



Telemedicine Reimbursement Report

**Prepared by the
Center for Telemedicine Law**

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The Center for Telemedicine Law (CTL) is a non-profit entity founded by organizations committed to providing high-quality patient services through the use of telemedicine systems throughout the United States and the world. CTL is a leader in the gathering and analysis of information related to the legal and regulatory aspects of telemedicine. Because uncertainty about legal and regulatory issues often serves as a deterrent to the maximum utilization of telemedicine, CTL seeks to identify and clarify the legal and regulatory barriers and to offer solutions for overcoming these barriers.

Since 1996, CTL has provided periodic updates on state reimbursement activity impacting telemedicine. This report provides an overview of existing state telemedicine reimbursement policy as well as the state Medicaid agency survey.

The Center for Telemedicine Law

*1050 Connecticut Avenue, NW, Suite 700
Washington, DC 20036-5339*

*202-775-5722 (telephone)
202-857-6395 (fax)
telemedicine@ctl.org (email)
www.ctl.org (web address)*

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Part I.
Reimbursement Overview
And Legislation

STATE LEGISLATION IMPACTING TELEMEDICINE REIMBURSEMENT

Introduction

The absence of consistent, comprehensive reimbursement policies is often cited as one of the most serious obstacles to total integration of telemedicine into health care practice. This lack of an overall telemedicine reimbursement policy reflects the multiplicity of payment sources and policies within the current United States health care system. The vast majority of health care costs are paid by private insurers, Medicare, and Medicaid.

Partial Medicare reimbursement for telehealth services was authorized in the Balanced Budget Act (BBA) of 1997. The narrow scope of this reimbursement prompted efforts towards expansion and revision of the Medicare reimbursement regulations. The Benefits Improvement and Protection Act of 2000 (BIPA) included amendments to the Social Security Act and removed some of the prior constraints, yet maintained substantial limitations related to geographic location, originating sites, and eligible telehealth services.

Unlike Medicare, most state Medicaid programs provide reimbursement for health care-related transportation costs. A number of states with telemedicine programs entered into collaboration with state Medicaid programs to develop telemedicine reimbursement policies, often with the anticipation that telemedicine could offer transportation cost savings. Currently, 27 state Medicaid programs acknowledge at least some reimbursement for telehealth services. The most rapid expansion is in the area of behavioral health. Other state Medicaid agencies are amenable to establishing or enhancing telemedicine reimbursement policies, but are facing serious budget constraints; therefore, addition of any new coverage or services must be based on solid cost and benefit data.

As with Medicaid, regulations for telemedicine reimbursement by private insurers are set by the states. Five states have enacted laws requiring that services provided via telemedicine must be reimbursed if the same service would be reimbursed when provided in person. Some insurance programs cover specific telehealth services, e.g., behavioral health. Even in the absence of a definitive policy, some insurers and Medicaid agencies will reimburse for telemedicine services as long as the rationale for using telemedicine is justified to the agency's satisfaction. State waivers or special programs offering remote diagnostics, remote monitoring for specific disease entities or for particular populations, allow additional coverage of telemedicine services. A few states simply pay claims regardless of whether the encounter was in person or via telemedicine. Introduction of managed care, for both Medicaid and the private sector, complicates the telemedicine reimbursement picture, since a number of state programs acknowledge use of telemedicine within managed care but not to keep specific utilization data. In many cases, state Medicaid managed care and fee-for-service are separate programs with separate guidelines.

The array of non-traditional payers for telemedicine include charitable organizations (including foundations), long-term care and community health providers, special population agencies, self-pay and self-insured groups. Although telemedicine payment policies are evolving at a steady

but somewhat erratic pace, limited reimbursement continues to be a major barrier to the expansion of telemedicine. This barrier may preclude timely, quality, appropriate care for patients throughout the nation--especially those in rural or underserved areas.

Part I of this report includes a roster of state laws impacting telemedicine reimbursement and 2003 state legislative activity related to state reimbursement for telemedicine. Part II includes the results of a comprehensive survey of state Medicaid agencies to determine their telemedicine reimbursement policies, followed by recommendations to enhance telemedicine reimbursement through Medicaid.

OVERVIEW OF MAJOR PAYERS AFFECTING REIMBURSEMENT

Medicare

Medicare is the federal health insurance for America's senior citizens. Most of the financing and reimbursement for telemedicine services comes from Medicare. The Center for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), provides health insurance for over 75 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The expanding role of Medicare in reimbursement began when Congress passed the Balanced Budget Act of 1997 (BBA) that mandated that Medicare reimburse telemedicine care and fund telemedicine demonstration projects.

The BBA called for the coverage and payment for telemedicine consultations to Medicare beneficiaries in rural health professional shortage areas (HPSA). The BBA also required that a Medicare practitioner be with the patient at the time of the consultation and specified that teleconsultant fees had to be shared between the consulting physician and the referring physician. These new rules were seen, by some, to be too restrictive while attempting to implement telemedicine reimbursement schemes. The new statutory language did not match the practical realities of telemedicine practice. Under the BBA, Medicare rules required that a telehealth provider be present to be eligible for Medicare reimbursement. These requirements essentially limited the reimbursement to "live" telemedicine services, which constitute only about 10% of telemedicine services.

There was some hesitation about amending the BBA because of worries that telemedicine reimbursement would somehow threaten the Medicare trust fund. The HCFA had to ensure that health care expenditures did not outstrip funding, a major challenge given the growing senior citizen population.

A major concern in revising the telemedicine reimbursement provisions was the exceedingly high cost ("scoring") affixed to telemedicine reimbursement legislation by the Congressional Budget Office (CBO). In 2000, the Center for Telemedicine Law, with funding from the Office

for the Advancement of Telehealth, coordinated a project to use available telemedicine reimbursement claims data to develop a more accurate funding projection. The results of this project clearly indicated that expanding telemedicine reimbursement would have minimal financial impact. Data from this report was accepted by CBO in scoring proposed telemedicine reimbursement revisions.

After several attempts to amend current law and refine telemedicine reimbursement, the push to improve rural access to telemedicine prevailed in mid-December 2000, when Congress passed the final of its 13 appropriation bills, the Consolidated Appropriations Act of 2001 (CAA). In addition to appropriating funds for Departments of Labor, HHS, and Education, this bill contained a number of smaller bills such as one dealing with telemedicine reimbursement (H.R. 5661, Section 223).

Beginning October 1, 2001, H.R. 5661, also known as the Benefits Improvement and Protection Act of 2000 (BIPA), amended section 1834 of the BBA to provide for a new subsection (m) "Payment for Telehealth Services" which expanded the payment for telemedicine services. However, BIPA also limited reimbursement to those eligible individuals that received services at originating sites. These sites include: office of a physician or practitioner, critical access hospital, rural health clinic, federally qualified health center, or a hospital.

This amendment provided for an expansion of Medicare payment for telehealth services. The newly passed provisions expand the scope of reimbursement by not requiring a telepresenter and adding additional services over a broader geographic area. Among the provisions passed were the following:

- eliminated the provider "fee sharing" requirement;
- eliminated the requirement for a Medicare participating "tele-presenter";
- allowed Originating Sites to be paid a fee of \$20 per visit to recover facility costs, with increases commencing in 2003;
- expanded telemedicine services to include direct patient care, physician consultations, and office psychiatry services;
- included payment for the physician or practitioner at the Distant Site at the rate applicable to services generally;
- expanded the definition of Originating Sites to include physician and practitioner offices, critical access hospitals, rural health clinics, federally qualified health centers, and hospitals (but did not include nursing homes);
- expanded the geographic regions in which Originating Sites are located to include rural health professional shortage areas, any county not located in a Metropolitan Statistical Area, and from any entity approved for a federal telemedicine demonstration project; and
- permitted use of store and forward applications in Alaska and Hawaii for federal demonstration projects.

These Medicare reimbursement revisions were expected to expand the access of medical care to rural and other medically underserved areas. Just as importantly, it was anticipated that improved Medicare reimbursement would also pave the way for broader private payer reimbursement.

Medicaid

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. In 1965, this program became known as Medicaid and became law as a joint operation funded by both the Federal and State governments. Following Federal guidelines, a state may (1) establish its own eligibility standards; (2) determine the type, amount, duration, and scope of services; (3) set the rate of payment for services; and (4) administer its own program.

However, some Federal requirements are mandatory if Federal matching funds are to be received. A state's Medicaid program *must* provide specific basic services to the categorically needy populations. These services are: inpatient hospital services, outpatient hospital services, prenatal care, vaccines for children, physician services, nursing facility services for persons aged 21 or older, family planning services and supplies, rural health clinic services, home health care for persons eligible for skilled-nursing services, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse-midwife services, federally qualified health-care services, ambulatory services of an FQHC that would be available otherwise, and early periodic screening, diagnostic, and treatment services for children under age 21.

A significant development in Medicaid is the growth in managed care as an alternative service delivery concept, different from the traditional fee-for-service system. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers give states greater power and flexibility in their state Medicaid designs. Under sections 1915(b) and 1115 of the Social Security Act, these waivers allow states to develop innovative health care delivery or reimbursement systems and allow for statewide health care reform experimental systems without increasing costs.

CMS has not formally defined telemedicine for the Medicaid program, and Federal Medicaid law does not recognize telemedicine as a distinct service. But, reimbursement for Medicaid services is one of the options states have as a cost-effective alternative to the more traditional ways of providing medical care (face-to-face exams).

Telemedicine is an important component of the future of medicine, and it can be the answer to many problems that are faced today with health care. The practice of telemedicine utilizes technology for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care and better communication among providers.

At least 27 states have acknowledged some reimbursement for services provided via telemedicine for several reasons, such as improved access to specialized health care in rural areas and reduced transportation costs. There are many factors states use to determine the scope of coverage for telemedicine applications, such as the quality of equipment, type of services to be provided, and location of providers (e.g., remote rural sites).

Reimbursement for Medicaid-covered services, including those with telemedicine applications, must also satisfy federal requirements of efficiency, economy, and quality of care. With this in mind, states are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology. For example, states covering medical services that utilize telemedicine may reimburse for both the provider at the hub site for the consultation and the provider at the spoke site for an office visit. States also have the flexibility to reimburse any additional cost (i.e., technical support, line-charges, depreciation on equipment, etc.) associated with the delivery of a covered service by electronic means as long as the payment is consistent with the requirements of efficiency, economy, and quality of care. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the State. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service.

Private Payers

Another barrier to the expansion of telemedicine is a lack of reimbursement for services from private insurance providers. In addition to Medicare and Medicaid payments for telemedicine, several Blue Cross/Blue Shield plans, as well as other private insurers, pay for telemedicine services. The telehealth market operates on the assumption that private payers do not pay for telemedicine and will resist any kind of claims if asked. However, AMD Telemedicine conducted a survey that found that there is a critical mass for private payer reimbursement. According to their findings, 38 programs in 25 states currently receive reimbursements from private payers. Three programs receive reimbursement for store and forward, and seven programs receive reimbursement for facility fees. While the market assumption is that private payers do *not* reimburse for telemedicine, in reality over 100 private payers currently reimburse for telemedicine.

Several states have passed legislation mandating private payer reimbursement of telemedicine services. These states include: Louisiana, California, Oklahoma, Texas, and Kentucky. More private insurers are funding limited telemedicine coverage in certain states. For example, the California Managed Risk Medical Insurance Board awarded \$1.8 million to Blue Cross California to expand their telemedicine technology and help to encourage expansion of telehealth services. Blue Cross plans to use the money to help serve the medically underserved populations and provide equipment and support to 22 new telemedicine sites in 18 counties.

The American Telemedicine Association and AMD Telemedicine have created a Private Payer Reimbursement Directory based on a survey they conducted. The directory contains a listing of telemedicine providers receiving private payer reimbursement, private payers providing reimbursement, and state legislation mandating private payer reimbursement of Telemedicine services. This can be found at the website: http://www.americanmeddev.com/private_payer/about_survey.cfm.

State Reimbursement Policies

Several states reimburse for medical services based on policy or on a case-by-case basis rather than by codified state laws. The information in the accompanying charts is based solely on the state telemedicine reimbursement laws that have been enacted or legislation affecting reimbursement. The CMS website offers a list of states where Medicaid reimbursement of services utilizing telemedicine is available. However, according to CMS, this listing has not been updated in about three years.

