MEDICAL ASSISTANCE AND TELEHEALTH: AN EVOLVING PARTNERSHIP

This document is intended to help the telehealth organization, provider, and director to establish an action plan for obtaining full reimbursement from State Medical Assistance payers. It is intended to be utilized as a guide to be customized for the individual state initiative and used as a tool to develop a multifaceted approach that will work in the targeted state's budgetary environment.

Much of the information in this document has come directly from state and federal websites, which delineate programs for Medicaid and Medicare beneficiaries, including program descriptions, payment structures, and the relationship between federal and state health care expenditures and funding.

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Executive Summary

Telehealth/Telemedicine probably is not what you think it is. Forget Starship Voyager and its holographic physician and technology that suddenly push old-fashioned medicine into oblivion. Proponents will tell you that telemedicine is not about technology at all. It is about using technology – anything from an ordinary telephone to an ingestible biosensor – to extend the reach of medical practitioners and to support new applications of standard medical procedures ("Reinventing Government", Jan 12, 2001, http://govinfo.library.unt.edu/npr/rego/update3/telemed1.html). The financial, performance, and management challenges facing Medicaid programs are greater than ever before. Incorporating telemedicine into state programs can provide an important step toward improving access, quality, and cost-effectiveness of Medicaid services. This report provides a background on the current use of telehealth/telemedicine and its link to Medicaid.

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the word telehealth, which is often used to encompass a broader definition of remote healthcare that does not always involve interactive clinical services, provided by physicians or clinical services at all. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.

Telehealth/Telemedicine is not a separate medical specialty. Products and services related to telehealth/telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telehealth/telemedicine; often no separate coding is required for billing of remote services.

Telemedicine customarily uses two methods to transmit images, data and sound – either live, real-time transmission where the consulting professional participates in the examination of the patient while diagnostic information is collected and transmitted, or 'store and forward' transmission, where the consulting professional reviews data asynchronous with its collection. Many programs employ both transmission capabilities, to maximize efficient use of resources appropriate to the medical services being provided.

History

While the explosion of interest in telehealth/telemedicine over the past four to five years makes telehealth/telemedicine appear that it is a relatively new use of telecommunications technology, telehealth/telemedicine has been in use in some form or other for almost forty years. Three early examples are:

- **The Nebraska Psychiatric Institute** was one of the first facilities in the country to have closed-circuit television in 1955. The demonstration allowed a two-way link between the psychiatric institute and Norfolk State Hospital, 112 miles away. The link was used for education and for consultations between specialists and general psychiatric practitioners.
- **The National Aeronautic and Space Administration (NASA)** played an important part in the early development of telemedicine. NASA's efforts in telemedicine began in the early 1960s when humans began flying in space. Physiological parameters were telemetered from both the spacecraft and the space suits during missions.
- **The Massachusetts General/Logan International Airport Medical Station**, established in 1967, provided occupational health services to airport employees and to deliver emergency care and medical attention to travelers. Physicians at MGH provided medical care to patients at the airport using a two-way audiovisual microwave circuit. Nurses staffed the Medical Station 24 hours a day, supplemented by in-person physician attendance during four hours of peak passenger use. Evaluation of diagnosis and treatment of the nurse-selected patients was made by participating personnel and independent physician observers.

Current Status of Telehealth/Telemedicine

Telemedicine encompasses different types of patient services and delivery mechanisms. Each component involves different providers and consumers.

Services

- **Specialist referral services** typically involve a specialist assisting a general practitioner in rendering a diagnosis. The service may involve a patient 'seeing' a specialist over a live, remote consult, or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later. Recent surveys have shown a rapid increase in the number of specialty and subspecialty areas that have successfully used telemedicine. Radiology continues to make the greatest use of telemedicine with thousands of images 'read by remote providers' each year. Other major specialty areas include dermatology, ophthalmology, mental health, cardiology and pathology. According to reports and studies, almost 50 different medical subspecialties have successfully used telemedicine.
- **Patient consultations** such as using audio, video, and medical data between a patient and a primary care or specialty physician for use in rendering a diagnosis and treatment plan. A patient consultation might originate from a remote clinic to a physician's office using a direct transmission link or may include communicating to a physician over the Web.
- **Remote patient monitoring** uses devices to remotely collect and send data to a monitoring station for interpretation. Typically, such applications are from the home and might include a specific vital sign, such as blood glucose or heart ECG or a

variety of indicators for homebound patients. Such services can be used to supplement the use of visiting nurses.

- **Medical education** provides continuing medical education credits for health professionals and special medical education seminars for targeted groups in remote locations.
- **Consumer medical and health information** includes the use of the Internet for consumers to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

Current Status of Medicaid Reimbursement for Telehealth

Medicaid programs in all states currently reimburse for a variety of interpretive services using remote store-and-forward technology. Such services do not require a direct heath provider –to-patient interaction. Such interpretations include teleradiology, telepathology, ECG interpretation, tele-ultrasound, and echocardiography. These services typically are not tracked separately from in-office services and there is no distinction in coding or billing of the services.

In addition, as of June 2003, 23 states have some form of reimbursement for services delivered via telemedicine technologies for interactive consultations to Medicaid recipients.

Some states have enacted legislation for mandated benefits to prevent any exclusion of coverage if the service is provided via telemedicine, such as California, Colorado, Hawaii, Kentucky, Louisiana, Minnesota, Nebraska, Oklahoma, and Texas. Arizona and Virginia have legislated coverage for partial benefits. The overwhelming trend in legislated reimbursement for telemedicine to Medicaid beneficiaries is to cover all care provide via telemedicine if the care is a covered benefit when provided in-person. In 2003, there were an additional 11 pieces of legislation pending in eight states regarding reimbursement for services provided via telemedicine (CTL, 2003).

However, some states have recognized the value in appropriate services delivered in a timely manner and have recognized the significant cost savings in travel and other health care expenditures in communities where specialty services are available via telemedicine. In these states, the Medicaid agency, with the assistance of telemedicine providers within the state, has enacted regulatory language that supports the use of telemedicine as a tool for access to care for any service that is a Medicaid benefit if delivered in-person. Twenty-three states have regulatory language that provides reimbursement for some services delivered via telemedicine (AK, AR, CA, CO, GA, IL, IN, IA, KS, ME, MI, MN, MT, NE, NC, ND, OR, SD, TX, UT, VA, WI, WV).

In terms of policy agendas, non-payment of services via telemedicine (that are reimbursed if the service is provided in-person) creates a disparity and inequity for remote based populations. Often, the denial is in direct conflict with legislated language mandating service and payment for services in some state health agencies. In addition, most states are carrying the burden of transportation costs, which are simply eliminated when telemedicine technologies are employed to provide access to care for which the patient otherwise would have to travel long distances. Rationale for payment of services delivered by telemedicine for Medicaid recipients includes:

1. Care delivered by the right practitioner at the right time resulting in reduced annual cost of care and improved clinical outcomes.
2. Reduction of transportation costs to the Medicaid agency with budgetary constraints.
3. Reduction in the utilization of emergency care for chronic care or primary care.

Strategies for Successfully Gaining Medicaid Reimbursement for Services via Telehealth

There are a variety of methods to use to begin to approach one's state Medicaid agency. The key to success is to understand how one's state operates (legislatively or from a regulatory or agency determination standpoint), and the Medicaid budget, including expenditures, top priorities, legislative or regulatory mandates, and the top Medicaid expenditures related to telehealth

initiatives. There are several methodologies to use when approaching a state Medicaid agency, each with its advantages and disadvantages. Telehealth organizations may use one or a combination of the following strategies to obtain reimbursement for services delivered via telehealth technologies for Medicaid beneficiaries:

1) Medicaid agency internal determination for payment;
2) Medicaid regulated reimbursement for services;
3) State bill or rule passage mandating (legislating) payment for services;
4) Office of Insurance Commissioner regulatory decree barring discrimination in payment for services delivered via telehealth technologies; and
5) SCHIP, waiver, or other Medicaid authorized program determination for payment.

A telehealth organization must conduct an assessment of its state Medicaid agency and the telehealth organization's readiness to begin approaching the state for reimbursement. A comprehensive strategy using specific data about one's own state, supported by research data reflecting specific state population's health issues, is the best approach. Simultaneously putting together a team of strategists, mapping out a plan, and moving forward to build relationships will all increase the likelihood of success. Telehealth organizations should be prepared to write an initial document outlining the issues and prepare a specific plan for reimbursement on which to begin discussions with the state.

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DEVELOPMENT OF TELEHEALTH/TELEMEDICINE REIMBURSEMENT

The Balanced Budget Act (BBA) of 1997 opened the door to allow HHS to expand "face-to-face" contact with a patient to include care delivered via interactive technologies. Section 4206 of the BBA 1997 included provisions relating to telehealth. In the original legislative language, there was no restriction on the use of numerical CPT codes for telehealth billing or reimbursement. The only limitation noted was the use of the word "consultation", which effectively limited the availability of CPT codes. Specifically, Section 4206 of the BBA 1997 included the following provisions relating to telemedicine:

1) Allowed for payments for professional consultations provided to Medicare beneficiaries by a physician or eligible practitioner if:
    a. The beneficiary resided in a rural area defined as a primary care Health Professional Shortage Area (HPSA).
    b. The consultation was provided by a physician, nurse practitioner, physician's assistant, clinical nurse specialist, certified nurse midwife, clinical social worker, clinical psychologist, or certified nurse anesthetist.
2) Required a pass through payment to be shared between the referring physician or practitioner and the consulting physician or practitioner.
3) Subjected payments to the coinsurance and deductible schedules and based payments on the current fee schedules for physicians and other eligible practitioners.
4) Required a supplemental report from the Secretary of HHS to Congress containing a detailed analysis of how telemedicine and telehealth systems expand access to health care; the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications; the quality of telemedicine and telehealth services delivered; and the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

The Health Care Financing Administration (HCFA-now the Center for Medicare and Medicaid Services) published a set of proposed guidelines on-line in June of 1998 and opened a comment period of 60 days. A large volume of comments was received from telemedicine and telehealth providers indicating that many of the proposed rules did not accurately depict how telemedicine and telehealth were practiced. A small group met with HCFA and the rules were revised based on those discussions.

