GETTING PAID FOR TELEHEALTH SERVICES

Many hospitals and health systems are using telehealth technologies to improve patient access (particularly in remote or rural locations), monitor and manage chronic conditions and generally deliver health care in a more timely and cost-efficient fashion. There are currently three general modalities of telehealth services. First, the asynchronous transmission of images, test results or other data between a provider and either another provider or a patient. This is commonly referred to as "store and forward" technology and includes services such as the remote interpretation of radiological or cardiology data and email interactions between a patient and a provider. Synchronous or "live" remote communications between a provider and a patient through videoconferencing technology compose the second general category of telehealth services. And finally, telehealth includes remote monitoring and the real-time transmission of clinical data to a provider for purposes of managing chronic conditions such as congestive heart failure or atrial fibrillation.

Acquiring and maintaining telehealth infrastructure is expensive, and this has limited its adoption by many providers. Additionally, payment for telehealth services is very inconsistent between payers and between states. For instance, Medicare covers a limited number of Part B telehealth services for Medicare fee-for-service beneficiaries but only if the patient is present in an authorized rural facility and the interaction occurs in real-time through interactive audio and video systems. Medicare does not currently cover asynchronous store and forward services or remote patient monitoring, except in federal telemedicine demonstration programs in Alaska and Hawaii.

Medicaid coverage for telehealth services has widely expanded in recent years. As of March 2017, 48 states and the District of Columbia require some form of Medicaid payment for telehealth and/or telemedicine services. However, the scope of coverage varies significantly from state to state. The majority of Medicaid programs cover telehealth delivered by synchronous audio-video interactions between a patient and a provider, but fewer cover services through asynchronous store and forward technology or remote patient monitoring. Additionally, each state varies in its definition and usage of the terms "telehealth" and/or "telemedicine." While some states use a single definition to encompass the provision of a broad array of health care services through audio, video or other electronic means, others define "telemedicine" to include only the delivery of clinical services and "telehealth" to include other services such as remote monitoring and data interpretation. Some states also exclude certain modalities from a definition or requiring the service to be interactive or synchronous. Therefore, providers need to be familiar with their state's statutory and regulatory definitions in order to understand the scope of any applicable mandates.

Thirty-one states currently require private payers to provide coverage for telehealth services. Of these, Alaska, Arizona, California, Connecticut, Georgia, Indiana, Kentucky, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Oklahoma, Oregon, Tennessee, Texas and Vermont require private payers to include telehealth services as covered benefits but do not mandate payment for such services.[1,2] Therefore, hospitals and providers in these states may be paid less for a telehealth service than if the same service were provided in person. Additionally, the scope of required coverage varies widely. The most widely required telehealth benefit is the provision of a service through live interactive audio-video technology. However, several states require private payers to cover *all* telehealth services if the same service would be covered if delivered in person. And Alaska, by contrast, requires private telehealth coverage only for mental health benefits.

Arkansas, Colorado, Delaware, District of Columbia, Hawaii, Louisiana, Minnesota, Virginia and Washington require private payers to both cover and pay for telehealth services. However, of these states, only Arkansas, Delaware, Hawaii, Minnesota and Virginia require private payers to pay providers the same amount for a telehealth service as would be paid for the same service if delivered in person. Louisiana and a few other states also require private payers to pay a transmission fee to the originating site in some circumstances.

In addition to state mandates, each payer has its own policies regarding coverage and payment for telehealth services. These policies are often inconsistent between payers, products and/or states. Some private payers follow the more restrictive Medicare model (i.e., where the originating site needs to be a local health facility) while others are less restrictive as to where the patient receives the services. Payer-specific policies are typically available through the provider portal on each payer's website and upon request.

PRACTICAL TAKEAWAY

Telehealth technology is rapidly evolving, and payment for the delivery of telehealth services is currently under construction. Therefore, before making the significant investment into this foray, it is imperative for providers to familiarize themselves with applicable federal and state laws and regulations as well as payer-specific policies to ensure they know the extent of covered services and are appropriately paid for these services.

If you have any questions or would like additional information about this topic, please contact:

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[1] Rhode Island will also require telehealth coverage by private payers effective January 1, 2018.

[2] A few other states (Illinois, Massachusetts and Nebraska) do not require private plans to provide coverage for telehealth services but do regulate the provision of telehealth services in the event such coverage is offered.