TELEHEALTH AND PUBLIC PROGRAMS - EVOLUTION OF TELEHEALTH POLICY IN MEDICARE AND MEDICAID

The concept of using technology to provide health care services from a distance has been with us for centuries. One early example is physicians communicating via telegraph during a consultation. More sophisticated versions of this were even conceived back in the early part of the 20th century. In a cartoon from the February 1925 edition of Science & Invention Magazine, a doctor is shown treating a patient over video. That technology imagined in the illustration was called treating a patient “by radio,” but would not be feasible until decades later and be called telehealth. When the science finally caught up with the idea, policy was forced to respond.

In the mid-1990s, lawmakers on both the federal and state level began discussing creation of policy around a new way to deliver health services. At this point technology had managed to catch up with imagination, but the question was how to regulate it? There were no laws passed to ban the use of telehealth or statutorily limit it. Instead, the first telehealth related policies focused on reimbursing services provided via telehealth, specifically who and when someone would be paid for using telehealth to provide services. These policies were particularly dominant in public health programs, namely Medicare and Medicaid.

In subsequent years, telehealth policy has continued to evolve as policymakers realize the shortage and maldistribution of providers, especially specialists, with many concentrated in urban areas. Increase interest in telehealth has accelerated in recent years as federal and state policymakers face a myriad of concerns such as rising costs, limited resources and public health crises such as Zika and the current opioid epidemic. This increased interest is also affected by the improvements in the technology itself and decrease in cost of it. Telehealth policy has gone beyond just reimbursement issues to encompass areas such as licensing, prescribing and broadband as the technology becomes more intertwined into the health care system, however, reimbursement continues to play a major factor in the utilization of telehealth. This article will focus only on how telehealth policy has evolved in the Medicare and Medicaid programs.

1. TELEHEALTH

Telehealth is the delivery of health services from a distance through the use of technology. Sometimes it may be referred to as “telemedicine”. For the purpose of this article, the term “telehealth” is used. There are three distinct modalities to telehealth to deliver care:

- Live Video (Synchronous) - Live Video is two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service is also referred to as “real-time” and may serve as a substitute for an in-person encounter when it is not available.
• Store-and-forward (Asynchronous) - Store-and-forward technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email communication. The provider who receives the information often looks at it at a later time and the patient is not present when it is being reviewed.

• Remote patient monitoring (RPM) - Remote patient monitoring uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers.

A fourth modality is sometimes included and is referred to as “mHealth” which is the use of mobile devices to provide services but uses one of the other three modalities. Most may be familiar with such services through use of an app. Very little established policies exist that specifically relate to mHealth use and reimbursement because it is often simply providing a service via one of the other three modalities and is recorded as such (for example a real-time video interaction taking place over a patient's phone would be submitted for reimbursement as a live video consultation).

Where the patient is located is called the “originating site” and the location of the practitioner providing services is known as the “distant site.” A service is billed using Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and often must be accompanied by a specific modifier to signify the service was delivered via telehealth, either live video or store-and-forward. Often, payers' telehealth policies will cite specific types of services they will reimburse if the service is delivered via telehealth (for example, general office consultations) or may list specific CPT or HCPCS codes.

II. MEDICARE

Medicare is the federal health insurance program that covers people who are 65 years of age or older, certain youths with disabilities and people with end stage renal disease (ESRD). It was signed into law on July 30, 1965 by President Lyndon B. Johnson. The budget for Medicare was $10 billion and 19 million individuals signed up for it during its first year. In 2017, the budget for Medicare was $705.9 billion and 59 million people were covered. An enrollee receives services through Original Medicare (fee-for-service) which covers some services (Medicare Part A and B) and may have associated costs to the enrollee. To cover some of those associated costs, the enrollee can purchase Medicare supplemental insurance known as Medigap. An enrollee can also receive their Medicare benefits through a private, Medicare-approved insurance company in a Medicare Advantage plan that must cover Medicare Part A and B, but may also offer additional benefits not in Original Medicare. An enrollee generally cannot be in both a Medicare Advantage and Medigap plan at the same time.