More states are beginning to enact legislation acknowledging telemedicine as a legitimate medical service, and many of these states have enacted telemedicine reimbursement laws, and incorporated them into their respective state codes. These eleven states are: Arizona, California, Colorado, Hawaii, Kentucky, Louisiana, Minnesota, Nebraska, Oklahoma, Texas, and Virginia. In addition to these states, four more have enacted state legislation concerning telemedicine reimbursement. These states are: Massachusetts (S 503, SC 1252), New Mexico (NM H 665), New York (A 7155, S 463), and Oregon (HJR 4). There are several other states where Medicaid reimbursement for telemedicine is available; however, this report is only focused on those states with enacted state statutes or legislation.

While states are becoming more aware of this new medical technology called telemedicine, five states with telemedicine reimbursement enacted codes will not reimburse for services that are provided via phone or fax (Hawaii, Kentucky, Oklahoma, California, and Minnesota). Some of these states have a definition of telemedicine or telehealth that blurs the line between what is reimbursable as telemedicine and what is not. For example, Hawaii offers a broad definition of telehealth as the “use of telecommunications services. . . to deliver health care and health care service and information to parties separated by distance.” On the other hand, Kentucky defines telehealth more narrowly as the use of interactive audio, video, or other electronic media to deliver health care. The trend towards telemedicine consultations made through electronic media, two-way interactive video, or store and forward techniques is strong and growing. The overwhelming consensus is that consultation via telephone conversations or faxes is not eligible for reimbursement.

The purpose of telemedicine is to remove distance as a barrier to health care. Special telemedicine programs are now starting to be used to assure that physically and mentally needy individuals receive the best care medically possible. In Minnesota, state statutes provide funding for medical assistance and telehome care devices to improve the quality of life of needy patients. Nebraska has established a telehealth system to provide access for deaf and hard-of-hearing persons in remote locations to mental health, alcoholism, and drug abuse services. Pending legislation in other states, such as Hawaii and California, illustrates a movement toward utilizing telemedicine as a way to reach those with special needs and those in need of behavioral health care services.

Where does the money go? Six of the 11 states enacting state reimbursement laws have specifically addressed the manner in which physicians should be reimbursed. The trend seems to be that telemedicine consultations should be reimbursed at the full allowable rate or at the same rate as provided by medical assistance for a comparable in-person examination/consultation. Of the

six states, only Louisiana set the reimbursement rate lower by states that the physician will be reimbursed for not less than 75% of the reasonable and customary amount of payment. Legislation in other states, for example California, will provide mental health providers with equal reimbursement as providers of acute psychiatric inpatient hospital services.

What's Next?

The world is changing, and along with this change comes a new wave of technology. This new high-tech world has the power of minimizing distance as a barrier to health care. With the help of telemedicine, optimum health care can be available to patients around the world and right in their own backyard. One of the barriers to telemedicine becoming completely integrated into the US medical system is the absence of consistent, federal and state reimbursement policies. In order to optimize this new world of telemedicine, the financial challenges of reimbursement must be confronted. Within each of the major payer groups changes must occur.

The advancement of telemedicine promotes access to services, increases competition, has the potential to reduce costs, and is a good investment. AMD Telemedicine suggests that private payers treat telemedicine services as usual and customary medical practices, instead of singling it out and requiring a special modifier on the claim. Their survey shows that certain telemedicine programs have been successful in obtaining private-payer reimbursement by sending a letter to private payers and stating their intent to provide services, providing notification of future claims submittals, and encouraging questions. The Office for Advancement of Telehealth has indicated a willingness to collaborate with CMS, state Medicaid programs, and private third payers to create forums to encourage discussion of telemedicine reimbursement issues.

At the recent Second Annual Telehealth Leadership conference on June 2 - 4, 2003 in Washington, DC, several suggestions for Medicare Reform for Telehealth were discussed and included in a Fact Sheet for dissemination to Congress, including inclusion of provisions that were deleted from BIPA 2000. The leadership conference participants agreed that any new Medicare language should include the following corrections to the existing telemedicine Medicare regulations:

1. Add the following to the list of eligible originating sites for Medicare reimbursement: Skilled Nursing Facilities, Community Mental Health Centers (or other publicly funded mental health facility), and Indian Health Service sites.
2. Allow the Secretary the discretion to expand Medicare reimbursement for store and forward telehealth services beyond Alaska and Hawaii.
3. Make provider reimbursement independent of the Originating Site fee. Inappropriate restrictions were placed on practitioners' reimbursement by linking their professional payment only to sites eligible for facility fees. For example, a practitioner providing a telehealth service to an assisted living facility would not be reimbursed because that is not an eligible site for a Medicare telehealth facility fee.

Conclusion

Each of these measures represents small steps in promoting the future of telemedicine. The federal government has passed statutes that demonstrate its willingness to promote telemedicine, but these provisions do not go far enough in providing physicians and healthcare organization incentives to implement costly telemedicine programs. As illustrated by the map(s), there is a movement in much of the United States to incorporate some kind of reimbursement for telemedicine. However, these policies are not uniform, making application for and receiving payments difficult for health care providers and patients. In order for telemedicine to thrive, reimbursement must be a joint effort between the states, federal government, and private payers to help establish a reimbursement scheme that promotes the best interests of the patient and creates an environment in which the best health care possible is available to all those in need.

Sources:

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STATE TELEMEDICINE REIMBURSEMENT LAWS (ENACTED)

CITATION	PROVISIONS
<p>Arizona</p> <p>H.B. 2531, 2003 Ariz. Sess. Laws.</p>	<p>Appropriates funds for the use of telemedicine in immunization as well as \$1.16 million for a telemedicine network.</p>
<p>California</p> <p>Cal. Ins. Code § 10123.85 (Deering 2003)</p> <p>Cal. Ins. Code § 10123.13 (2003).</p> <p>Cal. Ins. Code § 10123.147 (2003).</p> <p>Cal. Health & Saf. Code § 1375.1 (Deering 1999).</p> <p>Cal. Wel. & Ins. Code § 14132.72 (Deering 1999).</p> <p>Cal. Health & Saf. Code § 1374.13 (Deering 1999).</p>	<p>On and after January 1, 1997, no disability insurance contract that is issued, amended, or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine.</p> <p>Requires every insurer issuing group or individual policies of disability insurance that cover medical, hospital, or surgical expenses, including telemedicine services, shall reimburse each claim as soon as practical but no later than 30 working days after receipt of the claim.</p> <p>Same as above (§ 10123.13), expands on procedure for contested claims.</p> <p>Requires that all health care service plans under the Knox-Keene Act have a procedure for the prompt payment or denial of claims, including those of telemedicine services.</p> <p>Provides reimbursement for telemedicine by Medi-Cal for health care services that are otherwise covered through Medi-Cal. Specifically excludes telephone and fax.</p> <p>Amends Medi-Cal contracts with health care service plans to add coverage of telemedicine and make any capitation rate adjustments.</p>

STATE TELEMEDICINE REIMBURSEMENT LAWS (ENACTED)

<p>KRS Acts 130 (2002)</p> <p>KRS Acts 430 (2002)</p>	<p>Defines telehealth as the use of interactive audio, video, or other electronic media to deliver health care.</p> <p>Authorizes the commissioner, to the extent that he finds it feasible and appropriate, require the use of telemedicine and telehealth in the independent medical evaluation process.</p>
<p>Louisiana</p> <p>La. R.S. 22:657 (2003).</p> <p>La. R.S. 45:835 (1999).</p>	<p>Requires insurance or health benefit policies to pay for any health care service provided for in the plan regardless if that service is preformed via telemedicine or face-to-face. The physician at the “originating health care facility or terminus who is physically present with the individual who is the subject” will be reimbursed for not less than 75% of the reasonable and customary amount of payment. Also adds that any health care service performed by telemedicine is subject to the applicable utilization review criteria and requirements of the insurer.</p> <p>Creates the Coordinating Counsel on Telemedicine and Distance Education. Repealed by Acts 2001, No. 1137, § 1.</p>
<p>Minnesota</p> <p>Minn. Stat. § 256b.0913 (2001).</p> <p>Minn. Stat. § 256b.0625 (1999).</p>	<p>Provides funding for “telehome care” devices to monitor patients in their homes if they qualify for the Minnesota Alternative Care Program. (Amendment substitutes the word “telehome care” in place of “telemedicine”.)</p> <p>Provides for medical assistance coverage for telemedicine consultations, with payments to be made to both the referring provider and the consulting physician specialist.</p> <p>To be covered under medical assistance,</p>

STATE TELEMEDICINE REIMBURSEMENT LAWS (ENACTED)

<p>Minn. Stat. § 256b.0913 (1998).</p> <p>Minn. Stat. § 256b.0913 (1998).</p>	<p>telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.</p> <p>Provides funding for telemedicine devices to monitor patients in their homes if they qualify for the Minnesota Alternative Care Program.</p> <p>Minnesota Medical Assistance for Needy Persons. Amended by 1999 Minn. ALS 245, specifically including telemedicine as covered under medical assistance. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation.</p>
<p>Nebraska</p> <p>NE ALS 49 (2002)</p> <p>NE L.B. 559 (1999).</p>	<p>Establishes a telehealth system to provide access for deaf and hard-of-hearing persons in remote locations to mental health, alcoholism, and drug abuse services. The commission shall set and charge a fee between \$20 and \$150 per hour for use of the telehealth system.</p> <p>The Nebraska Telehealth Act provides reimbursement for health care services delivered through telehealth under the Medicaid fee-for-service program; amends managed care plans to cover services delivered</p>

STATE TELEMEDICINE REIMBURSEMENT LAWS (ENACTED)

	<p>via telehealth. Sets the minimum reimbursement rate for telehealth consultations at the same rate as provided by medical assistance for a comparable in-person consultation.</p>
<p>Oklahoma</p> <p>36 Okla. Stat. Tit. §6802 (1997, 1998, 2002, 2003).</p> <p>36 Okla. Stat. Tit. § 6803 (1997, 1998, 2003).</p> <p>36 Okla. Stat. Tit. § 6804 (1997, 1998, 2003).</p> <p>17 Okla. Stat. Tit. § 139.109 (2002).</p>	<p>Defines telemedicine as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Excludes consultations by telephone or fax machines.</p> <p>For services that a health care provider determines to be appropriately provided by means of telemedicine, health care service plans, disability insurance, workers comp, or state Medicaid shall not require person-to-person contact. Telemedicine services are covered by, and reimbursed under, the fee-for-service provisions of the state Medicaid managed care program and state Medicaid managed care program contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.</p> <p>Informed consent provision for the use of telemedicine. Specifies that the health care practitioner who is in physical contact with the patient has ultimate authority over the care of the patient and is accountable for ensuring that patient information is provided. Consultations between health care practitioners are exempted.</p> <p>Each not-for-profit hospital in this state shall, upon written request, receive, free of charge, one telecommunications line or wireless connection sufficient for providing such telemedicine services as the hospital is equipped to provide. The telecommunications</p>

STATE TELEMEDICINE REIMBURSEMENT LAWS (ENACTED)

<p>OK. H.C.R. (1999).</p> <p>36 Okla. Stat. Tit. § 6801 (1997, 1998).</p>	<p>carrier shall be entitled to reimbursement from the Oklahoma Universal Service Fund for providing the line or connection. In no case, however, shall reimbursement from the fund be made for an Internet subscriber fee.</p> <p>House concurrent resolution calling on Congress to require HCFA to revise Medicare to make payments to health care providers that encourage telemedicine.</p> <p>Short title for “Oklahoma Telemedicine Act.”</p>
<p>Texas</p> <p>Tex. Ins. Code art. 21.53F (2002)</p> <p>Tex. Occ. Code § 153.004 (2001).</p> <p>Tex. Gov’t Code § 531.0216 (2001).</p>	<p>Provides definition of health benefit plan, health professional and telemedicine service. Specifies plans covered by this act. States that “a health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation.” Providers must adhere to informed consent and confidentiality guidelines. Reaffirms that the medical board has oversight of the quality of care provided through telemedicine or telehealth encounters.</p> <p>Permits the board to adopt rules to ensure that appropriate care is provided to Medicaid and Medicare patients who receive telemedicine medical services and to prevent abuse and fraud.</p> <p>Amends § 531.0215. In developing a system to reimburse telemedicine providers under the Medicaid program, the commission must consult with the Texas Department of Health and the telemedicine advisory committee, establish pilot programs under which the commission may reimburse a health professional who participates, and establish a separate provider identifier for telemedicine medical services providers.</p>

