Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services – SB 393
Senate Finance Hearing
January 27, 2021
FAVORABLE

Thank you for the opportunity to submit testimony in support of SB 393 which would make permanent the telehealth service delivery standards for mental health (MH) and substance use disorder (SUD) benefits in Medicaid and private insurance that have been available during COVID-19. Telehealth services, including audio-only service delivery, have been the lifeline for Marylanders during the pandemic. Continuation of these expanded telehealth standards in both Medicaid and private insurance will help address the skyrocketing need for MH and SUD services resulting from COVID-19 and help Maryland recover.

This testimony is submitted by the Legal Action Center, a non-profit law firm that uses legal and policy strategies to fight discrimination, build health equity and restore opportunity for people with substance use disorders, criminal records, and HIV or AIDS. The Center also leads the Maryland Parity Coalition, which issued Telehealth Recommendations in July 2020 to extend, beyond the public health emergency, the telehealth practices that Maryland Medicaid had adopted early in the pandemic to ensure access to and continuity of MH and SUD care. The Coalition's recommendations, endorsed by 36 state organizations, form the basis of SB 393 along with the extension of comparable standards to state-regulated private insurance.

SB 393 would adopt 5 essential standards to implement effective telehealth services for MH and SUD care:

- Authorize patients to receive telehealth services in their **homes or wherever they are located**.
- Authorize and require reimbursement for **audio-only/telephonic telehealth** delivered by licensed MH and SUD programs and licensed practitioners consistent with in-person service delivery.
- Require **reimbursement** for telehealth services (both audio-only and audio-visual) **at the same rate as in-person services (payment parity)**.
- Protect the **patient's right to consent** to receive services via the service delivery mode of their choice and retain current network adequacy standards that require member consent to count telehealth for satisfaction of Maryland's network adequacy metrics.
- Require health plans and Medicaid to comply with the **Mental Health Parity and Addiction Equity Act** so that authorization, utilization management, and reimbursement standards are comparable across MH, SUD, and medical/surgical services.

Other states have adopted these same standards for MH, SUD and other health services in Medicaid and private insurance on a permanent basis. We urge Maryland to build on our telehealth lessons over the past 10 months and do the same to meet the dire need for MH and SUD treatment and ensure continuity of care, post-pandemic.

I. Substance Use Disorders and Mental Health Conditions: Increased Demand for Treatment and Reliance on Telehealth Service Delivery for Care

COVID-19 has traumatized Marylanders, negatively affecting their health and creating significant economic and social hardship. Communities of color have experienced the harsh and disparate impact of COVID as well as mental health and substance use problems. Data reveal higher rates of alcohol and drug use, anxiety, and depression, overdose deaths and suicide across all populations. The need for treatment has never been greater.

- Overdose deaths from alcohol and drug use increased 12% in Maryland for the first 3 quarters of 2020 compared to 2019.
- Suicide rates among Black individuals in Maryland doubled during the initial COVID peak (March – May 2020) compared to Black suicide rates in 2017-2019, while suicide rates among whites dropped by one-half of the white suicide rate in 2017-2019 during March through July.
- Providers in Maryland's Public Behavioral Health System reported in the fall of 2020 that patients receiving MH and SUD services indicated more concerns or challenges with suicidal ideation, substance use and both housing and homelessness than in the spring of 2020 and reported ongoing and high levels of anxiety, depression and loneliness. (Univ. of Maryland Baltimore, "The Effects of COVID-19 on Individuals Receiving Behavioral Health Services and Supports in Maryland: Follow-up Survey" (Nov. 2020) at 17-18) (hereafter "BHA Survey").
    - As evidence of the need for treatment, the Behavioral Health Administration (BHA) has found that more "new" individuals were seeking MH and SUD services (p. 6, 29) and more individuals were keeping their treatment/service appointments more frequently than in spring 2020. (BHA Survey at 10, 29).
- Parents in Maryland have reported their children are experiencing increased rates of anxiety and depression over the period of mid-July to mid-December 2020: 40% of adults reported living with children experiencing anxiety and 25% reported their children experienced depression. (Annie E. Casey Foundation: Kids Count Data Center)
- Calls and online outreach to Maryland's 211 call center to connect residents with mental health resources increased by 355% in the fourth quarter of 2020 compared to 2019 and text volume increased by 425%.
- Patients who survive COVID have a significantly higher rate of being diagnosed with anxiety and mood disorders in the 3-month period following their COVID diagnosis than those with other diagnoses.