a. TELEHEALTH IN MEDICARE

Federal Statutory History of Telehealth in Medicare

The National Information Infrastructure (NII) was created from the High Performance Computing Act of 1991. The NII was to build communications networks, interactive services, interoperable computer hardware and software, computers, databases and consumer electronics to make vast amounts of information available to public and private sectors. Then Vice President Gore had identified telehealth as a key area requiring attention to ensure the progress in the development of the NII. In 1994, the Health Information Application Working group was created and had a subgroup on telehealth. In 1995, the Department of Health and Human Services (HHS) joined forces with the Commerce Department to form the Joint Working Group on
Telemedicine (JWGT). The JWGT was charged with assessing the Federal government's role in telehealth and coordinating telehealth activities across Federal cabinet agencies. Under the Telecommunications Reform Act of 1996, the Secretary of Commerce along with the Secretary of HHS and other appropriate agencies, were required to submit a report on the use of technology to provide health services. A summary of the JWGT's activities as well as findings from federally-funded telemedicine studies and demonstrations were also required. In addition, Congress requested that the report examine questions related to patient safety, the efficacy and quality of services provided and other legal, medical, and economic issues.

In that report, it was noted that, “Although many individuals believe strongly in the potential of telemedicine for providing cost-effective services, not much “hard data” is available to support that belief. Decision-makers want to know the value-added of telemedicine. Lack of solid evaluative information is a significant barrier to the deployment of telemedicine. Given the concerns about technical equipment standards and clinical guidelines, the Federal government has a legitimate interest in protecting the public from unsafe and untested medical technologies.”

These actions showed a keen interest in what telehealth could do, but it also expressed caution. There was much left unknown to policymakers and concerns such as privacy, effectiveness and cost were significant issues that they had very little answers to at that time.

One must also keep in mind that the technology in 1997 was not at the level that one could imagine telehealth accomplishing. In 1997, the accessible consumer technology included the Palm Pilot 1000, an electronic organizer that could synchronize with a desktop computer, the Motorola StarTAC flip phone, Windows 95, cordless telephones with “GigaRange,” DVD players and Apple Powerbook 1400. That same year the Institute of Medicine released a revised edition of a publication that first appeared in 1991, The Computer-Based Patient Record: An Essential Technology for Health Care. The revised edition noted that “support for CPR research and development for CPRs exists, but it has not been provided in the scope and scale necessary to enable major breakthroughs.”

Six years after noting computerized patient records were essential, very little progress in technology and adoption had been made. Technology was not keeping pace with what people thought could be accomplished.

However, despite these lingering concerns over telehealth, it would be a few months later that actual telehealth policy would be adopted by Congress and signed into law by President Bill Clinton. In the Balanced Budget Act of 1997, the first telehealth Medicare law was enacted requiring:

[T]he Secretary to make Part B payments for professional consultation via telecommunications systems with a health care provider furnishing a service for which Medicare payment would be made for a beneficiary residing in a rural county that was designated as a health professional shortage area. In determining the amount of payments for telehealth services, the payments would be subject to Medicare coinsurance and deductible requirements, and balanced billing limits would apply to services furnished by non-participating physicians. Beneficiaries could not be billed for any telephone line charges or any facility fees. In addition, payment for telehealth services would be increased annually by the update factor for physicians' services under the fee schedule.

Additional requirements when telehealth was used included requiring a practitioner physically be with the patient during a consultation and a fee share between the referring provider and the consulting provider.

The next major change in telehealth Medicare policy would come soon after. With the Benefits and Improvement Act of 2000, telehealth reimbursement in Medicare expanded. The types of services that could be delivered through telehealth were increased, the fee sharing was eliminated and telehealth could take place in more places. However, several limitations that restricted the use of telehealth remained in place: only reimbursing for one modality, live video with the exception of allowing the use of store-and-forward in Alaskan and Hawaiian demonstration projects; a specific lists of services that can be reimbursed; a specific list
of providers who could be reimbursed; and limitations on where a telehealth interaction can take place in regards to the type of facility and the geographic location. It is the geographic limitation, in a rural health professional shortage area (HPSA) or non-Metropolitan Statistical Area (MSA), that would in the future cause much consternation to telehealth proponents as it excludes a good portion of Medicare enrollees from accessing services via telehealth and would be cited by the Center for Medicare and Medicaid Services (CMS), the federal agency administering Medicare, as one of the greatest barriers to telehealth utilization.\textsuperscript{17}