The Federal Register of November 2, 1998, published by the Health Care Financing Administration, Department of Health and Human Services (HHS), contained the final rules for payments for consultations received by Medicare beneficiaries. The rules included the following regulatory provisions that are interrelated to the issues of reimbursement and CPT codes:

1) Eligible Providers – The number of reimbursement-eligible providers was limited to physicians, nurse practitioners, provider assistants, certified nurse anesthetists, and clinical psychologists. (Fed Reg, Vol 63(211), p. 58886)
2) Eligible Sites – Patients were required to live in or be presented from a site geographically located in a Primary Care Health Professional Shortage Area (HPSA). (Fed Reg, Vol 63(211), p. 58886)

3) Scope of Coverage – Covered services include initial, follow-up, or confirming consultations in hospitals, outpatient facilities, or medical offices delivered via interactive audio and video telecommunications systems (CPT codes 99241-99245, 99251-99255, 99261-99263, and 99271-99275) (Fed Reg, Vol 63(211), p. 58886)

Significant problems were experienced with the November 1998 set of regulatory rules. The use of primary care Health Professional Shortage Areas (HPSAs) as the designated geographic area excluded most patients from being eligible for reimbursement. The requirement of pass through payments violated many state anti-trust laws and set up tax law discrepancies where earned income was concerned. The elimination of the need for a referring provider to be a presenter was not clearly understood by many programs that held back growth of their services due to this misunderstanding. The list of eligible providers did not include several providers such as speech pathologists, occupational and physical therapists, registered dieticians, and diabetes nurse educators, who at that time had demonstrated need for access to services via telemedicine and telehealth.

From January to September of 2000, nine separate bills were introduced to legislatively address some of the discrepancies in access to care imposed by the HCFA regulatory rules for payment. On September 7, 2000, the U.S. House Commerce Subcommittee on Health and Environment held a hearing entitled "Telehealth: A Cutting Edge Medical Tool for the 21st Century", which initiated a significant legislative effort to fix the BBA of 1997.

On December 21, 2000, President Clinton signed into law P.L. 106-554, The Consolidated Appropriation Act 2001, which included H.R. 5661, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the following telehealth provisions:

1) Elimination of any requirement for presenter.
2) Elimination of the pass-through payment.
3) Establishment of reimbursement for eligible CPT codes within the ranges of 99241-99275, 99201-99215, 90804-90809, and 90862, with a provision to update annually the eligible CPT codes at the discretion of the Secretary of HHS.
4) Establishment of Originating Sites (those from which the patient may be presented) to include hospitals, critical access hospitals, a provider's office, a rural health clinic, a federally qualified health center, or any federally funded telehealth program in existence as of December 31, 2000 in a non-metropolitan statistical area.
5) Retention of the number of reimbursement-eligible providers, limited to physicians, nurse practitioners, physician assistants, certified nurse anesthetists, and clinical psychologists.
6) Establishment of a facility fee for originating sites of no more than $20.
7) Payment of store-and-forward consultations in demonstration projects in Alaska and Hawaii.
8) Payment for home health visits with Prospective Payment dollars. However, visits conducted via telecommunications shall not count as a visit for the purposes of triggering a higher or lower level of payment.

9) Realization of a study by the Secretary of HHS to identify services, settings and sites, additional practitioners, and additional geographic areas for the provision of services beyond the scope of this legislation, to be completed no later than two years from the date of the enactment of the Act.

BIPA significantly amended BBA 97 and forced new regulatory rules by CMS (Center for Medicare and Medicaid Services, formerly HCFA). The expanded list of CPT codes, the expanded geographic areas, and the expanded list of eligible originating sites greatly increased access to Medicare beneficiaries. However, further work still needs to be done.

The Medicare Prescription Drug, Improvement and Modernization Act of 2002 included provisions which required the Secretary (of HHS) to conduct a study on including skilled nursing facilities as an originating site for telehealth services. The actual language reads

TITLE IV--RURAL PROVISIONS

Subtitle B--Provisions Relating to Part B Only

SEC. 418. REPORT ON DEMONSTRATION PROJECT PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELEHEALTH SITES; AUTHORITY TO IMPLEMENT.

(a) EVALUATION- The Secretary, acting through the Administrator of the Health Resources and Services Administration in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)) are treated as originating sites for telehealth services.

(b) REPORT- Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

(c) AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES- Insofar as the Secretary concludes in the report required under subsection (b) that it is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(ii) of such section beginning on January 1, 2006. (Medicare Prescription Drug, Improvement, and Modernization Act Implementation Tracking System (MITS), 2006).

The language opens the door for the Secretary to include skilled nursing facilities without legislative amendment.

MEDICAID REIMBURSEMENT IN THE UNITED STATES

As of June 2003, 23 states have some form of reimbursement for services delivered via telehealth technologies for interactive consultations to Medicaid recipients. All states reimburse for telehealth store-and-forward for teleradiology, telepathology, ECG interpretation, ultrasound and echocardiography. Some states have enacted legislation for mandated benefits to prevent any exclusion of coverage if the service is provided via telehealth, such as:

1) California (CA Ins. Code § 10123.85, Code § 10123.13, Code § 14132.72 – specific to Medicaid or California's Medi-Cal)
2) Colorado (CO Rev. Stat. § 10-16-123, CO Rev. Stat. § 26-4-42)
3) Hawaii (HI Rev. Stat. § 431 :10A – 116.3)
4) Kentucky (KRS § 205.510 – 205.630 [specific to Medicaid}, KRS § 304.17A-138)
5) Louisiana (LA R.S. 22 :657)
6) Minnesota (MN Stat. § 256b.0913, Stat. § 256b.0625 – both specific to Medicaid)
7) Nebraska (NE ALS 559 – Medicaid and managed care plans)
8) Oklahoma (OK Stat. Tit. § 6803)
9) Texas (TX Govt. Code § 531.0217, Code § 21.53 – Medicaid specific)

Arizona and Virginia have legislated coverage for partial benefits. The overwhelming trend in legislated reimbursement for telehealth to Medicaid beneficiaries is to cover all care provided via telehealth if the care is a covered benefit when provided in-person. In 2003, there were 11 additional pieces of legislation pending in eight states regarding reimbursement for services provided via telehealth (Source: Center for Telemedicine Law, *Telemedicine Reimbursement Report*, June 2003).

However, some states have recognized the value in appropriate services delivered in a timely manner and have recognized the significant cost savings in travel and other health care expenditures in communities where specialty services are available via telehealth. In these states, the Medicaid agency, with the assistance of state based telehealth provider organizations, has enacted regulatory language that supports the use of telehealth as a tool for access to care for any service that is a Medicaid benefit if delivered in-person. Sixteen states have regulatory language that provides reimbursement for services delivered via telehealth (AR, GA, IL, KS, ME, MN, MT, NE, NC, ND, SD, UT, VA, WI, and WV).

States may have various approaches to reimbursement for services provided via telehealth. Illinois pays for physician consultations with a fee-for-service program for hub and spoke sites, using the consultative CPT codes with the modifier "TM" attached for interactive and store-and-forward services. Minnesota pays for physician consultations with a fee-for-service program for hub and spoke sites, using the consultative CPT codes with the modifier "CT" attached for interactive services, "VT" for store-and-forward services, and "GT" for services between emergency departments. Wisconsin pays for the professional fee as well as the facility fee. MI is now also reimbursing as of May, 2006 http://www.michigan.gov/documents/MSA_06-22_155090_7.pdf.

As of April, 2006, the CMS Medicaid website http://www.cms.hhs.gov/Telemedicine defines telemedicine and includes a listing of states and their reimbursement policies for coverage of telemedicine for Medicaid recipients. CMS/Medicaid states "telemedicine is generally described as the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers."

In addition, the website states "the Centers for Medicare & Medicaid Services (CMS) has not formally defined telemedicine for the Medicaid program, and Medicaid law does not recognize telemedicine as a distinct service. Nevertheless, Medicaid reimbursement for services furnished through telemedicine applications is available, at the state's option, as a cost-effective alternative to the more traditional ways of providing medical care (e.g., face-to-face consultations or examinations). At least 18 states are allowing reimbursement for services provided via telemedicine for reasons that include improved access to specialists for rural communities and reduced transportation costs." (accessed April 19, 2006).

The website, updated last on 12/14/2005, lists the following states as having coverage:

Arkansas	Medicaid recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services. The state uses specific codes to identify telemedicine services. The state contact is Will Taylor (501) 682-8362.
California	Medicaid recognizes physician consultations (medical & mental health) when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services. The state uses consultative CPT codes with the modifier "TM" to identify telemedicine services. The state contact is Dr. Michael Farber (916) 657-0548.
Georgia	Medicaid recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services. The state uses specific local codes to identify the consultation furnished at the hub site. No special codes or modifier is used at the spoke site. The state contact is Sherley Benson (404) 657-7213.
Illinois	The Medicaid agency recognizes physician consultations when furnished using

	interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services. The state uses specific codes to identify telemedicine services. The state contact is R. Calluza or Maryann Daily (217) 782-2570.
Iowa	Medicaid recognizes physician consultations when furnished using interactive video teleconferencing. Payment is based on the state's fee-for-service rates for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for telemedicine services. Specific local codes are used for the add-on payment and CPT codes with the modifier "TM" is used to identify the consultations. The State contact is Marty Swartz (515) 281-5147.
Kansas	Medicaid recognizes home health care and mental health services already covered by the state plan when furnished using teleconferencing. Home health is limited to certain services. Payment is on a fee-for-service basis for the mental health services, which is the same as the reimbursement for covered services furnished in the conventional manner. Compensation for home health care via telemedicine is made at a reduced rate. Reimbursement is made for only the service furnished at the hub site. Local codes have been established to specifically identify home health services furnished using visual communication equipment. No special modifiers are used for mental health services. The state contact is Ms. Fran Seymour-Hunter (785) 296-3386.
Louisiana	The Medicaid agency recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services. Physician Assistants are allowed to perform the service using telemedicine if they are authorized by a primary physician, which is the only one that is authorized to bill. The State uses consultative CPT codes. The state contact is Ms. Kandice McDaniels (504) 342-3891, E-mail: Kmcdanie@dhhmail.dhh.state.la.us.
Minnesota	The Medicaid agency recognizes physician consultations (medical and mental health) when furnished using interactive video or store-and-forward technology. Interactive video consultations may be billed when there is no physician present in the emergency room, if the nursing staff requests a consultation from a physician in a hub site. Coverage is limited to three consultations per beneficiary per calendar week. Payment is on a fee-for-service basis, suing the same payment rate as for covered services furnished in a conventional, face-to-face manner. Payment is made at both the hub and spoke sites. No payment is made for transmission fees. Minnesota uses consultation CPT codes with the modifier "CT" for interactive