Telehealth services have been essential for the delivery of MH and SUD care to Marylanders over the past 10 months and has far exceeded the level of service delivery for other health conditions.

- Lt. Governor Rutherford has highlighted the role of telehealth in "lifting barriers" to MH and SUD services during the pandemic and has called for "**continued expansion of the use**

of telehealth to reduce barriers to service delivery…[and] in particular…the authorization of audio-only telehealth services." (Commission to Study Mental and Behavioral Health in Maryland 2020 Report at p. 3 and Recommendation 10 at 21).

- BHA's Survey has found that telehealth succeeded in delivering MH and SUD care by: (1) removing the need to travel, (2) providing easier access to treatment and (3) increasing client participation in treatment. (Report at 20, 29). Over one-third of respondents (35%) offered the unsolicited observation that telehealth has "increased patient engagement, decreased no-shows, and increased access for new clients who otherwise may not receive treatment." (BHA Survey at 26).
- In commercial insurance, the utilization of telehealth for MH care has far exceeded that for any other health condition during the pandemic. FAIRHealth data for the region in which Maryland is located (southern region) show that utilization of telehealth services for MH **jumped 30 percentage points from 12.5% of claims in Oct. 2019 to 42.8% of claims in Oct. 2020;** the second most frequently billed condition – acute respiratory conditions – accounted for only 5.3% of telehealth claims. Two of the top 5 CPT codes billed were for psychotherapy. Nationally, over 51% of telehealth claims were for MH services in October 2020.

Post-pandemic, the increased need for MH and SUD care will be long-lasting. Telehealth, if properly regulated and reimbursed, will help fill long-standing gaps in access to and availability of MH and SUD treatment in rural and medically underserved areas in Maryland. **No insurance carrier has satisfied the state's network adequacy requirements for MH and SUD services, in full, for the past 3 years.** Telehealth services, if properly reimbursed, could expand MH and SUD service to those who choose this mode of service delivery.

II. SB 393 Would Authorize Telehealth Services to Meet the Needs of Marylanders with MH and SUDs.

SB 393 would ensure that individuals in both Medicaid and private insurance gain access to effective MH and SUD services through the adoption of 5 key standards.

A. Expand Originating Sites to Include the Patient's Home or Wherever the Patient is Located

Maryland's commercial insurance standards do not limit the location at which patients must receive health services care, while state Medicaid regulations limit the "originating site" of services for most health conditions to designated health facility or other settings. COMAR §§ 10.09.49.02, 10.09.49.06. The pandemic has demonstrated the value of patients receiving care in their home or other setting in which they can have a private counseling session. This expansion has allowed patients and providers to have greater flexibility in setting appointment times, has removed the stigma associated with visiting a MH or SUD program or practitioner's office, and can reduce the "triggers" for drug use that may be associated with neighborhoods in which SUD programs are located. It has also allowed individuals who are homeless or not safe in their home to gain access to essential care at locations in which they can have confidential conversations. While many patients

with MH and SUDs benefit from and need direct interaction with peers and practitioners through in-person services, "talk therapy" is uniquely well-suited for remote service delivery, consistent with the individualized treatment plan developed by the patient and provider.

