2021



# Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19 – December 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, December 3.

*Federal Regulations and Other Actions*

| **Policy** | **Details** |
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| On December 1st, CMS finalized the Physician Fee Schedule Rule (previously proposed on August 4th) which make certain Medicare telehealth flexibilities permanent and extend others for the remainder of the year in which the public health emergency (PHE) ends. | CMS finalized several changes to the Medicare telehealth covered services list. First, CMS is adding permanent coverage for a range of services, including group psychotherapy, low-intensity home visits, and psychological and neuropsychological testing, among others. Second, CMS has finalized temporary coverage for certain services through the end of the calendar year in which the COVID-19 PHE ends, including high-intensity home visits, emergency department visits, specialized therapy visits, and nursing facility discharge day management, among others. Finally, CMS is indicating |

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| | which services that have been covered on a temporary basis during the PHE it will not to cover on a permanent basis once the PHE ends. This includes services such as telephonic evaluation and management services, initial nursing facility visits, radiation treatment management services, and new patient home visits, among others. Notably, after significant public comment supporting the addition of more services to the list of services covered through the calendar year in which the PHE ends, CMS included extended coverage for several additional services that it had proposed ending coverage for at the end of the PHE.<br><br>Prior to the PHE, given statutory restrictions that telehealth services must be delivered via a "telecommunications system," which CMS has long-interpreted to preclude audio-only technology, CMS only covered certain audio-only services defined as communication technology-based services (CTBS), which are not considered Medicare telehealth services. During the PHE, recognizing that in-person visits posed a high risk of infection exposure and that not all providers and patients had access to video technology, CMS established temporary coverage for audio-only telephone (E/M) visits (CPT codes 99441-3). CMS is finalizing that at the end of the PHE, coverage for these audio-only telephone (E/M) |

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| | visits will end given the statutory restrictions on "telecommunications systems." However, recognizing that audio-only visits could still be beneficial, for CY 2021, CMS is establishing on an interim basis a HCPCS code, G2252, for CTBS audio-only services of 11-20 minutes of medical discussion. This code supplements existing code G2012 which is a CTBS audio-only service of 5-10 minutes of medical discussion.<br><br>In addition to the changes to the telehealth covered services list, CMS is finalizing that the 30-day frequency limit for subsequent nursing facility visits provided via telehealth be revised to a 14-day frequency limit. CMS is also finalizing that additional types of providers—including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists—be permitted to bill for brief online assessment and management services, virtual check-ins, and remote evaluations and has added new codes for these services.<br><br>On a temporary basis, CMS finalized a policy to allow for virtual supervision using "interactive audio/visual real-time communications technology" (i.e. two-way live video), by revising the definition of "direct supervision" to include virtual presence. This will allow "incident to" services to be |

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| | provided if furnished under the supervision of a virtually present physician or nonphysician practitioner in order to reduce infection exposure risk. CMS will continue allowing virtual supervision through the later of the end of the calendar year in which the PHE ends or December 31, 2021.<br><br>CMS finalized as proposed several changes to coverage of remote physiologic monitoring (RPM) services. CMS finalized that at the conclusion of the PHE, it will once again require that practitioners have an established patient relationship in order to initiate RPM services and that 16 days of data for each 30 days must be collected in order to meet the requirements of CPT codes 99453 and 99454. CMS also finalized that practitioners may furnish RPM services to beneficiaries with acute conditions—previously coverage had been limited to beneficiaries with chronic conditions. In addition, CMS finalized that consent may be obtained at the time the RPM service is furnished; that auxiliary personnel (including contracted employees) may furnish certain RPM device setup and supply services; that data from the RPM device must be automatically collected and transmitted rather than self-reported; and that for the purposes of discussing RPM results, "interactive communication" includes real-time synchronous, |

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| | two-way interaction such as video or telephone.<br><br>*A Manatt Insights summary of the Final CY2021 Physician Fee Schedule is forthcoming.* |
| On November 25th, HHS issued a request for information (RFI). | The RFI is soliciting input from a broad array of healthcare stakeholders on the costs and benefits of the regulatory changes the Department has made in response to the COVID-19 pandemic, including several telehealth-related flexibilities. HHS indicated that it will use comments from the RFI in its determination of which regulatory and sub regulatory actions it will make permanent (beyond the COVID-19 PHE). |
| In early November, CMS published a new final rule that enables health home agencies (HHAs) to use telecommunications technology or audio-only services. | Services provided to patients must be included in the plan of care and not substituted for or considered a home visit for eligibility or payment purposes. |
| 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. |
| On October 2, the U.S. Department of Health & Human Services (HHS) announced that the Public | The PHE was extended beginning on October 23 (the date the PHE was previously scheduled to expire) |