	video services and the modifier "WT" for consultations provided through store-and-forward technology. Emergency room CPT codes are used with a "GT" modifier for interactive video consultations done between emergency rooms. The state contact is Christine Reisdorf (651) 296-8822.
Montana	The Medicaid Agency recognizes any medical or psychiatric service already covered by the state plan when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine service. No special codes have been developed. Providers use codes from the existing CPT. The state contact is Dave Thorsen (406) 444-3634.
Nebraska	The Medicaid agency recognizes most state plan services when furnished using interactive video teleconferencing. In general, services are covered so long as a comparable service is not available to a client within a 30-mile radius of his or her home. Services specifically excluded include medical equipment and supplies; orthotics and prosthetics; personal care aide services; pharmacy services; medical transportation services; and mental health and substance abuse services and home and community-based waiver services provided by persons who do not meet practitioner standards for coverage. Payment is on a fee-for-service basis, which is the same as reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both the hub and spoke sites. Payment for transmission costs are set at the lower of the billed charge or the state's maximum allowable amount. Billing and coding requirements will vary depending on who bills for the service and which claim form is used. The state contact is Dr. Chris Wright (402) 471-9136.
North Carolina	The Medicaid agency recognizes initial, follow-up or confirming consultations in hospitals and outpatient facilities when furnished using real-time interactive video teleconferencing. The patient must be present during the teleconsultation. Payment is on a fee-for-service basis. The consulting practitioner at the hub site receives 75 percent of the fee schedule amount for the consultation code. The referring practitioner at the spoke site receives 25 percent of the applicable fee. Teleconsultations are billed with modifiers to identify which portion of the teleconsult visit is billed; i.e., the consulting practitioner at the hub site uses a GT modifier and the referring practitioner at the spoke site uses a YS modifier. The state contact is Janet Tudor (919) 857-4049.
North Dakota	Medicaid recognizes specialty physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services. Current CPT codes for consultative services are used with a "TM" modifier to specifically identify covered services which are furnished by using audio visual

	communication equipment. The state contact is David Zetner (701) 328-3194.
Oklahoma	Medicaid recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services. The state uses consultative CPT codes. The state contact is Ms. Nelda Paden (405) 530-3398, E-mail: Padenn@ohca.state.ok.us.
South Dakota	Medicaid recognizes physician consultations when furnished using (interactive & non-interactive) video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services. The state uses consultative CPT codes with a "TM" modifier to identify telemedicine services. The state contact is Linda Waldman (605) 773-3495.
Texas	The Medicaid agency recognizes physician consultations (teleconsultations) when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional face-to-face manner. Reimbursement is made at both ends (hub and spoke site) for the telemedicine services. Other health care providers, such as advanced nurse practitioners and certified nurse midwives are allowed to bill, as are "Rural Health Clinics and Federally Qualified Health Centers." The state uses consultative CPT codes with the modifier "TM" to identify telemedicine services. The state contact is Nora Cox Taylor (512) 424-6669, E-mail: nora.taylor@hhsc.state.tx.us.
Utah	The Medicaid agency recognizes the following services when furnished using interactive video teleconferencing: mental health consultations provided by psychiatrists, psychologists, social workers, psychiatric registered nurses and certified marriage or family therapists; diabetes self management training provided by qualified registered nurses or dieticians and; services provided to children with special health care needs by physician specialists, dieticians and pediatricians when those children reside in rural areas. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both the hub and spoke sites for diabetes self management training services and services provided to children with special health care needs. Reimbursement is made only to the consulting professional for mental health services. Payment is made for transmission fees. The state uses CPT codes with GT and TR modifiers to identify telehealth services. The state contact is Mr. Blake Anderson (801) 538-9925.
Virginia	The Medicaid Agency recognizes, as a pilot project, medical and mental health services already covered by the state plan when furnished using interactive video

	teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for only medical services. The state uses specific local codes to identify telemedicine services. The state contact is Jeff Nelson (804) 371-8857.
West Virginia	Medicaid recognizes physician consultations when furnished using interactive video teleconferencing. Payment is on a fee-for-service basis, which is the same as the reimbursement for covered services furnished in the conventional, face-to-face manner. Reimbursement is made at both ends (hub and spoke sites) for the telemedicine services. The state uses consultative CPT codes with the modifier "TV" to identify telemedicine services. The state contact is Laure L. Harbert (304) 926-1718.

(http://www.cms.hhs.gov/Telemedicine/03_StateProfiles.asp, accessed April 19, 2006)

OVERVIEW OF MEDICAID[1]

History of Medical Assistance in the United States

Medicaid is health insurance that helps many people who can not afford medical care pay for some or all of their medical bills. Medicaid began when Title XIX of the Social Security Act authorized a program providing medical assistance in the form of payment for care and services for certain individuals and families with low incomes and resources. The program known as Medicaid became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. Within broad national guidelines which the Federal government provides, each of the States:

1. establishes its own eligibility standards;
2. determines the type, amount, duration, and scope of services;
3. sets the rate of payment for services; and
4. administers its own program.

Covered Groups – Mandated and Optional

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

- **Low income families with children**, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the State's AFDC plan in effect on July 16, 1996;
- **Supplemental Security Income (SSI) recipients** (or in States using more restrictive criteria—aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the State's approved Medicaid plan as of January 1, 1972);
- **Infants born to Medicaid-eligible pregnant women** Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant;
- **Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level** (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133 percent, if as of certain dates the State had established a higher percentage for covering those groups.) States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 (or such earlier date as the State may choose) in families with incomes at or below the Federal poverty level. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in

[1] The following technical summaries may be found at http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp.

which the 60th day after the end of the pregnancy falls, regardless of any change in family income. States are not required to have a resource test for these poverty level related groups. However, any resource test imposed can be no more restrictive than that of the AFDC program for infants and children and the SSI program for pregnant women;
- **Recipients of adoption assistance and foster care** under Title IV-E of the Social Security Act;
- **Certain Medicare beneficiaries** (described later); and
- **Special protected groups** who may keep Medicaid for a period of time. Examples are: persons who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided 6 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 due to earnings, or 4 months of Medicaid coverage following loss of eligibility under Section 1931 due to an increase in child or spousal support.

States also have the option to provide Medicaid coverage for other **categorically needy** groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. Examples of the optional groups that States may cover as categorically needy (and for which they will receive Federal matching funds) under the Medicaid program are:

- infants up to age one and pregnant women not covered under the mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage to be set by each State);
- optional targeted low income children;
- certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level;
- children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;
- institutionalized individuals with income and resources below specified limits;
- persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers;
- recipients of State supplementary payments;
- TB-infected persons who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs); and
- low-income, uninsured women screened and diagnosed through a Center's for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast or cervical cancer.

Medically Needy Eligibility Groups

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid

expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

Eligibility for the medically needy program does not have to be as extensive as the categorically needy program. However, States which elect to include the medically needy under their plans are required to include certain children under age 18 and pregnant women who, except for income and resources, would be eligible as categorically needy. States may choose to provide coverage to other medically needy persons: aged, blind, and/or disabled persons; certain relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. In 1995, there were 40 medically needy programs, which provided at least some services to recipients.

Amplification on Medicaid Eligibility

Coverage may start retroactive to any or all of the 3 months prior to application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person's circumstances change. Most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No Federal funds are provided for State-only programs.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated above. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds. As noted earlier, categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the TANF program or from the SSI program. Medically needy persons who would be categorically eligible except for income or assets may become eligible for Medicaid solely because of excessive medical expenses.

States may use more liberal income and resources methodologies to determine Medicaid eligibility for certain AFDC-related and aged, blind, and disabled individuals under sections 1902(r)(2) and 1931 of the Social Security Act. For some groups, the more liberal income methodologies cannot result in the individual's income exceeding the limits prescribed for Federal matching.

Significant changes were made in the Medicare Catastrophic Coverage Act (MCCA) of 1988 which affected Medicaid. Although much of the MCCA was repealed, the portions affecting Medicaid remain in effect. The law also accelerated Medicaid eligibility for some nursing home patients by protecting assets for the institutionalized person's spouse at home at the time of the initial eligibility determination after institutionalization. Before an institutionalized person's monthly income is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted from the institutionalized spouse's income to bring the income of the community spouse up to a moderate level.

Medicaid – Medicare Relationship

The Medicare program (Title XVIII of the Social Security Act) provides hospital insurance (HI), also known as Part A coverage, and supplementary medical insurance (SMI), also known as Part B coverage. Coverage for HI is automatic for persons aged 65 and older (and for certain disabled persons) who have insured status under Social Security or Railroad Retirement. Coverage for HI may be purchased by individuals who do not have insured status through the payment of monthly Part A premiums. Coverage for SMI also requires payment of monthly premiums.
Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program. There are various benefits available to "dual eligibles" that are entitled to Medicare and are eligible for some type of Medicaid benefit.

For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the State's payment limit. Medicaid also covers additional services (e.g., nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids).

Limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses for certain other Medicare beneficiaries. The Medicaid program will assume their Medicare payment liability if they qualify. Qualified Medicare Beneficiaries (QMBs), with resources at or below twice the standard allowed under the SSI program and income at or below 100% of the Federal poverty level (FPL), do not have to pay their monthly Medicare premiums, deductibles, and coinsurance. Specified Low-Income Medicare Beneficiaries (SLMBs), with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% of the FPL, do not have to pay the monthly Medicare Part B premiums. Qualifying Individuals (QIs), who are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program, will get help with all or a small part of their monthly Medicare Part B premiums, depending upon whether their income exceeds the SLMB level, but is less than 135% of the FPL, or their income is at least 135%, but less than 175% of the FPL.

Individuals who were receiving Medicare due to disability, but have lost entitlement to Medicare benefits because they returned to work, may purchase Part A of Medicare. If the individual has income below 200% of the FPL and resources at or below twice the standard allowed under the SSI program, and they are not otherwise eligible for Medicaid benefits, they may qualify to have Medicaid pay their monthly Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal matching funds to provide certain *optional* services. Following are the most common of the thirty-four currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Home and community-based care to certain persons with chronic impairments.