In the 2008 Medicare Improvements for Patients and Providers Act, skilled nursing facilities were added to the list of eligible sites where telehealth could take place. There would not be any statutory changes to telehealth Medicare policy until a decade later when the 2018 Bipartisan Budget Act and the SUPPORT for Patients and Communities Act made some expansion in where telehealth can take place, but only for certain conditions, namely ESRD, acute stroke and substance use disorder (SUD).\textsuperscript{18 19}

\textsuperscript{12} Between 2015 and 2018, numerous Congressional members introduced a variety of bills addressing the limitations in law around the use of telehealth in Medicare. While there was bipartisan support for such legislation, the bills failed to move in Congress. Elements of some of these bills found their way into the Bipartisan Budget Act of 2018, but a telehealth bill itself addressing the most significant limitations in Medicare failed to move beyond the introduction phase.

Current Medicare telehealth reimbursement policy includes:

<table>
<thead>
<tr>
<th>Geographic Limitation on where the patient can be located when the services take place</th>
<th>Rural HPSA or non-MSA Statistical area</th>
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<tbody>
<tr>
<td>Type of facility the patient must be located in when the service takes place</td>
<td>• Offices of physicians or practitioners</td>
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<td></td>
<td>• Hospitals</td>
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<td>• Critical Access Hospitals</td>
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<td>• Rural Health Clinics</td>
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<td>• Federally Qualified Health Centers</td>
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<td>• Hospital-based or CAH-based renal dialysis centers (including satellites)</td>
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<td></td>
<td>• Skilled Nursing Facilities</td>
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<td></td>
<td>• Community Mental Health Centers</td>
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<td></td>
<td>• Renal Dialysis facilities (ESRD Services ONLY)</td>
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<td></td>
<td>• Home (certain ESRD and SUD services ONLY)</td>
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<td></td>
<td>• Mobile Stroke Units (acute stroke treatment ONLY)</td>
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<tr>
<td>Type of modality eligible to deliver the service</td>
<td>Live video unless it is a demonstration project in Alaska or Hawaii in which case store-and-forward was also eligible</td>
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<tr>
<td>Type of services that are reimbursed</td>
<td>Specific list of services noted by their CPT or HCPCS codes</td>
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<tr>
<td>Type of provider eligible to provide services and be reimbursed</td>
<td>• Physicians</td>
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<tr>
<td></td>
<td>• Nurse practitioners</td>
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<td>• Physician assistants</td>
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<td>• Nurse midwives</td>
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• Clinical nurse specialists
• Certified registered nurse anesthetists
• Clinical psychologists & clinical social workers
• Registered dietitians or nutrition professionals

*13 Medicare Advantage and Medigap plans at the moment are required to cover the same telehealth delivered services found in Medicare fee for services (FFS) and with the same restrictions discussed above. Should the plans offer telehealth coverage that goes beyond what is in FFS, the plan or the enrollee would need to cover the cost, Medicare would not. However, in 2018, under the Bipartisan Budget Act, Medicare Advantage plans were given greater flexibility to cover telehealth delivered services beyond what was in FFS. The proposed regulations currently would allow plans to decide what services it would allow to be covered under telehealth, as long as the services were those typically covered under Medicare. The policy is not finalized at the time this article was being written, but implementation of the policy would not occur until 2020.

In the decade between federal statutory changes in telehealth Medicare policy, there were developments in the Medicare program that altered how telehealth could be used and reimbursed. CMS could not revise or go beyond the law, but it could make administrative decisions that allowed for greater use of telehealth in the Medicare program.

*14 **Administrative Policy Changes to Telehealth in Medicare**

While a Medicare patient must be located in a “rural” area when receiving services via telehealth in order for those services to be reimbursed, “rural” was not defined in statute. In 2014, CMS offered its own definition for what “rural” would be, basing it on a complicated formula involving Census tracks. While this redefinition of rural offered some expansion, it was still very limited. However, it did show the agency adopting a policy that attempted to expand the use of telehealth without necessitating a change in law.

