2020

Executive Summary - Tracking Telehealth Changes State-by-State in Response to COVID-19

October, 2020

MTELEHEALTH

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As the COVID-19 pandemic continues across the United States, states, payers, and providers are looking for ways to expand access to telehealth services. Telehealth is an essential tool in ensuring patients are able to access the healthcare services they need in as safe a manner as possible. **In order to provide our clients with quick and actionable guidance on the evolving telehealth landscape, Manatt Health has developed a federal and comprehensive 50-state tracker for policy, regulatory and legal changes related to telehealth during the COVID-19 pandemic.** This summary of findings is current as of noon ET, Thursday, October 15.

Federal Actions and Legislation:
Select introduced federal legislation:

Bill	**Key Proposed Actions**
Recently Introduced	
H.R. 8476: The Telehealth Improvement for Kids' Essential Services (TIKES) Act of 2020	• Provide states with guidance and strategies to increase telehealth access for Medicaid and Children's Health Insurance Program (CHIP) populations. Guidance and strategies will include: ◦ Telehealth delivery of covered services ◦ Recommended voluntary billing codes, modifiers, and place-of-service designations ◦ Simplifications or alignment of provider licensing,

	credentialing, and enrollment ◦ Existing strategies States can use to integrate telehealth into value-based health care models ◦ Examples of States that have used waivers under the Medicaid program to test expanded access to telehealth • Require a Medicaid and CHIP Payment and Access Commission (MACPAC) study examining data and information on the impact of telehealth on the Medicaid population • Require a Government Accountability Office (GAO) study reviewing coordination among federal agency telehealth policies and examine opportunities for better collaboration, as well as opportunities for telehealth expansion into early care and education settings
Previously Introduced	
S. 2741: Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019	• Remove the Medicare geographic restrictions and allow the home to be an originating site for mental telehealth services • Remove the geographic restrictions for certain originating sites for emergency medical care services • Remove the geographic restrictions for federally qualified health centers (FQHCs) and rural health

	clinics (RHCs) and allow FQHCs and RHCs to furnish telehealth services as distant sites
S. 3917: Home-Based Telemental Health Care Act of 2020	• Establish a grant program for health providers in rural areas to expand telemental health services • Direct HHS secretary to award grants for provision of telemental services in rural areas
S. 3988: Enhancing Preparedness Through Telehealth Act	• Amend the Public Health Service Act with respect to telehealth enhancements for emergency response • Evaluate mechanisms for payment or reimbursement for use of telehealth technologies and personnel during public health emergencies • Evaluate infrastructure and resource needs to ensure providers have the necessary tools, training, and technical assistance to provide telehealth services
S. 3998: Improving Telehealth for Underserved Communities Act of 2020	• Establish payment parity for telehealth services provided to Medicare beneficiaries at RHCs and FQHCs during the COVID-19 pandemic
S. 3999: Mental and Behavioral Health Connectivity Act	• Permanently remove Medicare's geographic restrictions for certain originating sites for emergency medical care services for mental and behavioral health services

	• Continue eligibility of care for the expanded list of non-physician providers • Allow Medicare to cover audio-only telehealth services
S. 4039: Telemedicine Everywhere Lifting Everyone's Healthcare Experience and Long Term Health (TELEHEALTH) HAS Act.	• Permanently extend a provision of the CARES Act that temporarily allows health savings account eligible high-deductible health plans to offer first-dollar coverage of telehealth services
S. 4103: Telehealth Response for E-Prescribing Addition Therapy Services (TREAT) Act	• Extend ability to prescribe Medication Assisted Therapies (MAT) and other necessary drugs without needing a prior in-person visit • Extend ability to bill Medicare for audio-only telehealth services
S. 4103: Treat Act	• Extend ability to prescribe MAT and other necessary drugs without needing a prior in-person visit • Extend ability to bill Medicare for audio-only telehealth services
S. 4211: Facilitating Reforms that Offer Necessary Telehealth In Every Rural (FRONTIER) Community Act:	• Remove geographic barriers for originating site • Expand access to mental health services through telehealth in frontier states • Direct FCC and Department of Agriculture to work with IHS and HRSA to award grants for broadband infrastructure

