

State of Alaska

**Alaska Telehealth Advisory Council
Medicaid Telehealth Reimbursement
Research Project**

I. OTHER STATES' PRACTICES

Final Report

For

Alaska Native Tribal Health Consortium

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The Alaska Telehealth Advisory Council

The Alaska Telehealth Advisory Council (ATAC) is a group of private and public stakeholders (e.g., hospitals, professional practitioner groups, utility companies, and government agencies) that all have an interest in promoting telehealth in the state of Alaska. ATAC's primary goals are to accomplish the following:

- Explore and document the potential for and challenges to telehealth development and delivery in Alaska.
- Propose a framework for rational development and deployment of statewide capacity for telehealth systems.
- Establish core principals to ensure a coordinated, cost-effective, and integrated approach to telehealth in Alaska.
- Consider ways to assess effectiveness, efficiency, and whether or not telehealth is improving equity of access to health services for all Alaskans.
- Recommend a long-term process for addressing issues as they emerge with changing technologies and practice patterns.

Subcommittees or “workgroups” have been formed to deal with certain telehealth issues. In 1999, ATAC created a Reimbursement Workgroup to (1) determine the scope of current coverage of Medicaid programs across the country for telehealth applications, (2) analyze issues relevant to Alaska's unique geographic environment, and (3) assist in collecting information to support recommendations for future telehealth coverage for Medicaid beneficiaries. Teri Keklak is the Alaska Department of Health and Social Services/Division of Medical Assistance (the Medicaid office) Designated Representative to the ATAC Reimbursement Workgroup.

Project Overview

The Alaska Telehealth Advisory Council (ATAC) ATAC agreed to fund a contract with a private consultant who could assist the Reimbursement Workgroup with the development of reimbursement policies. Accordingly, Alaska's Division of Medical Assistance engaged Myers and Stauffer, LC to develop a reimbursement methodology for Medicaid telehealth services. Myers and Stauffer's workplan for this project contains three components: a report summarizing other states' telehealth initiatives; a report outlining Alaska's telehealth issues; and a final report recommending coverage and reimbursement policies. This report is the first of a series of reports Myers and Stauffer will prepare for ATAC.

Summary of other States' Initiatives

Myers and Stauffer worked with the Division of Medical Assistance and the ATAC Reimbursement Workgroup to develop a list of questions regarding other state Medicaid programs' telehealth initiatives. The final questions that were agreed upon are set forth below:

1. What unique health care issues in your state, if any, led you to consider telehealth services? What are the goals / objectives of telehealth coverage? Has implementing telehealth services achieved your objectives? If not, why?
2. What is your scope of coverage for telehealth applications (e.g., interactive video physician consultations and/or store and forward teleradiology)?
3. In regard to telehealth services, does your state require out-of-state physicians to be enrolled in your Medicaid program and/or have a valid state license in the state where the patient is located? What about other medical practitioners?
4. Does your state reimburse providers at the hub-site for the consultation, or does it reimburse providers at the spoke-site for office visits, or both?
5. In terms of medical reimbursement codes, does your state use modifiers with CPT codes (e.g., TM or TV), or has your state developed its own local codes to distinguish telehealth services?
6. Does your state keep track of the number of telehealth encounters? Could you share this data with us?
7. Does your state reimburse for additional costs associated with electronic telehealth services such as technical support, line-charges, depreciation on equipment, etc.? If so, are these add-on costs incorporated into fee-for-services rates or are they separately reimbursed by the state?
8. Does your state use utilization management (e.g., prior authorization and annual limits) to monitor or limit telehealth services? Do you limit telehealth coverage to certain individuals, age groups, or diagnoses?
9. Does your state measure outcomes resulting from telehealth practices (e.g., back-end reporting and/or evaluation of the services)?
10. How are physicians reimbursed in your state program (e.g., RBRVS, percent of charges)? Is reimbursement for telehealth services reimbursed using the same methodology? Does your state use a payment differential for telehealth services (e.g., 60 percent of standard physician rates)?
11. Does your state allow telehealth services to be provided in an FQHC/RHC? If so, what special considerations, if any are given to these services? For example, are these reimbursed differently from FQHC visits? Are the costs for telehealth services included in the facility cost report? If so, are costs associated with technology and infrastructure for telehealth services allowable costs?
12. Has the implementation of telehealth services affected your budget?

13. Did your state use a pilot program to implement telehealth or was it implemented unilaterally?
14. Do you communicate with your state's legislature regarding telehealth practices to support the continuation of telehealth funding appropriations?
15. What advice can you offer to other states that are considering reimbursement for telehealth services?