STATE TELEMEDICINE REIMBURSEMENT LAWS (ENACTED)

<p>Tex. Gov't Code § 531.02161 (2001).</p>	<p>The commission by rule shall establish policies that permit reimbursement under the state Medicaid and children's health insurance program for services provided through telemedicine medical services and telehealth services to children with special health care needs. The policies must be designed to provide for reimbursement of multiple providers of different services who participate in a single telemedicine medical service if the commission determines it to be cost-effective.</p>
<p>Tex. Gov't Code § 531.02161 (2001). Note: there are two sections 531.02161.</p>	<p>The commission and the Telecommunications Infrastructure Fund Board by joint rule shall establish and adopt minimum standards for an operating system used in the provision of telemedicine medical services by a health care facility participating in the state Medicaid program, including standards for electronic transmission, software, and hardware.</p>
<p>Tex. Gov't Code § 531.0217 (2001).</p>	<p>The commission by rule shall require each HHS agency that administers a part of the Medicaid program to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician at the same rate as the Medicaid program reimburses for a comparable in-person medical service. A health care facility that receives reimbursement shall establish quality-of-care protocols and patient confidentiality guidelines to ensure that the telemedicine medical service meets legal requirements and acceptable patient care standards.</p>
<p>Tex. Gov't Code § 531.02172 (2001).</p>	<p>Establishes the Telemedicine Advisory Committee to monitor the types of telemedicine programs receiving reimbursement.</p>
<p>Tex. Gov't Code § 531.0215 (1999).</p>	<p>Requires Texas HHS to develop and implement a system to reimburse telemedicine providers under the state Medicaid program. In doing so HHS must review programs, establish billing codes and fees, and provide an approval process before a provider can be</p>

2003 STATE LEGISLATION IMPACTING REIMBURSEMENT FOR TELEMEDICINE AND TELEHEALTH

BILL	PROVISIONS	ACTION
Arizona S 1230	Concerns money allocation from tobacco tax for telemedicine pilot programs in medically underserved areas by the Health Care Cost Containment System.	2/20/03 Held in Senate Committee on Health
California A 939	Provides that mental health providers that provide services to Medi-Cal beneficiaries under a contract with a provider of psychiatric inpatient hospital services and mental health providers that provide mental health services to Medi-Cal beneficiaries through telemedicine shall be reimbursed in the same manner as providers of acute psychiatric inpatient hospital services.	3/03/03 To Assembly Committee on Health
Hawaii S 1647	Appropriates funds from the universal service program special fund to provide individuals who are blind or visually impaired with telephonic access to time-sensitive information.	4/15/03 To Conference Committee
Massachusetts S 503 SC 1252	Authorizes and directs the Division of Health Care Finance and policy and the Division of Medical Assistance to establish a rate of reimbursement for home health agencies that allow for the use of technology. Relates to Medicaid telemedicine services program.	1/1/03 To Joint Committee on Health Care Profile, language of legislation pending study group report
New Mexico NM H 665	The New Mexico Telehealth Act. Specifies rationale for the bill, defines terms and adds language stating: "The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in New Mexico. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in telehealth	1/27/03 Do Pass from Senate Committee on Health, Human Services and Senior Citizens

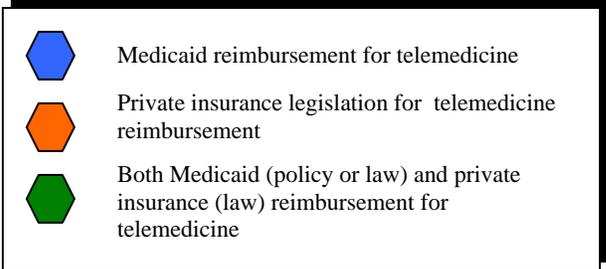
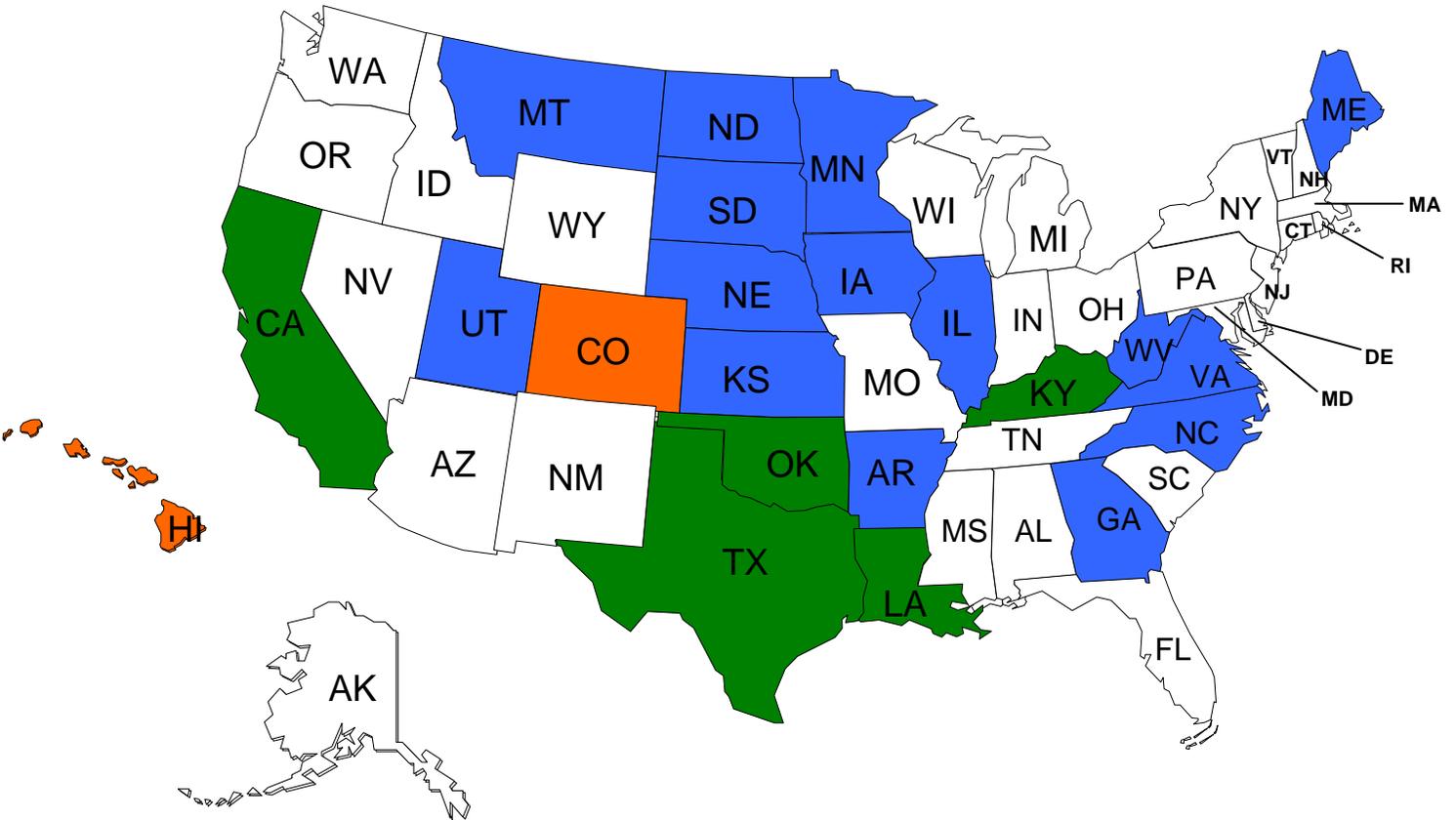
2003 STATE LEGISLATION IMPACTING REIMBURSEMENT FOR TELEMEDICINE AND TELEHEALTH

	<p>pursuant to the New Mexico Telehealth Act. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines.”</p>	
<p>New York A 7155 (also S 463)</p>	<p>Establishes a statewide telemedicine/telehealth task force to make recommendations to the governor and legislature on the development of telemedicine and telehealth systems, standards in the applications of such systems, changes in licensure and certification verification necessary to effectuate such systems, and the methodology for determining payments due for health care service provided by means of such systems.</p>	<p>3/24/03 To Assembly Committee on Health S 463: From Senate Committee on Health</p>
<p>Oregon HJR 4</p>	<p>“Whereas the Oregon Telecommunication Coordinating Council recommends that telemedicine reimbursement policies apply to all Oregonians; now, therefore, Be It Resolved by the Legislative Assembly of the State of Oregon:</p> <p>(1) That we, the members of the Seventy-second Legislative Assembly, encourage and support the following policies for telemedicine reimbursement in the State of Oregon:</p> <p>(a) Medical providers who are reimbursed for services provided in person should be reimbursed for the same services when provided via telecommunications.</p> <p>(b) Any clinical service or diagnosis that is reimbursed when provided in person and that can be delivered appropriately via telecommunications should be eligible for reimbursement.</p> <p>(c) With the exception of medically appropriate 'store and forward' technology to deliver clinical services or diagnoses, reimbursable services should include clinician-to-patient services and not clinician-to-clinician services.</p> <p>(d) A patient informed consent document should be used for telemedicine services. This document should contain the components outlined in a model informed consent document.</p> <p>(e) A patient should have the right to choose either telemedicine or in-person services when</p>	<p>4/8/03 Passed Senate</p>

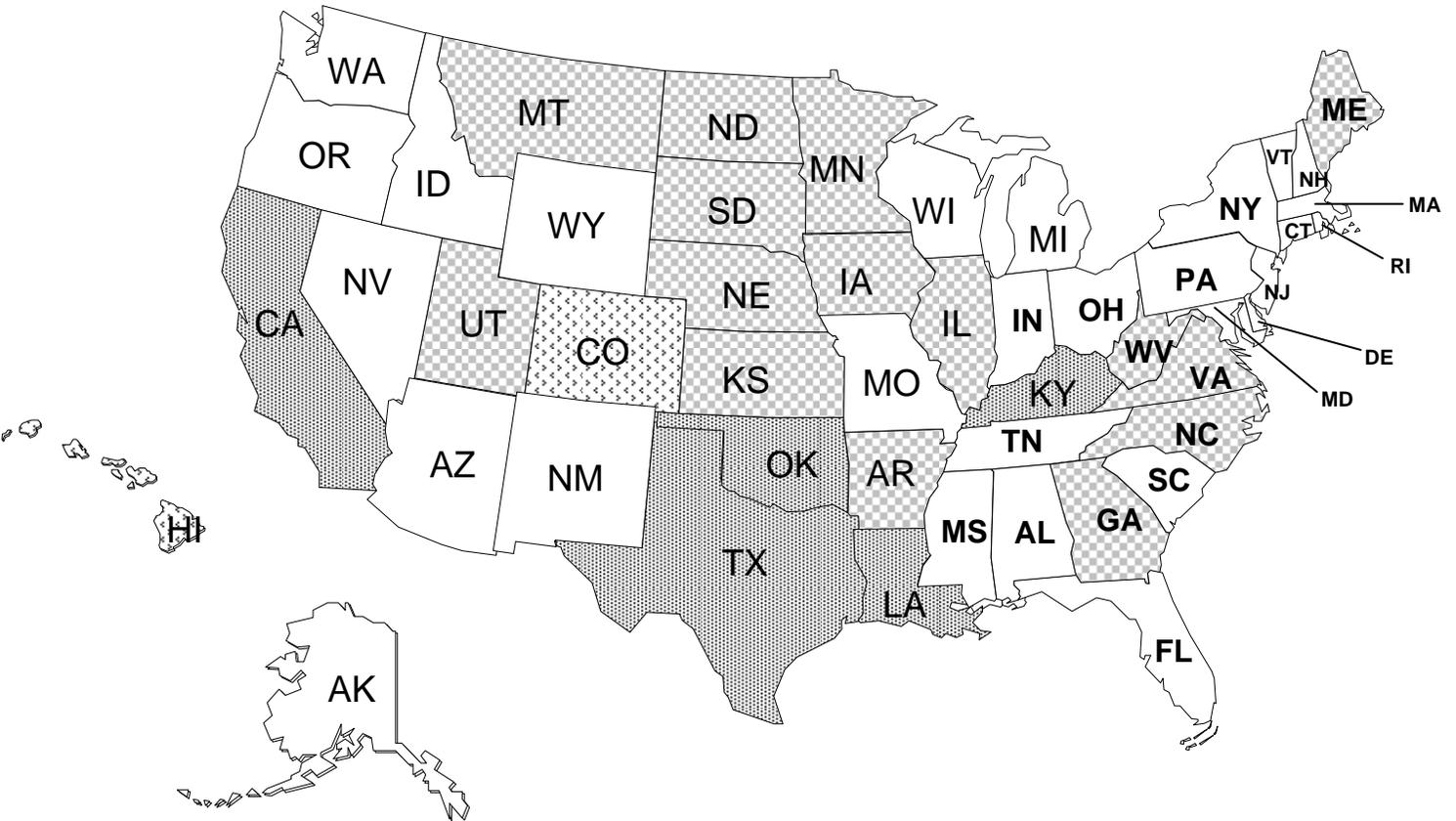
2003 STATE LEGISLATION IMPACTING REIMBURSEMENT FOR TELEMEDICINE AND TELEHEALTH

<p>Oregon SJR 6</p>	<p>both are available. (f) Payers should consider transmission costs when reimbursing for telemedicine services. (2) That as used in this resolution, 'telemedicine' means using telecommunications technology to deliver healthcare, including but not limited to clinical diagnosis, clinical services and patient consultation.”</p> <p>Expresses legislative views on reimbursement policies for medical services provided via telecommunications (same text as HJR 4).</p>	<p>2/17/03 To Senate Committee on Human Resources</p>
<p>Texas S 691 H 3531</p>	<p>Relates to reimbursement for telemedicine medical services under the Medicaid program and other government-funded programs.</p>	<p>4/14/03 From Senate Committee on Health and Human Services--reported favorably with amendment</p>

