



# State Telehealth Laws and Medicaid Program Policies

Fall 2023

## SUMMARY REPORT:

The Highlights & Findings of a  
Comprehensive Scan of 50 States, D.C.,  
Puerto Rico and the Virgin Islands.

The Center for Connected Health Policy's (CCHP) Fall 2023 Summary Report of the state telehealth laws and Medicaid program policies is now available as well as updated information on our online [Policy Finder](#) tool. The most current information in the online tool may be exported for each state into a PDF document. The following is a summary of the current status of telehealth policy in the states given these new updates. Historically, CCHP has provided these bi-annual summary reports in the Spring and Fall each year to provide a snapshot of the progress made in the past six months. Moving forward, the summary report will transition to being released once per year in the Fall only, with three separate rounds of updates being made to each jurisdiction in the Policy Finder per year. CCHP is committed to providing timely policy information that is easy for users to navigate and understand through our Policy Finder. Additionally, in 2020 the COVID-19 category was added to CCHP's online policy finder. The temporary COVID-19 policies were never factored into this report since they were temporary and contingent on the existence of COVID-19 public health emergency (PHE) designations. Since the federal COVID-19 PHE officially ended on May 11, 2023, and most state PHE designations have ended, the policy finder's COVID-19 section will be phased out of the next round of updates occurring in Winter 2023-2024. Policies that have been made permanent or extended for multiple years have been (and will continue to be) incorporated into the other appropriate relevant sections of the policy finder. **The information for this summary report covers updates in state telehealth policy made between late May and early September 2023.**

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Amy Durbin, Policy Advisor or Christine Calouro, Senior Policy Associate at [info@cchpca.org](mailto:info@cchpca.org). For further information, visit [cchpca.org](http://cchpca.org).

**This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.**

**Mei Wa Kwong, JD, Executive Director**

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## Introduction

The Center for Connected Health Policy's (CCHP) Fall 2023 analysis and summary of telehealth policies are based on information contained in its online [Policy Finder](#). The Summary Report provides highlights on certain aspects of telehealth policy and the changes that have taken place between now and the previous edition, Spring 2023. The research for this edition of the Summary was conducted between late May and early September 2023. This summary offers the reader an overview of telehealth policy trends throughout the nation. For detailed information by state, see CCHP's online telehealth [Policy Finder](#) which breaks down policy for all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands.

Please note that although many states have incorporated their COVID-19 emergency policies into permanent policies (especially now that the federal COVID-19 public health emergency has ended), some COVID policies are still siloed from permanent telehealth policies. These temporary policies are not included in this summary, although they are listed under each state in the online Policy Finder under the COVID-19 category. In instances where the state has made policies permanent, or extended policies for multiple years, CCHP has incorporated those policies into this report.

## Methodology

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the primary resources for the online Policy Finder, from which the findings in this summary are taken. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, bulletins or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in the policy finder specifically focuses on fee-for-service; however, managed care plan information has also been included if available from the utilized sources.

Every effort was made to capture the most recent policy language in each state at the time it was reviewed between late May and early September 2023. Note that in some cases, after a state was reviewed, it is possible that the state may have enacted a policy change that CCHP may not have captured. In those instances, the changes will be reviewed





and catalogued within our Winter online policy finder update, and changes incorporated into next year's Fall 2024 summary report. CCHP also reports on significant changes for each state that was updated in the previous month in our newsletter, which is released the second Tuesday of each month ([subscribe to the CCHP newsletter](#)). Additionally, even if a state has enacted telehealth policies in statute, these policies may not have been incorporated into its Medicaid program. For purposes of this summary, CCHP only counts states as reimbursing for a specific modality or removing a restriction if there is documentation to show that the Medicaid program has explicitly implemented a policy or statute. Requirements in newly passed legislation will be incorporated into the findings of future editions of CCHP's summary report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming implementation.

Last year, CCHP received funding from the National Association of Community Health Centers (NACHC) to create an FQHC specific section on Medicaid fee-for-service policies. NACHC has provided funding again this year allowing CCHP to continue to update that category within our policy finder. COVID-19 is also currently included as a category in CCHP's 50 State policy finder tool, however as mentioned previously, COVID policies are not included as part of this report and the category will be phased out of the policy finder during CCHP's Winter 2023/2024 updates.

The information is  
organized in the policy  
finder into four major  
categories:



- .....
1. Medicaid reimbursement
  2. Private payer laws
  3. Professional requirements
  4. Federally qualified health centers (FQHCs)

**Within each of the four major categories, information is organized into various topic and subtopic areas in CCHP's policy finder. These topic areas include:**

• **MEDICAID REIMBURSEMENT:**

- o Definition of the term telemedicine/telehealth
- o Reimbursement for live video
- o Reimbursement for store-and-forward
- o Reimbursement for remote patient monitoring (RPM)
- o Reimbursement for email/phone/fax
- o Consent requirements
- o Out-of-state providers

• **PROFESSIONAL REQUIREMENTS:**

- o Definitions
- o Consent
- o Online Prescribing
- o Cross-State Licensing
- o Licensure Compacts
- o Professional Board Standards

• **FQHC:**

- o Definition of Visit
- o Modalities Allowed
- o Same Day Encounters
- o Eligible Originating Sites
- o Eligible Distant Sites
- o Facility Fee
- o PPS Rate
- o Home Eligible
- o Patient-Provider Relationship

• **PRIVATE PAYER LAWS:**

- o Definitions
- o Requirements
- o Parity (service and payment)



## Key Findings

Since the release of CCHP's last 50 state report in May 2023, several Medicaid programs have gone beyond merely reimbursing office visit evaluation and management codes, moving to add a range of specific services as reimbursable when delivered via telehealth. For instance, Nebraska Medicaid released guidance incorporating many PHE policies into their permanent reimbursement policies. This includes reimbursement for services such as health check services, mental health and substance use, physical and occupational therapy, physician services, speech pathology and audiology, visual care, and chiropractic services. Additionally, the bulletin specifies that Indian Health Services (IHS) And Tribal 638 facilities can bill the encounter rate for telehealth services as long as these services meet the definition of an encounter. Louisiana's Medicaid Managed Care Organization Manual now includes provisions for treatment-in-place telehealth services by ambulance providers, with defined eligible services and rendering providers. Meanwhile, North Dakota has introduced through their General Information Provider Manual reimbursement for Digital Health Evaluation and Management Services, which consists of patient-generated inquiries. Moreover, various Medicaid programs have adopted strategies reminiscent of Medicare, detailing eligible telehealth service codes in a list for providers to reference, with some states identifying a subset of the codes as suitable for audio-only interactions. Iowa Medicaid, for example, lists eligible codes, and includes information on whether they can be delivered through audio-only interactions, resembling CMS's approach. Likewise, Connecticut, Colorado, and Oklahoma, have all utilized the CPT code list format (though reimbursable codes may vary) to indicate which services are eligible for telehealth reimbursement.