Before contacting state Medicaid programs to answer the questions set forth above, Myers and Stauffer used three information sources to answer as many survey questions as possible. These sources are:

1. The Center for Telemedicine Law Report entitled, *Medicaid Telemedicine and Telehealth Update* by Holly Russo, RN, MS.
2. The Health Care Financing Administration's (HCFA's) website (<http://www.hcfa.gov/medicaid.telelist.htm>). This website contains a brief article entitled, *States Where Medicaid Reimbursement of Services Utilizing Telemedicine is Available*. The article briefly outlines the telehealth initiatives in 14 states.
3. Results from the telehealth survey conducted by Alaska's Division of Medical Assistance.

The sources above revealed that 20 state Medicaid programs have either implemented or are in the process of implementing reimbursement for telehealth services. These states are:

- Arkansas
- California
- Georgia
- Illinois
- Iowa¹
- Kansas
- Kentucky
- Louisiana
- Maine
- Minnesota
- Montana
- Nebraska
- North Carolina
- North Dakota

¹ Telemedicine is no longer a covered service under the Iowa Medicaid Program. Iowa's legislature allowed Iowa's pilot telehealth program to "sunset" during the 2000 legislative session.

- Oklahoma
- South Dakota
- Texas
- Utah
- Virginia
- West Virginia

Myers and Stauffer contacted each of these states' Medicaid offices in order to gather and confirm information regarding the states' telehealth initiatives.²

State Responses to the Survey Questions

The full text of each states' responses to the 15 survey questions are contained in Appendix A of this report. Below is an overall summary of the states' responses to the 15 survey questions. Please note that this report uses the terms, "telehealth" and "telemedicine" synonymously, though the terms are not synonymous to the Alaska Division of Medical Assistance. Preliminary research when developing survey questions revealed a tendency for most payers to use the terms, "telehealth" and "telemedicine" to describe the same service delivery practices. To insure standardization of information collected and standardization of state responses to the survey, the terms, "telehealth" and "telemedicine" were used interchangeably for soliciting and recording the information contained in this report. Activities related solely to Alaska will reflect the correct usage of the terms.

Question Number 1: What unique health care issues in your state, if any, led you to consider telehealth services? What are the goals / objectives of telehealth coverage? Has implementing telehealth services achieved your objectives? If not, why?

The survey revealed two primary reasons why states have implemented reimbursement for telehealth services. First, to increase access to specialty healthcare services in rural areas, and second, to decrease transportation costs.

In many states, providers at medical affiliated teaching hospitals were already providing telehealth services before they approached their state Medicaid office about reimbursement. In other states, successful Medicare telehealth demonstration projects or other telehealth grant projects persuaded Medicaid programs to provide reimbursement for telehealth. The state of Kansas began providing reimbursement for outpatient mental health services via telehealth when some of its state psychiatric facilities were closed.

Providers in some states have persuaded state legislatures to pass laws regarding telehealth reimbursement. The Nebraska and Kentucky legislatures have passed laws that direct their Medicaid agencies to implement telehealth reimbursement for nearly every Medicaid covered service.

² Myers and Stauffer also contacted the State of Idaho. Although Idaho does not currently reimburse for telehealth, its Bureau of Mental Health and Substance Abuse will soon be approaching the Idaho Medicaid agency to request reimbursement for tele-psychiatric consultations.

Most of the states reported that it is too early to tell whether implementing telehealth reimbursement has achieved state goals and objectives. Low service volumes and difficulties associated with tracking telehealth encounters have prevented states from ascertaining the benefits of telehealth initiatives. Many states report that the main reason for low service volumes is that only a small number of providers have access to the technology necessary to deliver healthcare via telehealth.

Question Number 2: What is your scope of coverage for telehealth applications (e.g., interactive video physician consultations and/or store and forward teleradiology)?

Most of the states surveyed reimburse for physician consultations when furnished using interactive video teleconferencing equipment. California, North Dakota and Virginia also recognize other selected services provided by psychiatrists (and Ph.D. psychologists in North Dakota and Virginia).

In Georgia and Texas, physician consultations are restricted by the requirement that hub site consulting providers be located at teaching hospitals. Georgia requires hub site providers to be located at a medical center managed through the Medical College of Georgia, and Texas requires hub site physicians to be employed by or affiliated with an accredited medical or osteopathic school.

West Virginia requires its spoke site providers to be in rural health shortage areas. Similarly, Texas requires its spoke site providers to be in rural areas (a county with a population of less than 50,000) or an underserved area (an area that meets the definition of a Medically Underserved Area or Medically Underserved Population by the U.S Department of Health and Human Services).