Telemedicine Reimbursement (Authorized by State Codes)



Telemedicine Reimbursement (Authorized by State Codes)



	Medicaid reimbursement for telemedicine
	Private insurance legislation for telemedicine reimbursement
	Both Medicaid (policy or law) and private insurance (law) reimbursement for telemedicine

Telemedicine Reimbursement Chart*

State	Medicaid reimbursement for telemedicine (by law or legislation)	Private insurance legislation for telemedicine reimbursement	Both Medicaid (legislation or law) and private insurance (law) reimbursement.	No reimbursement in state statutes
Alabama				X
Alaska				X
Arizona				X
Arkansas	X			
California			X	
Colorado		X		
Connecticut				X
Delaware				X
District of Columbia				X
Florida				X
Georgia	X			
Hawaii		X		
Idaho				X
Illinois	X			
Indiana				X
Iowa	X			
Kansas	X			
Kentucky			X	
Louisiana			X	
Maine	X			
Maryland				X
Massachusetts				X
Michigan				X
Minnesota	X			
Mississippi				X
Missouri				X
Montana	X			
Nebraska	X			
Nevada				X
New Hampshire				X
New Jersey				X
New Mexico				X
New York				X
North Carolina	X			
North Dakota	X			
Ohio				X
Oklahoma			X	
Oregon				X
Pennsylvania				X
Rhode Island				X
South Carolina				X
South Dakota	X			
Tennessee				X
Texas			X	
Utah	X			
Vermont				X
Virginia	X			
Washington				X
West Virginia	X			
Wisconsin				X
Wyoming				X

*Based on current enacted state statutes.

Part II.
Medicaid State Agency Survey

MEDICAID STATE AGENCY SURVEY

Introduction

The lack of consistent reimbursement policy for telemedicine services is a frequent topic of discussion among telemedicine providers as well as policy makers. Many observers believe that until reimbursement is more consistently available, telemedicine cannot fully be incorporated into health care practice as a viable practice modality. As noted earlier, the primary sources for health care reimbursement are Medicare, private insurers, and state Medicaid programs. Since Medicare is a federal program and reimbursement policies are based on federal law, a number of state agencies seem to view the Medicare reimbursement policies as the “benchmark” for telemedicine reimbursement. Reimbursement standards for both Medicaid and private insurance are set at the individual state level, resulting in substantial variation from state to state and often from program to program within individual states. The survey of state private payers was discussed earlier in this report; this section will focus on the results of the survey of state Medicaid agencies.

Project Description

Since state Medicaid telemedicine reimbursement policies have the potential to impact the long term viability of existing telemedicine programs, several attempts have been made to ascertain details of state Medicaid telemedicine reimbursement policies. For the most part, prior surveys involved contacting telemedicine providers to assess their experience with Medicaid reimbursement. Individual provider experiences varied widely, based not only on state Medicaid policy, but also on the particular population served by the telemedicine program.

This study was designed to directly contact state Medicaid agencies and, based on a questionnaire, to gather reimbursement information. The intent was to determine whether the state has an official policy for reimbursing for telemedicine, whether the state is considering development of such policy or has no plans to reimburse for telemedicine. For states that reimburse for telemedicine, the objective was to identify reimbursement policy information, identify and obtain utilization data, and identify any cost savings or offsets to transportation expenses. It had been anticipated that transportation costs, paid through Medicaid but not Medicare, would be an important variable in whether states were open to paying for telemedicine services. Medicaid agencies were also queried about their knowledge of or involvement with state telemedicine projects, whether managed care was impacting their policies, as well as whether their current state budgetary situation was impacting the agency and/or the telemedicine reimbursement policies. State agencies were queried about participation in pilot projects, waiver programs, or demonstration projects. Each agency was asked about whether any changes in reimbursement policy are anticipated, whether to begin reimbursement or change existing policies.

Although the original plan was to schedule appointments and conduct telephone interviews, two important variables surfaced. Except for those few states that have designed a “point of contact” for telemedicine policy, finding the state agency person with knowledge about telemedicine was problematic. In many cases, multiple calls and inquiries were necessary to locate a person within the Medicaid agency that was knowledgeable about telemedicine. Typically, the calls wound up in the state Medicaid Policy Division or the unit responsible for decisions about inclusion of new Medicaid services. In many cases, the state Medicaid policy section, which makes decisions about reimbursement, did not have knowledge about actual reimbursement decisions or utilization. It was not unusual to be referred from one agency to another before finding someone who could address telemedicine reimbursement. In those states not currently reimbursing for telemedicine nor engaged in active discussion about adding reimbursement, a frequent response was that the agency had not received any requests for telemedicine reimbursement, so assumed that no policy change was imminent. A second dilemma was that, even though the initial plan was to schedule interviews, it quickly became apparent that state Medicaid agency personnel are functioning under intense time pressure, so the only choice was to ask the as many relevant questions as possible during the time that calls were returned.

Some states with more formal telemedicine reimbursement programs have designated a central contact person for telemedicine. These individuals tended to be much more involved with the details of their state reimbursement programs. Many of these individuals had either visited a telemedicine program or were knowledgeable about the services offered. A further factor in gathering information was that many Medicaid agencies have separate state units for fee-for-service and managed care programs. The programs within the fee-for-service division utilize the typical billing processes, but managed care programs often have the latitude to expend funds in any matter deemed effective and efficient in meeting the needs of the patient base. Several state contacts were under the impression that the managed care section allowed use of telehealth, but did not have a mechanism to identify determine use or collect data on utilization of telemedicine services.

Yet another confounding discovery was that, in many states, even when the central policy agency was unaware of any discussions about telemedicine reimbursement, specific programs such as behavioral health and home health were either implementing or considering policies to cover telemedicine. Often, policies for these programs were developed and implemented separately from the policies of the “mainstream” Medicaid services. In several instances, the Medicaid agency denied knowledge of any pending telemedicine reimbursement deliberations for new services, yet local telemedicine providers indicated that discussions were indeed underway with the agency in an effort to change policy. It was obvious that in some states, such as Pennsylvania, Florida and New Mexico, the Medicaid agency is considering telemedicine reimbursement from a “big picture” policy perspective in terms of state population based health needs. Other states’ reimbursement programs seem to have evolved based on the initiative of one or more telehealth providers who pushed for reimbursement for the services provided by their program.

Many state Medicaid agencies indicated that radiology and pathology are covered services, but a number of states did not distinguish whether the service was performed through “tele” methodology. The American College of Radiology suggests that over 80% of radiology

reimbursement policies are set at the state level. Many states tend to pattern reimbursement after the Medicare program. The College is not aware of any expressed concerns of radiologists about their reimbursement from state Medicaid agencies. A number of states indicated that their policies reference “prevailing standards of practice.” Several agencies were under the impression that using electronic means to transfer radiology images is simply the current “prevailing standard of practice” and were not clear about the distinction between that and telemedicine. Thus, as more and more technology-based services are incorporated into practice, at what point are telemedicine consultations seen as the “prevailing standard or practice”?

From the survey of state Medicaid agencies, the following results are of particular significance to future telemedicine reimbursement endeavors:

- At the present time, at least 27 state Medicaid agencies indicate that they are reimbursing for at least for some telemedicine services. Of the 23 that do not presently reimburse, at least seven are interested in or considering establishment of reimbursement policies.
- The state Medicaid program structure may or may not designate a role for coordination of all telehealth reimbursement policies. Behavioral/mental health, managed care, and/or home care may be managed by separate units and may utilize and reimburse for telemedicine within their respective programs.
- States with substantial managed care programs tended to establish separate divisions or sections and employed separate policies for fee-for-service and managed care.
- Managed care agencies tended to focus on outcomes and quality indicators and allowed substantial latitude about the methods by which the services were provided.
- A number of state transportation programs were provided through a managed care contract, thus any savings resulting from use of telemedicine would accrue to the vendor rather than to the state Medicaid program.
- A number of state Medicaid agency personnel indicated that if or when their states began to reimburse for telemedicine, they would likely emulate Medicare guidelines. Most were unaware of Medicare limitations on reimbursement and denied that their intent was to reimburse only in rural areas or from specific originating sites.
- In states that are not reimbursing for telemedicine, most had not given substantial consideration to any potential cost savings for transportation. Almost all states indicated that they were very interested in data from other Medicaid agencies showing transportation cost savings based on telemedicine reimbursement.
- Most states indicated that the state budget was a substantial problem and budget constraints could impact the Medicaid program. However, for those states reimbursing for telemedicine, none anticipated that telemedicine reimbursement would be impacted by budget concerns. Factors influencing this conclusion were: a belief that telemedicine provides services and enhances access for patients in remote areas, the utilization is too low to impact the budget, and the telemedicine program is simply “below the radar screen.”
- In states that reimburse for telemedicine, several agency representatives openly question the low utilization of this service. Although some acknowledged the complexity of their billing process, other potential issues included: the limited number of active telemedicine programs in their states, the limited number of physicians engaged in telemedicine; the natural resistance to adopting new methods of practice, and lack of awareness by consumers that telemedicine is an option.

- Most states reimbursing for telemedicine had evaluated their policies in light of HIPAA regulations, but had not made changes other than to eliminate local codes and bring their coding processes in compliance with HIPAA.
- States with high saturation of managed care seem particularly open to using telemedicine to provide care and recognize it as a program with the potential to provide services in a cost effective manner.

The following section provides narrative results of contacts with state Medicaid agency personnel, followed by a chart summarizing each state’s specific reimbursement policies.

State Medicaid Payment Policy Overviews

States That Reimburse

ALASKA

Alaska began reimbursing in 2003, and will make payments for telemedicine applications as an alternative to traditional methods of delivering services to Medicaid recipients. The division will only reimburse for live or interactive applications made through camera, video, or audio conference on a real-time basis; store-and-forward services; and self-monitoring or testing where the telemedicine application is based in the recipient’s home and the provider is only indirectly involved in the provision of the service. To qualify for reimbursement, the treating or consulting provider must use applicable modifiers to bill for telemedicine applications as stated in 7 AAC 43.104. The division will reimburse only fee-for-service telemedicine applications. Reimbursement is made at both hub and spoke sites, but spoke sites are only eligible for reimbursement for live or interactive telemedicine application.