Just as in previous issues of this Summary Report, since the onset of the COVID-19 PHE, states continue to expand their audio-only reimbursement policies. However, the transition to permanent policy changes has typically been characterized by a more deliberate and cautious approach compared to the rapid implementation of temporary measures during the COVID-19 pandemic. North Dakota's General Information Provider Manual was updated, for instance, to provide for reimbursement of audio-only telephone evaluation and management (E/M) services, but only when initiated by an established patient or guardian of an established patient. In June, Vermont Medicaid issued a Banner Notice related to their coverage of audio-only services, announcing that they will continue to allow audio-only services for a defined list of codes, which mirrors the Medicare list of codes. They note that Medicaid will consider covering audio-only services not on the approved list when unforeseen circumstances require the service to be delivered via audio-only. Taking a more careful approach, South Carolina Medicaid's recent update indicates that COVID-19 PHE flexibilities for audio-only telephonic services will be extended for further evaluation. Reimbursement is limited to specific codes and can only be rendered by a physician, nurse practitioner, physician assistant or licensed independent practitioner (LIP). Finally, Alabama's revamped Telemedicine Policy indicates that although audio-only reimbursement is continuing, new rates will be established for audio-only services by October 1, 2023.



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Not every policy change expanded telehealth reimbursement. For example, in a program update for Medi-Cal providers (California Medicaid), the California Department of Health Care Services announced that they would no longer be reimbursing HCPCS code G0071 (communication technology-based services that consists of virtual non-face-to-face communication) for Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Indian Health Services-Memorandum of Agreement (IHS-MOA) and Tribal FQHC providers for dates of service after the public health emergency (PHE) ends. Washington Medicaid issued an alert announcing the end of coverage for emailing and texting for telehealth services to coincide with the end of the PHE as well.

States also took steps to incorporate a wider range of providers that can deliver telehealth services. Most states temporarily expanded their eligible telehealth provider lists in their COVID-19 PHE policies, but had not yet officially incorporated these changes into their permanent policies. South Dakota, for example, updated its telemedicine billing manual to include audiologists, occupational therapists, and physical therapists. Likewise, South Carolina recently extended their flexibility for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed for telehealth, although they note that the extension is temporary and further evaluation is needed. Many states are now adopting the place of service (POS) code system previously introduced by Medicare, where POS 10 indicates services provided at a patient's home and 02 indicates telehealth services provided at an originating site other than the patient's home. Examples of states recently adding this billing procedure include the District of Columbia, North Dakota, Kansas, Nebraska, and New Jersey. The District of Columbia has also added POS 03 to indicate patients at school-based sites. Many states, including North Dakota and Nebraska, also continue to use the 95 modifier to indicate services provided through audio-visual technology and the 93 modifier for synchronous telephone or audio-only services.

In addition to audio-only telephone, a limited number of states are expanding into other modalities including store-and-forward and remote patient monitoring. For example, California Medicaid added coverage for certain Continuous Glucose Monitoring (CGM)

## TELEHEALTH FACT:



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codes. Utah now defines telemedicine services as including asynchronous store and forward transfers, and reimbursement for interprofessional internet assessment and management services for psychiatrists are listed as covered in their provider manual. In contrast, while Florida released a Medicaid Alert clarifying that store-and-forward and remote patient monitoring are allowed, audio-only telehealth services are no longer covered. Finally, Texas passed HB 2727 which amends the statute related to its home telemonitoring services to modify the program to allow FQHCs and RHCs to be eligible providers. It also adds end stage renal disease or a condition that requires renal dialysis treatment to the list of eligible conditions for remote telemonitoring services, among other changes.

Policies addressing requirements for provider enrollment, including rules around an in-state address, is the newest phenomenon in Medicaid telehealth policy. States appear to be taking different approaches to this issue. Alabama's telemedicine policy, for instance, now requires an in-state or qualifying bordering state site of practice address from which telemedicine services can be provided. Similarly, a new bulletin from ForwardHealth (Wisconsin Medicaid) limits out-of-state provider enrollment by only allowing enrollment of out-of-state border-status providers in Medicaid. Out-of-state providers that do enroll as telehealth only border-status providers are required to obtain prior authorization from ForwardHealth before providing non-emergency services. In some states, this has become such an issue that legislation was passed forbidding Medicaid programs from requiring an in-state address or provider's presence for Medicaid enrollment. Indiana's HB 1352 is one such bill that now prohibits the Office of Medicaid and Planning from requiring a provider or telehealth provider group that exclusively offers telehealth services to maintain a physical address or site in Indiana to be eligible to enroll as a Medicaid provider. Likewise, Kentucky House Bill 311 stipulates that Medicaid cannot require a health professional or medical group to maintain a physical location or address in the state to be eligible for enrollment. Finally, Virginia H 1602 also maintains that a health care provider licensed in Virginia providing services through telemedicine cannot be required to have a physical presence in Virginia to be considered an eligible provider for enrollment as a Medicaid provider.

In addition to incorporating traditional coverage policies for telehealth into Medicaid guidance documents, a few state Medicaid programs have begun taking a further step and describing policies typically left up to the state professional boards. For example, Alabama's Telemedicine Policy describes practice, prescribing and documentation guidelines. Connecticut's latest telehealth guidance bulletin outlines requirements related to telehealth services, HIPAA and privacy, location and informed consent. MassHealth (Massachusetts Medicaid) also released a new bulletin on their telehealth policy effective Oct. 1, 2023 addressing a concern some state policymakers have that patients will be forced into telehealth despite preferring in-person care. The new section states that the availability of telehealth does not mitigate the provider responsibility to accommodate member choice for in-person services and that although MassHealth allows reimbursement for telehealth, they do not require providers to deliver services via telehealth.



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Although not as prevalent among states as changes to Medicaid programs, a few states also did make adjustments to their private payer law since Spring 2023. Most of the adjustment revolved around payment parity requirements. For example, Nevada passed Senate Bill 119 which amends Nevada's private payer law (and requires Medicaid to submit a state plan amendment). The new law requires the same reimbursement amount if services are received at specific types of originating sites (except for audio-only interactions). The same reimbursement amount will also be required for counseling or treatment relating to a mental health condition or a substance use disorder, including without limitation, when such services are provided through audio-only interaction. Nebraska passed LB 296 which requires the reimbursement rate for any telehealth service to be at a minimum the same as a comparable in-person health care service if the provider also provides in-person health care services at a physical location in Nebraska or is employed by or holds medical staff privileges at a licensed facility in Nebraska and the facility provides in-person care services in Nebraska. Hawaii went in a different direction with audio-only services, passing HB 907 which maintains payment parity for interactive telecommunication system interactions, but requires that reimbursement for two-way, real-time audio-only communication technology for mental health disorders to the patient's home to be reimbursed at only eighty percent of the reimbursement for the same in-person service. It also requires a prior in person visit or telehealth visit that is not audio only within six months prior to the initial audio-only visit or within twelve months prior to any subsequent audio-only visits. This policy is reminiscent of Medicare permanent policy regarding mental health telehealth visits (although not yet implemented in Medicare due to continuation of temporary COVID PHE policies until Dec. 31, 2024).