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| Health Emergency (PHE) declaration for COVID-19 will be renewed for another 90 days. | and extended through January 20, 2021.<br>*For more information regarding the renewed PHE, please see our Manatt Newsletter.* |
| 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 which the public health emergency (PHE) ends. | 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 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.<br><br>*For a summary of the proposed Physician Fee schedule Rule, please* |

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| | *see the August 7 Manatt Insights summary* |
| 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<br>• **Section N.** Payment for Audio-Only Telephone Evaluation and Management Services: Temporary increase in the reimbursement rates for telephonic care<br>• **Section AA.** Updating the 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<br><br>*For a summary of the second IFR, please see the May 5 Manatt Insights summary.* |

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| 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):<br><br>• 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.<br>• FQHCs and RHCs are paid a flat fee of $92 when they serve as the distant site provider for a telehealth visit.<br>• 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.<br><br>Expansion of Virtual Communication Services (telephone, online patient communication):<br><br>• Virtual communication services now include online digital evaluation and management services. CPT codes 99421–23 have been added for non-face-to-face, |

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| | patient-initiated, digital communications using a secure patient portal.<br><br>*For more information on Expanded Telehealth Reimbursement for FQHCs and RHCs, see our June 9 Manatt newsletter.* |
| 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-enacted Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. | 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 medication adherence with prescribed medication regimes."<br><br>*For a summary of this bulletin, please see the April 6 Manatt Insights summary.* |
| On March 30, CMS released an interim final rule (IFR) outlining new flexibilities to preexisting Medicare and Medicaid payment policies in the midst of the COVID-19 public health emergency (also, PHE). | These provisions include adding over 80 additional eligible telehealth services, giving providers flexibility 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 |

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| | March 31, with applicability beginning on March 1.<br><br>*For more information on the IFR, see our April 9 Manatt newsletter.* |
| 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 connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." | 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 communicate to patients; these applications can include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, and Skype.<br><br>*For more information on our HIPAA summary, see our April 23 Manatt newsletter.* |
| 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:<br><br>• 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 agreements with Medicare.<br>• Waive, in full, requirements for gatekeeper referrals where applicable.<br>• Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility. |

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| | • 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.<br><br>*For more information on Medicare changes, see our March 17 Manatt newsletter.* |

Federal Legislation

| **Bill** | **Key Proposed Actions** |
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| **Introduced in the last 3 weeks:** | |
| **H.R.8723:** To condition receipt of State funding from the Bureau of Health Workforce on adoption by the State of the Interstate Medical Licensure Compact, and for other purposes. | • Prevents states from receiving funds from the Bureau of Health Workforce, unless they join the Interstate Medical Licensure Compact<br>• Prevents state licensing boards from receiving certain federal grants unless they have a public awareness campaign on telemedicine |
| **H.R. 8755:** Expanded Telehealth Access Act | • Ensures Medicare coverage for telehealth services provided by occupational therapists, physical therapists, audiologists, and speech language pathologists<br>• Allows the Secretary of Health and Human services to expand the list of eligible providers |
| **Introduced more than 3 weeks ago:** | |

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| **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<br>• Remove the geographic and distant site restrictions for federally qualified health centers (FQHCs) and rural health clinics (RHCs) |
| **S. 3917**: Home-Based Telemental Health Care Act of 2020 | • Establish a telemental health grant program for health providers in rural areas<br>• Direct HHS secretary to award grants for provision of telemental services in rural areas |
| **S. 3988**: Enhancing Preparedness Through Telehealth Act | • Evaluate mechanisms for payment or reimbursement for use of telehealth technologies and personnel Evaluate infrastructure and resource needs to ensure providers have the necessary tools 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/FQHCs during the pandemic |
| **S. 3999**: Mental and Behavioral Health Connectivity Act | • Remove Medicare's geographic restrictions for originating sites for emergency medical, mental and behavioral health services<br>• Allow Medicare to cover audio-only telehealth services |
| **S. 4039**: Telemedicine Everywhere Lifting Everyone's Healthcare | • Permanently extend a provision of the CARES Act that temporarily allows health savings account eligible |