ARIZONA

The Arizona Health Care Cost Containment System (AHCCCS) covers medically necessary consultative and/or treatment telemedicine services for all eligible members within the limitations described by policy when provided by an AHCCCS-registered provider. Services provided via telemedicine are billed by the consulting provider. Non-emergency transportation to and from the telemedicine spoke site is covered. AHCCCS does not require prior authorization for medically necessary telemedicine services performed by fee-for-service providers. Covered Behavioral Health Services (BHS) include: diagnostic consultations and evaluations, case management, individual and family counseling, and psychotropic medication adjustments and monitoring (all in real-time only). Services must be delivered “via real time telemedicine” or store-and-forward technology. Both the referring and consulting providers must be registered with AHCCCS. Consultative CPT codes are used with a “GT” modifier for all telemedicine services.

ARKANSAS

The Medicaid agency recognizes physician consultations at the hub and spoke sites when furnished using interactive video conferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services. Medicaid reimbursement to outpatient hospitals and physicians for telemedicine services will be the same amount Medicaid allows for the same services performed in a traditional manner. CPT codes must be indicated. The modifier TM is used to identify a telemedicine service. Physician interpretations of fetal ultrasounds are covered expenses if the physician views the echography or echocardiography output in real time, while the patient is undergoing the procedure.

CALIFORNIA

The Medicaid agency recognizes physician consultations (medical and mental health) when furnished using interactive video conferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner.

Both consulting and referring providers can be reimbursed for telemedicine at both the hub and spoke sites. Psychotherapy and Evaluation and Management (E & M) are covered. The state uses consultative CPT codes with the modifier "TM" to identify telemedicine services for both the hub and spoke sites.

The modifier TM must be used for E&M. The telemedicine service must use interactive video, audio, or data communication to qualify for reimbursement (store and forward is excluded). E&M services must be in real time to qualify as interactive two-way transfer of medical data and information between the patient and practitioner. The equipment used must be of the quality to adequately complete all necessary components to document the level of service for the CPT-4 code to be billed. Documentation of the medical necessity of the service must be included, as well an explanation of the barrier to a face-to-face visit. The interpretation and report of x-rays and EKG are not interactive but may be reimbursable. The cost of telemedicine equipment and transmission is not reimbursable. Telephone and fax are excluded. No disability insurance contract that is issued for medical coverage can require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine.

Since the 1996 state law authorizing Medicaid reimbursement for telehealth services, the only substantive change has been for psychiatry. Non-physician services are covered for other services. Both fee-for-service and managed care programs use telemedicine. Transportation is covered under the fee-for-service program (separate provider type). It is not anticipated that budget issues will have an impact on the telemedicine reimbursement program. Studies are underway to validate outcomes and cost savings in the telehealth program.

COLORADO

State law requires that no Medicaid managed care organization, on or after January 1, 2002, may require face-to-face contact between a provider and a client for services appropriately provided through telemedicine if the client resides in a county with a population of 150,000 residents or fewer and if the county has the technology necessary for the provision of telemedicine. The use of telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance. Any health benefits provided through telemedicine must meet the same standard of care as for in-person care.

In the case of emergency services, covered persons shall have access to health care services 24 hours per day, seven days per week. Sufficiency shall be determined in accordance with agency requirements and may be established by reference to any reasonable criteria used by the carrier, including but not limited to, "Provider-covered person ratios by specialty, which may include the use of providers through telemedicine for services that may appropriately be provided through telemedicine."

GEORGIA

The Medicaid agency recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services. The agency uses specific local codes to identify the consultation furnished at the hub site. No special codes or modifier is used at the spoke site.

ILLINOIS

The Medicaid agency recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Illinois reimburses for store and forward encounters meeting certain conditions. Hub and spoke sites are both eligible for reimbursement for telemedicine services. CPT codes with the modifier TM identify telemedicine consultations.

IOWA

The Medicaid agency began reimbursement through a pilot program that was legislatively mandated and upon completion legislatively terminated. The agency recognizes a limited number of physician consultation codes for use of interactive video teleconferencing. Only three providers initially entered into agreement to participate, but only two remain. Many providers indicated that completion of the forms (designed to collect data) was too burdensome. Payment is based on the state's fee-for-service rates for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both the hub and spoke sites for telemedicine services. Specific local codes are used for the add-on payment, and CPT codes with the modifier "TM" is used to identify the consultations. Based on conclusions of the

legislative study, it does not appear that the data supports the cost expenditure for telehealth. Some mental health services are provided through a managed care waiver, and since the inclusion of the new mental health CPT code, the agency reimburses limited amounts for telepsychiatry. Services which meet “accepted standards of care” are paid, so services using telemedicine as a core method of care may be being reimbursed without inclusion of the modifier.

KANSAS

The state reimburses for home health care and mental health services already covered by the state plan when furnished using video equipment. Payment is on a fee-for-service basis for the mental health services, the same as the reimbursement for covered services furnished in the conventional manner. Home Care services have certain restrictions, and compensation for home health care via telemedicine is made at a reduced rate. Reimbursement is made for only the service furnished at the hub site. Payment is on a fee-for-service basis, the same normally reimbursed in a face-to-face encounter per the fee schedule. Local codes specifically identify home health services furnished using visual communication equipment. No special modifiers are used for mental health services.

KENTUCKY

According to KRS 205.510 to 205.630, Medicaid will reimburse for telehealth consultations that are provided by Medicaid-participating practitioners who are licensed in Kentucky and that are provided in the telehealth network. A telehealth consultation means a medical or health consultation for the purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology. Telemedicine consultations are not be reimbursed if provided with an audio-only telephone, fax machine, or electronic mail. The law recognizes professional services including dietitians, nutritionists, chiropractors, dentists, nurses, pharmacists, psychologists, physicians, optometrists, social workers, etc. The telehealth network can coordinate with training centers of no more than 25 rural sites. The state is attempting to engage third-party insurers in exploring telemedicine options for their beneficiaries. The Act states that a health benefit plan shall not exclude coverage solely because the service is provided through the telehealth network. Services provided through telehealth may be subject to a deductible or co-payment.

Approximately 25% to 30% of Medicaid services are provided through managed care. Transportation costs are provided through the Department of Transportation. Modifiers are used on an ad hoc basis. The GT modifier is now used to ensure HIPAA compliance. The agency expressed concern that number of encounters is unreasonably low, perhaps because providers are not billing correctly. It appears that the majority of encounters are for consultation. It is impossible to gather useful data unless billing occurs correctly.

LOUISIANA

The state reimburses for any health care service, including, but not limited to, diagnostic testing, treatment, referral, or consultation, and such health care service is performed via transmitted

electronic imaging or telemedicine. Only physicians are reimbursed for telemedicine consults, but a physician assistant may perform the service using telemedicine equipment if a primary physician authorizes them. The state pays for teleconsultation using interactive video conferencing equipment. The state will not pay for store and forward consultations. Reimbursement should not be less than 75% of the reasonable and customary amount of an intermediate office visit to a licensed physician. Reimbursement is on a fee-for-service basis and is made at both the hub and spoke sites.

No changes are anticipated except perhaps expansion of mental health services. The program is not aware of a single physician with a telemedicine system in their office. They are aware of one psychiatrist with a monitor who was doing group therapy in a developmental home, even though the state has some restrictions on payment for group therapy. From a continuing education perspective, all state medical schools are linked to Charity Hospital in New Orleans. Louisiana uses consultative CPT codes.

MAINE

Effective in January, 2003, Maine adopted a policy to cover services provided via telemedicine by enrolled providers. Transmission costs, consultations between professionals, or attendants instructing a patient in the use of the equipment are not reimbursed. Providers submit a specific description of the procedures and codes that will be used, a statement explaining the rationale for needing telemedicine capabilities, a policy noting criteria to determine when telemedicine services are appropriate, and a quality assurance plan. Services delivered via telemedicine are not billable if the provider does not have a letter of approval. Telemedicine services may not be provided only for the convenience of the provider. The same procedure codes and rates apply as if services were rendered in a face-to-face encounter. Claims must be submitted for review on an individual basis.

MINNESOTA

The Medicaid agency recognizes physician consultations (medical and mental health) to recipients in the MN Health Care Program when furnished using interactive video or store-and-forward technology. Interactive video consultations may be billed when there is no physician present in the emergency room, if the nursing staff requests a consultation from a physician in a hub site. Coverage is limited to three consults per beneficiary per week. Payment is on a fee-for-service basis, the same as a face-to-face encounter. Payment is made at both the hub and spoke sites. No payment is made for transmission costs. A communication between two physicians that solely consists of a telephone conversation is not a telemedicine consultation. CPT codes with the modifier “CT” are used for interactive video services and the modifier “WT” for consultations provided through store-and-forward technology. Emergency room CPT codes are used with a “GT” modifier for interactive video consultations done between emergency rooms. The referring provider can be a physician, nurse practitioner, clinical nurse specialist, physician assistant, podiatrist, mental health practitioner, or certified nurse midwife. The hub provider must be a specialty physician or oral surgeon. The out-of-state coverage policy applies to services provided via telemedicine. A request for and the need for a consultation must be documented in the patient’s record. The patient record must include a written opinion from the

consulting physician providing the telemedicine consultation. Funding is provided for “telehomecare” devices, if the patient qualifies for the MN Alternative Care Program.

MONTANA

The Medicaid agency recognizes any medical or psychiatric service already covered by the state plan when furnished using interactive video teleconferencing. The consulting provider is paid, but the referring provider is paid only if he provides a service. The agency recognizes any medical or psychiatric service already covered by the state plan when furnished using interactive video conferencing equipment. Payment is on a fee-for-service basis, the same that is traditionally paid for covered services furnished in a face-to-face encounter. Facility fees are not covered. Existing CPT codes are used. The “TM” modifier is to be noted when billing for tracking purposes. Reimbursement is made at both the hub and spoke site, with the state maximum as the allowable amount.

Changes have been made in local modifiers to comply with national standards. The agency does not pay for telephone encounters. Only one mental health center is currently billing Medicaid for services. The hospital is supplementing the service with a medication management project. Office visits with a GT modifier are reimbursed without diagnostic restrictions. Providers performing the E&M evaluation are reimbursed, subject to reduction rates. Due to the state budget crisis, legislation is pending for rate and service reductions. However, it appears that the telemedicine program is “below the radar screen” and may not be impacted by cutbacks.

NEBRASKA

The Medicaid agency recognizes most state plan services when furnished using interactive video teleconferencing. Services are covered as long as comparable service is not available to a client within a 30-mile radius of his/her home. Services specifically excluded include medical equipment and supplies, orthotics and prosthetics, personal care aide services, pharmacy services, medical transportation services, mental health and substance abuse services, and home and community-based waiver services provided by persons who do not meet practitioners standards for coverage. Payment is on a fee-for-service basis, the same as face-to-face. Reimbursement is made at both the hub and spoke site. Payment for transmission costs is set at the lower of the billed charge or the state’s maximum allowable amount. Billing and coding requirements vary based on the provider and the claim form is used. Telehealth transmission is reimbursed at a rate of \$.08/minute based on the highest Universal Service Fund subsidized monthly rate and the expected usage availability. Medicaid will reimburse for mileage to transport a client to a telehealth site. Out-of-state practitioners may provide services to clients in Nebraska if they comply with licensure, registration, and certification regulations and are enrolled with the Nebraska Medicaid. Service occurs at the client’s location. Nebraska Law 692 allowed for 10% of the NE Health Care Cash Fund to be for grants for health infrastructure including telemedicine.

Nebraska covers all services that would be covered if occurring face to face. Transmissions fees can be included on hospital cost reports. No special codes are used, but based on billing

instructions, use of telemedicine should be visible. On an annual basis, less than \$1,000 is paid out for all telemedicine services. According to Dr. Chris Wright, “nobody is using it.” Nine telehealth sites are enrolled, with 103 eligible practitioners. In 2002, 631 encounters occurred. In Nebraska, the urban medical centers are only about 60 miles apart. Large budget deficits will impact the Medicaid program, but probably not telemedicine.

It is interesting to note that the Nebraska legislature defined the practice of medicine as occurring where the patient is physically located. The billing and coding requirements will vary depending on who bills for the service and which claim form is used.

