City University of New York (CUNY)
CUNY Academic Works

Publications and Research

CUNY Graduate School of Public Health & Health Policy

4-21-2017

Legal Mapping Analysis of State Telehealth Reimbursement Policies

Kate E. Trout
Peru State College

Sankeerth Rampa
University of Nebraska Medical Center

Fernando A. Wilson
University of Nebraska Medical Center

Jim P. Stimpson
CUNY School of Public Health

How does access to this work benefit you? Let us know!

Follow this and additional works at: http://academicworks.cuny.edu/sph_pubs

Part of the Health Law and Policy Commons, and the Public Health Commons

Recommended Citation
Trout, Kate E.; Rampa, Sankeerth; Wilson, Fernando A.; and Stimpson, Jim P., "Legal Mapping Analysis of State Telehealth Reimbursement Policies" (2017). *CUNY Academic Works.*
http://academicworks.cuny.edu/sph_pubs/152

This Article is brought to you for free and open access by the CUNY Graduate School of Public Health & Health Policy at CUNY Academic Works. It has been accepted for inclusion in Publications and Research by an authorized administrator of CUNY Academic Works. For more information, please contact AcademicWorks@cuny.edu.

Legal Mapping Analysis of State Telehealth Reimbursement Policies

Kate E. Trout, PhD MPH[1], Sankeerth Rampa, MBA MPH[2], Fernando A. Wilson, PhD[2], Jim P. Stimpson, PhD[3]

1 Peru State College, P.O. Box 10, Peru, NE 68421, 402-872-2231 | ktrout@peru.edu

[2] University of Nebraska Medical Center, 984350 Nebraska Medical Center, Omaha, NE 68198-4350

[3] City University of New York, Graduate School of Public Health and Health Policy, 55 W. 125th St., New York, NY 10027

Corresponding author: Jim P. Stimpson, City University of New York, Graduate School of Public Health and Health Policy, 55 W. 125th St., New York, NY 10027, 646-364-9773, jim.stimpson@sph.cuny.edu

ABSTRACT

Background: There exists rapid growth and inconsistency in the telehealth policy environment, which makes it difficult to quantitatively evaluate the impact of telehealth reimbursement and other policies without the availability of a legal mapping database.

Introduction: We describe the creation of a legal mapping database of state-level policies related to telehealth reimbursement of healthcare services. Trends and characteristics of these policies are presented.

Materials and Methods: Information provided by the Center for Connected Health Policy was used to identify state-wide laws and regulations regarding telehealth reimbursement. Other information was retrieved using: (1) LexisNexis database, (2) Westlaw database, and (3) retrieval from legislative websites, historical documents, and contacting state officials. We examined policies for live video, store and forward, and remote patient monitoring (RPM).

Results: In the United States, there are 24 states with policies regarding reimbursement for live video transmission. Fourteen states have store and forward policies and 6 states have RPM related policies. Mississippi is the only state that requires reimbursement for all three types of telehealth transmission modes. Most states (47 states) have Medicaid policies regarding live video transmission, followed by 37 states for store and forward and 20 states for RPM. Only thirteen states require that live video will be reimbursed “consistent with” or at the “same rate” as in-person services in their Medicaid program.

Discussion: There are no widely accepted telehealth reimbursement policies across states. They contain diverse restrictions and requirements that present complexities in policy evaluation and determining policy effectiveness across states.

INTRODUCTION

Telehealth technologies have the potential to provide diverse cost savings, and an array of positive outcomes including increased volume of healthcare services, time-savings for healthcare professionals, and a reduction of waste.[1-3] Telehealth makes it possible for people in remote areas to connect to primary care physicians and specialists across geographical distances, improving access to health assessments, diagnosis, interventions, consultation, supervision, and access to information.[4] Thus, telehealth technologies can substantially improve quality of care, and create efficiencies in healthcare delivery, which provides motivation for state policymakers and other relevant stakeholders to develop and implement policies that translate into increased utilization of these technologies. In fact, about half of state laws related to telehealth services were implemented within the last five years.[5] Many of these policies related to reimbursement, which has been the biggest barrier to telehealth use.[6] In order for providers to more widely adopt and utilize these technologies, services delivered via telehealth need to be reimbursable. Unfortunately, there is a wide range of telehealth-related reimbursement and other policies across the states, and it is unclear which of these policies are most promising in helping telehealth achieve its potential benefits for patients and providers.

An important reason for this inconsistency and uncertainty in the telehealth policy environment is that it is difficult to quantitatively evaluate the impact of telehealth reimbursement and other policies without the availability of a legal mapping database. Legal mapping involves the creation of a database suitable for statistical analysis by defining variables based on specific characteristics of a law or statute. This methodology has been used to create legal mapping databases for laws pertaining to distracted driving, air quality, child care safety seat, dental hygiene, and several other categories of laws.[7] Without a legal mapping database, it

is difficult to empirically determine the statistical impact of laws and their specific characteristics after they are implemented. A legal mapping database for telehealth policies would provide an opportunity to determine whether these policies are achieving their goals in promoting utilization of telehealth technologies, improving health outcomes, and increasing access to care. It would also help identify the specific characteristics of telehealth policies that were effective or ineffective in achieving these goals.

In this paper, we describe the development of a legal mapping database for telehealth reimbursement policies which maps every state law related to telehealth that has been implemented over the preceding twenty years. We present an overview of the telehealth reimbursement policy environment faced by healthcare providers in every state. Finally, we discuss state Medicaid program policies that have been enacted to address reimbursement of services delivered via telehealth technologies.

METHODS

The Center for Connected Health Policy (CCHP) develops a report on state telehealth policies and reimbursement schedules for all states plus the District of Columbia. We used the CCHP's September 2014 report on state telehealth policies and reimbursement schedules as a secondary source to identify current state-wide laws and regulations regarding telehealth reimbursement for all healthcare professionals.[8] Only legislative statutes were included and, thus, executive orders and other regulations were excluded from the analysis. We examined statutes related to both commercial insurers and state Medicaid coverage. CCHP's February 2015 report was used as the secondary data source to identify Medicaid policies and regulations regarding telehealth reimbursement.[9] Effective dates of laws and regulations were manually retrieved by using three different sources: (1) LexisNexis database, (2) Westlaw database, and (3) retrieval

from legislative websites, historical documents, and contacting state officials. Policies and regulations were included if they were state-wide policies that govern telehealth reimbursement or policies and regulations specific to Medicaid programs related to telehealth. The codebook was created by extracting themes and variables that emerged in the course of a complete review of the legal texts.

Every effort was made to ensure accuracy of the legal text interpretation and data entry. Thirty percent of entries were randomly selected, and entered using two raters. The second rater was blinded to the initial rater's results, and independently coded the legal texts for all of the variables. Arguments in data entry were examined by the supervising researcher, and complete agreement was reached among the two raters and supervising researcher. The full codebook, dataset, and protocol are available on the Open Science Framework.[10] To determine the internal validity of the secondary data source, approximately 30 percent of the policies and regulations were randomly selected to confirm the accuracy of the legal text. Each legal text was validated from digital archives on state legislative websites, and content was compared to that documented in the CCHP report. Only one (0.7%) discrepancy was found in the content of the legal texts among the 131 entries that were validated.

RESULTS

There are 3 major transmission modes of telehealth including: (1) live video, (2) store and forward, and (3) remote patient monitoring (RPM). Live video transmission allows distant physicians to see patients in real time through the use of telehealth technologies. Store and forward telehealth technologies store images for physicians to review at a later time. Remote patient monitoring allows distant physicians to monitor patient vitals and conditions from

another location. Each transmission mode has benefits in different sectors of the healthcare delivery system.