S. 4230: Telehealth Expansion Act of 2020	• Remove Medicare's geographic restrictions for all evaluation and management (E/M) services • Categorize mental health services as E/M services in order to expand telehealth coverage of mental health services in Medicare
S. 4318: American Workers, Families, and Employers Assistance Act	• Allow (but not require) the HHS Secretary to extend the temporary telehealth flexibilities made available during the PHE until December 31, 2021 or until the end of the PHE, whichever is later • Require the Medicare Payment Advisory Commission (MedPAC) to provide a report on the impact of telehealth flexibilities on access, quality, and cost by July 1, 2021 • Require HHS to post data on use of telehealth throughout the pandemic and provide a report including legislative recommendations to Congress to later than 15 months after the bill is enacted • Extend for five years beyond the end of the PHE a provision of the CARES Act which permits FQHCs and RHCs to serve as distant sites for the purposes of delivery telehealth *For more information on this bill and the Senate Republican's stimulus package, see our July 28 Insight summary.*

S. 4375: Telehealth Modernization Act	• Remove geographic barriers for originating site • Require telehealth services to be covered by Medicare at FQHCs and RHCs • Direct HHS to permanently expand the telehealth services covered by Medicare during the PHE • Require Medicare to cover additional telehealth services for hospice and home dialysis care
S.4421: Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act	• Enable health care professionals licensed in good standing to care for patients—in-person or through telehealth visits—from any state during this national emergency without jeopardizing their state licensure or facing potential penalties for unauthorized practice of medicine

S. 4515: Accelerating Connected Care and Education Support Services on the Internet (ACCESS) Act	• Authorizes $2 billion in dedicated funding across the government for distance learning and telehealth initiatives, including:
	  ○ $400 million for the Federal Communications Commission (FCC) COVID-19 Telehealth Program, including a 20% set aside for small, rural providers that may have been left out of the competitive first round of telehealth funding
	  ○ $100 million for the Department of Veterans Affairs (VA) Telehealth and Connected Care Services for

	the provision of Internet-connected devices and services for veterans in rural, unserved areas
H.R. 3228: VA Mission Telehealth Clarification Act	• Allow trainees satisfying health professional training program requirements to use telehealth systems while supervised by an appropriately credentialed VA staff member
H.R. 4900: Telehealth Across State Lines Act	• Establish a uniform standard of nationwide best practices for the provision of telehealth across state lines
H.R. 5473: EASE Behavioral Health Services Act	• Codify the removal of geographic restrictions waived in Medicare during the PHE • Require federal reimbursement of telehealth SUD treatment under Medicaid
H.R. 6792: Improving Telehealth for Underserved Communities Act of 2020	• Establish payment parity for telehealth services provided to Medicare beneficiaries at RHCs and FQHCs during the COVID-19 pandemic
H.R. 7078: Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act of 2020	• Require CMS to study the effects of telehealth changes on Medicare and Medicaid during COVID-19

H.R. 7187: HEALTH Act	• Codify Medicare telehealth reimbursement for community health centers and RHCs
H.R. 7233: Keep Telehealth Options Act	• Direct the HHS Secretary and the Comptroller General of the United States to conduct studies and report to Congress on actions taken to expand access to telehealth services under the Medicare, Medicaid, and Children's Health Insurance programs during the COVID-19 emergency
H.R. 7338: Advancing Telehealth Beyond COVID-19	• Codify the removal of geographic restrictions waived in Medicare during the PHE • Require telehealth services to be covered by Medicare at FQHCs and RHCs
H.R. 7388: A bill to amend title XVIII of the Social Security Act to permit the Secretary of Health and Human Services to waive requirements relating to the furnishing of telehealth services under the Medicare program, and for other purposes	• Permit the HHS Secretary to waive requirements relating to the furnishing of telehealth services under the Medicare program
H.R. 7391: Protect Telehealth Access Act	• Codify the removal of geographic restrictions waived in Medicare during the PHE