NEW MEXICO

New Mexico is in the beginning stages of reimbursement with formal policies currently being developed. Telemedicine providers participated in a comprehensive approach toward addressing statewide health issues. After being told that cost was an issue, a contract was issued to a university school of management to develop a business forecast showing cost savings based on use of telemedicine. The collaborative approach has resulted in representatives of non-telemedicine organizations, such as managed care, becoming champions for telemedicine. Even though all managed-care organizations have agreed to reimburse for telemedicine, the report of the total statewide health plan will be released on July 9, 2003. Participants in this process are extremely positive about the value of involving the Medicaid agency, managed care and other providers. The value of “hard facts” accompanied by quantitative and qualitative analysis was without dispute. Tailoring the facts with a plan focused on meeting the health needs of state produced positive response to telemedicine reimbursement.

NORTH CAROLINA

North Carolina recognizes initial, follow-up, or confirming consultations in hospitals and outpatient facilities when furnished using real-time interactive video teleconferencing. The patient must be present during the teleconsultation. Payment is made on a fee-for-service basis. The consulting practitioner receives 75% of the fee schedule amount for the consult, and the referring practitioner at the spoke site receives 25% of the applicable fee. Teleconsultations are billed with modifiers to identify which portion of the teleconsultation is billed. Both the consulting practitioner at the hub site and the referring practitioner at the spoke site use the GT modifier. The YS modifier was eliminated to conform with national standards.

Agency personnel are aware of the telemedicine services provided by the East Carolina University program, especially related to geriatric care. The agency is moving toward reimbursement for behavioral health, based on Medicare addition of the mental health code. The number of billed encounters is extremely low. If providers are billing for these services, the modifiers are not being used. Although the state is facing serious budget limitations, it is not anticipated that the telemedicine reimbursement program will be impacted.

NORTH DAKOTA

The Medicaid agency recognizes specialty physician consultations when furnished using interactive video teleconferencing. These include outpatient or inpatient, including follow-up services, initial and second opinions. The consulting provider is paid, while the referring provider is paid only if he/she provides a service. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Facility fees and store-and-forward consults are not covered. The TM modifier is used to identify covered services with the consulting site using a GT modifier. Psychotherapy provided by psychiatrists or PhD psychologists is reimbursed. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services. Current CPT codes for consultative services are used with a "TM" modifier to specifically identify covered services which are furnished by using audio visual communication equipment. Reimbursement is also available for actual line charges.

The Medicaid office is aware of many uses for telemedicine, psychiatric consults, seizure management, follow-up care for burns (from Mayo), etc. The greatest expansion will be for behavioral care. Medicaid covers services the same as if the encounter occurred face-to-face. Providers at both the hub and spoke sites are eligible for reimbursement. The state has a system to collect data on telemedicine encounters. According to the agency, Medicaid does not see much utilization of telemedicine. Although the budget limitations may impact all services, telemedicine is viewed as a cost saver. Even though utilization is very low, no policy changes are anticipated.

OKLAHOMA

Oklahoma reimburses for physician consultations when furnished using interactive video teleconferencing and for teleradiology. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both the hub and spoke sites. The state uses consultative CPT codes. Each not-for-profit hospital in this state can receive free of charge, upon written request, one telecommunications line or wireless connection sufficient for providing such telemedicine services as the hospital is equipped to provide. The telecommunications carrier is entitled to reimbursement from the Oklahoma Universal Service Fund for providing the line or connection. In no case can the reimbursement from the Fund be made for an Internet subscription fee.

Under the 1115 Medicaid waiver demonstration (Urban Managed Care Plans), one of the goals is to develop a referral system with a minimum of 25 rural sites. Few, if any, of the plans have chosen this option.

SOUTH CAROLINA

Beginning in 1999, the South Carolina Medicaid program initiated reimbursement for teleconsultations as well as telepsychiatry. Reimbursement is only available for live two-way interactive encounters. Teleconsultations may be provided by physicians, nurse practitioners and nurse midwives. The referring physician and consulting physician must use the supplemental telemedicine codes. Reimbursement is provided on a fee-for-service basis. Telepsychiatry may only be provided by a psychiatrist who is licensed and enrolled with the

South Carolina Medicaid program. Both the referring physician and the psychiatrist use the correct codes with the modifier “TM.”

SOUTH DAKOTA

The South Dakota Medicaid agency recognizes physician consultations when furnished using real-time interactive video teleconferencing or using near real-time store-and-forward applications such as email, phone, and fax. Medicaid pays the consulting provider; the referring provider is paid only if he/she provides a service. Payment is on a fee-for-service basis, the same as a face-to-face encounter. Reimbursement is made at both the hub and spoke sites. Facility fees are not covered. Medicaid pays for consultation CPT codes only; all mental health services are excluded from payment. The modifier “TM” must be used to identify telemedicine services. Over two-thirds of the Medicaid population participates in the Managed Care Program.

TENNESSEE

The Tennessee Medicaid program is a component of the managed-care TennCare program, and thus almost all services are provided in a “managed” environment. As such, the agency is aware of the use of telemedicine and encourages providers to use any cost-effective mechanism to provide care as long as the quality measures are ensured. Since the program is not a reimbursement program, providers are not required to indicate which services or how much of their care is provided via telemedicine.

TEXAS

The Medicaid agency recognizes physician consultations (teleconsultations) when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, the same as reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services. Other health care providers, such as advanced nurse practitioners and certified nurse midwives are allowed to bill, as are Rural Health Clinics and Federally Qualified Health Centers.

The State uses consultative CPT codes with the modifier "TM" to identify telemedicine services. Under the Medicaid Program of Texas, telemedicine medical services are reimbursable in counties with a population of under 50,000 or in area designated as medically underserved. Covered services are interactive video communication at the hub and remote site, unless service may be reimbursed using telemedicine, without ‘face-to-face’ contact like teleradiology and telepathology.

Other health care providers eligible to bill for services are advanced nurse practitioners, nurse midwives, and doctors of osteopathy, as are Rural Health Clinics and Federally Qualified Health Centers. Payment is made on a fee-for-service basis, the same as for face-to-face encounters. The state uses consultative CPT codes with a “TM” modifier. Store and forward reimbursement is available under the medical assistance program for services provided with the use of imaging by way of still image and capture in connection with a video conference consultation.

The Texas Medicaid telemedicine program has provided consultation for many other states that are developing telemedicine reimbursement policies. Mental health is probably the fastest growing telemedicine area for the Medicaid program. New legislation will include addition of any services that can be proven to be clinically effective as well as cost-effective. A review process will be included in the procedure for adding services. Concern was expressed that many of the telemedicine programs in Texas know very little about the services available through the state Medicaid program, and thus utilization is low. In light of a state budget deficit of over \$10 billion, the agency anticipates cutbacks, but since the telemedicine program can demonstrate cost effectiveness, it is not anticipated that the program will be negatively impacted.

UTAH

The following services are recognized when furnished using interactive video teleconferencing: mental health consultation provided by psychiatrists, psychologists, social workers, psychiatric registered nurses, and certified marriage or family therapists; diabetes self-management training provided by qualified registered nurses or dietitians; and services provided to children with special health care needs by physician specialists, dietitians, and pediatricians when those children reside in rural areas. Payment is on a fee-for-service basis, the same for the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both the hub and spoke sites for diabetes self-management training services and services provided to children with special health care needs. Reimbursement is made only to the consulting professional for mental health services. Payment is made for transmission fees. The state uses CPT codes with GT and TR modifiers to identify telehealth services.

VIRGINIA

Department of Medical Assistance Services (DMAS) recognizes that telemedicine is another means of delivering medical care. Beginning on July 1, 2003, the following types of providers enrolled with DMAS may utilize telemedicine for the delivery of some covered services: physicians, nurse practitioners, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and licensed professional counselors. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. CPT codes are used with “GT” as the modifier. Reimbursement is available at the hub and spoke site. Providers enrolled with DMAS and intending to bill telemedicine services must first notify DMAS. This is a one-time activity and must occur at least ten days in advance of the telemedicine service date.

WASHINGTON

The Medicaid program in Washington is in the process of developing guidelines for reimbursement of telemedicine services. The program can be implemented by administrative process and will include development of billing instructions for providers. Although the number of managed-care programs is decreasing, at the present time, they are allowed to use telemedicine within their programs. Also, the current fee for service system includes a mechanism for “exceptions to policy” which could be utilized for providers wishing to use

telemedicine at this time. Although the state has been interested in telemedicine for some time, there was not a substantial number of providers indicating an interest being paid for these services.

WEST VIRGINIA

West Virginia recognizes physician consultations when furnished using interactive video teleconferencing. Payment is made on a fee-for-service basis, the same as face-to-face encounters. Reimbursement is made at both the hub and spoke site. The state uses consultative CPT codes with the modifier “GT” to identify telemedicine services.

The agency perceives telemedicine as an beneficial way of providing services, but continues to be aware of low utilization. This may be in part due to the fact that, at the outset, the University of West Virginia Medical Center was pushing telemedicine, but they seem to have backed off. The geography of the state lends itself to use of telemedicine. There seems to be some reluctance on the part of physicians to use telemedicine. The agency pays claims, but “not many people send bills.” Telemedicine lends itself to care for people in remote geographic areas, but with surrounding state health facilities, not too many people have difficulty accessing the health system. State budget issues are impacting the entire Medicaid program, but not as dramatically as many other states. Budget issues are important but not a priority. The agency does not anticipate the budget impacting reimbursement for telemedicine.

States Not Currently Reimbursing

ALABAMA

At this point, the agency is not considering reimbursement for telemedicine. There has been minimal expressed interest or requests for telemedicine reimbursement; therefore, there is no impetus to change their policy. Transportation costs comprise a negligible portion of the state Medicaid budget. The agency is aware of some telemedicine program, particularly in the behavioral health area, but has had no formal contact.

Even if there were requests from telemedicine providers, due to state budget limitations, it is not likely that any new programs or services would be considered. To consider reimbursing for telemedicine, the agency would need compelling evidence, e.g., research/data showing cost savings while maintaining quality. However, the agency is open to policy change based on evidence.

CONNECTICUT

The agency is not formally considering a policy change related to telemedicine reimbursement. It initially participated in a pilot project linking primary, acute, and long-term care of the elderly. The goal was development of a comprehensive assessment database to be used by all agencies. The focus was primarily on persons at risk, but not eligible for nursing home care. Due to budget constraints, this project was abandoned prior to completion. The Medicaid Director has

been apprised of telemedicine programs in the state and has participated in demonstration projects. Medicaid transportation costs are minimal.

Due to budget constraints, the state is cutting back on services. Managed care is used primarily for the younger Medicaid population. Approximately 12,000 clients are involved in a state-funded Medicaid home-care waiver. The agency is aware of a home medication demonstration project through a program at Yale. In this program, if a Medicaid recipient fails to use medications from a preloaded unit, the EMS system can be automatically activated. Yale is conducting another project with elderly clients to study the relationship between falls and medications.

DISTRICT OF COLUMBIA

At this point, the agency is not considering reimbursement for telemedicine. The agency has not received evidence that reimbursing for telemedicine is needed and telemedicine has not been deemed to be widely available or to offer substantial benefit to DC Medicaid recipients.

DELAWARE

There is no policy consideration for covering telemedicine at this point. The agency is aware of one waiver program to provide remote monitoring programs for the elderly and disabled (through home care agency). Managed-care programs cover emergency services; non-emergency services are fee-for-service.

Due to the geography of the state (only three counties), every citizen is within fifteen minutes of a medical facility. There is an approved code for telemedicine in the event the state amends its reimbursement policy.

FLORIDA

The department is very interested in telemedicine and is actively considering reimbursement options. At this stage, the agency is leaning toward following Medicare guidelines. Due to needs of the state population, telemedicine is perceived as having the ability to substantially reduce costs, especially for transportation. Data is needed to determine the most effective policy. The agency is also interested in policies of other states which have proven effective

Many pilot programs are being conducted in the state. These programs focus on care of the elderly, home care, and remote disease management. Home care organizations are collecting data on outcomes and will report findings to state Medicaid agency. Florida utilizes both managed-care and fee-for-service programs. The managed care programs are free to utilize funds as necessary to accomplish objectives. This would include use of telemedicine services.

HAWAII

Hawaii is in the process of developing rules for reimbursement of telemedicine. It has received inquiries from telemedicine programs, especially those which provide health services among the

various islands. Transportation costs are reimbursed and can be substantial, but the more important factor is ensuring appropriate access to needed services and the ability to ensure follow-up and monitoring.

The Hawaii Medicaid program is supportive of reimbursement for telemedicine services, yet must follow an established process for making changes in reimbursement policies. They are considering using Medicare reimbursement policies as a guideline.