Statewide policies and regulations

Statewide telehealth reimbursement for live video transmission

In the United States, there are 24 states that have policies regarding reimbursement for live video transmission for services. Over half (53%; n=16/30) of the live video related policies were implemented in 2012 or later (Figure 1). Twenty-one states (22 policies) have policies requiring some type of reimbursement for live video transmission via telehealth (Table 1), which may include restrictions. Out of these states, five (24%) states restrict live video based on provider type, service type, and/or facility type. For example, Montana restricts live video by provider to include telehealth reimbursement for physicians, Advanced Practice Registered Nurses (APRNs), Registered Professional Nurses (RPNs), certified diabetes educators, and certified genetic counselors. Montana also restricts reimbursement by the facility type to include reimbursement for facilities such as Critical Access Hospitals (CAHs), hospitals, long-term care facilities, mental health centers, hospice, outpatient centers for surgical services, and outpatient centers for primary care.

Statewide telehealth reimbursement for store and forward

Fourteen states (16 policies) have store and forward policies (Figure 1). The majority of the policies were effective in 2014 (Figure 2). Out of the fourteen states (16 policies) that have store and forward policies, only 4 states require any type of reimbursement. In contrast, 7 states exclude reimbursement for store and forward technologies because their telehealth definition states that interactions of telehealth and/or telemedicine must occur in “real-time”, “interactive”,

or with the patient and/or physician "physically present" during the interaction. All policies (n=4) requiring any type of reimbursement for store and forward transmission were implemented in 2013 and 2014.

Of four states that require any type of reimbursement for store and forward telehealth transmission, two (50%) states restrict reimbursement based on provider type, service type, and/or facility type. Similar to live video, Montana restricts store and forward by provider and by facility type, and coverage is required for the same providers and facilities as live video transmission. Providers include physicians, Advanced Practice Registered Nurses (APRNs), Registered Professional Nurses (RPNs), certified diabetes educators, and certified genetic counselors. Facilities requiring reimbursement for store and forward include Critical Access Hospitals (CAHs), hospitals, long-term care facilities, mental health centers, hospice, outpatient centers for surgical services, and outpatient centers for primary care. Only one state (OH) has restrictions for store and forward transmission by the type of service delivered, these services include coverage for speech language pathology.

Statewide telehealth reimbursement for remote patient monitoring (RPM)

Six states have RPM related policies (Figure 1) For RPM, 67% (n=4/6) of the policies were implemented in 2014. Out of the 6 states (6 policies) that had RPM related policies, only 4 require any type of reimbursement for these telehealth technologies. Mississippi is the only state that requires reimbursement for all three types of telehealth transmission modes. However, Mississippi restricts RPM reimbursement by the service type where a person must be diagnosed in the last 18 months with one or more chronic condition, as defined by CMS. Two other states (AL, NY) have policy restrictions for RPM transmission based on facility type, which include applications under the law for home health agencies and licensed home care services agencies.

Additionally, Mississippi and New York have restrictions on policies regarding RPM telehealth reimbursement based on the monitoring device utilized. Figure 4 summarizes the states which have different types of reimbursement restrictions.

Statewide laws requiring Reimbursement at the "same rate"

Table 2 summarizes the current states that require telehealth reimbursement at the same rate as in-person services; few states have incorporated "same rate" or "consistent" reimbursement to in-person services into their policies.

Medicaid Policies and Regulations

Medicaid Telehealth Reimbursement Policies

Medicaid policies vary in content across each state. There are diverse characteristics regarding Medicaid policies content for live-video transmission, store and forward, and remote patient monitoring. Most states (47 states, 118 policies) have Medicaid policies regarding live video transmission, followed by 37 states (48 policies) for store and forward and 20 states (35 policies) for RPM. Forty-five states (100 policies) require some type of Medicaid coverage for live video transmission, which may include restrictions. Twelve states (19 policies) require any type of Medicaid reimbursement for store and forward, and eighteen states (29 policies) for RPM respectively. Table 3 shows the states that have Medicaid policies requiring any type of reimbursement for live video, store and forward, and remote patient monitoring.

Medicaid telehealth reimbursement for live video transmission

Out of the forty-five states (100 policies) that require some type of Medicaid coverage for live video, the most common restrictions included service type (31 states; 69%), provider type

(20 states; 44%), and facility type (9 states; 20%). Figure 5 shows the most common restrictions in Medicaid live video reimbursement policies. Figures 6 through 8 illustrate the common services, providers, and facilities covered when restrictions in the policies are present for Medicaid live video reimbursement.

Medicaid telehealth reimbursement for store and forward

Out of the twelve states (19 policies) that require any type of Medicaid reimbursement for store and forward, the most restrictions included service type (7 states; 58%) and program plan (3 states; 25%) with no restrictions listed for provider type and facility type. Twelve states exclude store and forward in the definition of telehealth and/or telemedicine (Table 4). When restrictions are present some services reimbursed include radio/ultrasound (AZ, CO, KY, MS, NE, OK), dermatology (AZ, CA), ophthalmology (AZ, CA). Program plans include fee for service for specific health services (AZ), fee for service and managed care program (AZ), and state medical assistance programs (CO, MN). However, policies also provide multiple restrictions in the same policy. For example, Arizona has a policy to cover store and forward technologies under the managed care program for dermatology, radiology, ophthalmology, and pathology, where the reimbursement is restricted by program plan and service type.

Medicaid telehealth reimbursement for remote patient monitoring (RPM)

Out of the eighteen states (29 policies) that require any type of Medicaid reimbursement for RPM, the most restrictions included service type (8 states; 44%), health conditions (8 states, 44%), provider type (7 states; 39%), program plan (7 states; 39%), technology device requirements (7 states; 39%), and facility type (4 states; 22%). All 8 states that restricted by service type for RPM included coverage of home health services, and 4 states reimburse for

skilled nurse visits (IN, KS, TX, UT). One state (MD) excludes reimbursement for home health monitoring services. Diabetes (AL, CO, IN, TX, UT), congestive heart failure (AL, CO, IN, KS, TX, VT) were common health conditions reimbursed by Medicaid when restrictions by condition were present. Six states (CO, IN, KS, PA, TX, UT) also identified other health conditions reimbursed by Medicaid when restricted by health condition. Technology specifications for RPM Medicaid reimbursement included the following: program equipment will have full transmission capability in the patient's home (CO), data transmission occurs through a secure telephone call (AL), telemedicine as "not a telephone transmitter for trans-telephonic monitoring" (IN), home telehealth uses real-time, interactive, audio/video telecommunication equipment to monitor (KS), and the use of Personal Emergency Response System devices (MO). Some states offer more detail regarding the device for RPM. For example, Louisiana requires that the devise at a minimum the system must: (1) monitor the home's points of egress and entrance, (2) detect falls, (3) detect movement or lack of movement, (4) detect whether doors are opened or closed, (4) provide a push button emergency alert system. All four states (IN, TX, UT, VT) that restricted Medicaid reimbursement by facility type included home health agencies as reimbursed facilities.

Medicaid policies requiring Reimbursement at the "same rate"

Thirteen states require that live video will be reimbursed "consistent with" or at the "same rate" as in-person services in the Medicaid program (Table 5). Only one state for each store and forward (MS) and RPM (TX) requires that reimbursement will be at the "same rate" or "consistent" with in-person services in their Medicaid program. Texas stipulates that the Medicaid program will reimburse for home tele-monitoring in the "same manner" as other

professional services provided by a home health agency. For store and forward, Mississippi requires that the Medicaid program cover store and forward services equal to in-person services.