H.R. 7663: Protecting Access to Post-COVID-19 Telehealth Act of 2020	• Eliminate most geographic and originating site restrictions in Medicare and establish the patient's home as an eligible distant site • Authorize CMS to continue reimbursement for telehealth for 90 days beyond the end of the PHE • Allow HHS to expand telehealth in Medicare during all future emergencies • Require a study on the use of telehealth during COVID-19
H.R. 7695: COVID–19 Emergency Telehealth Impact Reporting Act of 2020	• Require HHS to study telehealth use during the pandemic and impact on care delivery
H.R. 7992: Telehealth Act	• Packages nine telehealth bills introduced by Republican lawmakers including: ◦ H.R. 7338: Advancing Telehealth Beyond COVID-19 ◦ H.R. 5473: EASE Behavioral Health Services Act ◦ S. 4039: Telemedicine Everywhere Lifting Everyone's Healthcare Experience and Long Term Health (TELEHEALTH) HAS Act ◦ H.R. 3228: VA Mission Telehealth Clarification Act ◦ H.R. 4900: Telehealth Across State Lines Act ◦ S. 4103: Treat Act ◦ H.R. 7233: Keep Telehealth Options Act

	◦ S. 3988: Enhancing Preparedness Through Telehealth Act ◦ H.R. 7187: HEALTH Act
H.R. 8156: Ensuring Telehealth Expansion Act of 2020	• Extend telehealth all provisions in the CARES Act through December 31, 2025 • Remove geographic barriers for originating site • Require payment parity for telehealth services furnished at FQHCs and RHCs
H.R. 8308: Telehealth Coverage and Payment Parity Act	• Prohibit restrictions on which conditions can be managed remotely • Establish parity between telehealth and in-person visits • Guarantee all medically necessary benefits in ERISA plans are covered via telehealth • Remove location-based regulations for providers

Federal Flexibilities and Reports:
Flexibilities

On Friday, October 2, the U.S. Department of Health & Human Services (HHS) announced that the Public Health Emergency (PHE) declaration for COVID-19 will be renewed for another 90 days, beginning on October 23 (the date the PHE was previously scheduled to expire) and extending through January 20, 2021. For more information the renewed PHE, please see our Manatt Newsletter.

Policy	COVID-19 Change	Expiration Date
Relevant Legislation		
The Coronavirus Preparedness and Response Supplemental Appropriations Act, signed on March 6, contains a provision to make telehealth services more widely available to Medicare enrollees in their homes during a declared emergency.	The act makes two changes to existing Medicare telehealth coverage policies under emergency circumstances: • First, the act allows the CMS to extend coverage of telehealth services to beneficiaries regardless of where they are located. This means even if the beneficiary is not in a healthcare facility or located in a nonurban or physician shortage area, the beneficiary can receive a covered telehealth visit. This new provision should allow beneficiaries to access telehealth from their homes or from other community locations. • Second, the act allows CMS to extend coverage to telehealth services provided by "telephone" but only those with "audio and	End of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
	video capabilities that are used for two-way, real-time interactive communication" (e.g., smartphones). However, to deliver the services, as the act is currently structured, a provider or member of the provider's practice must have treated the patient within the past three years. *For more information on Medicare changes, see our March 17 Manatt newsletter.*	
CMS Guidance		
On March 10, CMS introduced significant new flexibilities for Medicare Advantage (MA) and Part D plans to waive cost-sharing for testing and treatment of COVID-19, including emergency room and telehealth visits during the crisis.	MA plans are required to: • Cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at noncontracted facilities; this means that facilities that furnish covered A/B benefits must have participation	End of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
	agreements with Medicare. • Waive, in full, requirements for gatekeeper referrals where applicable. • Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility. • Make changes that benefit the enrollee effective immediately without the 30-day notification requirement at 42 § 422.111(d)(3). Such changes could include reductions in cost-sharing and waiving of prior authorizations. *For more information on Medicare changes, see our March 17 Manatt newsletter.*	
On March 30, CMS released an interim final rule (IFR) outlining new flexibilities to preexisting	These provisions include adding over 80 additional eligible telehealth services, giving providers flexibility	End of public health emergency

Policy	COVID-19 Change	Expiration Date
Medicare and Medicaid payment policies in the midst of the COVID-19 public health emergency (also, PHE).	in waiving copays, expanding the list of eligible types of providers who can deliver telehealth services, introducing new coverage for remote patient monitoring services, reducing frequency limitations on telehealth utilization, and allowing telephonic and secure messaging services to be delivered to both new and established patients. The provisions listed in this rule are effective March 31, with applicability beginning on March 1. *For more information on the IFR, see our April 9 Manatt newsletter.*	(currently 1/20/21)
On April 2, CMS issued an informational bulletin regarding Medicaid coverage of telehealth services to treat substance use disorders (SUDs)—one of many guidance documents required by the October 2018-	This guidance provides states options for federal reimbursement for "services and treatment for SUD under Medicaid delivered via telehealth, including assessment, medication-assisted treatment, counseling, medication management, and	Permanent