Some states are much more liberal regarding the scope of services that can be provided via telehealth. For example, the state of Nebraska will soon implement a telehealth initiative that recognizes most state plan services when furnished using interactive video teleconferencing. Kentucky's recently passed telehealth law appears to recognize almost as many telehealth services as Nebraska, however these services will have to be provided through a network created by the telehealth law.

Kansas and Utah reimburse for a select number of home health services provided through telehealth. This allows home health providers in these states to monitor recipients via telehealth instead of home visitation.

Four states – Kentucky, Nebraska, South Dakota, and Minnesota - specifically reported that they reimburse for store and forward telehealth practices (e.g., teleradiology and telepathology). California and Louisiana allow store and forward consultations to be reimbursed, but these claims are not to be submitted with telehealth modifiers. Other states admitted that store and forward telehealth practices probably take place without their knowledge.

Question Number 3: In regard to telehealth services, does your state require out-of-state physicians to be enrolled in your Medicaid program and/or have a valid state license in the state where the patient is located? What about other medical practitioners?

The practice of medicine without a license is prohibited. State licensing boards determine who can practice medicine within state borders, with varying rules of reciprocity for licenses awarded in other states. This system works well for the traditional healthcare model in which patients and healthcare providers see each other face-to-face in the same location. However, telehealth separates healthcare providers from patients, and sometime the separation goes beyond state boundaries. When this occurs, the issue becomes, “where is medicine being practiced?” Is medicine occurring at the place where the doctor is located, or is it occurring at the location of the patient?

The Nebraska legislature passed a law making it emphatically clear that medicine occurs at the site where the patient is located. Therefore, if an out-of-state physician treats a Nebraska resident through telehealth, he or she is presumed under the law to be practicing medicine in Nebraska, and therefore must be licensed to practice medicine in Nebraska.

Dr. Michael Farber from the state of California’s Medi-Cal Program takes the opposite view of the Nebraska legislature. Dr. Farber believes that physicians practice medicine in the place where they themselves are located. Accordingly, hub site telehealth physicians in California need only be licensed to practice medicine in the state where they are located. While at first blush this seems like a liberal view, it becomes less so when one discovers that the issue has never arisen in California. Stated differently, no out-of-state physician has ever provided a telehealth consultation to a California Medicaid recipient, because out-of-state consultations require prior authorization, and it is difficult to explain why a physician consultation could not be done in California. Likewise, the Minnesota and West Virginia Medicaid Programs do not require hub site providers to be licensed in their states, but telehealth services provided by out-of-state providers require prior authorizations that may be difficult to obtain.

The majority of the states Myers and Stauffer contacted have passed legislation, promulgated rules, or published policies requiring both hub and spoke site providers to be licensed in the state that is providing Medicaid reimbursement for telehealth services. However, the Texas Medicaid Program left the matter up to its State Board of Medical Examiners. Texas Medicaid, in its response to comments submitted to a proposed rule regarding telehealth, stated the following:

If the State Board of Medical Examiners licenses providers outside the state to provide telehealth services, the state will reimburse those physicians for telehealth services provided to Texas Medicaid recipients. If the State Board of Medical Examiners does not license providers outside the State to provide telehealth services, the state will not reimburse them for telehealth services.

When Myers and Stauffer interviewed Texas Medicaid about this issue, it explained that Texas has a very strict medical practice act. Anyone providing medical services to Texas

residents must meet the requirements of the act. Therefore, for purposes of telehealth, there is no reciprocity; providers must meet the requirements of the Texas medical practice act to provide telehealth services to Texas residents.

Montana and Oklahoma take a more lenient view than Texas when it comes to reciprocity for providing telehealth services. The Montana Medical Association and Board of Medical Examiners are trying to institute a certificate for out-of-state practitioners who want to practice telehealth on Montana recipients. This proposed process will not give practitioners full certification, but it will give them a certificate to practice telehealth. Similarly, the Oklahoma Medicaid Program supports the recommendations of the Telehealth Committee of the Southern Governor's Conference concerning this matter. This committee suggests a reciprocity agreement between states to honor each other's Medical licensing.

Question Number 4: Does your state reimburse providers at the hub-site for the consultation, or does it reimburse providers at the spoke-site for office visits, or both?

All but a few of the states surveyed provide reimbursement at both the hub and the spoke site. However, most of these states insisted that the referring spoke site practitioner must provide a service during the telehealth encounter in order to be reimbursed. West Virginia takes the matter a step further in its written telehealth policy by stating:

Reimbursement is made only at the hub site. However, on the day the teleconsultation occurs, the referring spoke site physician may bill for the office, outpatient, or inpatient visit that preceded the need for a consultation. Additionally, the referring physician could bill for other services as ordered by the consultant or for services unrelated to the medical problem for which a consultation was requested. However, the referring physician is prohibited from billing for a second visit for his or her role in presenting the patient at the time of the consultation.