As telehealth has become more prevalent the past few years, professional boards have moved to regulate telehealth practice. One of the primary questions often addressed in professional practice standards is whether or not a telehealth interaction can qualify to form a provider-patient relationship. Different states and professions have answered that question in different ways. For example, Oregon SB 232 amended statute on forming

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a provider-patient relationship for physicians and physician assistants to specify that they may use telemedicine to engage in the practice of medicine and provide health care services, including establishing a provider-patient relationship. The West Virginia Nursing Board amended their telehealth practice requirements to remove a requirement for an in-person patient encounter, allowing for telemedicine live video encounters to establish a relationship, as well as audio-only (although audio-visual contact is preferable). It also specifies that a relationship cannot be established through text-based communications such as email, internet questionnaires, text-based messaging or other written forms of communication. Professional practice standards can also address issues beyond the patient-provider relationship. For example, the Louisiana Board of Psychology added telepsychology practice standards and includes a requirement for telehealth informed-consent to be obtained at the start of all services. Nevada Assembly Bill 432 enacts practice standards for optometrists requiring that a licensee can only engage in synchronous or asynchronous optometric telemedicine for a new patient if the licensee has completed (or received information from) a comprehensive examination within the immediately preceding two years. It also provides a list of exceptions by which an optometrist may engage in asynchronous telemedicine in the case that a comprehensive examination has not been conducted within the preceding two years.

Prescribing is another key issue often addressed either in statute or practice standards that involve healthcare professionals authorized to prescribe. In fact, several bills have passed since CCHP's Spring 2023 update that have centered around controlled substances. Oklahoma HB 2686 provides an exception to prescribing a controlled substance via telemedicine if it is a Schedule III, IV or V controlled substance approved by the US Food and Drug Administration (FDA) for medication assisted treatment of detoxification treatment for substance use disorder. New Hampshire House Bill 500 allows advanced practice registered nurses (APRNs) to prescribe non-opioid and opioid controlled drugs classified in schedule II through IV by means of telemedicine after establishing an advanced practice registered nurse-patient relationship with the patient. The bill requires subsequent in-person exams to be conducted by a practitioner licensed to prescribe the drug at intervals appropriate for the patient, medical condition, and drug, but not less than annually. Another distinct concern tied to prescribing has also surfaced, involving instances where pharmacies decline to dispense prescriptions issued through telemedicine. Virginia addressed this issue by passing H 2374 which forbids a pharmacy from implementing a policy that prevents pharmacists from dispensing a prescription solely on the basis of the prescriber's use of a telemedicine platform to provide services.

Finally, states are slowly developing alternatives to full licensure for out-of-state telehealth providers. This includes Maryland, District of Columbia and Virginia which have now entered into a licensing reciprocity agreement to facilitate the expedited licensure of physicians practicing within the three jurisdictions. New Mexico HB 384 specifies requirements related to a temporary or provisional license, including requirements for an expedited license for providers from other states. Similarly, Utah passed HB 159 which establishes a temporary license for telemedicine and allows individuals with such a license to provide telemedicine services under certain circumstances. A temporary license still requires an application for license by endorsement, and would only be applicable when the division that processes the endorsement applications has determined that they will be unable to process the application within 15 days. Despite these individual state allowances for out-of-state licensing, interstate compacts continue to be the most widely used tool to allow for out-of-state practitioners practice in various professions. We saw the largest jump in participation in the Professional Counseling Compact and the Interjurisdictional Psychology Compact (PSYPACT) during this Fall 2023 edition of the report.



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## Additional findings include:

- **Fifty states and Washington DC** provide reimbursement for some form of live video in Medicaid fee-for-service. Both the jurisdictions of Puerto Rico and Virgin Islands do not explicitly indicate they reimburse for live video in their permanent Medicaid policies.
- **Thirty-three state Medicaid programs** reimburse for store-and-forward. Florida, Montana, North Dakota, South Carolina and Utah are the states which added reimbursement for store and forward, although each in a limited capacity, and some only through specific communication technology-based service (CTBS) codes since the Spring update.
- **Thirty-seven state Medicaid programs** provide reimbursement for remote patient monitoring (RPM). Three states, (Florida, Idaho, and Iowa) added reimbursement for RPM since Spring 2023.
- **Forty-three states and DC Medicaid programs** reimburse for audio-only telephone in some capacity; however, often with limitations. Seven states including Alabama, Idaho, Kansas, Montana, Nebraska, Oklahoma, and Vermont added reimbursement for audio-only telehealth in some capacity since Spring 2023.
- **Twenty-five state Medicaid programs** including Alaska, Arizona, California, Hawaii, Illinois, Iowa, Kentucky, Maine, Massachusetts, Maryland, Michigan, Minnesota, Missouri, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin reimburse for all four modalities (live video, store-and-forward, remote patient monitoring and audio-only), although certain limitations may apply.
- **Forty-three states, the District of Columbia and Virgin Islands** have a private payer law that addresses telehealth reimbursement. Not all of these laws require reimbursement or payment parity. Twenty-four states have explicit payment parity. No new states have added a private payer law since Spring 2023, though a few states have made modifications to private payer law requirements.



Below are summarized key findings in each category as of September 2023. While this report provides an overview of findings, it must be stressed that there are nuances in many of the telehealth policies. To fully understand a specific policy and all its intricacies, the full language of it must be read and can be accessed via [CCHP's telehealth Policy Finder](#).

## Definitions

The way a term is defined can shape the scope of a state's telehealth regulations. For instance, certain states include specific limitations within their definition of telehealth or telemedicine, like the requirement for "live" or "interactive" contact, thereby excluding store-and-forward and remote patient monitoring (RPM) from the definition and, consequently, from reimbursement. All fifty states, along with the District of Columbia (DC), Puerto Rico, and the Virgin Islands, have established legal, regulatory, or Medicaid program definitions for telehealth, telemedicine, or both.

States vary in their choice of terminology, switching between "telemedicine" and "telehealth," with some opting to use both terms interchangeably. "Telehealth" is often employed to encompass a broader scope, while "telemedicine" is typically reserved for describing the provision of clinical services. Moreover, there has been a growing trend in adopting terms prefixed with "tele," such as "telepractice" or "teletherapy" for physical and occupational therapy, behavioral therapy, and speech-language pathology, as well as "teledentistry" for dental services. When referring specifically to psychiatry services, "telepsychiatry" is commonly used as an alternative





term. Additionally, following the onset of the pandemic, though not yet widespread, a few Medicaid policies and programs have introduced the term “virtual care.” The utilization of these various terms can potentially lead to confusion for providers, especially when they are accompanied by distinct and separate definitions.

The most common restriction some states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. However, due to the allowance for the telephone modality since COVID-19 policies were put in place, some states have amended their definitions to either remove the explicit exclusion of telephone or explicitly include audio-only services in their telehealth/telemedicine definitions.

In some instances, CCHP found that a state Medicaid program provided a definition of telehealth or telemedicine that is inclusive of modalities such as store-and-forward, remote patient monitoring and/or audio-only but did not provide further explicit guidance on whether or not those modalities are reimbursed.

## Medicaid Reimbursement

All 50 states and the District of Columbia have some form of Medicaid reimbursement for telehealth in their public program. CCHP was unable to locate any permanent telehealth reimbursement policy in Puerto Rico and the Virgin Islands’ Medicaid programs, though they may have definitions available for the modalities or the term “telehealth/telemedicine”. Reimbursement policies for telehealth services varies across states, with some jurisdictions providing more comprehensive guidance than others.