Policy	COVID-19 Change	Expiration Date
enacted Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.	medication adherence with prescribed medication regimes." *For a summary of this bulletin, please see the April 6 Manatt Insights summary.*	
On April 17, CMS released Frequently Asked Questions (FAQs) on Medicare Fee-for-Service Billing and highlighted several changes to RHC and FQHC requirements and payments.	New Payment for Telehealth Services (real-time, audio visual): • Section 3704 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare beneficiaries. Services can be provided by any health practitioner working for the RHC or the FQHC as long as the service is within their scope; there is no restriction on locations where the provider may be to furnish telehealth services.	End of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
	• FQHCs and RHCs are paid a flat fee of $92 when they serve as the distant site provider for a telehealth visit. • CMS will pay for all reasonable costs for any service related to COVID-19 testing, including relevant telehealth services. RHCs and FQHCs must waive the collection of co-insurance for COVID-19 testing-related services. Expansion of Virtual Communication Services (telephone, online patient communication): • Virtual communication services now include online digital evaluation and management services. CPT codes 99421–23 have been added for non-face-to-face, patient-initiated, digital communications	

Policy	COVID-19 Change	Expiration Date
	using a secure patient portal. *For more information on Expanded Telehealth Reimbursement for FQHCs and RHCs, see our June 9 Manatt newsletter.*	
On May 1, CMS released a second IFR with comment period (IFC), "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program," outlining further flexibilities in Medicare, Medicaid, and health insurance markets as a result of COVID-19.	• **Section D.** Opioid Treatment Programs (OTPs) – Furnishing Periodic Assessments via Communication Technology (42 CFR 410.67(b)(3) and (4)): Temporary change to allow periodic assessments of individuals treated at OTPs to occur during the PHE by two-way interactive audio-video or audio-only communication • **Section N.** Payment for Audio-Only Telephone Evaluation and Management Services: Temporary increase in the reimbursement rates for telephonic care • **Section AA.** Updating the	End of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
	Medicare Telehealth List (42 CFR 410.78(f)): Temporary change to remove Medicare regulations that require amendments to the list of covered telehealth services be made through the physician fee schedule (PFS) rulemaking process and allow changes to be made to the list of covered telehealth services through subregulatory guidance only *For a summary of the second IFR, please see the May 5 Manatt Insights summary.*	
On August 4th, CMS released a proposed Physician Fee Schedule Rule which would make certain Medicare telehealth flexibilities permanent and extend others for the remainder of the year in	For CY 2021, CMS is proposing several changes to the Medicare telehealth covered services list. First, CMS is proposing to add permanent coverage for a range of services, including group psychotherapy, low-intensity home visits, and	Permanent and end of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
which the public health emergency (PHE) ends.	psychological and neuropsychological testing, among others. Second, CMS is proposing to add extended temporary coverage for certain services through the end of the calendar year in which the COVID-19 PHE ends, including high intensity home visits, low-intensity emergency department visits, and nursing facility discharge day management, among others. Finally, CMS is indicating which services that have been covered on a temporary basis during the PHE it does not propose to cover on a permanent basis once the PHE ends. This includes a wide range of more than 70 services such as telephonic evaluation and management services, nursing facility visits, specialized therapy services, critical care services, end stage renal disease dialysis-related services, and radiation management services, among others. *For a summary of the*	