In 2015, CMS would go further with its efforts by beginning to offer reimbursement for services it called “Chronic Care Management” (CCM) which was remote monitoring of a patient's chronic condition when they were at home, or RPM, one of the telehealth modalities that was not reimbursed, under law, by Medicare. However, by calling it CCM and not “telehealth”, CMS was not required to impose the statutory telehealth restrictions. CMS imposed other requirements such as a type of patient that could receive CCM, but the telehealth statutory limitations such as needing to be in a specific type of facility and geographic area did not apply. This reasoning behind CCM would be the basis for CMS’ most expansive administrative actions for telehealth.

**2019 CMS Communication Technology-Based Services**

In July 2018, CMS released its annual proposal for changes to the Medicare Physician Fee Schedule (PFS). In the PFS proposal, CMS typically includes a few services that they deem eligible for reimbursement should they be provided via telehealth and 2018 was no different. What CMS also included though, were a series of new services they proposed to begin reimbursing when delivered via “communication technology-based services.” More specifically, they would be reimbursing:

- Virtual Check-In - Brief communication technology-based service by a physician or other qualified health care professional who can report Evaluation/Management (E/M) services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Remote Evaluation of Pre-recorded Patient Information - Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

Interprofessional Internet Consultation - Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional. Commonly referred to as “eConsult.”

Like CCM, these services, despite being provided via telehealth technologies, were not called “telehealth” and would not be subject to the same statutory limitations in Medicare. CMS stated that telehealth delivered services under Medicare are limited in statute by 1834(m) of the Social Security Act which restricts Medicare reimbursement telehealth delivered services to specific types of services, providers, technology (mainly live video) and patient locations (needing to be in certain types of healthcare facilities in rural areas). CMS, in their rule, expressed concern that these requirements may be limiting the coding for new kinds of services that utilize communication technology.

The proposed rule expressed CMS’ belief that their obligation to impose those restrictions only apply to “the kinds of professional services explicitly enumerated in the statutory provisions, like professional consultations, office visits, and office psychiatry services.” These are services that are paid for as if they were furnished during an in-person encounter between a patient and health care professional. Certain other kinds of services that are furnished remotely using communications technology are not considered “Medicare telehealth services” and are not subject to the restrictions.

Through these administrative actions, CMS was able to allow the other two modalities of telehealth, store-and-forward and RPM, to be used more widely, eliminate the geographic and site location for some services, create a broader base of telehealth providers to be reimbursed when using technology to provide services, and began to reimburse for consultations between practitioners. While other limiting factors exist with these more expansive policies such as certain qualifications patients need to meet to be able to receive CCM services and low reimbursement for the Virtual Check-In, there was a definite expansion of policy, and one that did not take a Congressional route.

The reasoning behind CMS’ action was stated in their PFS proposal for CY 2019: As we considered the concerns expressed by commenters about the statutory restrictions on Medicare telehealth services, we recognized that the concerns were not limited to the barriers to payment for remotely furnished services like those described by the office visit codes. The commenters also expressed concerns pertaining to the limitations on appropriate payment for evolving physicians’ services that are inherently furnished via communication technology, especially as technology and its uses have evolved in the decades since the Medicare telehealth services statutory provision was enacted.

CMS notes that it is marching forward, attempting to keep policy in pace with the evolution of technology. The agency is still hampered by what is in federal statute, but it is finding other means to continue the expansion of telehealth and much of this is out of necessity.

III. MEDICAID
Medicaid is administered by the states and jointly funded with the federal government. It provides health coverage to eligible low-income adults, children, pregnant women, the elderly and people with disabilities. As of October 2018, over 66 million have Medicaid coverage. While there are some basic requirements that provide commonalities across Medicaid programs, each state can tailor their programs to address the particular needs of their state. Medicaid telehealth policy is no different, showing wide variation among states in what will be reimbursed.

Like the Medicare program, state legislatures in the mid-1990s also began to pass legislation or created administratively their own telehealth reimbursement policies in Medicaid. In 1996, the California legislature passed the Telemedicine Development Act that would include requiring some reimbursement for telehealth delivered services in California's Medicaid program, Medi-Cal. The modality reimbursed was primarily for live video though later store-and-forward services in dermatology, ophthalmology and dentistry would be reimbursed and while not specified in law, Medi-Cal was not prohibited from limiting what services, providers and where telehealth could take place, leaving it to the program to decide the details. Given this flexibility, Medi-Cal did limit the type of providers who could be reimbursed for telehealth delivered services as well as the type of facility in which it could take place and the type of services. Unlike Medicare, Medi-Cal did not have a geographic limitation.

