

To: Uniform Law Commission Drafting Committee on Telehealth

From: Michele Radosevich, Chair
Quinn Shean, Vice Chair
Kristin Madison, Reporter

Re: April 30, 2021 Meeting

Date: April 23, 2021

On April 30, 2021, the Drafting Committee on Telehealth will meet from 10am to 2pm Central Time. In this meeting, we will:

- (1) Present revisions of the proposed uniform/model act arising out of our March 26 meeting.
- (2) Discuss the potential addition of provision(s) related to barriers to entity formation.
- (3) Discuss the potential addition of provision(s) related to provider payment and insurance coverage for telehealth.

This memo and its attachment provide background information about each of these agenda items.

Revisions to Proposed Uniform Act

In the attached document, we accepted all style-related changes that were suggested by the Style Committee before the March 26 meeting and were presented in markup during the meeting. We then made further changes based on the conversation on March 26; those changes are visible in markup in the attached document.

In keeping with suggestions made during the meeting, we have:

- Reorganized the draft into six sections
- Provided a definition for “board”
- Edited provisions related to the standard of care so as to avoid implying that the standard of care will apply in exactly the same manner to telehealth and in-person services; the same general standard of care applies, but the application of that standard may differ depending on the context.
- Made clear that while boards cannot establish a separate standard of care for telehealth, they can adopt rules that prohibit the prescription of controlled substances when a practitioner’s encounters with the patient have occurred predominantly through telehealth.
- Eliminated further detail on what a practitioner may or may not prescribe to patients.
- Clarified that suits arising out of the delivery of telehealth services can be brought in the patient’s county or other location authorized by law.
- Removed references to the concept of “venue” for administrative actions.
- Clarified that boards could adopt rules to administer the entire act, except as prohibited by this act itself.

We have also added legislative notes or comments on the following topics:

- The definition of board.

- The intended breadth of the term telecommunication technology.
- The fact that this act is not intended to displace statutes or rules concerning the prescription of abortion-inducing medications or other controlled substances.
- The scope of the “otherwise authorized by law” provision. Providers need not be licensed or registered to provide telehealth services if they are not required to be licensed to provide equivalent services in person (e.g., a pharmacist working for a licensed pharmacy, provider delivering emergency services, provider authorized under EMAC).

Administrative Barriers to Entity Formation: Corporate Practice of Medicine

In the Drafting Committee’s March 26 discussion, it was acknowledged that legal requirements related to the corporate practice of medicine vary by state and that they can create barriers to multistate delivery of telehealth services. However, it was suggested that these barriers can be and are overcome by creating multiple legal entities or taking other steps to ensure compliance. Ultimately, the conversation suggested that while there may be costs associated with these variations in law, the gains from uniform law provisions focusing on this topic would be limited.

The discussions of the Study Committee, however, pointed to one particular issue that may benefit from attention in a uniform state law: the requirement that individuals associated with an entity providing telehealth services to patients within the state hold a license in that state.

The current draft of the uniform or model act makes clear that licensed practitioners may deliver telehealth services to patients present in the state, and that practitioners licensed elsewhere may seek registration to do so. The current draft focuses on registration as a substitute for a license in the context of a medical professional’s delivery of services to patients. It does not specifically reference other contexts in which a license might be required. The draft could be revised to clarify that if state laws require that entities providing services be controlled by a licensed practitioner, practitioners could meet this requirement through registration rather than licensure within the state.

For Discussion: To what extent would requirements for control by a licensed physician be satisfied by registration under the provisions of the current draft? Is it the case that because corporate practice restrictions arise out of the requirement that those delivering health care be licensed to provide that service, that an alternative form of authorization to provide the service would be sufficient? If so, then we could add a comment under section 4 that makes clear that registered physicians meet this requirement:

Comment

Under this provision, an out-of-state practitioner who registers with the appropriate board is authorized to provide telehealth services to patients located within the state. If a state requires entities providing health care services to be controlled by individuals authorized to practice within the state, then this requirement may be met through registration, so long as any health care services provided by the entity in the state are limited to telehealth.