DISCUSSION

There are limited statewide telehealth reimbursement policies that require reimbursement for telehealth across the 50 states and the District of Columbia. Less than half of the states have policies for reimbursement of services delivered via live video. Furthermore, policies regarding store and forward and RPM telehealth transmission are less common, with only 14 store and forward policies and 6 RPM policies across the states. However, even some of these policies exclude coverage based upon the definition of telehealth. Only four states require any type of coverage for store and forward and RPM transmissions. Healthcare reform through the Affordable Care Act (ACA) and Health Information Technology for Economic and Clinical Health (HITECH) Act has had a positive impact on technology adoption in the US healthcare system.[11] The results suggests that policy makers also increased their focus on telehealth reimbursement-related policies during this time, because the majority of telehealth reimbursement policies became effective in recent years, from 2012 to 2015.

There is some evidence that reimbursements for telehealth may be lower than for the comparable service delivered face-to-face despite the recent proliferation of laws related to telehealth. A recent study found that telehealth reimbursements for primary care providers were 40% lower than non-telehealth reimbursements of services.[5] Our analysis of state laws suggests that few states specifically mandate that reimbursement rates be equitable between telehealth and non-telehealth services. Therefore, providers have little incentive to utilize, adopt, or code for these technologies if they are reimbursed at a lower rate than in-person services. If services delivered via telehealth are being reimbursed, but at a lower rate than in-person services, there is

reduced incentive for providers to use technologies that require significant investments and increase operational costs, even if these technologies ultimately improve patient outcomes. In contrast, providers face significant economic incentives to adopt EHRs because this was an important federal policy priority. It is unclear how provider incentives to invest in telehealth technologies will change under alternative payment models such as pay-for-performance reimbursement. In this case, providers will have to evaluate whether telehealth's improvement of patient outcome and process measures—and thus reimbursement—relative to non-telehealth service delivery justifies the additional cost of the technology.

Our study found that most states have policies for live video transmission, but a limited number of states provide reimbursement policies for store and forward and RPM transmissions. State policy makers should focus on expanding telehealth definition policies to include diverse transmission modes, where each different transmission mode increases access to different healthcare services. Live video transmission occurs in real time, and offers the delivery of the most diverse services such as consultations, treatments, and diagnostic evaluations. Store and forward telehealth technologies store images for physicians to review at a later time, often used for services such as dermatology images, x-rays, and other diverse medical images. Remote patient monitoring allows distant physicians to monitor the vitals and conditions of patients from another location. Requiring reimbursement for all these modes could increase access to care for diverse patient populations, especially those located in rural or medically underserved areas.

Our results found that Mississippi is the only state that requires coverage for all three types of telehealth transmission modes for statewide policies. Additionally, Mississippi has separate policies in Medicaid that require coverage for all three modes of transmissions.[9]

Consequently, Mississippi has been identified as the emerging leader in telehealth,[12,13] and has outperformed the traditional healthcare system for many patients.[14]

The main limitation of the study is that it is possible that our review may have overlooked laws relevant to telehealth. In this analysis, we relied on the policies reported by CCHP. However, efforts were made to validate these policies by selecting 30% of the policies and comparing the content to that presented on legislative websites. In addition, the telehealth policy environment is rapidly changing, and thus there may be newly introduced bills or laws after September 2014 that were not included in our legal mapping database. Last, Medicaid and statewide policies were collected at two different time points (February 2015 and September 2014) where statewide policies may have become effective during the time period, making it difficult to directly compare Medicaid and statewide policies directly to each other. However, the information provides the most comprehensive understanding of gaps that may exist in the currently policy environment.

CONCLUSION

Statewide telehealth reimbursement policies should promote utilization of telehealth technologies to improve health outcomes and healthcare service efficiency. We determined that there are no current standards or widely accepted telehealth policies across the states. Policies regarding telehealth reimbursement contain diverse restrictions and requirements that present complexities in policy evaluation and determining policy effectiveness across states. Research is needed to examine reasons for this and to identify policy solutions to remedy this disparity, if necessary. The results of this legal mapping database will provide a foundation for future evaluations of telehealth policies.

ACKNOWLEDGEMENTS

This study was funded by the Health Care Cost Institute.

This project was found to be exempt from IRB review by the University of Nebraska Medical Center IRB (#174-15-EX).

REFERENCES

1. Department of Health and Human Services (DHHS HRSA). How can telehealth technology benefit primary care? Retrieved from: http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/howcantelehealth.html Accessed October 14, 2015.

2. Zawada ET, Herr P, Larson D, Fromm R, Kapaska D, Erickson D. (2009). Impact of an intensive care unit telemedicine program on a rural health care system. Postgraduate medicine 2009;121(3):160-170.

3. Mueller KJ, Potter AJ, MacKinney AC, Ward MM. Lessons From Tele-Emergency: Improving Care Quality And Health Outcomes By Expanding Support For Rural Care Systems. Health Affairs 2014;33(2):228-234.

4. Kvedar J, Coye MJ, Everett W. Connected health: A review of technologies and strategies to improve patient care with telemedicine and telehealth. Health Affairs 2014;33(2):194-199.

5. Wilson FA, Trout K, Rampa S, Stimpson JP. *An Examination of Private Payer Reimbursements to Primary Care Providers for Healthcare Services Using Telehealth, United States 2009–2013*. Washington, DC: Health Care Cost Institute and National Academy for State Health Policy; February 2016. DOI: 10.13140/RG.2.1.1049.5765. http://www.healthcostinstitute.org/files/HCCI-Issue-Brief-Examination-of-Private-Payer-Reimbursements.pdf

6. American Telemedicine Association (ATA). (2015). 2015 ATA Fall Forum. Retrieved from: http://www.americantelemed.org/2015-ata-fall-forum/conference-overview#.Vh6sO03rvL8. Accessed October 14, 2015.

7. Policy Surveillance Program: A LawAtlas Project. http://lawatlas.org/. Accessed January 4, 2017.

8. Center for Connected Health Policy (CCHP). State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia. September 2014. Retrieved from: http://cchpca.org/state-laws-and-reimbursement-policies. Accessed October 15, 2015.

9. Center for Connected Health Policy (CCHP). State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia. February 2015. Retrieved from: http://cchpca.org/state-laws-and-reimbursement-policies. Accessed October 15, 2015.

10. Stimpson JP, Wilson FA. State-Level Analysis of Telehealth Policies. January 2017. Retrieved from: osf.io/uz5m7. Accessed January 12, 2017.

11. DesRoches CM, Charles D, Furukawa MF, et al. Adoption of electronic health records grows rapidly, but fewer than half of US hospitals had at least a basic system in 2012. *Health Aff* 2013;32(8):1478-85.

12. Pittman D. Mississippi emerges as telemedicine leader. 2015. Retrieved from: http://www.politico.com/story/2015/02/mississippi-telemedicine-115515. Accessed October 14, 2015.

13. Versel N. Mississippi emerges as a leader in telemedicine. 2015. Retrieved from: http://medcitynews.com/2015/05/334644/. Accessed October 15, 2015.

14. Robert Wood Johnson Foundation (RWJF). Mississippi Leads the Nation in Telehealth. 2014. Retrieved from: http://www.rwjf.org/en/library/articles-and-news/2014/12/mississippi-leads-the-nation-in-telehealth.html. Accessed October 15, 2015.