### › Live Video

The most common form of telehealth reimbursement, live video, enjoys widespread coverage across every state and the District of Columbia in their Medicaid programs, except for Puerto Rico and the Virgin Islands, as previously mentioned. However, the criteria pertaining to live video reimbursement varies considerably from state to state. Generally, Medicaid programs typically impose limitations on live video telehealth in three key areas:

- **Eligible services for reimbursement**, such as office visits or inpatient consultations.
- **Qualified healthcare providers who can receive reimbursement**, including physicians, nurses, physician assistants, and more.
- **Location of the patient**, known as the originating site.

Given the long-standing presence of extensive live video policies, there haven’t been as many groundbreaking developments in this domain in the last few months. Nevertheless, states continue to make gradual adjustments to their Medicaid programs, often offering further clarification on covered modalities, eligible providers, and billing requirements.

## STATE EXAMPLES: Q

**OKLAHOMA MEDICAID** provides four separate lists of telehealth and audio-only codes that became eligible for reimbursement once the PHE Ended (May 11, 2023), including separate lists for medical codes and behavioral health codes.

**MONTANA MEDICAID** takes a different approach, allowing all covered services to be delivered via telemedicine/telehealth as long as they are medically necessary and clinically appropriate, follow their guidelines and do not specifically require face-to-face contact.



## › Store-and-Forward

Store-and-forward services are defined and reimbursed by thirty-three Medicaid Programs. Florida, Montana, North Dakota, South Carolina and Utah are the states which added reimbursement for store and forward since the Spring 2023 update. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered ‘telehealth’). In certain states, the definition of telemedicine and/or telehealth explicitly requires services to be conducted in “real-time” or to be “interactive,” effectively excluding store-and-forward as a component of telemedicine and/or telehealth within those states. Among the states that do provide reimbursement for store-and-forward services, some impose restrictions on the type of services that qualify for reimbursement.

Five additional states (Colorado, Connecticut, Mississippi, New Hampshire, and New Jersey) have laws requiring Medicaid reimbursement for store-and-forward services, but CCHP has not been able to locate any official Medicaid policy indicating that they are in fact reimbursing. In some cases, although a definition of telehealth or telemedicine applicable to their Medicaid program included store-and-forward, there was no further indication of the modality being reimbursed, or the only specialty referenced was teleradiology which CCHP does not count as store-and-forward reimbursement for purposes of this list.

Store-and-forward is slowly being introduced in some states through specific CPT codes that include store-and-forward in its description. For example, Hawaii, Iowa, Rhode Island, and South Dakota allow for the reimbursement of a teledentistry code that specifically includes in its description the asynchronous review of information by a dentist. Several more states have authorized store-and-forward reimbursement due to their reimbursement of Communication Technology Based Services (CTBS), some of which explicitly incorporate the store-and-forward modality within their descriptions. CTBS is discussed further in a subsequent section, but it’s important to understand that five (Illinois, Ohio, North Carolina, South Carolina, and Utah) out of the 33 states that reimburse for store-and-forward do so through these CTBS codes.

## STATE EXAMPLE:

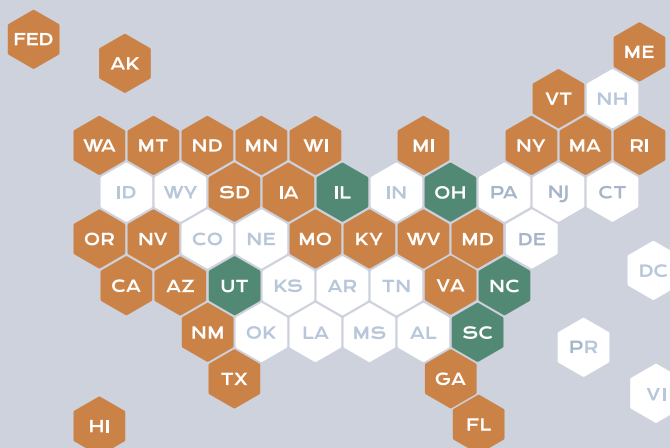


**NORTH DAKOTA** added reimbursement for Digital Health which consists of online digital evaluation and management services, which it describes as “not in real-time.” Established patients must initiate the service through HIPAA compliant secure platforms. Permanent documentation storage (electronic or hard copy) of the encounter is required.

### Store-and-Forward Map

#### MAP KEY:

- **White** – No reimbursement for store and forward
- **Orange** – Reimbursement for store and forward
- **Green** – Store and forward only reimbursed through CTBS



### › Remote Patient Monitoring (RPM)

Thirty-seven states have some form of reimbursement for RPM in their Medicaid programs. Since Spring 2023, Florida, Idaho and Iowa added reimbursement for RPM, though some additional Medicaid programs did make modifications or expand their RPM reimbursement to additional conditions. Four of the states reimburse only for specific remote patient monitoring CTBS codes, including California, Massachusetts, Hawaii, and West Virginia. Note that states may cover additional RPM codes beyond the traditional CTBS codes. For example, California Medicaid now covers continuous glucose monitoring. While the majority of the other states reimburse for CMS' remote physiologic monitoring codes, West Virginia also reimburses for remote therapeutic monitoring codes that were adopted by Medicare in the finalized 2022 physician fee schedule (PFS) in order to account for the management of patients using medical devices that collect non-physiologic data. It should also be noted that while Alaska Medicaid is included as covering RPM due to listing self-monitoring as a covered service in their Medicaid manual, CCHP has received anecdotal reports that the service is not actually being covered in Alaska.

Many of the states that offer RPM reimbursement also have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical conditions for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected. Connecticut, New Hampshire, and New Jersey Medicaid have laws requiring Medicaid reimbursement for RPM but at the time each state was reviewed for this report, they did not have any official Medicaid policy regarding RPM reimbursement. Note that CCHP's methodology does not include searches through Medicaid fee schedules. Therefore, if a state was reimbursing for specific CTBS codes (including RPM or RTM codes) but it is not mentioned in their telehealth policy, it would not be captured in this report.

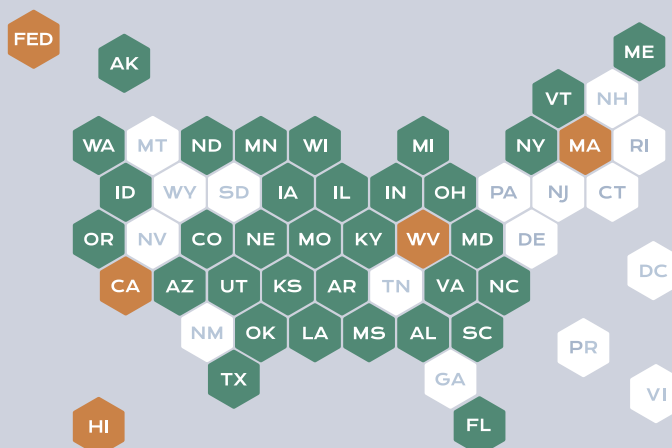
### STATE EXAMPLE:

**TEXAS** expanded their reimbursement of home telemonitoring in Medicaid through passage of HB 2727 which allows FQHCs and RHCs to provide home telemonitoring services and expands eligible conditions to include end stage renal disease or a condition that requires renal dialysis treatment.

