States eye new laws in light of huge increase in use of these services; ideas include removing statutory restrictions, ensuring payment parity, and setting standards of care

by Jan Davis (jdavis@csg.org)

Greater acceptance and use of telehealth services—the transmission of audio/visual signals and data between physically disconnected sites like a hospital or a doctor’s office and a patient’s house—seem likely to be permanent legacies of the COVID-19 pandemic. The U.S. Centers for Medicare & Medicaid Services included 144 services (such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services) to its list of Medicare-eligible telehealth coverage for the duration of the official public health emergency. But without legislative (or administrative) measures, that eligibility will disappear when, or shortly after, the emergency is declared over. CMS took the first step toward permanency in December when it added more than 60 telehealth services that will continue to be covered by Medicare beyond the emergency. Will telehealth also become an enduring part of services covered by Medicaid and private insurers? The answer will depend partly on the actions taken by states and their legislatures, with far-reaching consequences for health providers and consumers alike. For example, about one in five Americans get their health insurance through Medicaid. “No two states [are] alike in how telehealth is defined, reimbursed or regulated,” the Center for Connected Health Policy noted in its fall 2020 study of state laws. (The center, an initiative of the Public Health Institute, aims to promote a greater acceptance and use of telehealth.)

**TELEHEALTH POLICIES IN MIDWEST ENTERING 2021**

All U.S. states reimburse for “some form of live video” for Medicaid fee-for-service, while 21 states— including Illinois, Indiana, Kansas, Minnesota and Nebraska in the Midwest—do so for remote patient monitoring, according to the center’s report. Minnesota was among 18 U.S. states (as of 2020) reimbursing for “store-and-forward,” or “asynchronous,” transfers of data: pre-recorded videos or digital images stored at a point of origin (such as a patient’s home) and forwarded at a later time to a doctor’s office or hospital for analysis or consultation.

And Minnesota was the only Midwestern state with a Medicaid payment parity law in place, requiring that payments for telehealth services be equal to those for in-person services. A bill introduced this session, HF 1412/SF 1160, would extend this kind of “telehealth parity” to private insurance plans in Minnesota as well. Across the Midwest, myriad telehealth-related bills have been introduced this session, and some already signed into law, a signal that many legislators envision these services being a part of their state’s health system long after the COVID-19 pandemic is in the rear-view mirror. “Telehealth parity” is the subject of several current bills. As of late March, measures requiring parity among private health insurers were active in states such as Illinois (HF 3498) and Iowa (SF 92). In Nebraska, LB 314 would require telehealth consultations to be reimbursed at the same rate as in-person ones, and LB 487 would require parity for mental health treatments. HB 122 in Ohio would prevent private insurers from charging different cost-sharing rates for telehealth than for in-person health treatments. (The most common mental health diagnoses among insured Pennsylvania adults: major depressive disorder, bipolar disorder, and dysthymic disorder. 1) Ohio’s mental health advocates, through commonwealthhealth.com, offer a free screening for depression, anxiety and substance abuse disorders.)

**Majority of diagnoses for telehealth claims in Midwest (Missouri included) are related to mental health**

- **2021 was for mental health conditions**
- **62.8% of telehealth claims in January 2021 were for mental health conditions**
- **18.2% of telehealth claims in January 2021 were for other conditions**

**6% claim lines in January 2021 for mental health conditions**

**42% claim lines in January 2021 were for other conditions**

Source: FAIR Health

**Majority of diagnoses for telehealth claims in Midwest (Missouri included) are related to mental health**

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**Question of the Month**
- **Have any states in the Midwest introduced or passed “right to repair” laws for agricultural and/or electronics equipment?**

**Around the Region**
- **Midwest has been part of this year’s big surge in legislative proposals on voting and election administration**

**Capital Insights**
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- **FirstPerson article**: Michigan Sen. Jim Runestad on legislation to help children with dyslexia

**CSG Midwest News**
- **Family-friendly Midwestern Legislative Conference Annual Meeting will be held July 11-14 in Rapid City, S.D.**

**BILLD News & Alumni Notes**
- **May 14 is deadline for newer legislators to apply for 2021 BILLD Fellowship**
services, as well as require that health care practitioners eligible to use telehealth be reimbursed for it. Ohio's HB 122 would also allow eligible health care practitioners to bill the states' Medicaid program for such services.

**HERE TO STAY**

The Council of State Governments’ Health States Task Force, which convened in 2019 to examine how states can meet the challenges of rapidly evolving technologies and policies, included a side section on telehealth policy in its final report (released in the fall of 2020). That report identified several actions already taken in states, from the creation of a cabinet-level position in Kentucky to a new law in New Hampshire eliminating restrictions on where telehealth services can originate. "We need to make telehealth and broadband more accessible to people. We know the need for both is great," says Ohio Rep. Brigid Kelly, who served as co-chair of the task force’s subcommittee on telehealth policy.

A lot of problems that existed before COVID-19 persist or were exacerbated by COVID-19,” she says. Legislators should look not just at what’s happening now, she adds, “but what’s likely to happen in the future” and ensure that telehealth laws are flexible enough to evolve with technology.