Amount and Duration of Medicaid Services

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply:

1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and
2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions:

1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional

services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and

2) States may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within Federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full.

States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services.

The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. The Federal Government pays States a higher share for children covered through the SCHIP program. This "enhanced" FMAP averages about 70 percent for all States, compared to the general Medicaid average of 56.6 percent.

The Federal Government also reimburses States for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the twelve States that furnish the highest number of emergency services to undocumented aliens, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs

are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program, the Qualifying Individuals (QI-1) program, and DSH payments, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

Other Medicaid Programs

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-93)—known as the "welfare reform" bill—made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are State options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstituted by Public Law 105-33, the BBA.

Aid to Families with Dependent Children (AFDC)

In addition, welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

State Children's Health Insurance Program (SCHIP)

Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing State insurance program, SCHIP provides more Federal funds for States to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

Medicaid coverage may begin as early as the third month prior to application—*if* the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

Ticket to Work and Work Incentives Improvement Act of 1999
The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Those with higher incomes may pay a sliding scale premium based on income.

Programs of All-Inclusive Care for the Elderly (PACE)
The BBA included a State option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a *nursing facility level* of care. The PACE team offers and manages *all* health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program, as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

Medicaid Summary and Trends

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and economic recessions.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.

- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low birth weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2000, for example, indicate that Medicaid payments for services for 21.6 million children, who constitute 50 percent of all Medicaid beneficiaries, average about $1,290 per child (a relatively small average expenditure per person). Similarly, for 9.6 million adults, who comprise 22 percent of beneficiaries, payments average about $1,930 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4.1 million aged, constituting 10 percent of all Medicaid beneficiaries, average about $11,345 per person; for 7.5 million disabled, who comprise 18 percent of beneficiaries, payments average about $10,040 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2000 payments to health care vendors for 42.8 million Medicaid beneficiaries average $3,935 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2000 show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled $34.4 billion for more than 1.7 million beneficiaries of these services—an average expenditure of $20,220 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled $3.1 billion for more than 995,000 beneficiaries—an average expenditure of $3,135 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner.

The BBA provided States a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 58 percent in 2002.

More than 42.8 million persons received health care services through the Medicaid program in FY 2000 (the last year for which beneficiary data are available). In FY 2002, total outlays for the Medicaid program (Federal and State) were $258.2 billion, including direct payment to providers of $185.8 billion, payments for various premiums (for HMOs, Medicare, etc.) of $45.1 billion, payments to disproportionate share hospitals of $15.4 billion, and administrative costs of $11.9 billion. Outlays under the SCHIP program in FY 2002 were $5.4 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach $425 billion and $7.5 billion, respectively, by FY 2008.

CMS estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

KNOW YOUR STATE MEDICAID AGENCY – AN ASSESSMENT TOOL

Each program considering approaching the state Medicaid provider for reimbursement for services provided via telehealth technologies must be familiar with their own state's program. This assessment tool is designed to assist the telehealth program in obtaining appropriate and pertinent information that will be helpful in educating themselves, constructing arguments for reimbursement, and finding the options that might best fit the state in which the program resides. This tool is not meant to be all-inclusive, but serves as a template for starting the process. This assessment tool assumes that the state does not pay or the state has minimal reimbursement for health care delivered via telehealth strategies.

Assessment Questions/Data Search

1. **What is your state's governmental/organizational structure?**
   Obtain a copy of your state's organizational chart and familiarize yourself with key offices that may have contributory input into decisions regarding budget, insurance, regulatory language, etc.

2. **Who are the key people in each state office? Do you know them? What relationships does your organization have with these offices?**
   Create a small organizational chart or reference list for yourself of key offices, the key individual in that office and what relationship you have with them. Think about the offices that include budget writers, budget analysts, human services, mental health agencies, etc.

3. **What is the organizational structure of your state Medicaid agency?**
   Obtain a copy of your state's Medicaid agency structure that lists all its departments and directors/department managers along with key individuals you might already know in those departments.

4. **What do you know about your state's Medicaid budget?**
   a. What is the annual budget for Medicaid?
   b. What percentage of the total state budget is the Medicaid budget?
   c. What are the top three health related expenditures in the Medicaid budget?
   d. What percentage of the total Medicaid budget is each of the top three expenditures?
   You may find some of this information on your state's government website. Other useful sources include the Census Bureau, the Centers for Disease Control, and any sites that provide health statistics, such as NIH, ARHQ, etc. Look specifically for health care expenditures for populations of underserved, uninsured, etc.

5. **What are the national Medicaid numbers corresponding to the top three expenditures in your state? Are they higher? Lower?**

6. **What are the top five health related issues in your state in relation to the demographic population served by health care institutions?**
   a. Do those correlate with the national or state Medicaid expenditures? How?

b. How are they different?

7. **What services are mandated by legislative statute in your state to be provided by county agencies, public health, or other health and human services agencies in your state to specific and/or targeted populations?**

   Look in other departments of health and human services (called Department of Health and Family Services in most states). Do you see any stated mandated programs? Do these programs provide health care services to populations in your service area and in the clinical services you have available via telehealth? Typical areas include mental health, substance abuse, minority populations, and services for children with disabilities. Mandated services for the elderly typically are not health care related, but may provide some insight into other opportunities for telehealth programs.

8. **How does your state make major changes in health and human services agencies with respect to mandated services, covered services, and payment strategies?**
   a. Does your state require legislative changes, regulatory changes, or both?
   b. Is there another mechanism for obtaining a change in reimbursement policy for telehealth?

   Look up the last five major changes that your state has made to payment under the Medicaid program. Were they legislative, regulatory, or internal decisions? This will help you identify the possible route you might take in requesting a change in reimbursement policy.

9. **Does your Medicaid agency use waivers?**
   a. How many waivers have they issued for payment of service in the last five years?
   b. What type of services did they cover?
   c. What was the payment scheme?
   d. Are any of the services/populations that are covered by a waiver offered/served by your telehealth program?

10. **What do you know about transportation costs in your state?**
    a. Does Medicaid pay transportation costs for Medicaid recipients?
    b. What is the payment structure?
    c. If transportation is not paid for by Medicaid, who pays for the transportation costs?
    d. Is there any other budget incentive that you can find related to transportation that might be beneficial when constructing your argument?

11. **What does your state's Medicaid website say about reimbursement equity?**
    a. Are there any statements specific to telehealth?

12. **Do you have a copy of the legislative or regulatory language regarding telehealth in your state, even if it is an absence of language?**

    Have you checked all agencies, such as consumer protection agencies, Office of the Insurance Commissioner, etc., regarding regulatory or legislative language pertaining to telehealth or payment for services provided via telehealth?

13. Do you know your state representative, your state senators, etc.? What are their views on telehealth?

a. When was the last time you met with them?
b. Are they aware of your needs?
c. Do you need help in contacting their office?
d. Do you have a government relations person in your organization that can help you?
e. Where else can you enlist support for this project?
f. Will the consulting/referring organizations be willing to help?

THE ROLE OF CHRONIC DISEASE IN LONGITUDINAL COSTS IN MEDICAL ASSISTANCE PROGRAMS

Telehealth Disease Management is a rapidly growing segment of services that can be provided via telehealth technologies. The level of interest in and knowledge about disease management is growing dramatically. The Institute of Medicine's report, entitled ``Crossing the Quality Chasm,'' (2001) highlights the challenge of managing chronic conditions within a system that was designed to treat acute illness. Major national organizations such as the Disease Management Association of America (DMAA) have been formed to advance the practice of disease management, and the National Committee for Quality Assurance (NCQA) has established standards for disease management programs.

Early efforts at disease management occurred mainly in managed care settings, as the plan and the providers had clear incentives to manage care and the patients were enrolled and "locked into" a delivery system. More recently, a variety of health care organizations including physician group practices, private insurers, commercial firms, and academic medical centers, have developed programs designed to address the challenges inherent in managing chronic illnesses within the context of a fee-for-service (FFS) system oriented around episodic care.

The NDMA, NCQA, and other organizations such as the National Pharmaceutical Council have put forward definitions of disease management that contain certain common elements. These definitions view disease management as an approach to delivering health care to persons with chronic illnesses that aims to improve patient outcomes while containing health care costs. These programs tend to target persons whose primary health problem is a specific disease, although certain co-morbid conditions are usually addressed as well. Patients with a similar level of severity of a disease tend to face similar problems and therefore receive similar treatment plans. These disease management interventions tend to be highly structured and emphasize the use of standard protocols and clinical guidelines.

Certain common features are found in all of these definitions:

1) Identification of patients and matching the intervention with need.
2) Use of evidence-based practice guidelines.
3) Supporting adherence to the plan of care.
4) Supporting adherence to evidence-based medical practice guidelines by providing medical treatment guidelines to physicians and other providers, reporting on the patient's progress in compliance with protocols, and providing support services to assist the physician in monitoring the patient.
5) Services designed to enhance patient self-management and adherence to their treatment plan. Examples of these services are patient education, monitoring and reminders, and behavior modification programs aimed at encouraging lifestyle changes.
6) Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).
7) Communication and collaboration among providers and between the patient and providers. Related services include team conferences, collaborative practice patterns, and routine reporting and feedback loops. In addition, care managers are often used to relay communication and to coordinate care across providers and between face-to-face encounters with chronically ill patients. Programs that address co-morbid conditions

extend their communication efforts to include all of the patient's providers and the entire spectrum of care.

8) Collection and analysis of process and outcomes measures.

In addition to these standard features, programs may include use of information technology such as specialized software, data registries, automated decision support tools, and callback systems. Although disease management services usually do not include actual treatment of the patient's condition, many disease management programs augment the services provided in the traditional FFS system by adding such services as comprehensive geriatric assessment, social services, preventive services, transportation, including prevention services and necessary prescription drugs and outpatient medications. The interventions provided go beyond those services generally covered under the Medicare FFS program.