#### Remote Patient Monitoring (RPM) Map

##### MAP KEY:

- **White** – No reimbursement for remote patient monitoring
- **Orange** – Remote patient monitoring only reimbursed through CTBS
- **Green** – Reimbursement for remote patient monitoring



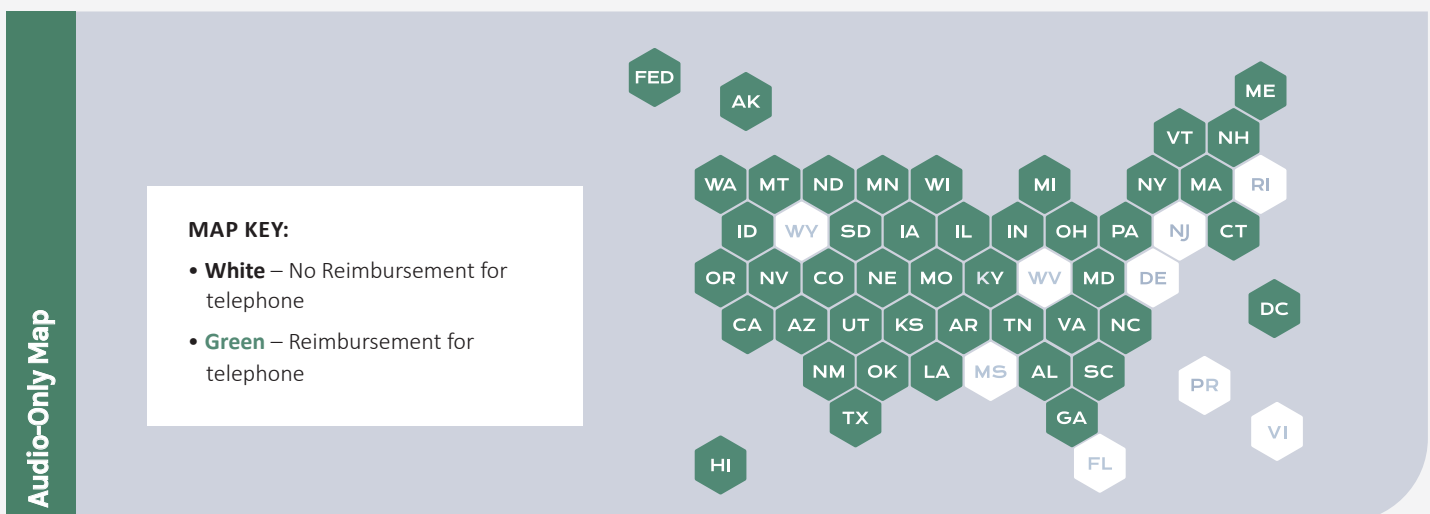


### › Audio-Only

Due to the significant effects of the COVID-19 pandemic and the necessity for patients to reach healthcare providers, particularly when a stable internet connection is not available, the adoption of telephone or audio-only service delivery has experienced rapid transformation. It has shifted from being often ineligible for reimbursement to becoming the second most commonly utilized telehealth modality eligible for Medicaid reimbursement in recent years, closely following live video services. In the Fall 2023 update, Alabama, Idaho, Kansas, Montana, Nebraska Oklahoma, and Vermont added reimbursement for audio-only services (although some in a limited capacity), making it forty-three state Medicaid programs and D.C. now allowing for telephone reimbursement in some way. Sometimes states will only reimburse specific specialties such as mental health, or specific services such as case management.

## STATE EXAMPLES:

Medicaid programs take one of two approaches with audio-only services. Some, such as **COLORADO MEDICAID**, simply state that telemedicine can be provided through telephone, leaving the services that can be rendered vague. Others are more specific. For example, **IOWA MEDICAID** has an approved list of telehealth codes, some of which are designated as allowed to be delivered via audio-only.



### › Communication Technology Based Services (CTBS)

States continue to utilize the CTBS codes established by CMS. CTBS includes the virtual check-in (G2012) and remote evaluation of pre-recorded information (G2010), audio-only service codes, e-visits, interprofessional consultations and remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM) codes. Examples of states that reimburse these codes include Arizona, California, South Carolina, Virginia, and West Virginia. Those codes were originally reimbursed in Medicare as an alternative to traditional telehealth. In cases where those codes were added and the state has no other form of reimbursement for the modalities (i.e. store-and-forward, telephone and RPM), it should be noted that coverage is extremely limited.

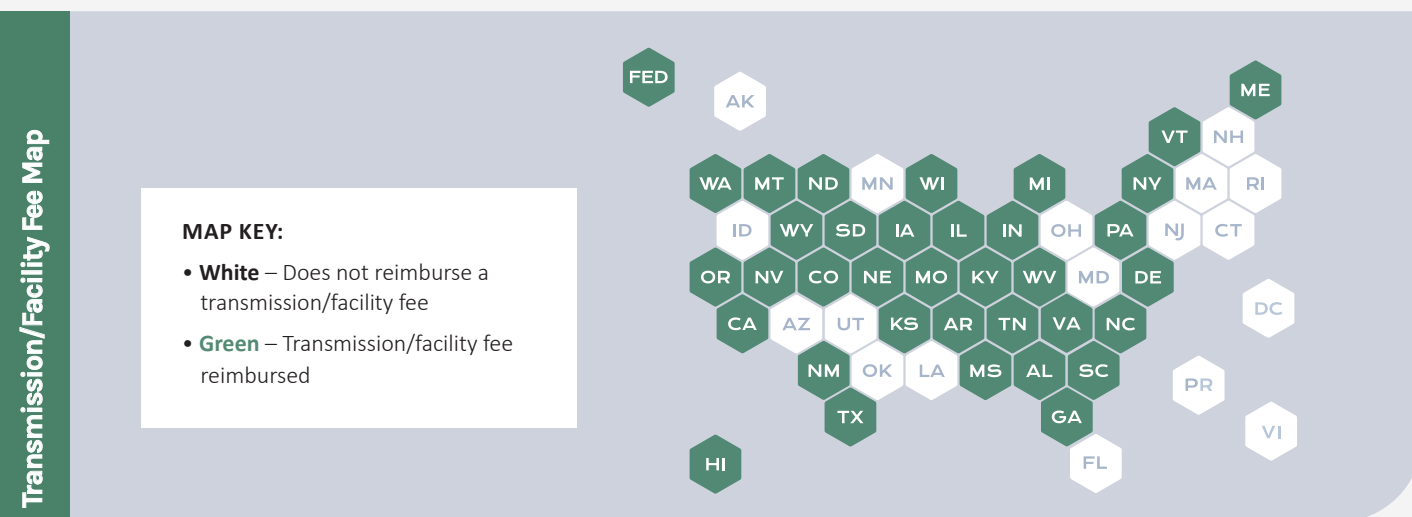
States have adopted a variety of strategies when it comes to integrating these codes into their healthcare systems. It has been observed that Medicaid programs often integrate CTBS codes within their telehealth infrastructure while making use of Medicare's coding system for identification and reimbursement purposes. Additionally, our previous research indicates that some states choose to include these codes in their fee schedules, keeping them distinct from their telehealth policies. For the purpose of CCHP's policy finder and the subsequent summary report, we have exclusively included CTBS codes that have been incorporated into state telehealth policies. It's worth noting that we did not examine state Medicaid fee schedules as a source for this summary. In CCHP's Summary Chart, states that solely reimburse a modality through the CTBS codes have been identified by adding an asterisk (\*).