*Oklahoma passed similar legislation in 1997 (going into effect in 1998) called the Oklahoma Telemedicine Act. The Act would require Oklahoma Medicaid managed care and fee-for-service to cover telehealth delivered services, however, the term used, telemedicine, and definition provided in statute limited coverage to only live video. Additionally, while the law may appear to provide broad leeway on how telehealth is used, how those laws are carried out under Medicaid policies or regulations may be more restrictive similar to what happened in California.

When a survey of state Medicaid directors was conducted in 2004, 24 states were reimbursing for some telehealth services. The survey noted that, “Several core issues are related to reimbursement, including what is covered (e.g., diagnoses, procedures), which provider is reimbursed (MD or extender), which site is reimbursed (hub or spoke), whether live or store-and-forward consultations are reimbursed, coding conventions for how telemedicine is billed, and licensing issues.” As with Medicare policies, the primary mode that was reimbursed was live video and the survey also noted that some states had geographical limitations (three states) and nearly half (ten states) limited the types of services that would be reimbursed. These types of limitations reflect many of the ones in Medicare policy though as noted in the survey, not all states replicated all of them, e.g., the rural limitation.

While states continued to make some changes in their policy, a spike in activity was not seen until much later. From 2014-2018, there was a significant increase in state telehealth related legislation. This spike mirrors the increased interest on the federal level and can be attributed to a variety of factors including the passage of the Affordable Care Act (ACA) and continued shortage of health care providers that is discussed in further detail below.

Today, telehealth policy in Medicaid programs have expanded greatly. Nearly all Medicaid programs reimburse for some type of live video, 11 for store-and-forward and 20 for RPM. There are still limitations on who can provide it, the types of services, and where it can be provided, the typical limitations seen around telehealth reimbursement policies. However, geographic limitations have begun to be eliminated from Medicaid policies with New Hampshire recently eliminating their limitations in 2017.

In the last few years, Medicaid programs have been pushing much more forward-thinking policies such as reimbursement for RPM and store-and-forward, though, as was seen in the beginnings of telehealth policy in the Medicare and Medicaid programs, the reimbursement included many caveats. For example, store-and-forward is typically limited to specific specialties such as dermatology and ophthalmology. RPM also includes many conditions, usually around the condition of the patient. Maryland Medicaid's RPM policy is typical of what is seen across states in that the Medicaid enrollee must be diagnosed with one of these conditions: chronic obstructive pulmonary disease, congestive heart failure or diabetes (Type 1 or 2). In addition to being enrolled in Maryland Medicaid, the patient must consent to RPM, have an internet connection, be capable of using the equipment and have one of the following scenarios in the past 12 months:
TELEHEALTH AND PUBLIC PROGRAMS - EVOLUTION..., 15 J. Health &... 

- Two hospital admissions with the same qualifying medical condition as the primary diagnosis

- Two emergency room department visits with the same qualifying medical condition as the primary diagnosis

- One hospital admission and one emergency department visit with the same qualifying medical condition as the primary diagnosis. 38

State Medicaid programs on the whole have not limited telehealth services to rural areas but have limited the types of facilities in which they can take place. However, in this area they too have been more permissive in their policies than Medicare. For example, 15 state Medicaid programs have explicit written policies allowing schools to be eligible originating sites (where the patient is located). 39

They have also been more permissive in who can provide telehealth delivered services. Federal statute prohibits Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from acting as Medicare reimbursable distant site providers (consulting providers in a telehealth interaction). 40 However, at least 13 state Medicaid programs explicitly allow FQHCs and/or RHCs to act as distant site providers of telehealth delivered services in their written policies. 41