The role of chronic disease management has taken a front seat in the cost containment and health improvement debate. Any efforts to help reduce the cost of care by averting unnecessary hospitalizations and emergency department visits while maintaining or improving health status will be viewed as favorable by government payers such as Medicaid. Top Medicaid expenditures for most programs are for the elderly, skilled nursing facility care, and children with special needs. All of these populations have a higher incidence and prevalence of chronic disease. There is a multitude of information available through the Agency for Health Research and Quality (AHRQ), CMS studies on disease management, NIH's evidence-based chronic disease guidelines, and CDC's evidence based practice guidelines regarding cost savings per patient year of care when disease management approaches to care are used. In addition, there are several studies regarding congestive heart failure patients who use remote monitoring and the clinical outcomes and cost savings associated with telehealth strategies. The Veterans Administration, the Department of Defense, and Indian Health Services have all used telehealth strategies in a disease managed population with exceptional outcomes.

Approaching Medicaid for reimbursement may begin by identifying the largest sector of services provided to patients with chronic diseases and developing a business performa that shows cost savings to Medicaid for one of their chronic disease populations. The narrower scope of services may be more palatable to Medicaid as a place to start rather than a broad sweeping approach to full reimbursement for all services. Demonstration projects such as those funded by CMS may also be another option to propose, although, demonstration projects are less desirable, as the results usually take three to five years to complete. Reimbursement typically follows the conclusion of demonstration projects. If a demonstration project is offered, the telehealth organization must insist on payment for services during the demonstration project at a rate that is equal to what is reimbursed for in-person care.

ASSESSMENT TOOL FOR CHRONIC DISEASE MANAGEMENT

The purpose of this tool is to get the telehealth organization to think about the role telehealth may play in the delivery of chronic care in their service area and how that care is connected to Medicaid costs. Every program should attempt to complete the assessment tool to improve their readiness in approaching the state for Medicaid payment, even if the organization does not think chronic care plays a major role in their overall delivery of health care.

1. **What chronic disease program(s) do you have at your institution?**
    i. CHF clinic
    ii. Certified Diabetes Management
    iii. Wound Therapy
    iv. Pacemaker Clinics
    v. Obesity
    vi. Depression Clinics

2. **Do you have a home care agency connected with or a part of your institution?**
    i. What are their top five disease conditions?
    ii. How do these correlate with your information on Medicaid top chronic diseases?

3. **What do you know about cost savings for disease management?**
    i. Have you conducted internal studies? What were the results?
    ii. Have you collected external information on disease management with regards to quality improvement, cost savings, decreased utilization?
    iii. How can this information support your initiative to gain Medicaid reimbursement?

4. **What is the link between your organization's disease management initiative, Medicaid beneficiaries, and the literature results?**
    i. Make a case for cost savings and the same or improved outcomes. Cost savings with the same quality outcomes will be attractive to Medicaid. Don't underestimate this argument! Cost savings with improved outcomes is the ultimate goal and also can be achieved.

MEDICAID PAYMENT STRATEGIES

LEGISLATIVE INITIATIVES

One opportunity to gain reimbursement for services delivered via telehealth is to take a legislative approach. The legislative approach involves drafting legislation that mandates coverage for services via telehealth, finding a sponsor for the bill, and entering the bill into your state's legislative session.

Writing a Bill

(Excerpt from a document written by Allen Jerry Taylor Jr. Reference: American Legion. *The American Legion Boystate Manual*: *Beginning of a Lifetime*. Orlando: American Legion, 1989)

A bill is a statement of proposal for some call to action, and when writing a bill you should focus on the following things: what will happen, where it will happen and when it will happen.

When writing a bill you should have a single purpose and effect in mind. You can only have one action per bill. The heading of your bill should be called *A Bill To Be Entitled.* Directly under this you should write *An Act Relating To Your Proposal*. There are at least three sections that deal with what, where and when it will happen.

In order to improve a bill that you are debating on, you can add amendments to it. An amendment is an alteration proposed or affected by such process. For example, what if you have a bill to be entitled *An Act Relating To Control Street Construction.* This bill is stating that street construction should only be done three miles at a time. You can amend this bill by saying street construction should only take place during night hours and should do more than three miles at a time. When writing a bill you should have numbered lines to identify the amendments you have placed there. Make sure your amendments are clear and specify what you are trying to say.

What will happen if the bill passes will be your first section of the bill. Is the bill going to make a major change? Can the bill be enforced without a lot of disciplinary actions? Will people live by this bill without any problems?

Where it will happen if the bill passes will be your second section of the bill. In this section you will clearly state where the bill is going to be active. Why are you going to have the bill passed there? Will there be any problems there? For example, when writing a bill to be entitled **An Act To Make St. Patrick's Day A National Holiday**, you have to consider the following: You are going to have to think about whether or not this bill is going to cause problems with any other states. Maybe you didn't know that the state of Colorado never celebrated St. Patrick's Day as a holiday. Now you are probably going to have a whole state debating against your bill; therefore, you will have to do research on bills that may cause problems to a city or state.

When it will happen if the bill passes will be your final section of the bill. An easy section to explain: just simply state a date. Why are you picking that date to pass the bill? Is this time going to be a problem with other times? Make sure you do your research before setting that date.

When writing a bill, your paper will be formatted in this order:

A Bill To Be Entitled
An Act Relating To (Your bill title, summarizing what your bill is about)

The bill will be enacted by (What legislature, state)

Section 1: (This is where you will begin the text, followed by sections 2, 3)

Remember that your bill must be on line-numbered pages.

Your conclusion will be stated at the end of the bill.
(accessed 11-15-04 at http://www.sarasota.k12.fl.us/bhs/bryan/bryan_bill.html)

A bill does not include your ideas or testimony as to why it should be passed, or even what future benefits will come from the adoption of the procedures in the bill. Those issues can be brought up at committee hearings or in debate on the floor.

Example of how to write a bill:

A Bill To Be Entitled

An Act to Limit the Weighting of Standardize Test Scores Required for Public Universities.

Section 1: Lower the weighting scale of standardize test scores required for admission to public colleges. Base the admissions more on your high school academics, teacher recommendations and your potential.

A) Lower the scale on the SAT and ACT tests.
B) Look more at the person rather than at his application.
C) Have an advisory board for each college to interview the applicant.

Section 2: This will be instituted in all public universities.

Section 3: The bill will be active in the fall of 1998. The entering freshmen class will be the first affected.

Section 4: It is the responsibility of the deans and presidents to make sure all weighting scales on test scores are limited and are based more on your high school academics, teacher recommendations and your potential.

(Written by Allen Jerry Taylor Jr. References: American Legion. *The American Legion Boystate Manual*: *Beginning of a Lifetime*. Orlando: American Legion, 1989)

Taking the legislative route has its advantages and disadvantages. The advantages of taking the legislative route include obtaining reimbursement through legislative language that will require further legislative language to change. In addition, legislative language can be broad enough to encompass a variety of issues. However, there are many more disadvantages to the legislative process. The first involves the relationship between your organization and your state Medicaid agency.

REGULATORY INITIATIVES

Medicaid Payer Directive

One obvious choice of state Medicaid offices and the first choice that should be discussed is the option of the state Medicaid office to determine its own payment system and simply issue the order to do so. The ability of the Medicaid office itself to determine its covered services and guidance for payment may be a condition of legal or regulatory authority in any particular state. In Wisconsin, the state Medicaid office issues a Department of Health and Family Services numbered memo. The numbered memo is a description of the covered service, the procedures for billing services, the contact information for questions, and any other specifics that providers need to know for billing purposes. Often included in the numbered memo are appropriate CPT codes, modifiers, etc., that are necessary in order to receive payment for services.

Telehealth organizations should check with their state budget offices, the organization's government liaison, or their internal reimbursement office to determine if the state Medicaid office has the authority to determine covered services and payment for those services independent of legislated or regulated state congressional input. If so, the burden then falls on the telehealth organization to determine the key individuals at the state level and write the proposal for payment. Doing homework ahead of time may help the telehealth organization to discover if the state office directive is an option to pursue.

Investigate whether the state has issued internal directives in the past and what content was covered. The process of disseminating the information is usually in a document or communiqué of sorts that is a formal communication tool from the Medicaid agency out to any health care organization that may bill Medicaid for services. Any communiqué on decisions that may be similar to services delivered via telehealth, such as teleradiology, pacemaker clinics, care conferences where patients are not present, etc., is helpful.

In addition, the pursuit of a Medicaid departmental directive requires that the telehealth organization have contact with and develop a relationship with the Secretary or Director of the Department of Health and Family Services (or similar title) as departmental directives typically are not considered unless the request to investigate the option has come 'from above.' An initial informal meeting or communication with the top person helps to pave the way for discussion. Oftentimes, it is the CEO or administrator of a hospital or clinic who may be in the best position to have this informal conversation. A formal request with background information may be requested from the Secretary or Director. This report/request is best written by the telehealth program, but should be sent with a cover letter from the CEO or Administrator. The cover letter should include a cleverly worded suggestion that the telehealth organization would be willing to

sit on a state committee. Include the name of a contact person intimately involved with the telehealth program who would be ideal for further communication.

Key to the success of obtaining an internal department directive is to have a champion on the inside. The telehealth organization needs a person in one of the top level departments in DHFS to follow-up on conversations, follow the status of the project, and be a communicator for and with the telehealth organization. This inside person is also helpful in understanding the lay of the land when it comes to pushing for results. Always continue to work with the telehealth organization's government liaison as this person, too, can give great advice and guidance on when, how, and what contacts should be made.

Office of the Insurance Commissioner Directive

A similar approach to the internal decision/determination is to work with the regulatory agency in the state governing structure that deals with insurance, coverage, HIPAA, and other regulated health care payment systems. Often, this regulatory body is a committee of the legislative branch of the state government and has formal hearing processes through which a telehealth organization can file a brief and a petition. Again, it would be helpful if a high-level informal conversation could occur initially to test the waters regarding an OIC directive. Typically, the directive is a consumer protection statement that indicates that payers cannot deny payment for covered services if those services are available through telehealth, as in an anti-discriminatory clause.

State Medicaid PPO/HMO Contracts

In a cost saving strategy, many states have offered managed care contracts to third party payers. The contracts typically involve coverage at a pre-determined monthly rate per enrollee or for a capitated amount per enrollee. The insurance payer then must manage the Medicaid population in a manner that provides necessary basic services while reducing costs and improving quality. This scenario is ripe for the benefits of many telehealth strategies. The method of obtaining reimbursement is no different than those discussed above. However, with a more limited population, and a private vested interest in reducing costs by improving quality (reduced ED visits, reduced hospitalizations and re-hospitalizations, higher functional scores, etc.), managed care insurance organizations are very interested in any strategy that might be helpful to lower costs.