## STATE EXAMPLE:

**VIRGINIA MEDICAID's** update to their Telehealth Supplement includes reimbursement for 'virtual check-ins' codes G2010 and G2012 which can be reported by a physician or other qualified health care professional, as well as G2251 and G2252, which are also listed as brief communication technology-based services. All codes are for established patients and cannot result from a procedure or service provided within the previous 7 days nor leading to one within the following 24 hour or soonest available appointment.

### › Transmission/Facility Fee

A total of thirty-five state Medicaid programs reimburse for either a transmission or facility fee, with the facility fee being far more common. These policies typically outline a defined list of eligible facilities that may receive the facility fee, and specify that when the patient's home or other non-medical sites serve as the originating site, the facility fee would not be applicable.



### › Eligible Providers

While specific guidance regarding telehealth services may be absent in some state Medicaid programs, others have implemented restrictions regarding which providers are allowed to deliver telehealth services from a remote location. It's worth noting that there has been a notable expansion in the types of eligible providers in many Medicaid programs in recent years, with most states now allowing a diverse array of providers to offer telehealth services. Since Spring 2023, several states have added additional providers to their eligible provider telehealth lists, owing to the end of many COVID temporary expansions and incorporation of COVID policies



into permanent ones. For example, Colorado Medicaid expanded their eligible providers to include physical therapists, occupational therapists, hospice, home health providers, and pediatric behavioral health providers. States that do not maintain a provider list often state that any Medicaid-enrolled provider is eligible for reimbursement when delivering services through telehealth.

With the increasing prevalence of cross-state telehealth services, Medicaid programs are now faced with the challenge of determining how to manage out-of-state providers who possess valid in-state licenses while offering their services within the state. Although the majority of states have not yet explicitly addressed this issue, a small number of states have begun to tackle this specific concern. Wisconsin, for example, describes an allowance for an out-of-state border-status provider in a provider bulletin, and details requirements for enrolling telehealth-only out-of-state border-status providers, noting that prior authorization is required before providing non-emergency services. Other states, such as Indiana, Kentucky and Virginia, have specified through legislation that physical presence (or address) within the state cannot be required of a health professional to be eligible for Medicaid enrollment.

#### Federally Qualified Health Centers & Rural Health Clinics

Considering that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) seek reimbursement as organizational entities rather than individual providers, they are occasionally overlooked on telehealth eligible provider lists. Notably, Medicare has excluded these clinics from billing as distant site providers for telehealth services in their permanent policy. However, it's important to note that they may still be eligible for reimbursement for facility fees associated with originating site services and for mental health consultations conducted through interactive telecommunication systems. Thirty-nine states and DC have specifically addressed this issue for FQHCs, RHCs or both allowing them to serve as distant site providers. Some states have also begun addressing the reimbursement amount in their policy, clarifying whether or not FQHCs and RHCs will receive the same amount they typically receive under the prospective payment system (PPS) or all-inclusive rate (AIR). For example, Hawaii Medicaid issued a memorandum in May which states that FQHCs and RHCs will be reimbursed the PPS rate when applicable. During the Fall 2022 edition, CCHP's Policy Finder was enhanced to encompass a distinct category dedicated to FQHC Medicaid fee-for-service telehealth policies. For in-depth insights and comprehensive information on trends and findings in state FQHC policies, readers can refer to CCHP's FQHC Telehealth Policy Factsheet.

#### STATE EXAMPLE:



**ALABAMA MEDICAID** added to the telemedicine section of its manual a list of provider types eligible for reimbursement when using telehealth. The list includes providers extending beyond conventional physician and behavioral health providers, to include providers such as, rehabilitative option providers, optometrists, early intervention providers, pharmacists/ pharmacies and targeted case management providers, among others.

#### STATE EXAMPLE:



**SOUTH CAROLINA** specified in a bulletin describing telehealth policies following the end of the PHE, that FQHCs and RHCs can continue to be reimbursed (as they have during the COVID-19 PHE) for services rendered through telehealth. They also specify throughout the document, specific services that can be rendered through a FQHC or RHC including certain audio-only and behavioral health CPT codes.





## STATE EXAMPLE:



The geographic restriction CCHP has found for **MONTANA MEDICAID** dictates that the originating site and distant site providers must not be located within the same facility or community, with no definition of the term 'community' leaving it open for interpretation.

### › Geographic & Facility Originating Site Restrictions

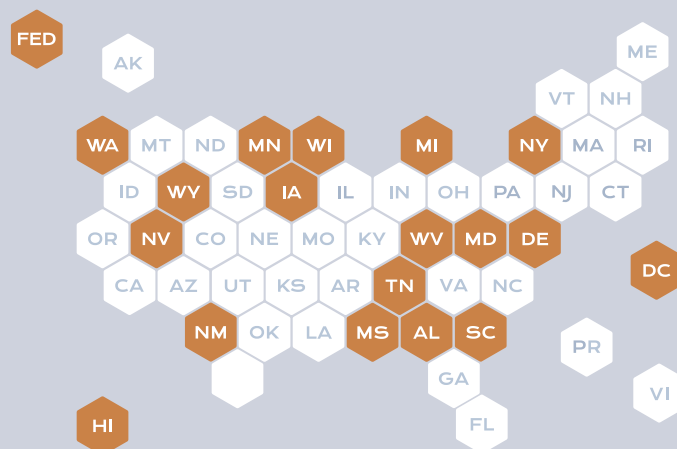
The approach of restricting reimbursable telehealth services exclusively to rural or underserved areas, as seen in Medicare's permanent policy, has significantly waned on the state level in prevalence. Only three states (Hawaii, Montana and Maryland) currently have these types of restrictions. For Hawaii and Maryland, these geographic restrictions are present in the states' regulations while contradictory policy exists in the states' statute, indicating the states have likely not yet updated administrative policies to be consistent with changes in law. For example, enacted legislation in Maryland requires that Medicaid not distinguish between rural and urban locations, however as of CCHP's last review of the state in May 2023, language related to telehealth mental health services requiring beneficiaries reside in one of the designated rural geographic areas or have a situation that makes person-to-person psychiatric services unavailable was still in their administrative code. Likewise, despite Hawaii enacting a law that bars geographic limitations on telehealth within their Medicaid program, such language continues to persist in their Medicaid regulations.

Instead of implementing geographical constraints, state Medicaid programs typically favor an approach that limits the types of facilities eligible to function as originating sites for telehealth services. Currently seventeen states and DC have a specific list of sites that can serve as an originating site for a telehealth encounter. In many states, originating site lists have evolved to encompass non-traditional settings like patients' homes and schools, resulting in broader eligibility criteria despite the presence of an initial list.