As 2018 ended, state Medicaid programs are continuing to push forward with advancing telehealth. Once again, California proposes to move to the forefront in providing trailblazing policy changes. At the end of 2018, Medi-Cal released draft proposals to changes in their telehealth policy that allowed providers to determine when and for what services could be appropriately provided via telehealth live video or store-and-forward and Medi-Cal would reimburse for that service as long as it was a covered service and could be provided via technology (for example a service requiring some in-person element would not be allowed). 42 This forward-thinking policy would leave the determination to the provider to decide what is appropriate for a patient in that specific situation. This policy would overcome many of the barriers that telehealth has faced on both the state and federal level. The proposed California policy would allow utilization of two of the three modalities with no overt limitation to a specific specialty such as dermatology. It would not limit what type of provider could use telehealth and be reimbursed. The proposal would not limit the type of services that could be provided via telehealth except to ensure the service itself didn't require some in-person element and is typically reimbursed by Medi-Cal. It would go far in ensuring that telehealth was treated not as some separate service, but simply another tool in the provider's toolkit in providing services to his/her patient. Telehealth would not be regarded or looked at as an “other.” A final policy is projected to be published in Spring 2019. 43

IV. WHY NOW?

What is behind the recent acceleration in telehealth policy changes in these public health programs? One very large reason is that the technology to provide these services has reached the point where the services they provide is as good, and perhaps better in some cases, as those provided in-person. In the 1990s, the technology was not simply there and it was understandable that policymakers would be cautious in their approach as noted earlier. Additionally, the cost of the technology has drastically lowered. Depending on what service is being provided, a patient's own smart phone may be enough for a telehealth consultation.

The ACA provided many more Americans with access to health services they previously did not have. According to a Commonwealth Fund report, the number of uninsured in the United States went from 41 million to 27 million. 44 This increase in patients into the health care system was not matched by a comparable increase in providers. In a report that projected the supply and demand of primary care practitioners, the Health Resources and Services Administration's Bureau of Health Workforce estimated that 29 states had a shortage of primary care physicians in 2013 and it was projected to rise to 37 states in...
The report also noted a disparity in where the shortages are and will be with Midwest and Southern states particularly hard hit, indicating a maldistribution of available providers. Specialists already in short supply, are concentrated in urban areas therefore leaving rural populations to do without or travel great distances to see such specialists.

Recent public health crises have forced policymakers to look at new and innovative ways to provide care. Natural disasters that present with difficult situations to deliver care in affected areas and public health crises such as the recent opioid epidemic have left policymakers trying to find ways to get specialists to the impacted areas. When Hurricanes Harvey and Irma struck in 2017, several telehealth providers offered free services to those affected by the hurricanes in Texas and Florida. Florida Hospital reported nearly 3,000 utilizing their free telehealth services over a three-day period.

Concerns over the opioid epidemic have caused even greater interest in the utilization of telehealth. As noted above, the federal SUPPORT Act for Patients and Communities have already eased some of the Medicare telehealth barriers in order to allow for greater use of telehealth to treat substance use disorders (SUD), but there have also been significant federal monies in pilot projects addressing SUD that contain a telehealth element. In 2018, HRSA awarded $400 million to address the opioid epidemic. Awards were made to HRSA-funded community health centers, academic institutions, and rural organizations to expand access to integrated substance use disorder and mental health services. Telehealth is a part of the HHS overall strategy to address the epidemic and several of the grant programs funded include telehealth within it. Specifically, there is interest in using telehealth to provide Medication Assisted Treatment (MAT) which is considered the gold standard in treating SUD. MAT is the use of a combination of medication and behavioral health counseling to wean a patient off of the substance being addressed. Telehealth has long been accepted as a mean of providing mental and behavioral health services, but there is also interest in how telehealth could be incorporated the medication administration side of MAT. However, at this time how telehealth can be used to provide MAT has been primarily focused on the counseling aspect.

There is also great belief that the use of telehealth could reduce costs. When the JWGT issued its report in 1997, it cited the lack of information regarding cost-effectiveness. In the last few years, studies and reports have cited savings due to the use of telehealth, studies that were acknowledged and cited within CMS' own report to Congress this year. For example, the CMS report cites a 2014 article published in Health Affairs written by DC Grabowski and AJ O'Malley that studied 11 nursing homes that utilized telehealth to provide physician coverage during off hours. The potential reduction of hospitalizations and eventual cost savings to Medicare would be $151,000 per nursing home, per year by using telehealth.