IDAHO

The state is actively considering reimbursement for telemedicine. Several telemedicine providers have requested a change in Medicaid policies to reimburse telehealth. A pilot to assess satisfaction and provide cost-benefit analysis has been designed but not funded. A university-based telehealth project was started several years ago and continues to date. A group of physicians have established a network to provide behavioral health services to particular indigent populations. Other projects link medical centers through telehealth. Transportation costs are a major issue due to the geography of the state. Data showing transportation cost savings or offsets would be invaluable.

The primary obstacle to reimbursing for telemedicine is budgetary concerns. Other apprehensions include over utilization and fraud and abuse. It appears that reimbursement for consultation could be initiated without changing the rules, but reimbursing the facility fee would require changing the rules and State Plan.

INDIANA

Although the agency has not responded to repeated inquiries, telemedicine providers are not aware of any discussions about reimbursing for telemedicine.

MARYLAND

Medicaid does not cover telemedicine services and is not aware of any claims or interest in pursuing reimbursement for these services. The agency representative had heard of a remote care project through the University of Maryland. Transportation costs are not a major cost issue for Medicaid.

The agency is interested in any services that are cost-effective and meet the needs of their constituents; however, at this time they do not have reimbursement for telehealth on the policy agenda.

MASSACHUSETTS

Reimbursement for telemedicine has been proposed, but the agency does not currently provide payment. Because of telemedicine programs within the state, the agency anticipates the topic will continue to be on the policy agenda. Through a home care pilot, a number of projects are funded through elder service agencies. Some local providers, such as Partners Health Care, are

promoting telehealth and are funding state specific programs. The agency covers transportation, but is unsure of the impact on the overall Medicaid budget.

Massachusetts Senate Bill 503, introduced in January 2003, authorizes and directs the Division of Health Care Finance and Policy and the Division of Medical Assistance to establish a rate of reimbursement for home health agencies that allow for the use of technology.

MICHIGAN

According to the director of Telehealth and Management Development with the Upper Michigan Telehealth Network, since Michigan is a managed-care state, there is little reimbursement occurring. However, Michigan is reimbursing on a case-by-case basis, although there have been few to no requests made. Blue Cross agreed to reimbursement that will begin in August or September by following Medicaid guidelines, which includes facility fees. The Michigan Telehealth Policy Group was formed to help push forward a telehealth agenda which includes requests for reimbursement for pilot programs in the Upper Peninsula. There is no current push for state legislation regarding Telemedicine Reimbursement.

MISSISSIPPI

The Medicaid agency is aware of some telemedicine programs, but due to serious state budget limitations, no reimbursement policy changes related to telemedicine are being considered.

MISSOURI

There is indication of a pilot program using telemedicine to monitor congestive heart failure patients. The Chief Executive Officer of the Department of Social Services says that Missouri Medicaid does not reimburse for telemedicine: "To do so would require appropriation authority from the Missouri General Assembly. Given current fiscal constraints, it is doubtful new programs of services will be added to the Medicaid program."

NEVADA

Consideration for reimbursement of telemedicine services is not on the policy agenda at this point, in part, because there have not been specific requests for payment. Transportation costs are substantial due to geography of the state, but the agency has not discussed any cost-offsets based on telemedicine.

NEW HAMPSHIRE

The agency is not reimbursing and is not considering reimbursement, since no requests for reimbursement have been submitted to the Medicaid agency to date.

NEW JERSEY

According to the agency representative, the agency is not considering any reimbursement changes that would impact telemedicine.

NEW YORK

The agency is not actively considering reimbursement at this time. Studies showing outcomes and effectiveness are needed for reimbursement policy changes. The agency representative was generally familiar with telemedicine, but not aware of specific New York programs.

Although the state Medicaid agency is not developing reimbursement policies, legislation has been introduced that establishes a statewide task force to study telemedicine and includes a section on developing reimbursement options.

OHIO

According to the agency representative, the Ohio Medicaid is not actively considering reimbursement for telemedicine and does not anticipate any such consideration in the near future.

OREGON

Oregon Medicaid does not have a telemedicine policy and does not do any significant amount of telemedicine reimbursement. Oregon does participate in a small amount of reimbursement for telephone calls in a small “smoking cessation” program and in a small “maternity case management” program. The 72nd Oregon Legislative Assembly drafted House Joint Resolution 4 which calls for reimbursement for services when these services are provided via telecommunications.

PENNSYLVANIA

The Medicaid agency is beginning to evaluate telemedicine from a “big picture” perspective. It is aware of substantial funding for a number of telemedicine projects around the state. Transportation costs are significant since Pennsylvania has one of the largest rural populations in the US.

Due to the infusion of telemedicine grants in Pennsylvania, the agency is considering policy options in the event that a decision is made to reimburse for telemedicine. The primary consideration at this point is linking facilities in rural areas with medical centers in urban areas.

RHODE ISLAND

The agency representative indicated that he is aware of the concept of remote monitoring, but not aware of any programs in the state. To date, there have not been requests for reimbursement of these services. Transportation costs comprise a very small percentage of overall Medicaid costs.

VERMONT

According to the agency, its only knowledge of interest in telemedicine is on the part of the home care agency. Nothing has been proposed through the legislative route. It is anticipated that the home care association may develop a proposal for consideration.

The agency does not rule out reimbursement, if claims could be appropriately coded. If a telemedicine reimbursement policy were developed, it would likely mirror Medicare reimbursement regulations.

WISCONSIN

According to agency interpretation, language in state law prohibits paying for telemedicine since it is delineated as a non-covered benefit. The agency is aware of the telemedicine outreach through the Marshfield Clinic.

Current debate on the state budget includes a provision that there will be no rate increase and no expansion within the Medicaid program. A special legislative committee is looking at a number of health issues including telemedicine.

WYOMING

According to the state Medicaid representative, Wyoming stands “ready, willing, and able” to reimburse for telemedicine but have not been asked, nor have any claims been filed. They are aware of plans for a home health project using telemedicine.

Recommendations for Moving State Medicaid Policies Forward

Two important objectives emerge from this survey of state Medicaid agencies. First, in the states currently paying for telemedicine services, these reimbursement programs must be utilized and enhanced. The most consistent concern of agency representatives in states with current reimbursement policies was the lack of utilization. Many attributed this to the limited numbers of physicians providing telemedicine services and the overall reluctance of the health system to adopt change – even if for the better. Second, states considering establishing telemedicine reimbursement policy must have necessary data and assistance to make affirmative reimbursement decisions. Finally, many providers have expressed concerns about the difficulty of the application process. Improvements should be made in order to make the Medicaid process simpler.

Representatives of Medicaid agencies in states not currently reimbursing for telemedicine reflected a continuum of knowledge and interest in telemedicine. Typically, states that expressed

minimum interest do not have active visible telemedicine programs in their states. States such as Florida, Hawaii, and Pennsylvania are engaged in active consideration of reimbursement policy and were quite knowledgeable about the potential benefits of telemedicine to their agency population base. Almost all agencies indicated a desire for information about other states' reimbursement policies and experiences. Agency representatives in states with a longer history of telemedicine reimbursement, such as Texas and California, reported that they regularly respond to inquiries from colleagues from other states about their state telemedicine reimbursement programs.

Medicaid agencies that reimburse as well as those not yet reimbursing have expressed interest in studies and data on telemedicine utilization, cost savings, patient acceptance and outcomes. Each representative indicated that this information would be invaluable for enhancing or initiating reimbursement policies. Several states asked whether any particular state programs are accepted as the "ideal" or "model" for other state agencies to emulate. A common theme was interest in identification of current state reimbursement policies that are deemed effective without each program needing to "start from scratch."

As gleaned from discussions with state Medicaid agency personnel, the following ideas are proposed for telemedicine providers desiring to ensure the most effective telemedicine reimbursement policies for their state Medicaid program.

State or Local Involvement

- Telemedicine providers should become knowledgeable about their state Medicaid agency structure, e.g., how policy decisions are made, how the fee-for-service and managed care programs are organized, and whether special programs such as behavioral health and home health are managed by separate units or are a component of other programs.
- Telemedicine programs must take the initiative to ensure that appropriate state Medicaid agency personnel are informed about state telemedicine programs, demonstration projects, and services offered in the state as well as the services offered through these programs. Attention should be drawn to the linkages between those telemedicine programs and the health services funded by Medicaid, with focus on enhanced access and remote monitoring services.
- Special attention should be paid to the process by which the state Medicaid agency changes or makes reimbursement decisions. Are decisions made on the basis of provider requests? Do agency policies require research and/or data to substantiate decisions? Must the law be changed to accommodate telemedicine or is the agency empowered to make reimbursement decisions?
- An analysis of the specific state Medicaid reimbursement policies that would be benefited by telemedicine services in the state would facilitate development of appropriate policy. Providers must be prepared to offer specific suggestions and/or refer to effective programs in other states.

- Providers could initiate efforts to evaluate state Medicaid reimbursement data to identify potential cost savings based on provision of services provided via telemedicine, e.g., transportation, consultations and behavioral health, etc.
- If necessary, consultation or collaboration with university management/data experts could be undertaken to identify potential cost savings for the Medicaid program and prepare reports or data on potential cost savings.
- Collaboration between telemedicine colleagues within the state as well as other states could enhance identification of program data that would be persuasive to the Medicaid agency.
- Providers could ensure collaboration with all state Medicaid programs, such as behavioral health and home care, that might benefit from telemedicine services.
- Telemedicine programs must maintain active interest and involvement with ongoing agency deliberations about new or modified reimbursement policies.

National or Interstate Collaborative efforts

- Two of the agencies with strong telemedicine reimbursement policies and utilization suggested convening a meeting with established state Medicaid program representatives. The purposes of this meeting would be to identify an overall master plan and strategies for broadening Medicaid reimbursement, develop a systematic approach to assisting states with development of reimbursement policies, and to ensure collection and dissemination of relevant state Medicaid data on telemedicine reimbursement.
- Telemedicine providers could collaborate with state Medicaid programs to identify knowledgeable consultants and champions, both in the provider community and the Medicaid agencies.
- Interested parties could participate in analysis of effective state reimbursement policies, as well as those that have not proven to be effective, and could develop a resource guide to be available to providers and agencies.
- A model or “ideal” telemedicine reimbursement policies with rationale for selected language would likely be in great demand by state Medicaid agencies.
- Model language could be augmented by inclusion of alternates and/or options to allow states with differing Medicaid policy structures, considering both fee-for-service and managed care programs to incorporate the most appropriate language.
- A resource network of telemedicine reimbursement “experts” to provide consultation for telemedicine providers and state Medicaid agencies could provide invaluable assistance to programs considering adding telemedicine reimbursement.

At least 27 state Medicaid programs currently reimburse for at least some aspects of telemedicine services, with another seven or eight states actively considering adoption of telemedicine reimbursement policies. Based on conversations with state agencies, it seems reasonable to predict that within a year almost 35 states will provide Medicaid reimbursement for telemedicine. Attainment of this critical mass of state Medicaid programs reimbursing for telemedicine will provide the basis to enhance existing reimbursement policies and encourage additional states to participate.

The majority of Medicaid agencies clearly communicated their commitment to supporting programs and services that provide quality, cost-effective benefits to constituents. While data on potential cost savings is essential, broader access to needed health care services is also an important incentive. The ultimate advantage of telemedicine in eliminating geographic and distance barriers for citizens needing care aligns with the role of state Medicaid agencies in providing quality health services. Thus, telemedicine providers must be informed and involved in fostering effective collaborative initiatives to achieve optimal state Medicaid reimbursement for telemedicine.