### Geographic & Facility Originating Site Restrictions Map

#### MAP KEY:

- **White** – No specific originating site list or restriction
- **Orange** – Has a billable originating site list or restriction





Forty-five states and D.C. Medicaid programs explicitly allow the home to serve as an originating site, although it's often tied to additional restrictions, and a facility fee would not be billable. This number does not include states that make broad statements that any patient location is covered without explicitly referencing the home or patient's residence. Since Spring 2023, eight state Medicaid programs explicitly added the home as an eligible site, many due to inclusion of place of service (POS) code 10 to indicate the service took place at the patient's home (along with any appropriate modifiers).

States are also increasingly allowing schools to serve as an originating site, with thirty-six states and DC explicitly allowing schools to be originating sites for telehealth-delivered services, although, as is the case with the home, restrictions often apply. Services allowed via telehealth in schools vary from state to state but the most common services allowed are therapy services, such as mental health therapy as well as speech, occupational and physical therapy.

## STATE EXAMPLE:



**NEBRASKA MEDICAID** recently issued a bulletin directing providers to use place of service code 02 (for patients in a location besides their home) and 10 (for patients in their home), and modifiers 93 (for synchronous telemedicine via telephone or audio-only) and 95 (for real-time with audio-visual component).

## Consent

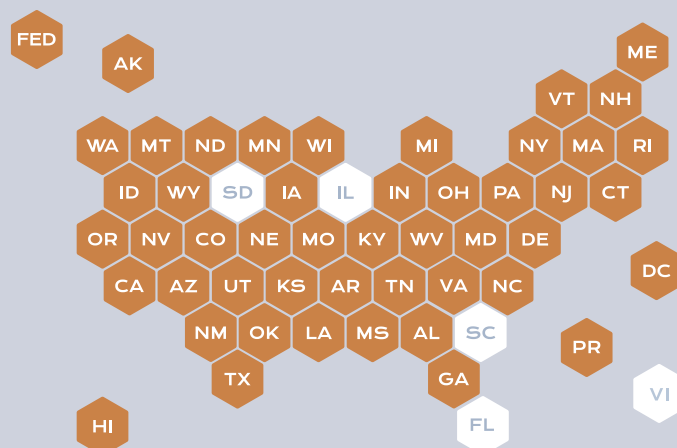
Forty-five states, DC, and Puerto Rico include some sort of consent requirement in their statutes, administrative code, and/or Medicaid policies. The application of the consent requirement can differ depending on the precise wording and extent of the policy, ranging from Medicaid programs to specific specialties or all telehealth encounters within a state. For example, Nevada recently passed a bill requiring that dentists specifically obtain informed verbal or written consent, and document it in the patient record. Meanwhile, Nebraska doesn't have a consent requirement that applies to its professions, but does for providers being reimbursed by Medicaid. A recent manual update requires written or email consent before initial service delivery with specific information required in the consent.

Additionally, while some state policies have a vague requirement for consent, others include many details. For instance, the Indiana Medical Board administrative code requires providers obtain informed consent for the use

### Consent Map

#### MAP KEY:

- **White** – No Consent Requirement
- **Orange** – Requirement for Telehealth Specific Consent





of patient-physician e-mail, with an agreement that includes the types of transmissions that will be permitted, outline fees involved, describe under what circumstances alternate forms of communication must be utilized, a statement that the e-mail is not to be used in emergency situations, and security and privacy measures taken, among other requirements. Louisiana has similar requirements for physicians to obtain informed consent, except statute also requires physicians to ensure that each patient they are serving by telemedicine is informed of the relationship between the physician and patient and the respective role of any other health care provider with respect to management of the patient as well as notify the patient that he or she may decline to receive medical services by telemedicine and may withdraw from such care at any time. California Medicaid addresses a similar concern, where the Medicaid program lays out a specific framework for consent, including the patient's entitlement to request an in-person service. Meanwhile, the general statute in California applicable to all providers is much more flexible in its consent requirement.

## Licensure

Twenty-six states and the Virgin Islands have professional boards that issue special licenses or certificates or otherwise have exceptions to licensing requirements related to telehealth, that may include registering with an in-state board rather than obtaining full licensure. Virginia, Maryland and District of Columbia all added a licensing exception in this update, due to each jurisdiction's Medical Board reciprocity agreement to facilitate the expedited reciprocity licensure of physicians in the three jurisdictions. The majority of the states that have added licensure exceptions in the past two years are for specific types of healthcare professionals or in specific situations, such as where the patient has moved or is visiting a certain state and has a pre-existing relationship with a provider in their former state. This has become a common issue of concern for college students wanting to continue care with their established mental health professionals in their home state, or for those that may be traveling for a limited amount of time.

For example, Idaho statute specifies that a license is not required for virtual care when a provider is licensed and in good standing in another state or jurisdiction in the US and has established a patient-provider relationship with a person who is in Idaho temporarily for business, work, education, vacation or other reason. Providers are also allowed to provide short term follow up care, which may be needed in the instance of a patient moving to the state and needing time to transition to a new provider. In recent years, more states have also begun creating their own telehealth registration processes that allow out-of-state providers to operate in the state through telehealth by completing a registration with the Board, agreeing to certain terms and conditions, and paying a fee to the Board. Note that the number of states with telehealth-related licensing exceptions or registrations does not include states that made allowances for out-of-state providers consulting or under the supervision of in-state providers when the responsibility for care remains with the in-state provider.

Another frequently observed licensing policy involves the implementation of interstate compacts. These compacts typically allow specific healthcare providers to practice in states where they are not licensed, provided they hold a valid license in their home state, and possess a special 'compact' license. Currently, CCHP monitors eleven different Compacts, each with its own distinct eligibility criteria. For instance, the interstate medical licensure compact streamlines the licensure process, although physicians are still required to apply for licenses in individual states.





## State Licensure Compacts CCHP Tracks:

1. **Advanced Practice Registered Nurse Compact:**  
3 state members (*Not yet active*)
2. **Audiology and Speech-Language Pathology  
Interstate Compact (ASLP-IC):**  
28 state members.
3. **Emergency Medical Services Personnel  
Licensure Interstate Compact (REPLICA):**  
24 state members.
4. **Counseling Compact:** 29 state members.
5. **Interstate Medical Licensure Compact:**  
38 states, DC and the territory of Guam.
6. **Nurses Licensure Compact:**  
37 state members and the territory of Guam  
and Virgin Islands
7. **Occupational Therapy Compact:**  
27 state members.
8. **Physical Therapy Compact:**  
34 state members and DC.
9. **Physician Assistant Compact:**  
1 state member (*Not yet active*)
10. **Psychology Interjurisdictional Compact:**  
38 state members and DC.
11. **Social Worker Compact:**  
1 state member. Legislation pending in 9 states.  
(*Not yet active*)

*\* Not all states listed above may be currently operating the compact as many just recently passed legislation and have not had the opportunity to start the issuing process.*

Some states have laws that do not explicitly cover telehealth or telemedicine licensing, but instead allow for practicing in neighboring states or grant temporary licenses under certain conditions that align with the licensing requirements of the specific state in question. Amid the COVID-19 pandemic, several states implemented temporary waivers of their licensing requirements, with most of them having expired by now, though a few may still be in effect. Those waivers are not tracked in this report, however the Federation of State Medical Boards is tracking those policies via their chart on [State COVID-19 Physician Licensing](#) and CCHP tracks the policies in the [COVID-19 Policies section](#) of our policy finder. Note that the majority of these waivers have now expired, and CCHP will cease tracking COVID-19 temporary policies as its own category after this 2023 Fall Summary Report is released.