In North Carolina, a single consultation fee is split between the hub and spoke sites. The consulting hub site provider receives 75% of the fee, and the referring spoke site provider receives 25% of the fee.

Kansas and Utah only reimburse the hub site providers. The Kansas Medicaid Program leaves it up to the participating telehealth providers to determine whether the spoke site will receive a percentage of the hub-site reimbursement received from Medicaid.

Question Number 5: In terms of medical reimbursement codes, does your state use modifiers with CPT codes (e.g., TM or TV), or has your state developed its own local codes to distinguish telehealth services?

Eight of the surveyed states use either a "GT" or a "TM" modifier to indicate that a consultation was provided via telehealth. The state of Minnesota only requires the hub site provider to use a "GT" modifier. In addition, it requires consulting providers to use a "WT" modifier to indicate if a consultation was done via store and forward technology.

Arkansas, Georgia, Illinois, and Virginia have developed local codes specific to telehealth services.

Similarly, the state of Kansas reserves the use of four CPT codes for its home health telehealth program (99350 thru 99353). These four codes cannot be used by home health agencies delivering traditional, face-to-face home health services.

Louisiana, Montana and Oklahoma do not track telehealth services at all. These states do not use telehealth modifiers, nor have they developed any special telehealth codes. Kentucky has not yet decided if it will use modifiers or special codes.

The state of Maine requires telehealth claims to include the diagnostic code V630 as a secondary diagnosis. In the same vein, Nebraska telehealth claims submitted on HCFA1500 forms must use the place of service code to indicate a telehealth encounter. Other modifiers will be used on other claim forms in Nebraska.

Finally, North Carolina uses pricing modifiers. This allows North Carolina to split a single consultation fee between the hub and spoke site providers. As stated above, 75% of the consultation fee goes to the consulting hub site provider and 25% of the consultation fee goes to the referring spoke site provider. The consulting practitioner at the hub site uses a GT modifier and the referring practitioner at the spoke site uses a YS modifier. The North Carolina claims system calculates the 75/25 percentages based on these modifiers.

The use of state created modifiers and local codes to indicate when services are being provided by telehealth will not comport with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under the Administrative Simplification provisions of HIPAA, the Secretary of Health of Human Services has been directed to adopt national electronic standards for automated transfer of certain healthcare data between healthcare payers, plans, and providers. HIPAA seeks to simplify and encourage the electronic transfer of data by replacing the many nonstandard formats currently used nationally, with a single set of electronic standards that would be used throughout the healthcare industry.

The GT modifier that is used by some of the surveyed states was created by HCFA for Medicare telehealth. Accordingly, the use of this modifier most likely complies with HIPAA's Administrative Simplification provisions. However, other state created modifiers and local codes will not comply with HIPAA, and states will have to develop alternative ways to identify telehealth services. Fortunately, the American Medical Association (AMA) recently announced that it is developing telehealth CPT codes for its next version of the CPT Code Manual.

Question Number 6: Does your state keep track of the number of telehealth encounters? Could you share this data with us?

As stated above, Louisiana, Montana, and Oklahoma cannot track telehealth services because these states do not use telehealth modifiers, nor have they developed any special telehealth codes.

Many of the states that use modifiers and local codes to identify telehealth services have not yet begun to track services. These states noted that while they have the capability to extract telehealth encounters, they have not yet done so. Most of these states said that they would extract data in the future when more providers began providing telehealth services.

The states that have extracted telehealth claims for analysis all report very low service volumes. Examples of low service volume are as follow:

- Illinois has only received spoke site claims, and there have only been approximately 60 to 65 claims since February of 1998.
- Since July 1, 1999, Minnesota has only paid one claim with a GT modifier.
- In Virginia, the bulk of telehealth claims have come from a single tele-psychiatry site. In 1999, approximately eight to ten claims a month were received from this site.
- In Texas, providers were permitted to bill for telehealth services in August of 1998. During the last fiscal year (September 1999 through August 1999), claims totaled approximately \$26,000.

Most of the states that require modifiers or local codes for telehealth encounters suspect providers are billing for telehealth services without using the modifiers/local codes. The state of Georgia reported that it has had a difficult time getting its hub site providers to use appropriate local service codes. Additionally, a few states reported that they know of providers who do not submit claims at all when they provide telehealth services.

The state of Iowa used a “TM” modifier for its now defunct pilot telehealth program. In addition, Iowa required survey forms to be submitted with telehealth claims. The hub and spoke site survey forms mirrored the patient/provider evaluation forms used by Medicare demonstration projects. During the three-year pilot project, only 18 telehealth claims were submitted. The Iowa Medicaid Program admitted that the survey forms were probably a burden for the providers. It suspects that some providers probably billed without using the “TM” modifier so that they would not have to fill out the survey forms.