Figure 1. Number of states that have any policy for live video, store and forward, and RPM

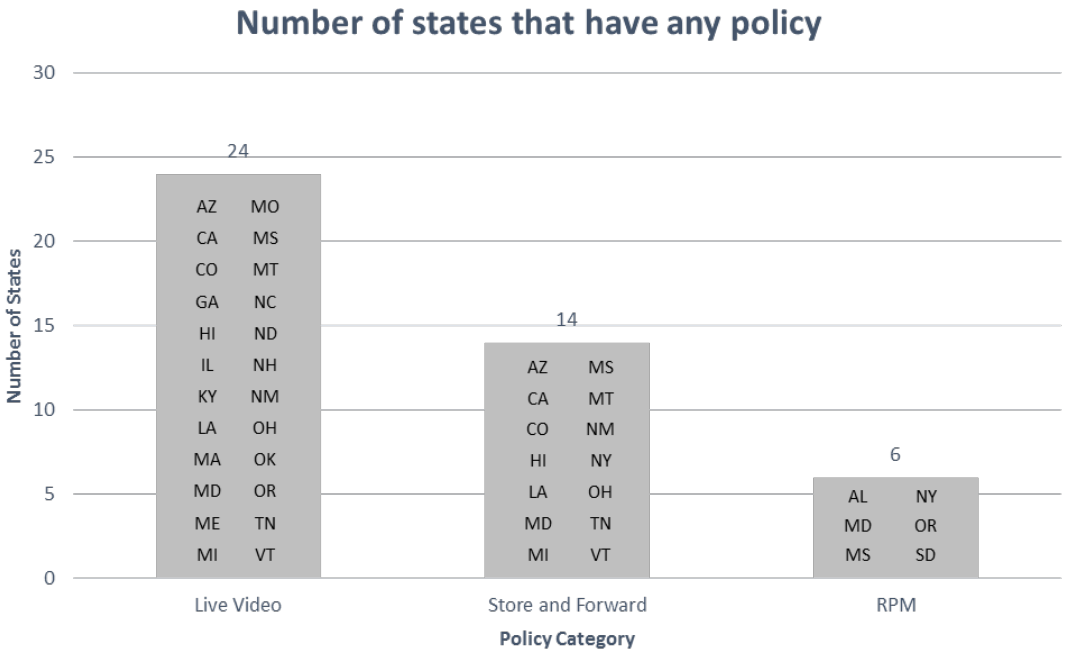


Figure 2. Effective dates of Telehealth Reimbursement Policies

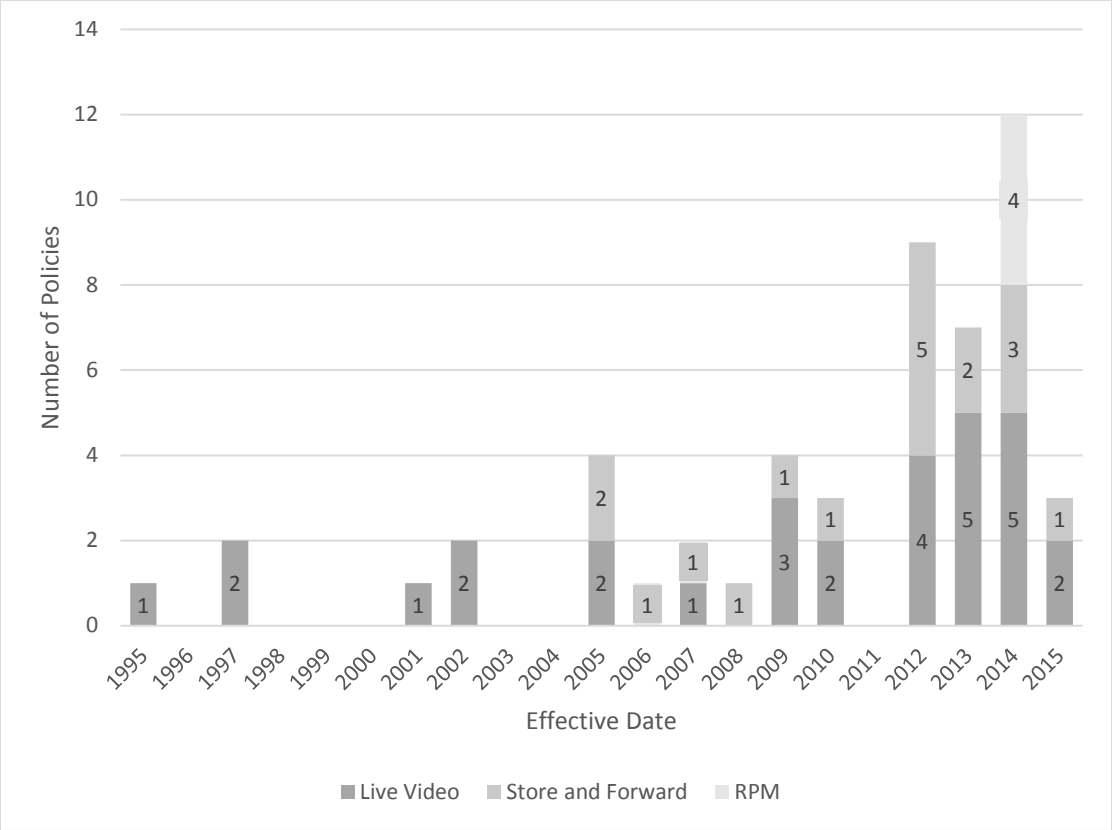


Table 1. States that require any coverage for live video, store and forward, remote patient monitoring via telehealth

States that require any type of coverage for…			
Live Video Transmission		**Store and Forward**	**Remote Patient Monitoring**
AZ	CO	**MS**	AL
GA	HI	MT	**MS**
KY	LA	NM	NY
ME	MD	OH	OR
MI	**MS**		
MO	MT		
NH	NM		
NC	ND		
OK	OR		
TN	VT		
VA			

*May include restrictions by type of services, providers, conditions, and/or monitoring devices

Analysis based on policies extracted from: Center for Connected Health Policy Reports (September 2014). State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia (CCHP, 2014).

Figure 3. Effective dates of Telehealth Reimbursement Policies Requiring Any Reimbursement