Most of these contractual HMO/PPO arrangements with the State to cover a certain percentage of Medicaid enrollees often mimic the state's own Medicaid payment guidance/rules. It is the job of the telehealth organization to present the arguments that reimbursing for telehealth will help improve health outcomes while saving costs for the HMO/PPO. A pilot project with payment structures identical to in-person coverage is a good way to suggest a starting point with HMO/PPO managed care contracts for Medicaid enrollees. The telehealth organization will want to determine who the HMO/PPO contracted payers are and begin to develop a strategy to approach the payers. Review claims data available through the telehealth organization's own billing and coding departments to determine what services are being billed to the Medicaid HMO/PPO and if cost savings are a potential. Identify any disease management strategies that the Medicaid HMO/PPO may have in place and if those strategies can be served through telehealth and/or remote monitoring.

Governor's Order

One of the early strategies to obtain Medicaid reimbursement was to discuss the issue with the Governor of the state and enlist his/her support in directing the Medicaid agency to develop payment strategies. Although contact with Governor's offices to put pressure on Medicaid agencies may have been useful in the past, this approach may be a political hotbed for many incumbents, and as most states are in significant financial distress. Governors today have a very difficult task at budget time. If a telehealth organization's top executives have an ear in the gubernatorial office, an informal discussion may be warranted to determine the best course of action to take to obtain reimbursement for services delivered via telehealth. A Governor's proclamation supporting telehealth may be more helpful. The proclamation might then be used as leverage in future discussions with Medicaid agencies.

Department of Health and Family Services Initiatives

Most states have legislated or regulated mandatory services that DHFS must cover. In most states, mental health and substance abuse services are legislated covered services and counties or other government agencies are required to provide services in specific areas such as crisis intervention or outpatient therapy. Many states require that certain services for children be provided. Often, counties and other government agencies are faced with legislated mandated services, with little or no access to professionals who may provide the service. Telehealth is an excellent tool to provide access in these situations. In addition, the state agencies mandated to provide services, including county health departments, make great allies in fighting the budget battles at the state Medicaid level. One Midwestern state gained Medicaid reimbursement for Telepsychiatry when five major mandated services for mental health were enacted by the state legislature. Unfortunately, the mandated services were to be provided by counties in which 100 percent of the geographic area was a mental health professional shortage area. Key individuals in the state Office of Strategic Finance, the Bureau of Community Mental Health, and the Bureau of Quality became advocates for the use of telepsychiatry and obtained reimbursement for all services in the mental health and substance abuse sector, if provided via telehealth. These key individuals continued to then pave the way for discussions for total reimbursement for services provided via telehealth to all Medicaid recipients. A telehealth organization should review any and all mandated services that are legislated in the state and make connections with the state agencies required to provide the services. County health departments are a good source of this information.

A state DHFS may also offer grants, block grants, special projects, or other one time initiatives that might provide the resources to begin a pilot for telehealth reimbursement. Although this is not the preferred method, as grants are self-limiting and demonstration projects have a definitive end with possibilities of no further reimbursement, for a state that is reluctant to pay for services delivered via telehealth technologies, this may be a place to start.

Third Party Payer Collaboration

It is important to not underestimate the partnerships that can be forged with third party payers that are paying for services delivered via telehealth. Most insurance companies have internal data on claims and can provide a compelling story to add to the discussions with the state. The telehealth organization should identify its private payers who pay for services delivered via telehealth and enlist their support for the discussions with the state. Collaboration between the

private payers and the telehealth organization will provide additional information, justification, and may be able to reassure the Medicaid agency that the risk is minimal in terms of increased costs due to improved access and increased claims. Examples may also be pulled from Medicare data that the telehealth organization may have. Of particular value is utilization statistics before and after the availability of services via telehealth. A telehealth organization many times can show that Medicare utilization did not increase once Medicare began paying for services.

Other Avenues of Pursuit

Waivers

Waivers may provide States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs.

The State may request a waiver for single health care entities, such as mental health facilities, physician offices, or juvenile correction facilities, or may ask for an award for a demonstration project to a single entity (St. Elsewhere Hospital). Both of these options would require application to and approval from the federal governing agencies. Neither of these options is required for a State Medicaid agency to begin to reimburse for services delivered via telehealth as the federal government has given the states the right to determine covered services. Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. The waiver process is useful when States want to go above and beyond those services but cannot attain equal access for all in their reimbursement process.

Some states are very concerned about the potential rise in cost to the budget if services delivered via telehealth were to be reimbursed. The use of a waiver would allow the state to incrementally begin to reimburse for services provided via telehealth and would allow the state to limit access to certain organizations or geographic areas. However, there are also drawbacks. The use of a waiver would not allow the state to appreciate the full savings of transportation costs or the savings associated with clinical improvement in persons who have better and timelier access to care and access to the right provider at the right time. In addition, CMS has indicated that it will be limiting the use of waivers in the next fiscal year and returning to the concepts of basic services. In reviewing the list of Section 1115 health care reform demonstrations (waivers), few waiver applications have been submitted to CMS since 2000 (12 awards, 3 of which are extensions of original waivers). Telehealth providers need to be aware of the use of waivers in their state, the history of waivers, and for what services waivers have been applied for and granted. One of the burdens of using the waiver process is the substantial administrative costs to using a waiver process for reimbursement to both sides. In most respects, added administrative burden is non-value added work.

In addition, with the ever-increasing budget crisis most states are experiencing, the request for a waiver for services delivered via telehealth may be seen as an increased administrative burden. The reluctance that may be shown by some states regarding discussions of the waiver process may simply be lack of resources to investigate, collect data, and write the waiver itself. The telehealth organization may be more successful in this initiative if they write a draft of a waiver and have that draft available as discussions with the states unfold. Existing waivers may be seen on http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI.

If a waiver option were to be considered the preferred option by the state, the following process might be suggested:

1) The organization requesting a waiver for the use of telehealth as a tool for access would write the initial request to the state of Medicaid Agency (MA) or Department of Families and Services (DHFS). The request would include:
    a. Guidelines for provision of services
    b. Geographic service area
    c. Rurality of service area
    d. Services to be provided
    e. Justification for the use of telehealth
    f. Completion of waiver requirements for justification and documentation
2) MA or DHFS would review the application for waiver and respond with a request for additional information or with approval of the waiver request.
3) MA or DHFS would submit the waiver request to CMS State Operations office on behalf of the organization.
4) MA or DHFS would coordinate requests for additional information or approval notification with the applicant organization.
5) Payment for services delivered via telehealth would be according to the guidelines defined in the waiver application.
6) Notification of payment would be made directly to the organization by MA or DHFS and would be published in the Medicaid Bulletin at the discretion of MA or DHFS.

SCHIP

One avenue for gaining reimbursement is working through specific single agencies in the state government who are responsible for reimbursement of health care services to specific populations. One of these populations who rely heavily on Medicaid benefits for health care is children and/or children with special needs. The State Children's Health Insurance Program (SCHIP) gave each state permission to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a state administered program and each state sets its own guidelines regarding eligibility and services. SCHIP is designed as a Federal/State partnership; SCHIP is designed to provide coverage to "targeted low-income children." A "targeted low-income child" is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income 50% higher than the state's Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families and not just children.

SCHIP offers states three options when designing a program. The state can either:

- use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program;
- design a separate children's health insurance program entirely separate from Medicaid; or,
- combine both the Medicaid and separate program options.

As of September 30, 1999, each of the states and territories had an approved SCHIP plan in place. Similar to Medicaid, a state's SCHIP state plan is the mechanism that begins Federal Financial Participation (FFP) in a given state. As in Medicaid, CMS must either approve or disapprove a state plan within 90 days of its submission to CMS. Similar to Medicaid, under SCHIP, states can modify their State Plans by submitting State Plan Amendments (SPAs). To review your state plan, go to CMS's website http://www.cms.hhs.gov/schip/stateplans to view your state's plan

Eligibility for SCHIP is targeted towards uninsured low-income children. As a result, certain groups of children cannot be covered under SCHIP. These ineligible groups include:

- children who are covered under a group health plan or under health insurance coverage;
- children who are members of a family that is eligible for state employee insurance based on employment with a public agency;
- children who are residing in an Institution for Mental Diseases; and,
- children who are eligible for Medicaid coverage.

If a state elects to establish an expanded Medicaid program using SCHIP, the eligibility rules of Medicaid apply. If a state opts for a separate child health program, certain other rules can affect eligibility:

- States can allow for self-declarations of citizenship;
- States are prohibited from enforcing duration of residency requirements;
- States may not enact lifetime caps or other time limits for eligibility;
- States can, at their option, choose to offer children 12 continuous months of eligibility; and,
- States may enforce enrollment caps and waiting lists for coverage, if these provisions are in the approved state plan.

For states that opt for a Medicaid expansion, the services provided under SCHIP mirror the Medicaid services provided by that state. For states that opt for a separate child health program, there are four options for determining coverage:

1. *Benchmark coverage*: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
2. *Benchmark equivalent coverage*: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.

3. *Existing state-based comprehensive coverage*: In the states where existing state-based comprehensive coverage existed prior to the enactment of SCHIP (i.e., New York, Pennsylvania and Florida), the existing health benefits package is deemed to be meeting the coverage requirements of the SCHIP program.
4. *Secretary approved coverage*: This may include coverage that is the same as the state's Medicaid program; comprehensive coverage for children offered by the state under a Medicaid demonstration project approved by the Secretary; coverage that either includes full EPSDT benefit or that the state has extended to the entire Medicaid population in the state; coverage that includes benchmark coverage plus any additional coverage; coverage that is the same as the coverage provided by New York, Florida or Pennsylvania; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

Regardless of the type of health benefits coverage provided by a state, they must provide coverage for well-baby and well-child care, immunizations and emergency services.
Other rules that affect which services are to be covered under SCHIP:

- Abortion services may only be provided to save the life of the mother, or to terminate a pregnancy resulting from an act of rape or incest.
- In general, states can not permit the implementation of preexisting condition exclusions.
- If SCHIP plans provide coverage through group health plans, preexisting condition exclusions are permitted only in so far as HIPAA rules allow.