## STATE EXAMPLE:



**FLORIDA** has implemented an out-of-state Telehealth Provider Registration. To qualify for the registry, providers must:

- Submit an application
- Maintain an active license in a US state or territory
- Not be subject to any disciplinary action from another state board
- Designate a duly appointed registered agent for service of process in Florida
- Maintain liability coverage provided to patients in Florida
- Not open a Florida office or provide in-person services
- Only use a Florida-licensed pharmacy to dispense drugs.





## Online Prescribing

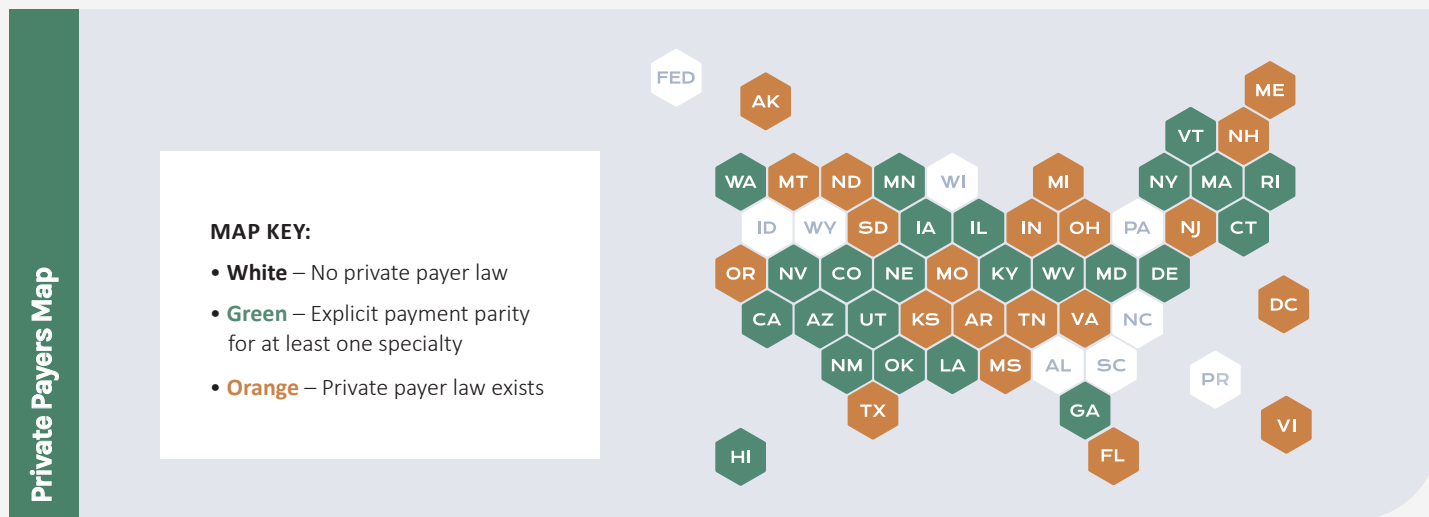
Variations in regulations governing the use of technology for prescribing are apparent when comparing different states. While many states do not mandate an in-person examination, telehealth consultations are frequently required to uphold the same standard of care as an in-person appointment. Notably, in recent years, there has been an emergence of clarifications from states that were previously silent on the matter, affirming the potential of telehealth interactions to establish a provider-patient relationship while also establishing specific parameters and requirements for this mode of healthcare delivery. For example, in this Fall 2023 update, CCHP discovered that the Wisconsin Psychology Board administrative code now specifies that telehealth is allowed for psychologists as long as the standard of care and professional conduct that apply to licensees is followed regardless of whether the health care service is provided in-person or by telehealth. In other states, more specific requirements are sometimes outlined. For example, Kentucky has more detailed telehealth standards for nine of the professions in the state. The standards for nutritionists and dietitians detail the steps a provider of dietetics or nutrition services must take in the initial meeting as well as additional requirements related to limiting telepractice to their area of competence, continuing education expectations, and documentation and information privacy requirements, among others.

States have also increasingly clarified whether or not controlled substances can be prescribed over telehealth, often creating two policies (one for non-controlled substances and the other for controlled substances). A state that addresses this is Oklahoma, which now provides an exception from the state prohibition against prescribing controlled substances via telemedicine if it is a Schedule III, IV or V controlled substance approved by the US Food and Drug Administration (FDA) for medication assisted treatment of detoxification treatment for substance use disorder. Note that providers would also need to comply with federal law related to the prescribing of controlled substances and limits enforced by the US Drug Enforcement Agency (DEA). An explicit allowance for telehealth to be used to qualify patients for medical cannabis is also a growing trend. In this update, Connecticut now permanently permits physicians, APRNs and physician assistants to certify a qualifying patient's use of medical marijuana and provide follow up care using telehealth if they comply with other statutory certification and recordkeeping requirements.



## Private Payers

Currently, forty-three states, DC and the Virgin Islands have laws that govern private payer telehealth reimbursement policies. No new states have added private payer laws since Fall 2022, although a few states did make adjustments to their existing private payer laws. In recent years, CCHP has noted that modifications to state private payer laws typically address either the question of payment parity or requirements around audio-only reimbursement. Nevada's recent amendment to their private payer law does both of those things. The law requires the same reimbursement amount if services are received at specific types of originating sites or furnished by a FQHC or RHC (excluding audio-only interactions) or for counseling or treatment relating to mental health conditions or a substance use disorder, which can include services provided through audio-only interaction. Some parity requirements in state private payer laws are still tied to the COVID-19 emergency, and include expiration dates. For example, Maryland recently passed legislation which extends from June 30, 2023 to June 30, 2025 coverage of audio-only as well as reimbursement parity requirements in both Medicaid and private payer laws. Likewise, Washington passed a bill extending the timeframe in which real-time telemedicine using both audio and video technology can be used to establish a relationship for purposes of providing audio-only telemedicine for certain services from Jan. 1, 2024 to July 1, 2024.



## EXAMPLE:

**GEORGIA** prohibits insurers from restricting coverage of telehealth or telemedicine to services provided by a particular vendor, or other third party or services provided by a particular electronic communication technology platform. Additionally, insurers are not allowed to place any restriction on prescribing medications through telemedicine that are more restrictive than in-person requirements. Among other prohibitions, an insurer is also not allowed to require a covered person to utilize telehealth or telemedicine in lieu of a nonparticipating provider accessible for in-person consultation or contact.

To learn more about state telehealth related legislation, visit CCHP's telehealth [policy finder tool](#).