With the elimination of transportation, childcare costs, and travel time, and the ability to reduce time away from work, providers report that patients enter and engage more consistently in treatment. *See* BHA Survey at 20 and 29. Indeed, Healthcare for the Homeless found a lower rate of "no-show" appointments for patients with telehealth appointments than for those with in-clinic appointments (17.9% v. 18.5%) from April to December 2020 and, more significantly, a sharp reduction in the patient "no-show" rate for in-clinic appointments (25%) for the same period in 2019. (Data on file with Legal Action Center). Finally, providers have reported the therapeutic value of seeing patients in their home or living environment via audio-visual telehealth: it has enabled them to more effectively adjust a patient's treatment plan and, as appropriate, engage family members in family therapy. **Removal of originating site requirements in Medicaid will lower barriers to care and improve treatment participation.**

B. Authorize and Require Reimbursement of Audio-only Telehealth

Equity in access to health care delivery is not possible without coverage of and reimbursement for audio-only telehealth. Approximately 36% of Marylanders lack access to high speed internet, as defined by the Federal Communication Commission standard, according to the Maryland Task Force on Rural Internet, Broadband, Wireless and Cellular Service. (p. 6). Many other residents lack the technological literacy to use audio-visual telehealth; others cannot afford the cost of internet plans, computers and smart phones needed for audio-visual services. As noted in the BHA Survey, the greatest telehealth challenges that public health system patients have experienced are: (1) access to internet connectivity; (2) access to hardware; and (3) the ability to use telehealth technology. (BHA Survey at 21, 29). "Access to telehealth" was among the services or supports most needed by public health system patients, second only to "continuation of service." (BHA Survey at 18). While Maryland must devote resources to ensure that all Marylanders have access to audio-visual telehealth, if preferred for service delivery, patients in need of MH and SUD care cannot wait for the digital divide to be bridged. **For this reason, the Lt. Governor's Mental and Behavioral Health Commission has recommended the permanent authorization of audio-only telehealth for behavioral health care.**

Apart from digital access barriers, audio-only telehealth also meets the therapeutic needs more effectively for some patients. Individuals with eating disorders and other mental health conditions are often more comfortable and willing to get care when they do not need to look at themselves – or their provider – on a screen. Providers who use audio-visual telehealth often have patients look away from their screens, as needed, to enable them to work on sensitive issues. MH and SUD providers who have relied on audio-only telehealth during the pandemic have observed that the care delivered through audio-only and audio-visual telehealth is the same. Practitioners have needed to develop different skills and strategies to deliver effective care, but the "talk therapy" is the same service.

Audio-only telehealth is an effective mode of service delivery for many individuals with MH and SUD conditions because the treatment relies primarily on verbal communication and support. Post-

pandemic, patients and providers will determine the appropriate service delivery mix on an individual basis, and audio-only telehealth will be an important option for some. Accordingly, **after 10 months of care delivery through audio-only telehealth, the failure to authorize coverage and reimbursement of this service delivery tool would disrupt care for countless Marylanders and re-erect barriers to care.** As described below, 7 states authorize audio-only telehealth for Medicaid and 6 states authorize this delivery mode in private insurance on a permanent basis.

C. Require Payment Parity for MH and SUD Care in Both Medicaid and Private Insurance.

Pre-pandemic, Maryland Medicaid reimbursed audio-visual telehealth for MH and SUD treatment at the same rates as in-person visits, because it considers audio-visual telehealth service to be the same service as an in-person visit. During the pandemic, Maryland Medicaid has also reimbursed audio-only visits at the same rate as an in-person visit. For private insurance, no statute establishes a statutory standard for reimbursement of telehealth services, and private carriers have continued to have discretion in telehealth reimbursement during the pandemic.