How to Use SCHIP to Your Advantage

In determining an effective strategy to approach your state with a request for reimbursement for telehealth, one area in which to start may be in the area of children. For most states, the elderly comprise the top Medicaid annual expenditures, followed by children and/or children with special needs. Becoming familiar with the SCHIP program of your state may give you some leeway in developing an argument for payment for beneficiaries in SCHIP. If your state has established benchmarks that include private payers who do pay for services delivered via telehealth, this may be an important point to make as you discuss payment with your Medicaid agency. Reviewing the reimbursement for services delivered via telehealth in New York, Florida, or Pennsylvania (pre-existing state-based programs), or in states where the Secretary has established benchmarks, will also give you additional information to develop your persuasive arguments for reimbursement by your state.

ASSESSMENT TOOL FOR DETERMINING ACCESS TO REIMBURSEMENT

1. **What is the name of your state health and human services organization?**

2. **How does your state health and human services make decisions?**
    a. Are they required to be legislated?
    b. Are they legislated and then regulated?
    c. Are they regulated only?

3. **Has your state Medicaid agency used waivers in the past?**
    a. What types of waivers have they obtained?
    c. Have those waivers been extended?
    d. How long did it take from request to authorization of the waiver?
        1. Would this timeframe be acceptable to you if you went after a waiver for payment for telehealth?
    e. Are any of the waivers intended to provide direct clinical services?
    f. What would be the pros and cons of going after a waiver in your state?

4. **Do you have an Office of the Insurance Commissioner or similar office in your state?**
    a. Has this office mandated payment for any other types of services?
    b. Do you have a relationship with the Commissioner?
    c. What would be the pros and cons of using this avenue in your state?

5. **Do you have mandated services in any branch or office of your state health and human services agency?**
    a. Do these mandated services fall in areas of health professions shortages?
    c. Are the mandated services intended for disparate, underserved, or minority populations?
    d. Are the mandated services those which you provide via telehealth?
    e. Do you have a relationship with anyone in the offices who have responsibility for mandated services?

6. **Is your state covered by HMO/PPO Medicaid contracts?**
    a. Does the HMO/PPO follow Medicaid guidelines for reimbursement or do they have programs that have expanded on Medicaid reimbursement?
    b. What is your relationship with these third party contracts?
    c. Can you develop a project with an HMO/PPO to show cost savings when telemedicine is used?

7. **Has the Governor in your state ever issued a mandate for covered services for Medicaid?**
    a. If so, what were they?
    b. If not, what is the potential to collaborate for a gubernatorial mandate?
    c. Is this an election year?
    d. What would be the pros and cons of using this approach?

DEVLEOPING YOUR STRATEGY FOR TELEHEALTH REIMBURSEMENT

A telehealth organization must conduct an assessment of their state Medicaid agency and the telehealth organization's readiness to begin approaching the state for reimbursement. A comprehensive strategy using specific data about one's own state supported by research data reflecting specific state population's health issues is the best approach. Simultaneously putting together a team of strategists, mapping out a plan, and moving forward building relationships will increase the likelihood of success. Telehealth organizations should be prepared to write an initial document outlining the issues, and a specific plan for reimbursement on which to begin discussions with the state.

Telehealth organizations should answer the questions posed in this Medicaid guide, complete the assessment tools, and then move on to the tool for developing a Medicaid strategy that follows this section. Although this guide is not intended to cover every single option available to the telehealth organization seeking Medicaid reimbursement, it is useful in directing the background work that is necessary to position the organization for success. Good Luck!

STEPS TO SUCCESSFULLY NEGOTIATING MEDICAID REIMBURSEMENT

2. **Create a task force within your organization comprised of financial services experts in Medicaid and Medicare reimbursement experts, strategic planners, the telehealth clinical and administrative team, and your government liaison (if you have one).**
    i. List your organization's top five Medicaid primary diagnoses.
    ii. List Medicaid's top three expenditures
    iii. List your geographic demographic top three health problems.
    iv. List any disease management programs that you have.

3. **List the cost data and/or outcomes data that you have to support the use of telehealth related to the conditions identified in #1. Include the reference citation.**

4. **Based on what you know about your state:**
    i. Is your state more or less likely to come to the table with you to discuss expanding reimbursement for telehealth?
        1. Yes – Develop your formal plan of approach
            a. Write a letter of request
            b. Make the initial contacts
            c. Develop relationships with staff of key departments
        2. No- Why not? Can you address the concerns? Can you overcome the barriers?
    ii. Is your state more or less likely to use a regulatory or internal directive approach to expanding telehealth reimbursement?
        1. Yes – Develop your written request
            a. Write a letter of request
            b. Develop two or three options for payment with your preference listed first.
            c. Support the options with your cost and outcomes data.
            d. Develop a list of what is needed to cover your program and what you might consider 'giving up' in negotiations
        2. No – Why not? What can you do to convince them that a regulatory route is the most efficient and effective for them?

    iii. Is your state more or less likely to hold out for a legislative mandate?
        1. Yes – Develop a strategy that lists the pros and cons
            a. Why would the state take this position?
            b. Do you know any legislators that would be willing to sponsor a bill?
            c. What is the likelihood of bipartisan support?
            d. What is the likelihood of passage?
            e. What is the likelihood that the intent of a legislative fix will create a broad reimbursement policy?
            f. What is the political fallout of taking this route?
        2. No – What is your next option?

iv. Is there an office in your state that would be more or less likely to issue a directive?
    1. Yes – Which office is more likely?
        a. Gubernatorial directive
        b. Office of the Insurance Commissioner
        c. Office of the Secretary of Health
        d. Develop a written plan of approach
        e. Who do you know in this office?
    2. No – What is your next option?

b. Develop your written plan

1. Identify the top priorities for payment
    i. Populations
    ii. Services
    iii. Sites
    iv. Codes
2. Support your request with research – both anecdotal and scientific.
3. Use a budget analyst from your organization to check your financial forecasts.
4. Identify the gaps in your plan in terms of financial discussion, support, pros and cons, etc., and develop a response to have ready when these gaps are identified by the Medicaid staff.

c. Make your initial contact!

Remember that you are acting on behalf of the patients that you serve. Your passion and commitment to access and quality care through telehealth is the most important part of your presentation. Enthusiasm is contagious! Remember to be tenacious! Your Medicaid agency has a lot on its plate, and they may put your issue on a back burner, may accidentally forget about it, or it just make take them a long time to make a decision. Don't be afraid to keep calling and working with them. Offer to participate in a work group. Being a member of a work group gives you an advantage of being able to drive the timeline without being too pushy. The group also gives you a chance to develop relationships with a larger group of people.

CASE STUDIES

The following case studies serve as examples of the approach some telehealth programs have used to gain reimbursement for services delivered via telehealth to Medicaid beneficiaries.

WISCONSIN MEDICAID AND TELEHEALTH

Marshfield Clinic TeleHealth Network (MCTN) was formed in 1997 as the result of the award of an Office of Rural Health Policy Rural Telemedicine Grant (HRSA, HHS, Washington, DC). The MCTN is a part of Marshfield Clinic, a physician group practice of 750+ physicians located in North and Central Wisconsin, serving primarily rural and underserved areas of the state. Currently, MCTN offers 40 clinical services in 28 sites including clinics, hospitals, nursing homes, schools, county jails, and rural dental clinics.

Before implementing telehealth, MCTN initiated an internal reimbursement group to look at reimbursement processes and billing options for telehealth. At that time in 1998, the State of Wisconsin did not reimburse for services delivered via telehealth. MCTN took a collaborative approach in contacting the state and working towards reimbursement, rather than a legislative or OIC mandate.

In order to pursue payment by Medicaid, MCTN met with Wisconsin's Secretary of Health in 1999, under Governor Thompson's term. Attending the meeting were 11 people from the state offices, including budget writers, budget analysts, the Medicaid director, and various other quality and services staff. The discussion was very cordial, and it was clear that the state team had done their homework. Medicaid indicated that they would postpone the decision to pay until the clinical outcomes of a pending MCTN teledermatology study were complete. Things did not look promising. Although Governor Thompson was aware of the telehealth initiatives at Marshfield Clinic and had attended several presentations, it was the Secretary of Health who would ultimately make the decision. During the next year, MCTN worked on getting the outcomes data and contacting the state again for a meeting.

Unfortunately, Governor Thompson resigned in 2001 to accept President Bush's nomination to Secretary of Health and Human Services, Washington, DC. A year of uncertainty ensued with many offices changing leadership. In 2003, Governor Doyle named Helene Nelson to the Secretary of Health for the state of Wisconsin. Secretary was well known for her support of health issues, and her attention to 'doing the right thing.'

In October of 2003, Michael Hillman, MD, the Medical Director of Telehealth, received a telephone call from the Bureau of Community Mental Health, Department of Health and Family Services, State of Wisconsin, to discuss telehealth, specifically telepsychiatry. The Bureau had received a request from a single provider office for an exemption to use telepsychiatry to cover two outpatient sites. The Bureau had little or no knowledge of telehealth or telepsychiatry, with which to respond to the request. The Bureau contacted Marshfield Clinic to educate the Bureau on how to proceed with the request.

The contact from the state presented an opportunity to work with the Bureau in developing the state guidelines as well as pursuing reimbursement from Medicaid. Although full reimbursement for all services would have been preferred, gaining reimbursement for mental health and substance abuse services via telehealth was a start. MCTN began to work with the state Office of Strategic Finance and the Bureau of Community Mental Health on developing the guidelines, which were reviewed by all appropriate agency personnel.

During the development of the statewide plan during 2004, discussions around payment began to arise. It was determined that even though the state had a plan for the use of telepsychiatry and counties had adopted telehealth and installed and made operational their plan, all was for naught if Medicaid did not pay for services delivered via telehealth. All participants in the working group for the statewide plan agreed on the reimbursement issue. The Office of Strategic Finance facilitated a meeting with the Medicaid Director and support for payment was garnered. Secretary Nelson was supportive of moving forward with payment for services delivered via telehealth.