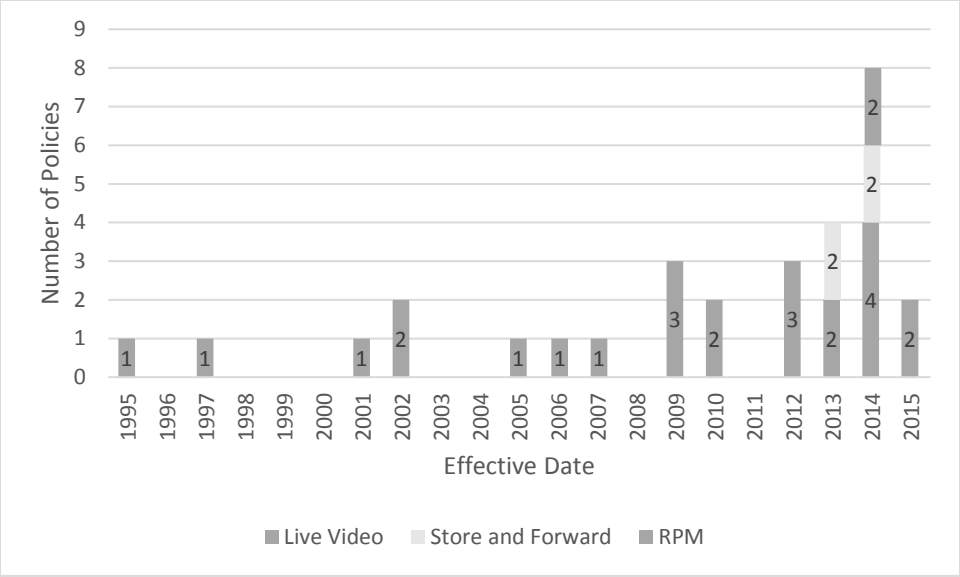


Figure 4. Telehealth Reimbursement Policy Restrictions

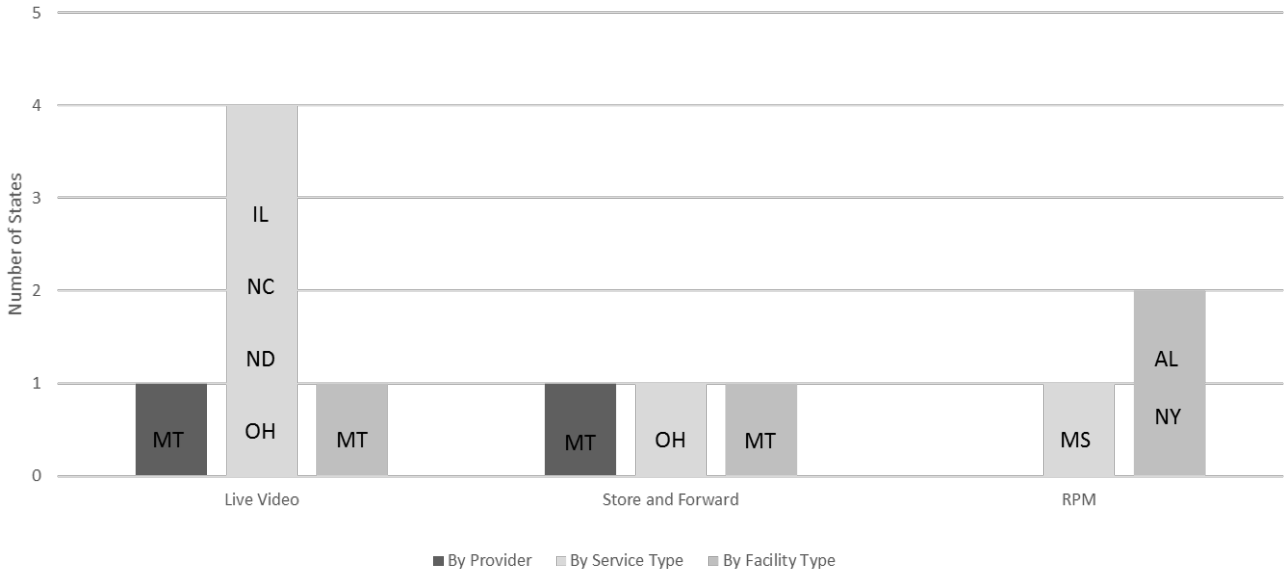


Table 2. States that reimburse at the "same rate" for live video, store and forward, remote patient monitoring via telehealth among statewide policies

States that require reimbursement at the "same rate" as in-person services among statewide policies		
Live Video Transmission	**Store and Forward**	**Remote Patient Monitoring**
HI	MS	(none)
MO	MT	
MT	NM	
NM		
TN		

Analysis based on policies extracted from: Center for Connected Health Policy Reports (September 2014). State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia (CCHP, 2014).

Table 3. Medicaid policies and regulations that require any coverage for live video, store and forward, remote patient monitoring via telehealth

States that require any type of coverage for…		
Live Video Transmission	**Store and Forward**	**Remote Patient Monitoring**
AK MS AL MT AR NC AZ ND CA NE CO NM CT NV DC NY DE OH FL OK GA OR HI PA ID SC IL SD IN TN KS TX KY UT LA VA MD WA ME WI MI WV MN WY MO	AK AZ CA CO IL IN KY MN MS NE NM OK	AK AL AZ CO IN KS LA MA MN MO MS PA SC SD TX UT VT WA

*May include restrictions by type of services, providers, conditions, and/or monitoring devices

Analysis based on policies extracted from: Center for Connected Health Policy Reports (September 2014). State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia (CCHP, 2014).