Question Number 7: Does your state reimburse for additional costs associated with electronic telehealth services such as technical support, line-charges, depreciation on equipment, etc.? If so, are these add-on costs incorporated into fee-for-services rates or are they separately reimbursed by the state?

Iowa and Nebraska are the only states that answered, “yes” to question number seven. Under Iowa’s now defunct pilot telehealth program, Iowa paid a supplemental “facility fee” to hub and spoke sites to cover the cost of scheduling and technical support associated with teleconsultations. For providing these site coordination services, sites were reimbursed \$11.73. The local billing code was W1282. In addition to the facility fee, the originating site

received a transmission fee of \$7.20. The local billing code for the transmission fee was W1281.

In Iowa, a patient's referring spoke site provider could be a physician, physician assistant, or nurse practitioner. However, if a non-physician practitioner presented a patient, only supplemental transmission and site coordination services could be billed.

Unlike Iowa, Nebraska's telehealth initiative has not yet been implemented. However, the Nebraska Medicaid Program intends to pay for line charges, otherwise known as or transmission costs. To come up with a rate, Nebraska took last year's highest USF subsidized rate for a T1 line for one month (approximately \$800.00) and converted this to eight hours a day, 5 days a week. The rate comes out to eight cents a minute, and Nebraska will ask providers to bill by the minute. Separate coding will be used to bill for line charges, and the coding will indicate how many minutes were used.

Nebraska filed a state plan amendment in order to reimburse for line charges, because it will be paying more for state plan services when they are provided via telehealth.

The state of Oklahoma does not currently reimburse for additional costs associated with providing telehealth services. However, a bill passed by the Oklahoma Legislature during the past legislative session allows the use of the Oklahoma Universal Service Fund to provide one free telehealth line or wireless connection. This law has not yet been implemented. The Oklahoma Corporation Commission must first promulgate rules for this expansion.

Question Number 8: Does your state use utilization management (e.g., prior authorization and annual limits) to monitor or limit telehealth services? Do you limit telehealth coverage to certain individuals, age groups, or diagnoses?

The majority of the states surveyed reported that prior authorization and annual limit requirements for telehealth services are no different than they are for conventional services. However, Minnesota, Texas, and Arkansas have enacted the following limit provisions that specifically pertain to telehealth services:

- In Minnesota, payment for telehealth consultations is limited to three per week per recipient, and payment will be made for only one reading or interpretation of diagnostic tests such as x-rays, lab tests, and diagnostic assessments.
- In Texas, more than one medically necessary telehealth consultation may be paid on the same day/time, same place of service, if the consults are billed by physicians of different specialties.
- In Arkansas, Medicaid limits its coverage of consultations to two per client per year in a physician's office or a hospital. For conventional face-to-face consultations, Medicaid only approves benefit limit extension requests for children, not adults. However, when consultations are performed via telehealth, Medicaid will approve benefit limit extension requests for recipients of all ages.

In addition to the above limit requirements, Nebraska, Kentucky, and California require assurance that face-to-face consultations are not reasonably available. For example, Kentucky's telehealth legislation states that the Medicaid agency shall not require a telehealth consultation if an in-person consultation with a Medicaid-participating provider is reasonably available where the patient resides, works, or attends school.

Similar to the Kentucky legislation is a Nebraska Medicaid proposed rule stating that a telehealth service is covered as long as a comparable service is not available to a client within a 30-mile radius of his/her home.

California requires telehealth claims to include a statement explaining the barrier (geographic or other) to a face-to-face visit. Examples of acceptable documentation are as follows: local provider unavailable, local provider wait time unacceptable, local provider unwilling to accept Medicaid, transportation unavailable, time off work for travel creates a financial hardship, and time off for travel creates a personal hardship.

In the state of Maine, providers must have a letter of approval from the Maine Medicaid office in order to bill for telehealth services. To obtain a letter of approval, providers must submit a specific description of the telehealth services they will provide, along with a list of servicing providers and copies of their licensure/certification documents. Documentation must be sent to the Division of Policy and Programs, Bureau of Medical Services. The Bureau reviews submitted documentation and returns a letter of approval, which must be kept on file. Services delivered via telehealth cannot be billed if the provider does not have a letter of approval.

The state of Utah is the only state that limits telehealth services to certain individuals, age groups or diagnoses. In the Utah Special Health Care Needs Child Demonstration Project, services are limited to children with special health care needs selected by Utah's local health departments.

