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Health

F-5 Telehealth: State Coverage in Medicaid Programs and Private Health Insurance and Barriers to Coverage

Overview of Telehealth

According to the National Conference of State Legislatures (NCSL), telehealth is defined differently by nearly all states and even by different entities within the federal government. For the purposes of this article, “telemedicine” refers to remote clinical services and “telehealth” encompasses a broader scope and can refer to remote non-clinical services, including provider training, administrative meetings, and continuing medical education, in addition to clinical services. Telehealth and telemedicine are often used interchangeably.

NCSL describes the three primary types of telehealth applications:

- Real-time communication: enables patients to connect with providers *via* video conference, telephone, or a home health monitoring device;
- Store-and-forward: the transmission of data, images, sound, or video from one care site to another for evaluation; and
- Remote patient monitoring: involves the collection of a patient’s vital signs or other health data while the patient is at home or another site, and the transfer of the data to a remote provider for monitoring and response as needed.

Additional information on telemedicine may be accessed at <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>.

Telehealth Coverage in Medicaid

States have significant control and flexibility in their Medicaid programs, which includes the decision to cover and reimburse telehealth. For example, states may reimburse the physician or other licensed practitioner at the distant site (where the provider is located) and reimburse a facility fee to the originating site (the location of the patient at the time the service is provided *via* a telecommunications system). Reimbursement for any additional costs, such as technical support, transmission charges, and equipment, also may be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If separately billed and reimbursed, these costs must be linked to a covered Medicaid service. States may reimburse for telehealth under

Medicaid as long as the service satisfies federal requirements of efficiency, economy, and quality of care. See <https://www.medicaid.gov/medicaid/benefits/telemed/index.html>.

According to NCSL's "2015 Telehealth Policy Trends and Considerations Report," Kansas is one of 49 states, along with the District of Columbia, that provide some form of Medicaid reimbursement for telehealth services. Telehealth services under Medicaid managed care are allowed in 24 states.

Nearly all states reimburse for live video telehealth, while only 9 states reimburse for store-and-forward services. At least 17 states, including Kansas, have some form of reimbursement for remote patient monitoring in Medicaid. Some coverage for mental or behavioral health services provided *via* live video is provided in 48 states. Some states restrict the types of providers allowed to receive telehealth reimbursement: 19 states allow fewer than 9 providers to receive reimbursement, with 4 of these states reimbursing only physicians, while 15 states and the District of Columbia do not specify the type of provider who may be reimbursed. See <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>.

Although some states require a patient to live in a rural setting for telehealth reimbursement, states are increasingly removing these geographic restrictions. Colorado removed this requirement in 2015. Other conditions for telehealth reimbursement imposed by states include the type of site that can be an originating site or the distant site, and the need for a telepresenter (another provider present with a patient at the time service is provided *via* a telecommunications system).

Additionally, some states have broad definitions of telehealth while others limit the definition to certain types of technologies. Most states exclude or do not specifically include e-mail, telephone, and facsimile in the definition of telehealth.

Telehealth state-by-state current and pending reimbursement policies, laws, and regulations, including an interactive policy map, are available on the Center for Connected Health Policy website (<http://cchpca.org/>). The "August 2016 State Telehealth Laws and Medicaid Policies Report" by

the Public Health Institute Center for Connected Health Policy, also located on the website, provides a comprehensive review of all state Medicaid policies, laws, regulations, and legislation.

Kansas. Kansas telemedicine reimbursement policies only apply to services provided under Medicaid and not to private payers. Office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided *via* telecommunication technology. According to the Kansas Medical Assistance Program Provider Manual (updated 5/20/14), the consulting or expert provider must properly bill the codes and will be reimbursed at the same rate as face-to-face services. Limitations include: the patient (beneficiary) must be present at the originating site; e-mail, telephone, and facsimile transmissions are not covered as telemedicine services; and documentation requirements are the same as face-to-face services.

NCSL's "2015 Telehealth Policy Trends and Considerations Report," citing information from the Center for Connected Health Policy, provides the following information for selected states.

Georgia. Georgia Code Annotated § 33-24-56.4 defines telemedicine as "the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured e-mail, or a combination thereof do not constitute telemedicine services." Georgia's telemedicine policies apply to Medicaid and private payers.