Figure 5. Common Restrictions in Medicaid Live Video Reimbursement Policies

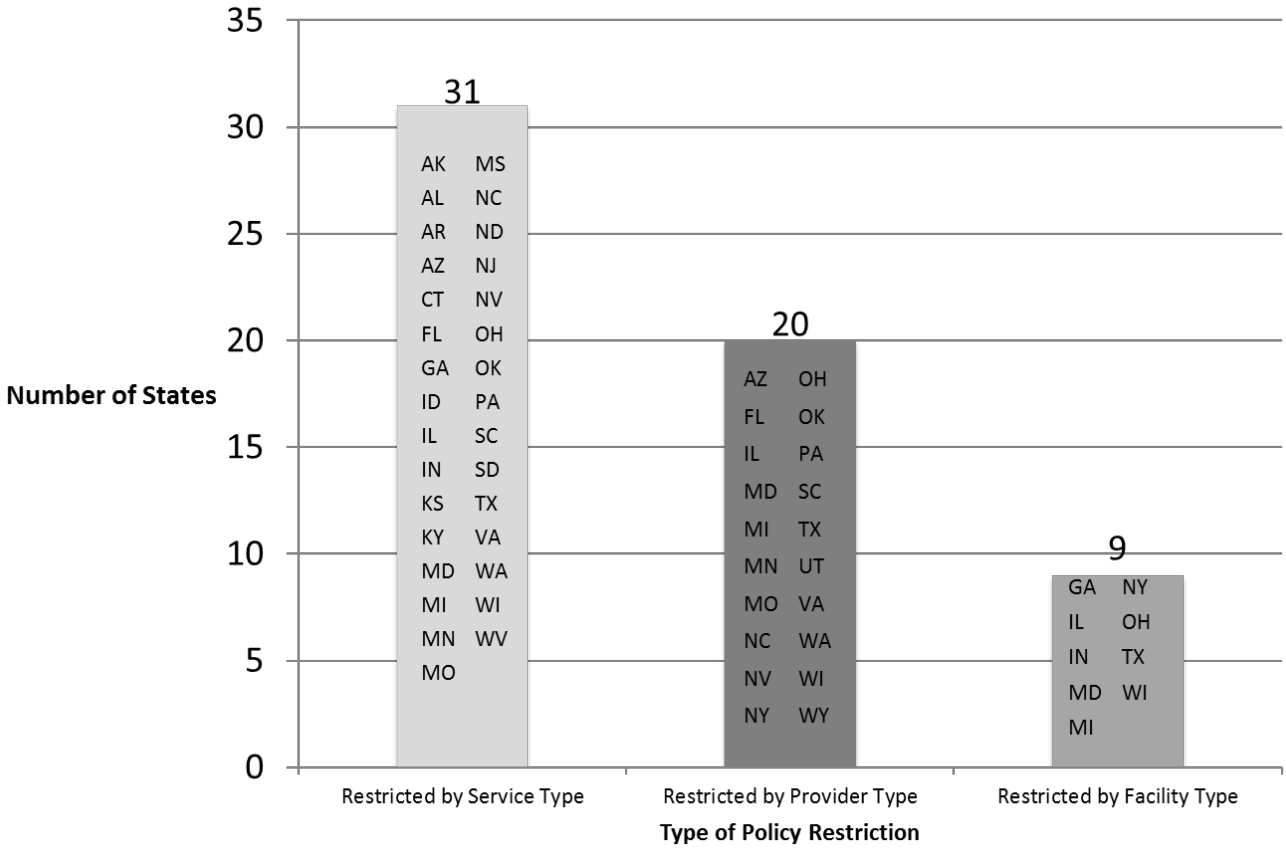
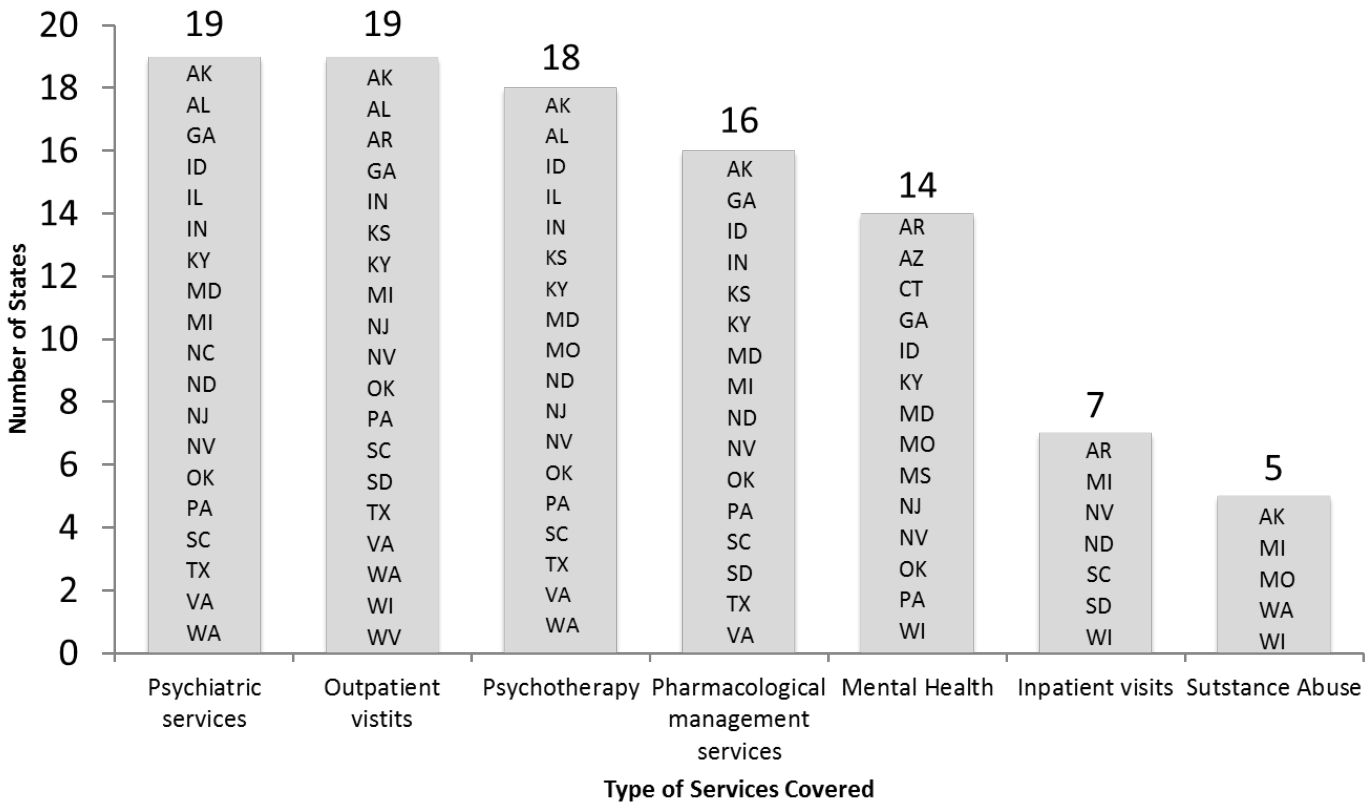
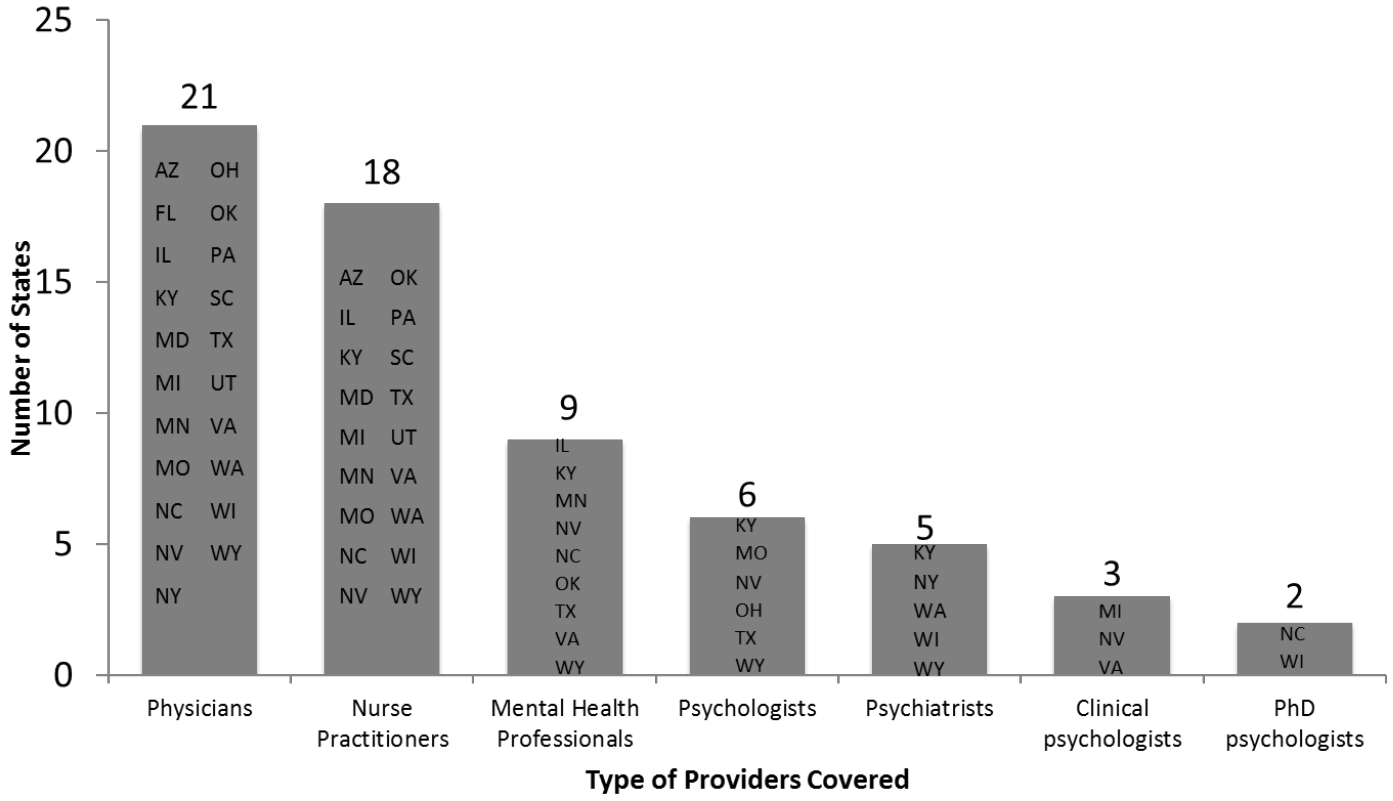


Figure 6. Type services covered by Medicaid when restrictions by service type are present