In the Utah home health care pilot project, nurse case managers select patients who meet the following criteria to participate in the project:

- Patient must be living in a identified rural area;
- Patient must meet diabetes eligibility requirements;
- Patient must be homebound;
- Patient requires two or more home care nursing visits per week; and
- The patient agrees to participate in telehealth home care services.

Question Number 9: Does your state measure outcomes resulting from telehealth practices (e.g., back-end reporting and/or evaluation of the services?)

None of the states Myers and Stauffer surveyed have begun to measure outcomes resulting from telehealth practices. Most states noted that they would like to have a larger volume of claims to work with before trying to evaluate telehealth services.

Before the state of Iowa's pilot project ended, it tried to measure outcomes by using required survey forms submitted with telehealth claims. However, only 18 of these forms were completed, so meaningful data did not exist.

Although the States of Texas and Georgia have not yet begun to measure outcomes, they require videotape documentation of teleconsultations to be available for review by the Medicaid agency or its designee.

Kentucky and Nebraska have plans to measure outcomes after their telehealth initiatives are implemented. For example, the Kentucky telehealth law requires the Kentucky Medicaid Program to issue a quarterly report to the Legislative Research Commission. The quarterly reports are supposed to analyze quality of care resulting from telehealth consultations.

Nebraska also intends to measure outcomes. It will begin by looking at whether infrastructure develops, and whether utilization of telehealth increases, which was the intent of allowing reimbursement for telehealth. Nebraska will also monitor whether providers are maintaining confidentiality standards.

Question Number 10: How are physicians reimbursed in your state program (e.g., RBRVS, percent of charges)? Is reimbursement for telehealth services reimbursed using the same methodology? Does your state use a payment differential for telehealth services (e.g., 60 percent of standard physician rates)?

For all but two of the surveyed states, telehealth services are reimbursed according to the same fee-for-service rates that are paid for conventional face-to-face services.

In the state of Kansas, home health telehealth services are reimbursed at a reduced rate. The four CPT codes that are reserved for telehealth home health services are comparable to other CPT codes billed for conventional home health services. However, instead of using the same reimbursement rates as the comparable codes, Kansas reduced the rates for the telehealth codes. The rates were reduced because home health agencies will save time and money by not having to travel to and from the patient's home.

In the state of North Carolina, rates for telehealth consults are the same as rates for conventional face-to-face consults. However, a single consultation fee is split between the hub and spoke site providers. The consulting practitioner at the hub site receives 75% of the consultation fee, and the referring practitioner at the spoke site receives 25% of the consultation fee.

Question Number 11: Does your state allow telehealth services to be provided in an FQHC/RHC? If so, what special considerations, if any are given to these services? For example, are these reimbursed differently from FQHC visits? Are the costs for telehealth services included in the facility cost report? If so, are costs associated with technology and infrastructure for telehealth services allowable costs?

Most of the surveyed states either did not know the answer to question 11 or stated that FQHCs and RHCs were not providing telehealth services. Arkansas, North Dakota and Texas are allowing FQHCs and RHCs to bill their encounter rates for telehealth services. North Dakota and Texas do not know whether these facilities include the costs associated with providing telehealth services in their facility cost reports, or whether it is allowable to do so. However, Arkansas has stated that it will not pay for the cost of providing telehealth services because these costs are part of office overhead. Nevertheless, Arkansas is tracking these costs in the following manner: FQHCs bill their encounter codes, and they also bill a local telehealth encounter code for additional costs incurred in providing telehealth services. Although Arkansas denies the telehealth code, it captures this information for cost settlement purposes. The state will compare what FQHCs billed to what they say it actually cost in their year-end cost reports.

The state of Nebraska contacted HCFA to find out whether FQHCs and RHCs can bill their encounter rates when providing telehealth services. HCFA's Medical Director, Dr. Gerald Zelinger, informed Nebraska in writing that FQHCs and RHCs cannot use encounter rates to bill for services provided via telehealth. This is because federal regulations require face-to-face visits when billing encounter rates. FQHCs and RHCs can bill fee-for-service rates when providing services through telehealth. However, they cannot bill the larger encounter rate. Additionally, the costs associated with providing telehealth are not allowable costs that can be included in FQHC and RHC cost reports.

Although North Carolina was unaware of HCFA's opinion regarding FQHC and RHC encounter rates, it is nevertheless complying with HCFA's opinion. In North Carolina, FQHCs and RHCs have two provider numbers. Core encounter visits are billed using a provider number that has an "A" suffix on the end of the number. Other services are billed using a provider number that has a "C" suffix on the end of the number. FQHCs and RHCs do not bill encounter rates when they provide telehealth services. Instead, they bill CPT codes and use their "C" suffix provider number.

Question Number 12: Has the implementation of telehealth services affected your budget?