Policy	COVID-19 Change	Expiration Date
	proposed Physician Fee schedule Rule, please see the August 7 Manatt Insights summary	
On October 14, CMS expanded the list of telehealth services Medicare Fee-For-Service will pay for during the PHE.	CMS added 11 new services to the Medicare telehealth service list, adding to the over 80 additional eligible telehealth services outlined in the May 1 COVID-19 IFC. The new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services.	End of public health emergency (currently 1/20/21)
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Guidance		
On March 18, the HHS and the Office for Civil Rights (OCR) issued a public notice stating that OCR will not impose penalties for noncompliance with regulatory requirements under the HIPAA rules "against covered health care providers in	This will allow providers to communicate with patients through telehealth services and remote communications technologies during the COVID-19 national emergency. Providers may use any non-public-facing remote communication product that is available to	End of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency."	communicate to patients; these applications can include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, and Skype. *For more information on our HIPAA summary, see our April 23 Manatt newsletter.*	
State Licensure Guidance		
The March 13 COVID-19 National Emergency Declaration temporarily waives Medicare and Medicaid requirements that out-of-state providers be licensed in the state where they are providing services, when they are licensed in another state.	Within Medicare, this waiver should allow providers licensed in one state to provide services to patients in another state (including via telehealth). Within Medicaid, this guidance does not preempt state-specific licensure restrictions, and states will need to waive these restrictions on their own. As of October 15, all 50 states and Washington, D.C., have introduced licensure flexibilities. *For more information on*	End of public health emergency (currently 1/20/21)

Policy	COVID-19 Change	Expiration Date
	our National Emergency Declaration summary, see our March 17 Manatt Newsletter.	

Reports:

On October 14, CMS released a Preliminary Medicaid and CHIP Data Snapshot to provide information on telehealth utilization during the PHE. This data shows more than 34.5 million services were delivered to Medicaid and CHIP beneficiaries via telehealth between March and June of this year—an increase of 2,600% when compared to the same period in 2019. Additionally, CMS updated its State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version to help providers and other stakeholders understand which policies are temporary or permanent, and to communicate telehealth access and utilization strategies to providers.

On July 28, HHS released the issue brief Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic. On July 15, CMS director Seema Verma released Early Impact of CMS Expansion of Medicare Telehealth During COVID-19, a blog on Health Affairs. This article highlights CMS's efforts to expand telehealth during COVID-19 through the addition of 135 allowable telehealth services and the expanded list of types of health care providers who can offer telehealth, and explores how various mechanisms that have allowed for the increase in telehealth utilization during the PHE may continue.

State Laws, Policy, and Guidance

In Medicaid, states have broad authority to permit coverage for telehealth services. Prior to the COVID-19 emergency, many states had implemented broad coverage for telehealth, and in recent months, all 50 states and Washington D.C. have issued guidance expanding telehealth for their Medicaid populations. Medicaid programs have the broad ability to cover telehealth services and the flexibility to rapidly scale up benefits and adjust

normal cost-sharing rules, making Medicaid well positioned to quickly address the needs of its beneficiaries during states of emergency.

Select State Legislation and Executive Orders

Since the COVID-19 public health emergency was declared, states have been moving to pass legislation that would permanently expand access to telehealth. The below chart lists telehealth legislation that has been enacted since March 13, the beginning of the PHE, and executive orders that have made the temporarily waived restrictions around telemedicine permanent.

State	**Summary of Key State Telehealth-Related Legislation and Actions**
Alaska	HB 29: Require insurance carriers that provide coverage for in-person mental health benefits to cover the same benefits via telehealth.
Colorado	SB 20-212: Bar insurance carriers from requiring pre-established patient-provider relationships prior to a telehealth encounter, and prohibits imposing additional certification, location, or training requirements as a condition of reimbursement for telehealth services. Require state Medicaid program to reimburse FQHCs, RHCs, and the federal Indian health service for telemedicine services provided to Medicaid recipients at the same rate as in-person services.
Connecticut	H.B. No 6001: Cements emergency telehealth orders into state law and requires payment parity for telehealth services until March 15, 2021

Delaware	H.B. 348: Update definitions for distant site, originating site, telehealth, and telemedicine; include audio-only in telehealth definition.
Idaho	Executive Order No. 2020-13: Make the temporarily waived restrictions around telemedicine permanent.
Iowa	SF 2261: Establish a patient-provider relationship with a student who receives behavioral health services via telehealth in a school setting and set forth requirements for schools in order to provide behavioral health services via telehealth in the school setting.
Louisiana	HB 449: Expand the definition of telehealth to include the delivery of behavioral health services.
	HB 530: Require any new policy, contract, program, or health coverage plan issued on and after January 1, 2021 to provide coverage of healthcare services provided through telehealth or telemedicine.
Maine	SP 676: Require at least some portion of case management services covered by the MaineCare program to be delivered through telehealth, without requiring qualifying criteria regarding a patient's risk of hospitalization or admission to an emergency room.
Maryland	SB 402 and HB 448: Authorize certain health care practitioners to establish a practitioner-patient relationship through telehealth interactions. Require a health care practitioner provide telehealth services to be