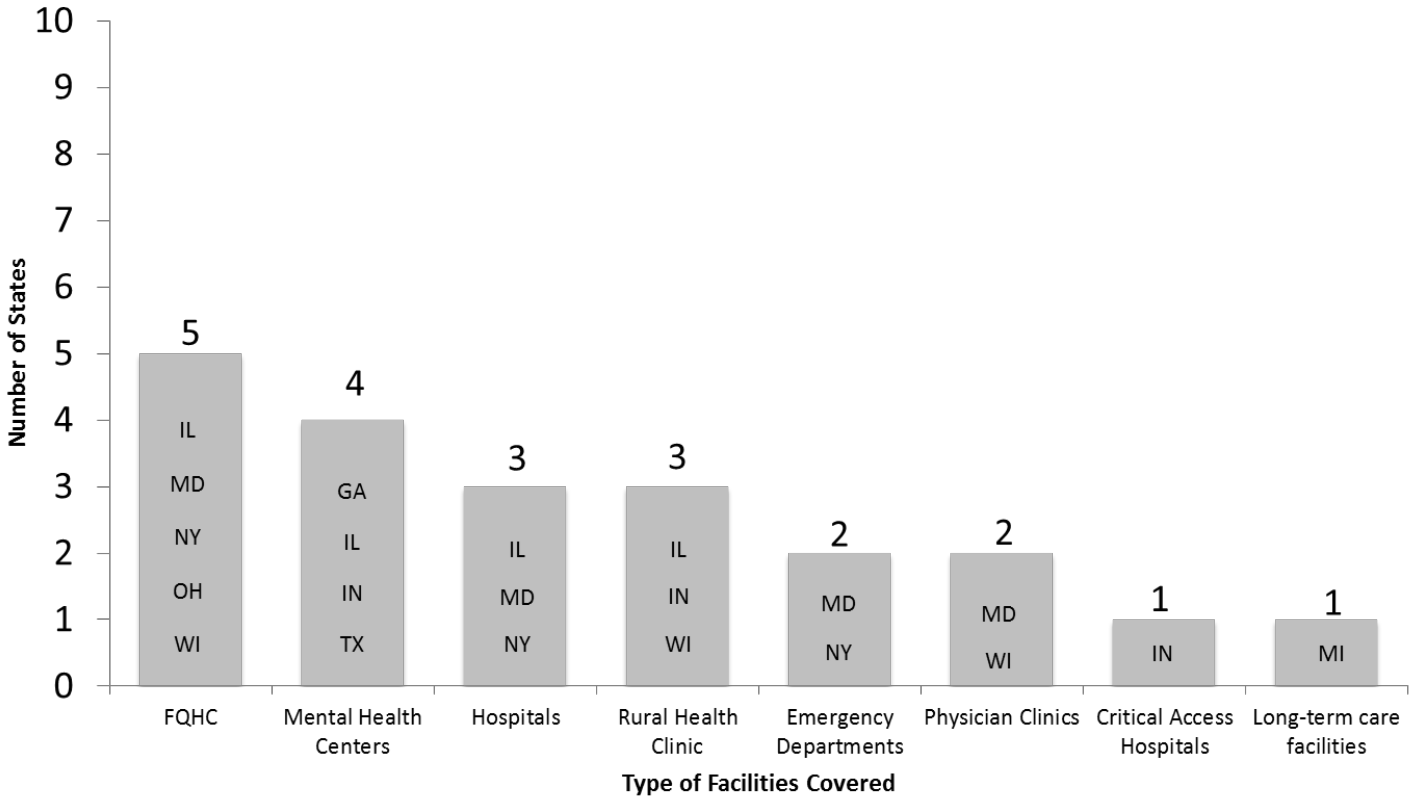
*not inclusive of all accepted services

Figure 7. Type providers covered by Medicaid when restrictions by provider type are present



*not inclusive of all accepted providers

Figure 8. Type facilities covered by Medicaid when restrictions by facility type are present



*not inclusive of all accepted facilities

Table 4. States that exclude store and forward in the definition of telehealth

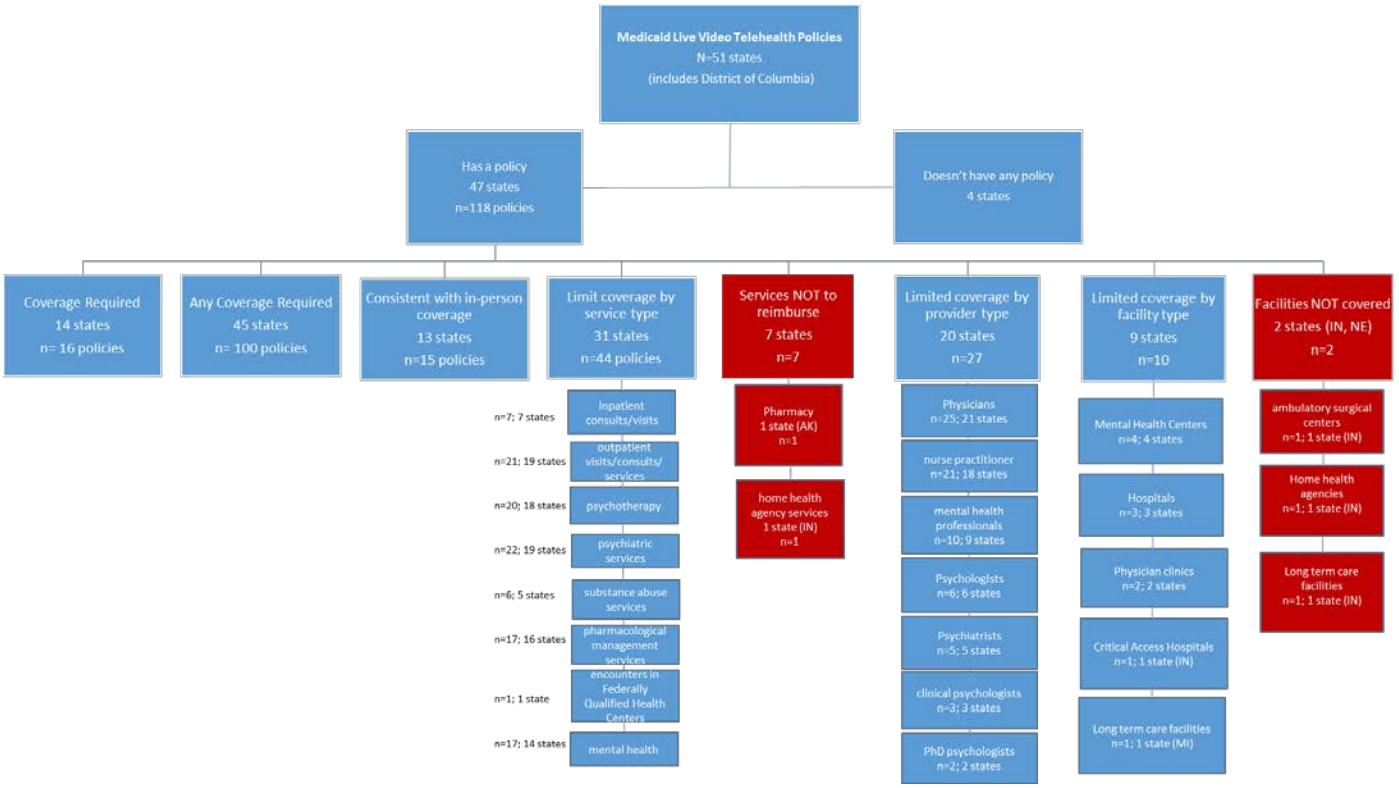
Definition that excludes Store and Forward for telehealth reimbursement	
Statewide	**Medicaid**
AZ	AR
CO	**CO**
LA	KY
MD	**LA**
MI	ME
NY	**MI**
TN	OH
	SD
	TN
	TX
	WV
	WY