Almost all of the surveyed states reported little to no impact on their budgets from telehealth services. This is due to low service volumes in most of the states.

Louisiana, Montana and Oklahoma are unable to ascertain the affect of telehealth on their budgets because they do not track telehealth services with modifiers or local codes.

Kansas' home health services are being provided at a lesser reimbursement rate via telehealth. Therefore, there has been a small decrease in the dollars spent on certain clients' home health services.

Both North Carolina and North Dakota believe that telehealth will eventually make a difference in transportation costs, but the difference will not be noticeable until the service volume increases. North Dakota believes that telehealth has already saved "wear and tear" on its recipients.

Finally, the state of Nebraska believes that its legislatively created far-reaching telehealth program will create a fiscal impact when it is implemented.

Question Number 13: Did your state use a pilot program to implement telehealth or was it implemented unilaterally?

All but three of the surveyed states implemented telehealth services unilaterally. States that implemented pilot telehealth programs are Iowa, Utah, and Virginia.

Iowa previously covered telehealth services under a three-year pilot program authorized by the state legislature. The pilot began in July of 1997 and ended on June 30, 2000. The legislature allowed the program to “sunset” during the 2000 legislative session, which was a formality since the program had ceased to exist anyway.

Utah has implemented three pilot programs. These pilots include a mental health pilot project, a home health pilot project, and the Special Health Care Child Demonstration Project. Utah wrote three separate waivers for these pilot projects, and corresponded with HCFA for eight or nine months until the waivers were approved.

Virginia Medicaid has covered telehealth on a limited basis since 1995 under a pilot project. The Medical College of Virginia, Virginia Commonwealth University participates in the pilot with the Blackstone Family Practice Center in Blackstone. The University of Virginia Hospitals participate in the pilot with Lee County Hospital, the Thompson Family Health Center in Van Sant, and with the Norton Community Hospital and Stone Mountain Health Center in Castlewood. Virginia also covers a psychiatric telehealth service available through a network involving medical practitioners at the Southwest Virginia Mental Health Institute in Marion, VA, and practitioners at nine Community Services Boards in the surrounding areas. Virginia did not seek a waiver to implement its pilot project, but HCFA advised Virginia that it would need to seek a waiver if the pilot project grew bigger.

Question Number 14: Do you communicate with your state’s legislature regarding telehealth practices to support the continuation of telehealth funding appropriations?

Over half of the surveyed states do not directly communicate with their legislatures regarding telehealth services. Some of these states indirectly communicate with their legislatures because telehealth services are part of their physician budgets presented to the legislature.

Six surveyed states have to submit periodic reports to various legislative committees to report on the status of their telehealth initiatives. Required elements of these reports include:

- Whether savings have been realized from the implementation of telehealth.
- Whether there has been an economic impact on the Medicaid budget.
- Whether telehealth has created benefits for the healthcare system.
- Recommendations for continuing coverage/expansion.
- Whether telehealth is cost-effective.

Sometimes legislatures request special reports from Medicaid programs. For example, in its 1999 budget bill, the Virginia legislature requested the Medicaid Program to develop protocols to address documentation of services and confidentiality of patient information with regard to telehealth.

The legislative process usually involves the legislature directing the state Medicaid agency to do something for the legislature. However sometimes Medicaid agencies go to legislatures with requests (e.g., requests for funding). For example, the Utah Medicaid Program tried to get additional money from its legislature during the past legislative session to expand telehealth services. Medicaid made a presentation to its legislative health policy commission and helped prepare a bill that would have granted additional funding. The legislators on the commission fought hard for the bill, but Medicaid only received the same appropriation it received the two previous sessions.

The state of Nebraska may also have to go to its legislature in the near future to request funding for telehealth services. The legislature did not give the Nebraska Medicaid Program any additional funding to implement telehealth because it believed that savings in transportation would offset any costs incurred from implementing telehealth. The Medicaid office will track telehealth encounters to determine if implementation creates a fiscal impact. Any fiscal impact would require the legislature to appropriate funds to support the continuation of telehealth services.

Question Number 15: What advice can you offer to other states that are considering reimbursement for telehealth services?

Advice from the surveyed states is as follows:

- Arkansas: Do not make a big deal out of this, just do it. Pay what you normally pay for visits and consultations and figure out a way to monitor the claims if you want to see where the money is going or if you want to compare outcomes.
- California: As the people at Nike say, “JUST DO IT!” Cover evaluation and management codes first. Do not get into a lot of other services right away. There is no clear-cut evidence that telehealth works for other types of services (e.g., home health).
- Georgia: Make sure that the hub provider is a licensed physician in your state. This gives you more control in determining whether the consulting physician is qualified to provide the service.
- Illinois: You must have identified providers who want to buy into the program and actually bill for telehealth services. Once you implement telehealth, you need to keep in contact with providers and ask whether you can help to facilitate telehealth services. For example, make sure the bills are going through.