The state guidelines for telepsychiatry were written and implemented in September of 2004. A copy is attached at the end of this case study. Each provider wishing to use telepsychiatry had to develop a plan for the use of telemental health (as it was called in the state guidelines), and submit that plan to the state for approval. The Quality Assurance Bureau, DHFS, conducted a site review along with their annual DHFS certification for mental health providers and issued a certificate that included being certified for telehealth. MCTN submitted the plan in January of 2005 and Marshfield Clinic became the first provider to be certified to use telepsychiatry in the state of Wisconsin, beginning billing in May of 2005. At that time, Medicaid paid only the professional component and no facility fee.

During the discussions regarding telemental health, MCTN had continuing discussions with the state regarding paying for all services delivered via telehealth, not just mental health and substance abuse. A meeting was called with the Medicaid director, the Medicaid budget analyst, the Office of Strategic Finance, and other critical staff, to begin the work on moving forward with payment for all other services. The concerns expressed by the state were the floodgate issues, the Medicaid cost-based reimbursement, and how to maintain quality (avoid renegade practitioners who really did not know how to use telehealth). Responding to these concerns was critical to the success of gaining payment. MCTN provided volume statistics for Marshfield and had positioned the state plan for telepsychiatry as the method to certify all organizations to use telehealth (the plan would be made generic). At that time, Marshfield Clinic had been providing services to about 150 patients per year who were Medicaid recipients. After hearing the number, the Medicaid staff was not concerned that the floodgates would open if they began paying for all other services. With a requirement to submit a state plan for telehealth in place, the state would know how many organizations were going to be using telehealth (at the time of the discussions, no other telehealth network was providing clinical services – all were CME programs) and would be able to calculate increasing volume over time. The State would also have control over who they would certify if there were concerns about quality of care. As a result of the meeting, MCTN was asked to submit a proposal on a reasonable compromise between what Medicare paid for with respect to telehealth and what the state Medicaid paid for in-person care. The proposal was sent in June of 2005.

The state appeared to move in the direction of adopting the Medicare guidelines with some adjustments. At this writing, the state has indicated that the programmatic changes will be announced in June of 2006, and will go into effect July 1, 2006. Medicaid will pay for services without restrictions on geographic or population HPSAs – payment will be made statewide. There is no originating site restriction. A facility fee will be paid.

Advice for Others

Our success was made easier for several reasons. The State needed something from MCTN and we took the opportunity to help them get what they needed. In exchange, we were able to identify a weakness in the strategy for leveraging mental health and substance abuse providers via telehealth – reimbursement. The other helpful part of the equation was the staff in the offices who were seeking

our help were strategically in good position or had respected tenures of service that facilitated the discussion with the Medicaid director on payment.

We would encourage other organizations to look into their state's DHFS mandates, and find a department or agency within DHFS that might benefit from the use of telehealth. Enlist the support of that agency in using telehealth to serve its populations. Obviously, children's services is a good place to start. Start with assisting in developing a strategy to meet the needs by using telehealth. Secondarily, bring in the issues of Medicaid reimbursement once you know interest in using telehealth is solidified.

Take advantage of any social interactions that might present positioning telehealth as a way to solve a problem for the Secretary, the governor, or other agency head with which you might be talking.

Most importantly, offer to do research, write documents, meet at the state capital, anything that might make the job go quicker and smoothly, and end up with the results that you want. State agencies are short staffed and many times will welcome your help. MCTN offered to write a state plan for telepsychiatry (after suggesting it as a way to ensure quality and control by the state) and believe that the job went much quicker and ended up closer to what we could live with than if the burden of the plan had been left up to the state to write.

MINNESOTA MEDICAID AND TELEMEDICINE

The history of payment in Minnesota is unclear at present. On April 5, 1999, Representative Howes, Mulder, Gooduo, Otremba, and Huntley introduced H.F. 807, Rural Health Initiatives, in the House of Representatives, State of Minnesota. The bill required the Commissioners of Health and Commerce to develop uniform billing standards for all Minnesota payers; modified the provisions of the rural hospital planning and transition grant program and appropriated money for the program; required MA and GAMC to cover telemedicine conferences between providers; and required certain services at critical access hospitals to be paid on a cost-based system. It appears that the telemedicine provisions were a part of a larger effort to correct some inequities in financing rural health care. The legislative language stated:

Section 3: Telemedicine consultations. Adds subd. 8d to § 256B.0625. Extends medical assistance (MA) coverage to telemedicine consultations, and provides that payment will be made to both the referring provider and the consulting specialist. Allows telemedicine consultations to occur through either two-way, interactive video or store-and-forward technology.

The bill was referred to the Committee on Health and Human Services Policy, who made the following changes in conference:

"Subd. 8b. [TELEMEDICINE CONSULTATIONS.] Medical assistance covers telemedicine consultations. Telemedicine consultations may be made via two-way, interactive video or store-and-forward technology. Payments will be made to both the referring provider and the consulting physician specialist. Physician specialist includes any physician consulting with an emergency department provider."

"(22) telemedicine consultations, which may be made via two-way, interactive video or store-and-forward technology. Payments will be made to both the referring provider and the consulting physician specialist. Physician specialist includes any physician consulting with an emergency department provider"

The bill was first read on February 18, 1999, referred to committee, and the Committee report was heard, amended, and passed on March 17, 1999, becoming law as of April 5, 1999.

The legislative route was taken in Minnesota, but little is know regarding who initiated the discussions and how the discussions were pursued. It appears that the legislative route taken was in the form of a subparagraph to an overall bill aimed at amending11 key legislative pieces dealing with rural health care. Many times this route is useful, particularly if several sponsors endorse a bill and the likelihood of passing with little revision is a possibility.

The final and current provisions can be found in section 256B.0625, subd. 3b. of the Minnesota State Code.

MONTANA AND MEDICIAD
EASTERN MONTANA TELEMEDICINE NETWORK

The Eastern Montana Telemedicine Network began as a cooperative effort between Billings Clinic and five rural healthcare facilities in eastern Montana to research the potential of interactive videoconferencing in improving access to medical specialty and mental health services. Today EMTN is a consortium of 28 not-for-profit medical and mental health facilities linking health care providers and their patients in 19 communities throughout eastern and central Montana and northern Wyoming. Operational since September 1993, EMTN continues to pursue its original goal: *To utilize two way interactive video conferencing technology to deliver specialist medical and mental health services, continuing medical and higher education, administrative and Telebusiness services.*

Today EMTN is a robust telemedicine network meeting clinical, educational and administrative needs of its partners. Multiple clinical services are provided over the network: mental health, drug and alcohol counseling, cardiology, infectious disease, ENT, allergy, sleep studies, neurology, diabetes education, and emergency medicine. Other clinical applications include registered dietician services, employee assistance counseling and geriatric assessment.

EMTN also provides access to continuing professional and consumer education. Rural healthcare provider participate in CME/CEU programs such as grand rounds, nursing grand rounds, tumor board and lab/radiology education. Consumer's benefit from programs like Women Heart Disease, Living with Diabetes and Breast Cancer Awareness.

The Eastern Montana Telemedicine Network is committed to providing access to high quality healthcare to the rural and frontier residents of Montana and Wyoming

The Story of Medicaid

At the time EMTN was established in 1993, a telemedicine advisory group(TAG) was formed to provide strategic direction and advise. This group was made up of representation from each member site, rural and urban physicians, technical partners and private and public payers (Medicare, Medicaid and Blue Cross/ Blue Shield) and other key stakeholders from both the rural and urban communities. During our growth and development the TAG met quarterly. Through membership in the advisory group, Montana Medicaid learned about the goals and operation of the network. In 1993, EMTN made a formal request to Montana Medicaid to develop a reimbursement policy for telemedicine services. The policy established in 1993 provided reimbursement for interactive telemedicine services. This policy was based on the HCFA-now-CMS policy that allows states to define coverage policy for interactive telemedicine services *as long as they are within the scope of practice of medicine or osteopathy defined by State Law*. In October of 1993 the Montana Department of Social and Rehabilitation Services granted EMTN permission to begin billing for evaluation and management codes at the same rate as in-person care. Through continued participation and representation in the TAG coverage expanded to include Medicaid services that were non- procedural based.

Montana Medicaid has been a national leader in the development of Medicaid reimbursement policy for telemedicine services and is a valued partner in Montana's telemedicine efforts.

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RESOURCES AND LINKS

Government Agencies	*Telehealth Programs*
Agency for Health Research and Quality url: www.ahrq.gov **American Telemedicine Association** 1100 Connecticut Avenue, NW Suite 540 Washington, D.C. 20036 202-223-3333 Phone 202-223-2787 Fax email: info@americantelemed.org url: www.americantelemed.org **AMD Telemedicine, Inc.** 650 Suffolk Street Lowell, Massachusetts 01854 978-937-9021 Phone 978-937-5249 Fax 978-454-8409 Video url: www.amdtelemedicine.com **Center for Disease Control** url: www.cdc.gov **Centers for Medicare and Medicaid Services** url: www.cms.gov **Center for Telemedicine Law** 1301 K. Street NW Washington, D.C. 20005-3317 202-230-5152 Phone 202-230-5352 Fax url: www.ctl.org *Telemedicine Reimbursement Sourcebook, 2002* *Reimbursement Report, 2003* **National Institute of Health** www.nih.gov **Telemedicine Information Exchange** url: www.tie.telemed.org **Telemedicine Journal and e-Health** url: www.liebertpub.com	**Arizona Telemedicine Network** P.O. Box 245106 Tucson, Arizona 85724 520-626-7330 Phone 520-626-1983 Fax url: www.telemedicine.arizona.edu **Children's Hospital and Regional Medical Center** 1100 Olive Way, Suite 500, Suite MPW 5-2 Seattle, Washington 98101 206-987-5733 Phone 206-987-5741 Fax url: www.seattlechildrens.org **Eastern Montana Telemedicine Network** 2800 10th Avenue North Billings, Montana 59101 800-252-1246 Phone email: emtn@emtn.org url: www.emtn.org **Kentucky TeleCare** University of Kentucky K128 Kentucky Clinic Lexington, Kentucky 40536 859-257-6404 Phone 859-323-8018 Fax www.mc.uky.edu.kytelecare **Marshfield Clinic Telehealth Network** 1000 N. Oak Avenue Marshfield, Wisconsin 54449 715-389-3694 Phone 715-387-5225 Fax url: www.marshfieldclinic.org/telehealth **University of Virginia Health Systems** P.O. Box 800711 Charlottesville, Virginia 22908 434-924-2481 Phone 434-982-1415 Fax email: krheuban@viginia.edu