Table 5. States that reimburse Medicaid at the "same rate" for live video, store and forward, remote patient monitoring via telehealth

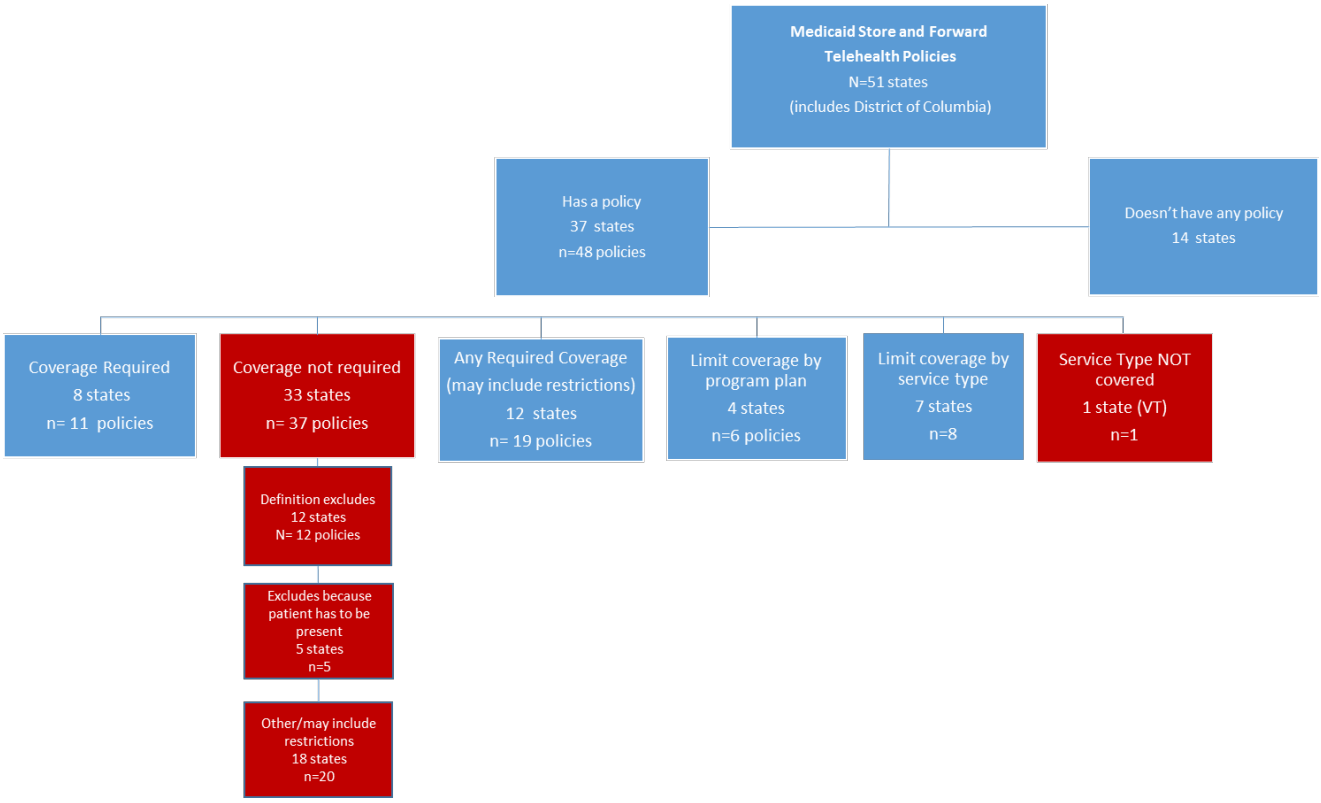
States that require reimbursement at the "same rate" as in-person services for Medicaid		
Live Video Transmission	**Store and Forward**	**Remote Patient Monitoring**
CO DC KS KY MN MO WI ND NE NM NV SD TX	MS	TX

Analysis based on policies extracted from: Center for Connected Health Policy Reports (September 2014).

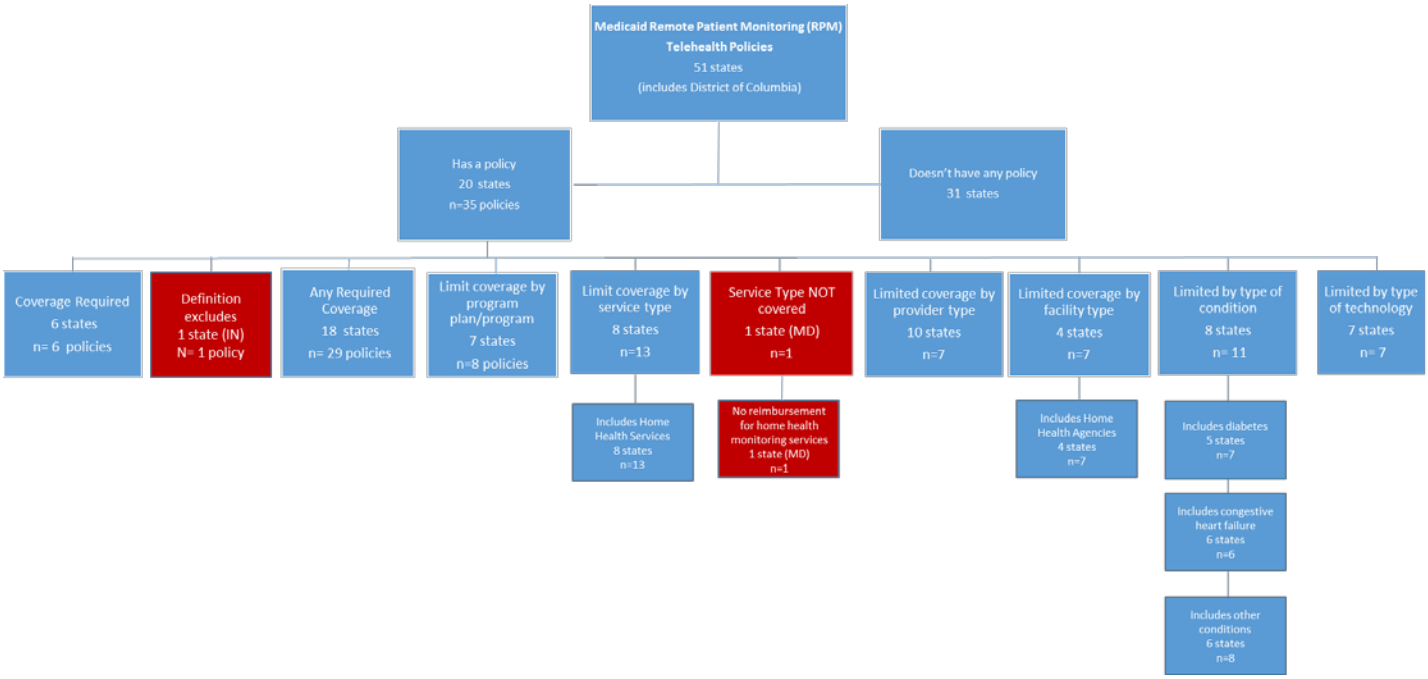
Supplemental Appendix A. Live Video Medicaid Reimbursement Policies



Supplemental Appendix B. Store and Forward Medicaid Reimbursement Policies



Supplemental Appendix C: Remote Patient Monitoring Medicaid Reimbursement Policies



*Categories do not add up to 100% because states may have more than one policy per category

§ Policies with exceptions may exist

Analysis based on policies extracted from: Center for Connected Health Policy Reports (February 2015).