Alternatively, if corporate practice restrictions require licensure, as opposed to other forms of authorization, the proposed uniform or model act could be modified to clarify that registration is an acceptable alternative to licensure. This provision would be bracketed, as it would only be adopted in

states that have imposed licensure requirements in the context of the corporate practice of medicine. Specifically, we could add subsection (c) to section (4):

[(c) Any requirement for licensure applicable to practitioners who control or are otherwise associated with an entity that delivers health care services to a patient located in this state, may be satisfied through registration under this [act], so long as the entity does not deliver in-person health care services to patients located in this state.]

Provisions Related to Insurance Coverage and Provider Payment

The Executive Committee authorized the Drafting Committee to consider issues related to insurance coverage and payment parity. Many states have now adopted statutes that address private insurance plans' practices with respect to telehealth coverage and provider payment for telehealth services. However, as indicated by this 2021 [50-state survey](#) prepared by Nathaniel Lacktman and colleagues at Foley & Lardner, as well as by the Center for Connected Health Policy's [ongoing tracking of laws](#) related to telehealth, state statutes vary considerably in their scope and approach. The remainder of this memo describes some common elements in these laws, identifying some questions we would need to answer to begin to develop uniform or model act provisions that address these topics.

Issue 1: Coverage of telehealth services

One of the most common insurance-related provisions in state telehealth laws is a provision requiring that insurers provide coverage for services delivered through telehealth if they would have covered the services, had they been delivered in person. We could integrate a coverage parity provision into the proposed uniform/model act. For example:

A health insurance contract that is issued, delivered, or renewed in this state shall provide coverage for health care services delivered via telehealth on the same basis and to the same extent the services would be covered if delivered in person.

(1) Should the uniform law include a coverage parity like the one above? If the answer to this question is yes, there are further questions to consider about how coverage requirements apply to telehealth. For example:

(2) Should the uniform law preclude insurers from providing coverage only through specialized telehealth providers? Some health care providers in an insurer's network may deliver services via telehealth in addition to delivering services in person. However, an insurer may prefer to include in its network providers that specialize in telehealth and may in some circumstances want to limit coverage to those providers. Some states have chosen to restrict such practices. For example, California states that "[c]overage shall not be limited only to services delivered by select third-party corporate telehealth providers." Kentucky states that a health benefit plan shall not "[r]equire a provider to be part of a telehealth network" or "be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person." By contrast, Missouri states that "a health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier."

(3) Should the uniform law address specialized services such as remote patient monitoring or store and forward services? Coverage parity provisions ensure that insurers will cover telehealth services just as they cover in-person services. However, there are health-related services that leverage telecommunication technologies without having a clear on-ground equivalent. Remote patient monitoring is one example. The Foley 2021 report finds that 17 states required commercial health plans to cover these services. For example, Maine (Title 24-A, §4316) requires carriers to cover telemonitoring if it is medically necessary for the enrollee. To what extent should a uniform law on telehealth mandate coverage of services that by their nature can only be delivered through telehealth?

(4) What other questions should a uniform law address if it speaks to the issue of insurance coverage for telehealth?

Issue 2: Patient cost-sharing

According to the Foley 2021 report, 30 states limit patient cost-sharing in the telehealth context. Cost-sharing is often limited through a parity provision that might resemble this one:

A health care service provided through telehealth shall not be subject to a deductible, co-payment, or coinsurance amount that exceeds the amount that would be charged if the health care service were delivered in person.

(5) Should the uniform law include a provision like the one above that caps patient cost-sharing? This provision ensures that coverage for telehealth is similar to coverage for in-person services, but limits insurer flexibility to make adjustments that reflect differences in telehealth costs or service use patterns.