SB 393 would require payment parity across all service delivery modes – audio-only telehealth, audio-visual telehealth and in-person services – for both Medicaid and private insurance. This standard will ensure that practitioners are paid fully for the services they deliver and have the resources and financial incentive to continue to deliver or invest in both audio-only and audio-visual telehealth. The cost of care delivery for MH and SUD programs and practitioners is the same regardless of the service delivery mode: the key costs points are personnel, fixed-site buildings, telehealth and communications technologies, none of which change when a practitioner delivers an audio-only or audio-visual telehealth service. Permitting lower reimbursement rates that do not cover the full cost of delivering care via audio-only telehealth will make it impossible for MH and SUD practitioners to offer that service and will preclude them from investing in the therapeutic innovation and technology that would make service delivery most effective for their patients.

Payment parity is essential to ensure continuity of care post-pandemic and ensure equity for those who cannot access or afford audio-visual telehealth. As noted below, most states authorize payment parity in Medicaid, 7 of which require payment parity for audio-only as well as audio-visual on a permanent basis. Fifteen (15) states require payment parity in private insurance, 5 of which also include audio-only at payment parity on a permanent basis.

Concerns have been raised that services delivered via audio-only telehealth may be billed inappropriately. While neither carriers nor Maryland Medicaid has offered support for that concern (and data from Optum on telehealth billing/reimbursement during the pandemic do not appear to be available), billing standards and audit practices should address these concerns. Providers are required to deliver services consistent with state regulatory standards that establish the length and intensity of services, and they must deliver and document services consistent with billing codes to submit and receive reimbursement. The same service codes and standards exist regardless of the service delivery mode, and carriers and Medicaid have the same audit authority for audio-only telehealth as other service delivery modes. Finally, programs have implemented effective

identification verification practices to verify patient identity for audio-only communications. **No evidence exists that payment parity for audio-only services will generate fraudulent billing**.

D. Ensure Patient Choice for Service Delivery Mode and Retain Existing Network Adequacy Standards that Require Patient Consent to Count Telehealth Services for Satisfaction of Network Adequacy Metrics.

Use of telehealth services during the pandemic has confirmed that individual patient/client choice is essential to ensure the most effective service delivery. BHA's Survey identifies among the telehealth successes that nearly half (47%) of respondents reported "individuals' [patient] satisfaction with telehealth." On the other hand, more than one in four respondents reported "discomfort using telehealth," "lack of privacy," and "difficulty of engaging clients" (both adults and children). (BHA Report at 20-21). One-third of respondents identified the reason clients are leaving treatment is client inability to use telehealth and client unwillingness to use telehealth. (BHA Report at 15). **Post-pandemic, patients and providers will choose the most effective service delivery model based on the individual's circumstances, and they – not carriers – should have full control over that choice.** SB 393 will protect a patient's right to choose their service delivery and not allow a carrier to require a member to use telehealth services in lieu of in-person care.

Patient willingness to use telehealth services is also needed to translate the promise of expanded access into reality. Telehealth expansion has improved access to MH and SUD care during the pandemic for those who reside in underserved communities with, for example, a limited number of psychiatrists or other practitioners who treat children, adolescents and patients with specific MH conditions. However, **such expansion will not amount to actual treatment if a patient does not wish to use telehealth.** For this reason, Maryland's network adequacy standards authorize carriers to use a telehealth appointment so satisfy their network adequacy obligations **only if the patient consents** to telehealth services. COMAR § 31.10.44.06(B). We believe this is the correct standard and should not be revised to allow carriers to count telehealth services without the patient's consent, as proposed by the Maryland Insurance Administration (MIA) in its network adequacy regulatory revision process.

In our view, many telehealth coverage and reimbursement issues for private insurance must be resolved in this and future legislative processes before an assessment of whether this network adequacy standard should be revised. For example, absent the adoption of audio-only coverage and payment parity on a permanent basis, the availability of telehealth services for many would be drastically reduced. Second, little public data exist on the covered health benefits for which, and the geographical areas in which, carriers would deliver telehealth. **No carrier other than CareFirst has reported using telehealth services to satisfy appointment wait time metrics in the 3 years preceding the pandemic, even though state law permits telehealth to be used in this way.** While carriers have certainly increased telehealth service delivery during the pandemic (at varying rates), the public has not seen data on the level of services by health condition, patient demographics, or geographical region.