- Iowa: Do not make it too burdensome for telehealth providers to provide services.
- Kansas: Be very clear about what is allowed. Be aware that telehealth is probably taking place. If you want to support it, make your policy official. If you do not want to pay for telehealth services, you must make this clear as well.
- Kentucky: No advice at this point in time.
- Louisiana: If your medical schools are the only providers doing telehealth, you might not have to track the services. However, as more private practitioners get involved, you will need a formal policy and a way to track the services.
- Maine: The concept is timely. There are many new technologies that can support telehealth. It is appropriate to experiment and try new service delivery models in this area. Ideally, there should be a forum where states could share information and interact with each other to learn more about how telehealth is provided in different environments.
- Minnesota: No advice
- Montana: Implement telehealth as simply as Montana did if you can get away with it.
- Nebraska: Start small (e.g., physician consultations under a pilot program). It has been very difficult to try and implement Nebraska's far-reaching telehealth initiative.
- North Carolina: North Carolina was fortunate because it had so much information from East Carolina University (ECU). Telehealth is a wonderful tool to increase access to healthcare in rural areas. North Carolina Medicaid is sending Myers and Stauffer two tapes made by ECU that explain ECU's telehealth program. These tapes should be given to the Alaska Medicaid Program.
- North Dakota: Telehealth might save money (e.g., transportation), but there are certain intangibles that you cannot measure, like better access to specialty care and providing better healthcare services in general to recipients who live in rural areas.
- Oklahoma: The experience of the Oklahoma Medicaid Program indicates that the development of an effective telehealth system requires the cooperation of medical providers, hospitals, and state government.
- South Dakota: Start out small, and reimburse for just a select number of services.
- Texas: States should bring all interested parties to the table at the beginning of the planning process. In Texas, there was strong disagreement between the academic health science centers and the professional associations as to what telehealth should look like. These groups kept submitting legislation to cancel each other out. Looking back, it would have been productive to bring these groups together to communicate

with each other, air-out the issues, and reach workable compromises. It would be helpful to have a statewide coordinating/facilitating entity for the planning process to fall under. Also, states should build in quality and outcome measurements, and have edits and audits to detect fraud and abuse (Texas has experienced lots of problems with fraud and abuse in its Medicaid program).

- Utah: You must fight to get financial backing from your legislature. Find people in your legislature who are willing to fight for your program. Start small with pilot projects so you can monitor quality. You will have to show your legislature that it works and that it makes a difference.
- Virginia: Start with a pilot program that reimburses for just a handful of services. Keep the spoke site physician involved in the process, at least during the embryonic stages of providing telehealth services.
- West Virginia: Follow the Medicare guidelines. Restrict what you will cover and be very specific on how telehealth services are to be provided.

Conclusion

Much can be learned from the 20 states that have implemented or are about to implement telehealth services.

The typical state reimbursing telehealth services has the following characteristics:

- ✓ Follows Medicare guidelines for telehealth services.
- ✓ Has recently introduced a structured telehealth delivery model.
- ✓ Has practitioners that have probably used telehealth methods to provide services prior to Medicaid recognition and reimbursement of such services.
- ✓ Probably reimbursed some telehealth services, not specifically identified as such, prior to Medicaid's formal recognition and reimbursement of such services.
- ✓ Reimburses primarily interactive telehealth services, rather than "store and forward".
- ✓ Requires referring and consulting providers to be licensed in the state that provides the reimbursement.
- ✓ Requires practitioners to use local codes, modifiers, and diagnosis codes for billing and tracking of telehealth services.
- ✓ Has experienced low service volumes.
- ✓ Does not reimburse infrastructure, lines, technical support, or equipment that practitioners use for service delivery.

- ✓ Does not restrict telehealth services any more stringently than the same services delivered via conventional methods.
- ✓ Does not offer enhanced reimbursement for telehealth services.
- ✓ Has experienced little budgetary impact related to telehealth program implementation.
- ✓ Implemented telehealth programs unilaterally, without a pilot program.

As Alaska designs reimbursement policies for its own Medicaid telehealth program, it is important to remember that each state has its own healthcare delivery environment. What works in one state might not necessarily work in another state. Alaska has unique considerations--geographically, culturally, climatic, and socially-- that may have a marked influence on the implementation of a telehealth delivery system. These unique considerations are examined in detail in Volume Two of this report entitled, "Medicaid Telehealth Services In Alaska: Issues for Consideration".