	held to the same standards of practice that are applicable to in-person settings and, if clinically appropriate, provide or refer a patient for in-patient services or another type of telehealth service.
	HB 1208 and SB 502: Require the Maryland Medical Assistance Program, subject to a certain limitation, to provide mental health services appropriately delivered through telehealth to a patient in the patient's home setting.
Michigan	HB 5412: Bar an insurer that delivers, issues for delivery, or renews in this state a health insurance policy from requiring face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer.
	HB 5413: Bar a group or nongroup health care corporation certificate from requiring face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer.
	HB 5416: Cover telemedicine services under the medical assistance program and Healthy Michigan program if the originating site is an in-home or in-school setting, in addition to any other originating site allowed in the Medicaid provider manual or any established site considered appropriate by the provider, beginning October 1.

Minnesota	S.F. 1: Continue expanded telemedicine access for CHIP, Medical Assistance, and MinnesotaCare enrollees until June 30, 2021.
Missouri	H.B. 1682: Physicians may establish physician-patient relationship via a telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.
New Hampshire	H.B. 1623: Establish telehealth reimbursement parity, extend audio-only coverage, remove geographic restrictions on originating and distant sites, expand list healthcare providers able to use telehealth, and eliminate various barriers for treating SUD via telehealth.
New Jersey	SB 2467: Extends telehealth flexibilities for a period of 90 days following the end of the PHE, including licensure flexibilities and payment parity.
North Carolina	SB 361: Enact the Psychology Interjurisdictional Licensure Compact and Increase public access to professional psychological services by allowing for telepsychological practice across state lines subject to Compact requirements.
New York	SB 8416: Adds audio-only forms of telehealth (e.g. telephone) to the state's definition of telehealth and telemedicine.
Tennessee	H.B. 8002: Establish telehealth reimbursement parity for compliant real-time,

	interactive audio, video telecommunications, or electronic technology, or store-and-forward telemedicine services; remove geographic restrictions on originating sites.
Texas	Governor Abbott announced Texas' major health insurers will continue to reimburse telehealth providers at the same rate which they pay for in-person office visits through the end of 2020. This agreement applies to state-regulated plans.
Utah	HB 313: Amend the definition of telemedicine services, clarify the scope of telehealth practice, and require certain health benefits plans to provide coverage parity and "commercially reasonable" reimbursement for telehealth services.
Virginia	HB 1332: Develop and implement, by January 1, 2021, a component of the State Health Plan a Statewide Telehealth Plan to promote an integrated approach to the introduction and use of telehealth services and telemedicine services.
	HB 1701: Require the Department of Health Professions to pursue reciprocal agreements with states contiguous with the Commonwealth for licensure for certain primary care practitioners under the Board of Medicine.
Vermont	HB 795: Extends telehealth flexibilities until July 1, 2021, including the expansion of telehealth access, provider reimbursement, and audio-only coverage.

Washington	SB 5385: Reimburse providers for telemedicine services at the same rate as health care service provided in-person beginning January 1, 2021. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier.
West Virginia	HB 4003: Require telehealth insurance coverage of certain telehealth services after July 1, 2020. The plan shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company.

State Trends

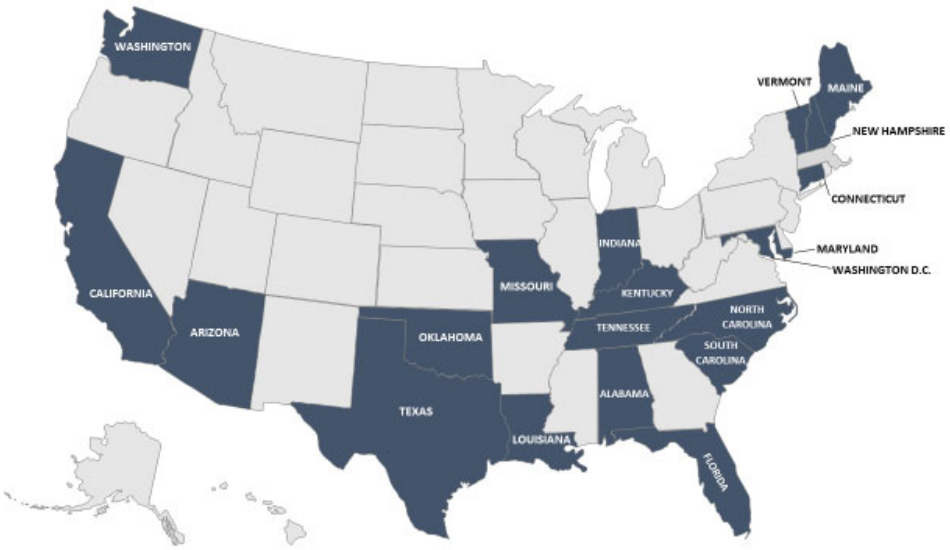
Coordination on Telehealth: Colorado, Nevada, Oregon, and Washington announced they will work together to identify best practices around access, confidentiality, equity, standard of care, stewardship, patient choice, and payment/reimbursement. The overarching goal of this partnership is to "ensure that the nation benefits from our knowledge as changes to federal regulations are contemplated, to support continued application and availability of telehealth in our states, and to ensure that we address the inequities faced in particular by tribal communities and communities of color".