Kyle Zbley, public policy director for the American Telemedicine Association, agrees states should be mindful to not preclude new technologies that don’t exist now but might in five or 10 years. By then, telehealth will provide better, more integrated telehealth care at every step of the process, from intake to outcomes, he says, adding that’s why the association recommends technology-neutral legislative language such as South Dakota’s SB 96. Signed by Gov. Kristi Noem in early March, the bill defines telehealth as "the use of secure electronic information, imaging and communication technology" by health care professionals to deliver services to a patient.

The new law also removes a requirement that an existing provider-patient relationship (such as a previous in-person visit) exist before telehealth services can be provided. And the state’s telehealth definition allows not only for live, remote visits, but the asynchronous delivery of health care services (store-and-forward technology). Telehealth is here to stay, Zbley says. "We made 10 years of advances in one year, 2020: millions of Americans tried telehealth and liked it."

**LEGISLATIVE ACTIVITY IN 2021**

Throughout 2020, the consumer awareness group FAIR Health collected data on telehealth by region and the entire country. In January 2020, prior to the COVID-19 pandemic, telehealth services made up 0.12 percent of total insurance claims in the Midwest. In December of that same year, they accounted for 4.9 percent of all claims. But without permanent changes to state and federal laws, many of the measures that made telehealth widely adaptable could disappear, Zbley says.

State legislators are aware of that cliff’s edge and looking to update their telehealth laws, he adds, noting that his association has seen “an absolute explosion” of telehealth-related legislation in areas such as parity and state professional licensing.

South Dakota’s SB 96, for example, spells out eight specific standards — verifying and disclosing the identities of participants, obtaining appropriate consent for treatment, ensuring appropriate medical practices are used to make diagnoses, and more. Many of this year’s measures also seek to specify the types of telehealth eligible for reimbursement, as well as who can provide the services.

Live video has traditionally been the telehealth mode most accepted in state laws. Other modalities include store-and-forward services, remote patient monitoring (for example, medical professionals evaluating patients at home in real-time via home monitors), and the use of smart tablets and devices.

Various proposals this year also would expand the list of telehealth-eligible practitioners.

- HB 1151, which passed the North Dakota House in January, would allow telehealth dental consultations or exams in certain situations, but would also require dentists using telehealth to “have adequate knowledge of the availability and location” of local dentists for follow-up care.
- Indiana’s HB 1286 and SB 3, passed by their respective chambers in February, would expand telehealth usage beyond just prescribers to other practitioners, including veterinarians. These measures also address record-keeping and specify that a Medicaid patient waives confidentiality of medical information “that is heard by another individual in the vicinity” of the patient during a telehealth consultation.
- North Dakota’s SB 2179 would allow telehealth to be used by advanced-practice nurses, optometrists, pharmacists, physician’s assistants, psychologists (and school psychologists), and chiropractors. It would also set a technology-neutral definition of telehealth and classify home monitoring devices as “medical equipment” (equipment used in a home to improve a patient’s quality of life).

Some bills in the Midwest are narrower in scope:

- HF 431, passed in February by the Iowa House, would require state licensing boards to allow for audio-only telehealth in the rules governing various health care providers.
- North Dakota’s SB 2179 would have allowed audio-only telehealth services if “no other means of communications technology are available to the patient.” It was amended to instead allow a study of telehealth during the interim.

**PROPOSED CHANGES IN TELEHEALTH LAWS**

This year’s proposed Telehealth Modernization Act (S 368 and HR 1332) would permanently allow homes to be originating sites for telehealth services. Rural health clinics and federally qualified health centers could serve as distant sites for all services, and all practitioners could use telehealth if approved by the U.S. Centers for Medicare and Medicaid Services.

The act also would allow Medicare hospice and home dialysis patients to receive care through telehealth.

**4 RECENT FEDERAL ACTIONS, PROPOSALS ON TELEHEALTH**

**AMERICAN RESCUE PLAN**

$500 million in grants will be made available to address rural health care needs related to the pandemic. These funds can be used to increase telehealth capabilities.

**CARES ACT**

Last year’s CARES Act created a $260 million COVID-19 Telehealth Program. Eligible health care providers received federal funding in order to serve patients at their homes or mobile locations during the COVID-19 pandemic. Another round of funding will be available this year.

**MORE FUNDING FOR BROADBAND**

Broadband funding approved last year included $1.2 billion for the Federal Communication Commission’s Emergency Broadband Connectivity Fund for households, $300 million for the broadband portion of Department of Commerce programs, and $100 million for the U.S. Department of Agriculture’s Rural Broadband ReConnect.

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The role of interstate licensure compacts in state health policy is likely to become more prominent with a rise in telehealth services. These agreements ease the process for professionals in one member state to practice in another member state — for example, an expedited pathway to licensure license reciprocity, or the ability to practice telehealth. (Each health compact has its own set of rules on licensure and practice across jurisdictional lines.) Here is a look at the status of three interstate health compacts in the Midwest.

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