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| Experience and Long Term Health (TELEHEALTH) HAS Act. | 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 prior in-person visit<br>• 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<br>• 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<br>• Expand access to mental health services through telehealth in frontier states<br>• 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<br>• Categorize mental health services as E/M services in order to expand telehealth coverage in Medicare |
| **S. 4318:** American Workers, Families, and Employers Assistance Act | • Allow the HHS Secretary to extend the temporary telehealth flexibilities made available during the PHE until |

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| | December 31, 2021 or until the end of the PHE, whichever is later<br>• 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<br>• Require HHS to post data on use of telehealth throughout the pandemic and provide a report including legislative recommendations to Congress no later than 15 months after the bill is enacted<br>• 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<br><br>*For more information on this bill and the Senate Republican's stimulus package, inquire for our July 28 Insight summary.* |
| **S. 4375:** Telehealth Modernization Act | • Remove geographic barriers for originating site<br>• Require telehealth services to be covered by Medicare when furnished by FQHCs and RHCs<br>• 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 |

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| **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 |
| **S. 4840:** Ensuring Parity in MA for Audio-Only Telehealth Act of 2020 | • Requires Medicare pay the same amount for services delivered via telehealth as in-person during the PHE<br>• Includes audio-only diagnosis in the determination of risk adjustment for Medicare advantage |
| **S. 4854:** Home Health Emergency Access to Telehealth Act | • Authorize Medicare reimbursement for audio and video telehealth services by home health agencies |
| **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 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<br>• Require federal reimbursement of telehealth SUD treatment under Medicaid |

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| **H.R. 6074:** Coronavirus Preparedness and Response Supplemental Appropriations Act | • Allows CMS to extend coverage of telehealth services to beneficiaries regardless of where they are located<br>• Allows CMS to extend coverage to telehealth services provided by "telephone" but only those with "audio and video capabilities that are used for two-way, real-time interactive communication" (e.g., smartphones)<br><br>*For more information on Medicare changes, see our March 17 Manatt newsletter.* |
| **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 |

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| **H.R. 7338:** Advancing Telehealth Beyond COVID-19 | • Codify the removal of geographic restrictions waived in Medicare during the PHE<br>• 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 HHS Secretary to waive requirements relating to telehealth services under the Medicare program | • 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<br>• Authorize CMS to continue reimbursement for telehealth for 90 days beyond the end of the PHE<br>• Allow HHS to expand telehealth in Medicare during all future emergencies<br>• 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 |

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| **H.R. 7992:** Telehealth Act | • Packages nine telehealth bills introduced by Republican lawmakers including:<br>◦ H.R. 7338: Advancing Telehealth Beyond COVID-19<br>◦ H.R. 5473: EASE Behavioral Health Services Act<br>◦ S. 4039: Telemedicine Everywhere Lifting Everyone's Healthcare Experience and Long Term Health (TELEHEALTH) HAS Act<br>◦ H.R. 3228: VA Mission Telehealth Clarification Act<br>◦ H.R. 4900: Telehealth Across State Lines Act<br>◦ S. 4103: Treat Act<br>◦ H.R. 7233: Keep Telehealth Options Act<br>◦ S. 3988: Enhancing Preparedness Through Telehealth Act<br>◦ H.R. 7187: HEALTH Act |
| **H.R. 8156:** Ensuring Telehealth Expansion Act of 2020 | • Extend telehealth provisions in the CARES Act through December 31, 2025<br>• 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<br>• Establish parity between telehealth and in-person visits<br>• Guarantee all medically necessary benefits in ERISA plans are covered via telehealth |

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| **H.R. 8642:** Safe Testing at Residence Telehealth Act of 2020 | • Requires Medicare coverage for COVID-19 tests along with an assistive telehealth consultation<br>• Requires demographic data to be disclosed for reimbursement |
| **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<br>• Require a Medicaid and CHIP Payment and Access Commission (MACPAC) study examining data and information on the impact of telehealth on the Medicaid population<br>• 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 |
| **H.R. 8528:** Ensuring Telehealth Expansion Act of 2020 | • Extends provisions to temporarily not apply originating site requirements<br>• Enhances telehealth services for FQHC and rural health clinics<br>• Provides a temporary waiver of requirement for face-to-face visits between home dialysis patients and physicians |
| **Passed Legislation** | |

