needed to be properly structured as to not run into conflict with state law. With prescribing, however, providers needed to be aware of both federal and state policies as both jurisdictions impact how telehealth can be used. He noted sometimes policies regulating the use of telehealth in prescribing may be found in how a patient-provider relationship is formed, and the impact on prescribing may not be explicitly stated. Additionally, Mr. Sherer noted a good number of states have consent laws or policies related to telehealth. The majority of states require some prior consent before a practitioner can deliver services via telehealth either in statute, or it may be found in a payer's policy, such as the Medicaid program. Malpractice coverage was also something providers should be aware of as they practice across state lines. A provider's malpractice insurance may not stretch into other jurisdictions, so it is important practitioners consult with their carriers to ensure their coverage extends to services provided via telehealth. Additionally, providers should be aware that when providing services in another state, you are most likely agreeing to submit yourself to the jurisdiction of the courts in that state should some legal action be taken against you.

Kathy Wibberly, PhD, Director, Mid-Atlantic Telehealth Resource Center

As a regional telehealth resource center (TRC), Ms. Wibberly noted that her organization covers multiple states and frequently assists providers with their interstate issues due to the number of providers who have practices that border other states and therefore see patients from across state lines. Among one of the major issues is related to the differences in coverage and reimbursement policies. Ms. Wibberly noted that no two states in her region had the exact same policy in Medicaid or for commercial payers for telehealth reimbursement and coverage. Medicaid in particular had many differences that a provider had to be aware of or risk not being reimbursed for the services they provide. Providers want to be able to offer any patient who comes to their practice the same level of care and package of services, without having to navigate the complicated policy landscape. Instead, providers need to be aware that limitations could be placed on the type of modality that would be eligible to be used, type of service provided, the type of provider and the location of the patient. Payment policies could

differ substantively depending on the entity covering the service and what each state may require. For example, a state may not require in law that a commercial payer reimburse providers at parity. Another example is a physical therapist's own state Medicaid program may reimburse for their services if telehealth is used, but if that same therapist offered the same services in a neighboring state, that state's Medicaid program may not reimburse physical therapists who use telehealth. Ms. Wibberly noted that providers face a very complicated policy landscape, one that practitioners must be aware of. Additionally, there were other factors that impacted how and how expansively telehealth could be used that Mr. Sherer and Ms. Horvath covered.

WEBINAR #2 – FEDERAL POLICY & TELEHEALTH: WHAT TO BE AWARE OF GOING FORWARD

State licensure of health care professionals has always been a major issue when discussing the use of telehealth. Many telehealth proponents saw the need to be licensed in every state the provider was operating in as a barrier to greater utilization of the technology. While much discussed prior to COVID-19, policy changes were slow with the most significant being the establishment of state licensure compacts. However, with COVID-19, the discussions took on more urgency as well as realization that not everyone was aware of the ways this issue has been addressed in the past and the impact on providers and patients.

John W. Gordon, Office of Evaluation and Inspections, Office of Inspector General

Mr. Gordon shared information about four recent reports the Office of Inspector General (OIG) released in relation to telehealth. The reports focused on the use of telehealth in Medicare during the first year of the pandemic. He noted that more than two in five Medicare beneficiaries used telehealth during the first year of COVID-19. While telehealth use peaked in the early part of the pandemic and then decreased through the end of 2020, use remained high in early 2021 compared to prior to the pandemic. Further, beneficiaries used telehealth to receive a larger share of their behavioral health services compared to their use of telehealth for other services. Over 80% of beneficiaries who received telehealth services did so from providers with whom they had an established relationship. Medicare beneficiaries located in urban areas were more likely to use telehealth than those in rural areas. About one in five beneficiaries used audio-only to receive telehealth services. These data, amongst others, led OIG to make a series of recommendations to CMS including temporary extension of telehealth use in urban areas and from home, temporary extension of audio-only, evaluation of the impact of audio-only, and using telehealth to advance health equity.

The OIG also examined the potential for fraud, waste, and abuse and in examining that first year of data flagged approximately 1,700 providers that posed a high risk to Medicare. Taken together, these providers billed for over \$127 million in Medicare fee-for-service claims, for about half a million beneficiaries. Based on these findings, OIG recommended to CMS that they strengthen monitoring and targeted oversight of telehealth services, provide additional education to providers on billing appropriately, improve the transparency of "incident to" services, and identify telehealth companies that bill Medicare. Mr. Gordon noted that the OIG will continue to closely examine telehealth going forward.

Carly L. Paterson, PhD, MPH, RN, Associate Director, Healthcare Delivery and Disparities Research Program, Patient-Centered Outcomes Research Institute (PCORI)

Carly Paterson from PCORI describe the work her organization does. PCORI is an independent research institute authorized by Congress in 2010. It funds comparative clinical effectiveness research that engages patients and other stakeholders throughout the research process. They were recently reauthorized by Congress through 2029. PCORI's telehealth research portfolio includes \$600 million that funds 123 comparative clinical effectiveness research studies. Sixty-one of these studies address disparities. Some studies continue to be ongoing, but Ms. Paterson was able to share the following:

- Addressing Childhood Hearing Loss Disparities in an Alaska Native Population: A Community Randomized Trial. This study used telehealth in a school setting to provide hearing screenings with an audiologist in 15 villages to 1,481 children. After nine months, students using the service were more likely to get diagnosed, and faster, than students using a standard process of referral.
- Evaluating the Comparative Effectiveness of Telemedicine in Primary Care: Learning from the COVID-19 Pandemic. This study is nearly complete, and looks at new or expanded telemedicine programs in primary care settings comparing three practice delivery models: synchronous telemedicine, telemedicine supplemented with in-person visits, primarily in-person visits and their impact on outcomes of avoidable ED visits, unplanned hospitalizations, continuity of care and days at home, with results anticipated in 2023.

Overall, the work done by PCORI will help inform policymakers as they decide what telehealth policies will be made permanent in a post-PHE environment.

Mei Wa Kwong, JD, Executive Director, Center for Connected Health Policy

Ms. Kwong provided an overview of where Medicare was on telehealth policy and what to expect after the PHE as of the date of the webinar. She noted that there have been some legislative action to date that would impact telehealth post-PHE. These actions included allowing mental health services to be provided via telehealth in the Medicare program without the rural restriction and the home can be an eligible originating site if certain conditions are met. Additionally, CMS has made a change to permanent policy that would allow audio-only to provide mental and behavioral health services as well as redefining what a mental health visit meant for federally qualified health centers (FQHCs) and rural health clinics (RHCs). The new definition of mental health visit for these two entities will include the use of live video and audio only to provide those services. CMS has emphasized that does not mean FQHCs and RHCs are telehealth providers, a change that only Congress can make. This action was a redefinition of a mental health visit and not a change in telehealth policy. Additionally, at the time of the webinar, we know that Congress had enacted legislation that would create a 151 day grace

period after the PHE is declared over that would allow some of the temporary telehealth COVID-19 policies to continue and delay certain newer permanent policies that were mentioned earlier.

CONCLUSION

As reflected by the speakers, the telehealth landscape continues to be ever-evolving. Both on the state and federal levels, changes have significant impact on how providers can and may wish to provide services to their patients. Additionally, ongoing research delves into how and where telehealth can be used effectively to meet patient needs. We can only anticipate that there will continue to be further developments in 2023.