Commercial Payment Parity: In light of the COVID-19 pandemic, states that previously did not require payment parity for telehealth services in commercial plans have begun to issue temporary guidance requiring payment parity for specific telehealth cases. Prior to COVID-19, 9 states (Arkansas, Delaware, Georgia, Hawaii, Kentucky, Minnesota, Missouri, New Mexico, and Utah) had payment parity laws for commercial payers in 2020. California, Arizona and Washington had also recently passed telehealth payment parity legislation in 2019 and early 2020 that would come into effect in January 2021, bringing the total to 12 states. The Governor of Washington recently issued an Executive Order in March which required immediate implementation of its payment parity law.

Appendix K Telehealth Flexibilities: As of October 15, CMS has approved Section 1915(c) Waiver Appendix K (Appendix K) from 47 states and Washington, D.C. Appendix K is a long-standing federal authority that helps states streamline and expedite changes to their 1915(c) home and

community-based services (HCBS) waivers to prepare for and respond to emergencies. As of October 15, at least 44 of the approved Appendix K waivers included telehealth flexibilities for states. Some of these flexibilities include adding electronic methods of delivery for case management; permitting personal care services that require only verbal cueing, in-home habilitation, or monthly monitoring; temporarily modifying provider qualifications; temporarily modifying processes for level of care evaluations and re-evaluations; and temporarily modifying medication management.

Audio-Only Telehealth Services: Many state Medicaid agencies are following Medicare's lead to expand telehealth coverage to audio-only. This includes states that are either adding coverage for telephonic evaluation and management codes or allowing providers to bill the usual service codes when the services are delivered via telephone. As of October 15, all 50 state Medicaid agencies and Washington D.C. have issued guidance to allow for a form of audio-only telehealth services.



Child Well-care and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits: EPSDT is a mandated benefit that provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. Each state is responsible to provide EPSDT services to children and adolescents enrolled in its Medicaid program. The American Academy of Pediatrics has issued guidance recommending all children still receive EPSDT visits. As of

October 15, only 19 states and Washington D.C. have issued telehealth guidance for Child Well-care and EPSDT visits.

Early Intervention Services: As of October 15, 16 states have issued guidance to providers to allow for telehealth or remote care delivery for early childhood intervention services. On April 5, Illinois' Chief Bureau of Early Intervention cleared all previous Illinois Department of Healthcare and Family Services requisites in order to implement and practice Illinois' first-ever Early Intervention Teletherapy. On April 6, the Illinois Early Intervention Program (IEIP) instituted use of Live Video Visits as a temporary measure until the Illinois state of emergency is lifted. The IEIP is now working on tip sheets for families in English and Spanish and developing resources to help families with internet fees and costs for a computer, camera, and microphone. On April 7, North Carolina (NC) Medicaid released new telehealth guidance expanding the services and provider types eligible to deliver telehealth during the COVID-19 pandemic. Special Bulletin COVID-19 #34 expands telehealth codes and guidance to services delivered through local education and children's developmental service agencies, and services pertaining to dietary evaluation and counseling, medical lactation, research-based behavioral health treatment for autism spectrum disorder, and diabetes self-management education. NC Medicaid also published an accompanying billing code summary to equip providers with the new codes pertaining to telehealth.