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| **S. 3548:** Coronavirus Aid, Relief, and Economic Security (CARES) Act | • Telehealth Provisions include:<br>  ○ Telehealth Network and Telehealth Resource Centers Grant Programs<br>  ○ Exemption for Telehealth Services<br>  ○ Increasing Medicare Telehealth Flexibilities During Emergency<br>  ○ Enhancing Medicare Telehealth Services for Federally Qualified Health Centers and Rural Health Clinics During Emergency Periods<br>  ○ Temporary Waiver of Requirement for Face-to-Face Visits Between Home Dialysis Patients and Physicians<br>  ○ Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care During Emergency Period<br>  ○ Encouraging Use of Telecommunications Systems for Home Health Services Furnished During Emergency Period<br><br>*For more information on the CARES Act, see our March 27 Manatt newsletter.* |

*Federal Reports:*

On November 9, 2020, MedPac issued a report on the expansion of telehealth in Medicare. The presentation highlights permanent (post-PHE) policy options that CMS may consider when expanding Medicare telehealth coverage. A *Manatt newsletter regarding this MedPac presentation is forthcoming*.

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 |
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| **Alaska** | HB 29: Require insurance carriers that provide coverage for in-person mental health benefits to cover the same benefits via telehealth. |

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| **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 |

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| | 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. |

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| | 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. |

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| **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,<br>interactive audio, video telecommunications, or electronic technology, or<br>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. |

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| **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. |
| | SB 5080: Allows providers to be reimbursed for telehealth services regardless of originating site, and enables patients to receive care via telehealth without being accompanied by a health professional. |
| **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. |

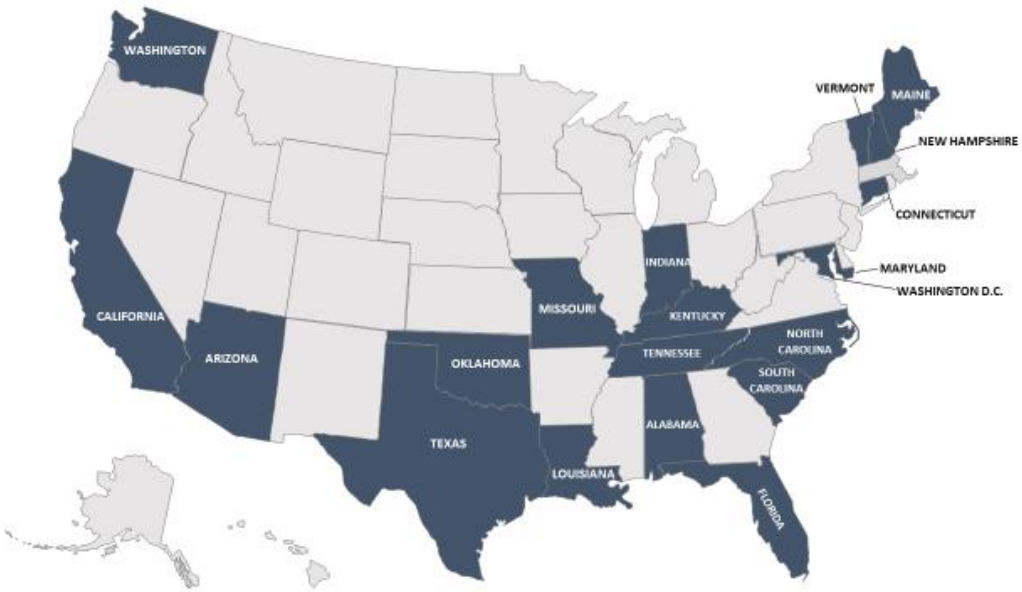
*State Trends*

***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 issued an Executive Order in March which required immediate implementation of its payment parity law.

***Appendix K Telehealth Flexibilities:*** As of December 3, 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 December 3, 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 December 3, 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 December 3, only 19 states and Washington D.C. have issued telehealth guidance for Child Well-care and EPSDT visits.

***Early Intervention Services:*** As of December, 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.