Minnesota. Minnesota telemedicine policies apply to both Medicaid and private payers. Minnesota Statute § 62A.671 defines telemedicine as "the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site... Telemedicine may be provided by means of real-time two-way interactive, audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health

care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care." Communications solely consisting of a telephone conversation, e-mail, or facsimile transmission do not constitute telemedicine consultations or services, regardless of whether the communication occurs between licensed health care providers or between a licensed health care provider and a patient.

Nevada. Nevada law N.R.S. 629.515 defines telehealth as "the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail." The definition applies to both Medicaid and private payer health insurance policies.

Telemedicine Coverage in Private Health Insurance Plans

NCSL reports 32 states and the District of Columbia currently have some form of private payer policy. Kansas law does not mandate private insurance companies cover telemedicine services. However, Blue Cross Blue Shield of Kansas (BCBSKS) covers certain telemedicine services.

Blue Cross Blue Shield of Kansas—Coverage of Telemedicine Services

Legislative testimony provided by BCBSKS in February 2015 to the House Vision 2020 Committee stated the company has covered certain telemedicine services since January 1993. These telemedicine services must involve a physician's specialty service not otherwise available in the patient's community. This includes services provided not only by a physician, but also by mid-level practitioners (*i.e.* physician assistants, advanced practice registered nurses, clinical nurse specialists, clinical psychologists, and clinical social workers).

Unlike some government-funded insurance programs, BCBSKS does not cover telemedicine services for basic primary care services. Specialty

providers can bill BCBSKS for consultations, office and other outpatient visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examinations, neurobehavioral status exams, individual medical nutrition therapy, and end stage renal disease-related services. BCBSKS also allows for additional telemedicine services to be billed when the services are medically necessary and a covered benefit.

In 2008, BCBSKS began reimbursing for telemedicine facility fees or what is sometimes referred to as the originating site fee. Acute care hospitals, including those that are defined as critical access hospitals, are considered to be eligible "originating sites" for purposes of reimbursement. BCBSKS also recognizes physician or practitioner offices, rural health clinics, federally qualified health centers, skilled nursing facilities, and community mental health centers as originating sites.

Kansas State Employee Health Plan Coverage of Telemedicine Services

Benefit descriptions associated with the 2017 Plan Year for the State Employee Health Plan under Plan A, BCBSKS, provide insight into how telemedicine services are covered and excluded pursuant to an insurance policy issued by BCBSKS.

BCBSKS defines telemedicine as "the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site." Telemedicine consultation means "a two-way real time interactive communication between the patient and the physician or practitioner located at a different location. This electronic communication uses interactive telecommunications equipment that includes audio and video."

Covered medical services include consultations and medical services, including telemedicine, "as medically necessary and appropriate." There is a general coverage exclusion for travel expenses for services provided through e-mail or electronic

communications. However, clarification is provided that “[f]or the purpose of this provision, electronic communications means communication other than telemedicine.” (This specific exclusion also is included in the 2017 Benchmark Plan for Kansas.)

Telehealth Coverage Barriers

Telehealth Costs and Standards. At present, not all telehealth costs are reimbursed in either the public or private health insurance coverages. Medicare, for example, reimburses those telemedicine services that mirror the normal face-to-face interaction between a patient and his or her health care provider, but does not cover certain applications (e.g. remote EKG applications) as this type of “store-and-forward-service does not involve a direct patient interaction.”

The federal Health Resources and Services Administration (HRSA) notes there is “no single widely-accepted standard for private payers.” Insurance companies, HRSA indicates, “value the benefits of telehealth” and reimburse for a variety of services, while other insurers have not developed comprehensive policies and reimbursement

and therefore require prior approval. A similar variance, as noted earlier in this article, exists for states’ Medicaid standards for reimbursement of telehealth expenses. [Note: Additional information regarding provider and health care benefits’ mandates for insurance coverage in Kansas law is provided in article [E-1 Kansas Health Insurance Mandates](#) of this Briefing Book.]

Provider License Portability. Another barrier to telehealth coverage often cited is the lack of provider licensure portability. During the 2016 Legislative Session, Kansas enacted HB 2615, which includes provisions allowing Kansas to join the Interstate Medical Licensure Compact (Compact). The Compact is governed by the Interstate Medical Licensure Compact Commission (Commission), which has the authority to develop rules to implement the provisions of the Compact. The cited purpose of the Compact is for the member states to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards and provides a streamlined process for physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients.

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