Issue 3: Payment policies

The number of states that have adopted statutes addressing provider reimbursement for telehealth services is increasing. According to the Foley 2021 report, 22 states address reimbursement, and of those, 14 require payment parity. This is California's approach to payment parity:

A contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(6) Should the uniform law require payment parity? If the answer to this question is no, the uniform law could be silent, or it could adopt an alternative provision defining parameters for negotiations between private payers and providers. North Dakota (Chapter 26.1-36-09.15) , for example, states that “[p]ayment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner . . . as the insurer establishes payment or

reimbursement of expenses for covered health services that are delivered by in-person means.” If the answer to this question is yes, then there are further questions to be answered to determine the scope of the payment provision.

(7) Should the uniform law expressly address alternative payment models? Payment parity provisions are most easily applied in a fee-for-service context, where it is straightforward to match a telehealth service to an in-person service to determine the appropriate reimbursement. However, insurers negotiate a variety of payment arrangements with providers. The California statute addresses this issue by saying, “this section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.”

(8) Should the uniform law allow an exception to parity for negotiated alternative arrangements? Some states may require equivalent payment policies generally, but then allow for exceptions. Kentucky law (304.17A-138) states that “Telehealth coverage and reimbursement shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to a lower reimbursement rate for telehealth services.” Washington (48.43.735) states that “a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine at the same rate as if the health care service was provided in person by the provider,” but then says that “[h]ospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate a reimbursement rate for telemedicine services that differs from the reimbursement rate for in-person services.”

(9) Are there other payment-related issues that a uniform law should address?

SELECTED EXAMPLES OF STATUTORY PROVISIONS RELATED TO PROVIDER PAYMENT AND INSURANCE COVERAGE

ARIZONA

Arizona Revised Statutes § 20-841.09

Telemedicine; coverage of health care services; definition

A. All contracts issued, delivered or renewed on or after January 1, 2018 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the subscriber and a health care provider and provided to a subscriber receiving the service in this state. A corporation may not limit or deny the coverage of health care services provided through telemedicine and may apply only the same limits or exclusions on a health care service provided through telemedicine that are applicable to an in-person consultation for the same health care service. The contract may limit the coverage to those health care providers who are members of the corporation's provider network.

B. This section does not prevent a corporation from imposing deductibles, copayment or coinsurance requirements for a health care service provided through telemedicine if the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation for the same health care service.

C. Services provided through telemedicine or resulting from a telemedicine consultation are subject to all of this state's laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona licensure requirements and any practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

D. This section does not apply to limited benefit coverage as defined in section 20-1137.

E. For the purposes of this section, "telemedicine":

1. Means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, consultation or treatment.

2. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

CALIFORNIA

Health & Safety Code § 1374.14 (see also Insurance Code § 10123.855)

(a) (1) A contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan and a health care provider for the provision of health care services to an enrollee or

subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(b) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2021, shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other provisions of law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(Added by Stats. 2019, Ch. 867, Sec. 3. (AB 744) Effective January 1, 2020.)

WASHINGTON

Revised Code of Washington 48.43.735

Reimbursement of health care services provided through telemedicine or store and forward technology.

(1)(a) For health plans issued or renewed on or after January 1, 2017, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015; and

(iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information.

(b)(i) Except as provided in (b)(ii) of this subsection, for health plans issued or renewed on or after January 1, 2021, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine at the same rate as if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate a reimbursement rate for telemedicine services that differs from the reimbursement rate for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's or other health care provider's office;

(e) Community mental health center;

(f) Skilled nursing facility;

(g) Home or any location determined by the individual receiving the service; or

(h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the

covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require a health carrier to reimburse:

(a) An originating site for professional fees;

(b) A provider for a health care service that is not a covered benefit under the plan; or

(c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8) For purposes of this section:

(a) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(b) "Health care service" has the same meaning as in RCW [48.43.005](#);

(c) "Hospital" means a facility licensed under chapter [70.41](#), 71.12, or [72.23](#) RCW;

(d) "Originating site" means the physical location of a patient receiving health care services through telemedicine;

(e) "Provider" has the same meaning as in RCW [48.43.005](#);

(f) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(g) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include the use of audio-only telephone, facsimile, or email.

[[2020 c 92 § 1](#); [2017 c 219 § 1](#); [2016 c 68 § 3](#); [2015 c 23 § 3](#).]