Medicaid Reimbursement Chart

State	Physician Consultation Only	Fee For Service	Managed Care*	Hub Reimbursement	Spoke Reimbursement	Special Code Required	Store and Forward Reimbursement	Telerehab**
Alaska	X	X	55.44%	X	X	Consultative CPT Codes with modifiers	X	
Arizona	X	X	94.40%	X	X	Consultative CPT Codes with "GT" modifier for telemedicine	X	
Arkansas	X	X	66.17%	X	X	Consultative CPT Codes with the modifier "TM" to identify telemedicine		X
California	X	X	52.54%	X	X	Consultative CPT Codes with the modifier "TM" to identify telemedicine		X
Colorado	X	X	92.94%	X	X			
Georgia	X	X	72.07%	X	X	Local codes-Hub No codes-Spoke		
Illinois	X	X	8.88%	X	X	Consultative CPT Codes with the modifier "TM" to identify telemedicine	X	X
Iowa	X	X	86.86%	X	X	Consultative CPT Codes with the modifier "TM" to identify telemedicine		
Kansas		X-mental health Red. Rate-home health	57.24%	X		Local Codes-Home Health No modifiers-Mental Health Services		
Kentucky	X	X	84.26%	X	Policy doesn't indicate spoke reimbursement	Modifiers on an ad hoc basis. GT for HIPPA		X
Louisiana	X	X	25.42%	X	X	No modifier for phy. exams Mod. For behavioral health & speech		X
Maine	X	X	53.98%	X	X	Same procedure and codes as face-to-face encounter		
Minnesota	X	X	68.60%	X	X	CT-inter. video VT-S&F GT-inter. vid. btwn. ER	X	

State	Physician Consultation Only	Fee For Service	Managed Care*	Hub Reimbursement	Spoke Reimbursement	Special Code Required	Store and Forward Reimbursement	Telerehab**
Montana	X	X	66.77%	X	X	Existing CPT Codes with TM for tracking purposes		
Nebraska	X	X	77.81%	X	X	Billing and Coding requirements vary depending on who bills		X
New Mexico*	Formal Policies are currently under development. A Statewide Health Plan will be released on July 9, 2003							
North Carolina	X	X	70.54%	X	X	CPT consultative codes with "GT" modifier		X
North Dakota	X	X	64.47%			Consultative CPT Codes TM-AV comm. equip. GT-consulting site		X
Oklahoma	X	X	70.53%	X	X	Consultative CPT Codes		
South Carolina	X	X	8.63%			Consultative CPT Codes with the modifier "TM" to identify telemedicine		
South Dakota	X	X	95.37%	X	X	Consultative CPT Codes with the modifier "TM" to identify telemedicine	X	
Tennessee*			100%					
Texas	X	X	38.02%	X	X	Consultative CPT Codes with the modifier "TM" to identify telemedicine	X	X
Utah	X	X	100%	X	X	Consultative CPT Codes with the modifier TR or GT to identify telemedicine		
Virginia	X	X	65.22%	X	X	Consultative CPT Codes with the modifier "GT" to identify telemedicine		X
Washington*	Currently, fee for service system is under an <i>exception to policy</i> , and formal guidelines are under development.							
West Virginia	X	X	50.65%	X	X	Consultative CPT Codes with the modifier "GT" to identify telemedicine		X

*These figures represent point-in-time enrollment as of June 30, 2002.

** This information was supplied by National Rehabilitation.

Managed Care Trends

ENROLLMENT	TOTAL MEDICAID POPULATION	MANAGED CARE POPULATION	OTHER POPULATION	% MANAGED CARE
2002	40,147,539	23,117,668	17,029,871	57.58%
2001	36,562,567	20,773,813	15,788,754	56.82%
2000	33,690,364	18,786,137	14,904,227	55.76%
1999	31,940,188	17,756,603	14,183,585	55.59%
1998	30,896,635	16,573,996	14,322,639	53.64%
1997	32,092,380	15,345,502	16,746,878	47.82%
1996	33,241,147	13,330,119	19,911,028	40.10%

The Total Medicaid population for 1996-2002 was collected by states at the same time the managed care enrollment numbers were collected instead of using HCFA-2082 data as in previous years. These figures represent point-in-time enrollment as of June 30 for each reporting year.

The unduplicated managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides unduplicated national figures for the Total Medicaid Population and Other Population. The statistics also include individuals enrolled in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Row Number	State	Medicaid Enrollment	Managed Care Enrollment	Percent in Managed Care
1	Alabama	730,619	405,090	55.44%
2	Alaska	90,841	0	0.00%
3	Arizona	738,556	697,171	94.40%
4	Arkansas	507,969	336,111	66.17%
5	California	6,074,019	3,191,168	52.54%
6	Colorado	299,207	278,095	92.94%
7	Connecticut	375,768	280,106	74.54%
8	Delaware	113,480	87,465	77.08%
9	Dist. of Columbia	127,059	80,300	63.20%
10	Florida	1,986,652	1,267,998	63.83%
11	Georgia	1,447,398	1,043,154	72.07%
12	Hawaii	168,616	132,787	78.75%
13	Idaho	147,202	58,284	39.59%
14	Illinois	1,475,137	130,988	8.88%
15	Indiana	687,603	484,116	70.41%
16	Iowa	261,923	227,495	86.86%
17	Kansas	227,392	130,162	57.24%
18	Kentucky	594,594	500,987	84.26%
19	Louisiana	814,134	206,992	25.42%
20	Maine	205,474	110,922	53.98%
21	Maryland	655,940	451,307	68.80%
22	Massachusetts	982,979	628,832	63.97%
23	Michigan	1,208,803	1,208,803	100.00%
24	Minnesota	536,722	368,186	68.60%

Managed Care Trends

25	Mississippi	709,260	0	0.00%
26	Missouri	905,683	413,361	45.64%
27	Montana	78,195	52,209	66.77%
28	Nebraska	210,487	163,772	77.81%
29	Nevada	156,585	60,823	38.84%
30	New Hampshire	90,800	9,206	10.14%
31	New Jersey	805,056	523,904	65.08%
32	New Mexico	371,353	243,069	65.45%
33	New York	3,129,731	1,099,900	35.14%
34	North Carolina	1,023,601	722,089	70.54%
35	North Dakota	47,788	30,808	64.47%
36	Ohio	1,490,097	378,476	25.40%
37	Oklahoma	480,373	338,819	70.53%
38	Oregon	436,645	378,739	86.74%
39	Pennsylvania	1,431,442	1,140,211	79.65%
40	Puerto Rico	1,036,168	865,285	83.51%
41	Rhode Island	171,673	117,024	68.17%
42	South Carolina	744,808	64,272	8.63%
43	South Dakota	90,040	85,868	95.37%
44	Tennessee	1,430,966	1,430,966	100.00%
45	Texas	2,209,031	839,798	38.02%
46	Utah	154,784	154,784	100.00%
47	Vermont	128,303	82,261	64.11%
48	Virgin Islands	17,039	0	0.00%
49	Virginia	496,555	323,863	65.22%
50	Washington	919,487	829,625	90.23%
51	West Virginia	286,123	144,911	50.65%
52	Wisconsin	585,305	317,106	54.18%
53	Wyoming	52,074	0	0.00%
	TOTALS	40,147,539	23,117,668	57.58%

The unduplicated Medicaid enrollment figures include individuals in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards. The unduplicated managed care enrollment figures include enrollees receiving comprehensive and limited benefits.

Source: Centers for Medicare and Medicaid Services,
<http://cms.hhs.gov/medicaid/managedcare/mcsten02.pdf>

Medicaid Agency Contacts/Websites

State	Yes/ No	Contact	Telephone/E-mail	Agency Website
Alabama	No	Kathy Hall	334-242-5007 khal@Medicaid.state.al.us	www.Medicaid.state.al.us
Alaska	No	Teri Keklak	907-334-2424	www.hss.state.ak.us/dma
Arizona	Yes	Bonnie Ballard	602-417-4035	www.ahcccs.state.az.us
Arkansas	Yes	Will Taylor	501-682-8368	www.medicaid.state.ar.us
California	Yes	Dr. Lipscomb	916-657-0560	www.dhs.ca.gov
Colorado	Yes	Bill Bush	303-866-7411	www.chcpf.state.co.us
Connecticut	No	Michelle Parsons	860-424-5117	www.dss.state.ct.us
DC	No	Pat Squires	202-698-1705	dchealth.dc.gov
Delaware	No	Jo Rubicki	302-255-9575	www.state.de.us/dhss/dph
Florida	No	Melanie Brown-Wooter	850-487-3881	www.fdhc.state.fl.us/Medicaid
Georgia	Yes	Margie Preston	404-651-5783	www.communityhealth.state.ga.us
Hawaii	No	Yvette Hanley	808-692-8072	www.state.hi.us/dhs
Idaho	No	Gail Gray	208-364-1833	www2.state.id.us/dhw/medicaid
Illinois	Yes	Steve Bradley	217-785-2867	www.state.il.us/dpa/html/medicaid
Indiana	No	Rhonda Webb	317-233-4455	www.state.in.us/fssa/servicedisabl/Medicaid
Iowa	Yes	Marty Schwartz	515-281-5147	www.dhs.state.ia.us/MedicalServices/MedicalServices.asp
Kansas	Yes	Brenda Kudar	785-296-4422	www.srskansas.org/main
Kentucky	Yes	Wanda Fowler	502-564-4321 wanda.fowler@mail.state.ky.us	chs.state.ky.us/dms
Louisiana	Yes	Kandis Whittington	225-342-9490	www.dhh.state.la.us/medicaid

State	Yes/ No	Contact	Telephone/E-mail	Agency Website
Maine	Yes	Lauren Biczak	207-287-1091 laureen.biczak@maine.gov	www.state.me.us/bms
Maryland	No	Linda Lee Green	410-767-1723	www.dhmh.state.md.us
Massachusetts	No	Janet Hunter Haley Terrell (Home Care)	617-210-5683 617-988-3231	www.state.ma.us/dma
Michigan	No	Carol Danieli	406-444-3995	www.mdch.state.mi.us/msa/mdch
Minnesota	Yes	Brian Osberg	651-284-4388	www.dhs.state.mn.us
Mississippi	No	Faye Johnson	601-206-2900	www.dom.state.ms.us
Missouri	No	Sanda Levels Greg Vadner	573-751-6926 573-751-6922	www.dss.state.mo.us/dms
Montana	Yes	Denise Brunette	406-444-3995	www.dphhs.state.mt.us
Nebraska	Yes	Dr. Chris Wright	402-471-9136	www.hhs.state.ne.us/med/
Nevada	No	Marti Cote	775-684-3748	http://www.hr.state.nv.us/
New Hampshire	No	Mindy Chavenalt	603-271-4357	
New Jersey	No	Edward Vaccaro	609-588-2721	www.state.nj.us/humanservices/dmahs
New Mexico	No	Suzanne Shannon	505-272-8055 (8033)	www.state.nm.us/hsd/mad
New York	No	Deborah Bush	518-473-5336	www.health.state.ny.us/nysdoh/medicaid
North Carolina	Yes	Janet Tudor (nurse)	919-857-4011	www.dhhs.state.nc.us/dma/
North Dakota	Yes	Karen Tescher	701-328-4893	lnotes.state.nd.us/dhs/dhsweb.nsf/ ServicePages/MedicalServices
Ohio	No	Robin Colby	614-466-6420	www.state.oh.us/odjfs/ohp/
Oklahoma	Yes	Nelda Paden	405-522-7398	www.ohca.state.ok.us
Oregon	No	Allison Knight	503-945-6958	www.dhs.state.or.us

State	Yes/ No	Contact	Telephone/E-mail	Agency Website
Pennsylvania	No	Dr. Chris Gorton	717-783-4349	www.dpw.state.pa.us/omap/dpwomap
Rhode Island	No	Ellen Morro	401-462-6311	www.dhs.state.ri.us/dhs
South Carolina	Yes	Jim Bradford	803-898-2622	www.dhhs.state.sc.us
South Dakota	Yes	Randy Hanson	605-773-3495	www.state.sd.us/social/medical
Tennessee	Yes	Susie Baird	615-741-8136	www.state.tn.us/tenncare
Texas	Yes	Nora Cox	512-424-6669	www.hhsc.texas.gov/Medicaid
Utah	Yes	Marilyn Haynes-Brokopp	800-622-9651	hlunix.hl.state.ut.us/medicaid
Vermont	No	Julie Trotter	802-241-3985	www.dsw.state.vt.us/districts/ovha
Virginia	Yes	Jeff Nelson	804-786-7933	www.cns.state.va.us/dmas
Washington	No	Dr. Eric Hougher	360-725-1586	fortress.wa.gov/dshs/maa
West Virginia	Yes	James Bradley	304-558-5984	www.wvdhhr.org/bms
Wisconsin	No	Russ Peterson	608-266-1720	www.dhfs.state.wi.us/Medicaid
Wyoming	No	Fran Kadez	307-777-5511	wdhfs.state.wy.us/WDH/medicaid

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