Each of these elements contribute to the accelerated interest and in some cases adoption of new telehealth policy in Medicare and Medicaid as well as other policy issues not touched upon in this article. Significantly, none of these elements are likely to disappear in a year or two, so it can be anticipated that there would be continued action in telehealth policy.

V. CONCLUSION

The reimbursement policies to telehealth based upon specific limitations of where telehealth could take place, who could provide it, and what services it could be used to provide, continue to create significant barriers to its more ubiquitous use. While such concerns were understandable two decades ago given the capabilities of the technology in the late 1990s and 2000s and lack of data, it has come so far now, that more policymakers need to realize that such impediments may do more harm to populations than help by denying them access to needed services. Medicare and Medicaid can be very influential in how private payers respond in their own policies regarding telehealth. By leading the way with more progressive telehealth reimbursement policies, Medicare and Medicaid can expand and more equitably disperse the limited resources in the US health care system, to ensure more patients who need care can have their needs met.

Footnotes
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7. Id.


9. Id.

10. Id.

11. See id. at Section 5, Subsection B. The FDA and Center for Device and Radiological Health are responsible for ensuring proper standards are being followed in order to protect the general public against unsafe medical devices. Id.

12. See the Evolution of Technology during the Life of Domain, DOMAIN COMPUTER SERVICES (Aug. 31 2017), https://www.go-domain.com/technology-1997-2017/. Technology has made incredible progress in the last twenty years considering the fact that Google was not incorporated until September of 1998. Id.


16. See id. at 1595-97 (explaining billing and eligibility criteria for telehealth providers).

17. See CTR. FOR MEDICARE & MEDICAID SERVICES, Information on Medicare Telehealth 4-5, 26 (2018), available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-
Medicare-Telehealth-Report.pdf (reporting to Congress) (last visited Feb. 21, 2019). The purpose is to provide information regarding Medicare beneficiaries, telehealth services, and barriers to telehealth services. Id. at 1.


See generally id. There is a remaining frequency limit to where codes can be put in to reflect health services provided. Id. at 35,723.

Id. at 35,723.

Id. at 35,723.

Id. at 35,723.


ichp.ufl.edu/files/2011/11/Telemedicine-in-Medicaid-and-Title-V-Report.pdf (last visited Feb. 23, 2019). “The first goal of this study was to conduct a nationwide survey with Medicaid programs in each of the 50 states regarding telemedicine services, with a specific target of identifying common strategies related to Medicaid reimbursement.” Id. at 5.

34 Id.

35 See id. at 8. In the 24 states who reimburse, the most common reimbursable services are medical and behavioral/mental health diagnostic consultations or treatment. Id.


37 See Jeremy Sherer, Amy Joseph, & David Vernon, CMS Proposes to Expand Telehealth Reimbursement under Medicare, AM. BAR ASS'N (Oct. 23, 2018), https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2018-2019/September2018/telehealth/ (last visited Feb. 10, 2019). “In its commentary, CMS recognizes that technology and its uses have evolved since the Medicare Act was amended to provide coverage for certain telehealth services furnished to patients in specified rural areas and health facilities (originating site and geographic restrictions).” Id.


39 See supra note 36. The States allowing eligibility are Delaware, District of Columbia, Georgia, Maryland, Minnesota, Mississippi, Nevada, New Mexico, New York, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington. Id.

40 42 U.S.C. 1395m(m)(3).

41 See supra note 36 at 8.


43 Id.


46 Id. at 11-12.

47 See Robin Warshaw, Health Disparities Affect Millions in Rural US Communities, ASS'N OF AM. MED. COLL. (Oct. 31, 2017), https://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/ (last visited Feb. 7, 2019). Warshaw states, Access to providers, even family physicians, is a problem, ... [i]f you want to go to an OB/GYN, depending on where you live in the country, you may have to go 200 miles. In a study published in September 2017 by researchers from the University of Minnesota School of Public Health, as of 2014, 54% of rural counties did not have a hospital with obstetrics services. According to the U.S. Department of Veterans Affairs (VA), 25% of U.S. veterans live in rural areas.
Compared with 36% of urban military veterans, more than half of rural-dwelling veterans are enrolled in the VA health system, yet many live far from the nearest VA medical center.


53 Id. at 20.