A full understanding of the cause of network deficiencies for MH and SUD services is also required before removing member consent as a condition of network adequacy satisfaction. **No**

carrier has satisfied Maryland's network adequacy metrics for MH and SUD service in full for any of the 3 reporting years, and carriers have failed consistently to inform the MIA of their efforts to contract with providers, which is essential to identify the source of network deficiencies. To the extent gaps exist because of low reimbursement rates or credentialing barriers, the expansion of telehealth at a similarly low reimbursement rate will not result in increased services on the ground. **Consumers will lose important rights under Maryland law, Ins. § 15-830, to receive services from a non-network provider when the network is not sufficient, if carriers can represent that an in-network telehealth service is available, notwithstanding a patient's discomfort or unwillingness to use telehealth care.** Thus, a full understanding of the source of network gaps is essential before a revision to the current regulatory standard that allows carriers to count telehealth services **only if** the patient consents.

Importantly, Massachusetts has considered this precise issue in the context of its telehealth expansion. The state has adopted a provision stating that Medicaid plans and commercial insurance plans "shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request." Mass. Gen. Law ch. 118E § 79(b); Mass Gen. Law ch. 175 § 47MM(b) (2020). **SB 393 would preserve the patient's right to access appropriate in-person or telehealth services for MH and SUD treatment under the State's current network adequacy standard.**

E. Require Private Health Plans and Medicaid to Comply with the Mental Health Parity and Addiction Equity Act.

Standards related to reimbursement, utilization management – including prior authorization requirements – and any other requirement that could limit access to telehealth services for MH and SUD benefits are subject to the Mental Health Parity and Addiction Equity Act (Parity Act). The MIA has identified violations of the Parity Act by state-regulated health plans in reimbursement rate setting and credentialing, and Maryland Medicaid regulations currently require prior authorization for MH and SUD telehealth services (COMAR § 10.09.49.09(E)(4)), while not imposing this same standard for somatic care. Telehealth standards for MH and SUD benefits must be comparable to and imposed no more stringently on MH and SUD benefits than on medical/surgical benefits. SB 393 will ensure that private plans and Medicaid assess telehealth standards for compliance with the Parity Act to prevent discriminatory coverage policies.

III. State Adoption of Audio-Only Telehealth and Payment Parity Standards

Like Maryland, many state legislatures are examining telehealth delivery standards to ensure the continuation of service delivery post-pandemic. An examination of state standards for audio-only and payment parity requirements in Medicaid and private insurance, both pre-pandemic and in response to expanded service delivery during the pandemic, (Attachment 1) reveals important trends:

- 3 states – Colorado, Massachusetts, and New Hampshire – have enacted legislation that requires coverage of audio-only telehealth and payment parity for telehealth services in both Medicaid and private insurance.

- 3 states – New York, Ohio, and Oregon – and the District of Columbia require coverage of audio-only telehealth and payment parity in Medicaid alone.
- 2 states – Delaware and Georgia – require coverage of audio-only telehealth and payment parity in private insurance alone, and the District of Columbia requires coverage of audio-only (and does not address payment parity).
- Most states require payment parity in Medicaid for telehealth, as defined by those states.
- 10 states – Arkansas, California, Hawaii, Minnesota, New Jersey, New Mexico, North Dakota, Vermont, Virginia, and Washington – require payment parity in private insurance for telehealth, as defined by those states.

Massachusetts is unique insofar as it authorizes payment parity for **MH and SUD benefits delivery** via telehealth on a permanent basis in both Medicaid and private insurance (including audio-only) while limiting payment parity for other health care conditions to 2 years.

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The expansion of telehealth services is an important tool to improve access to MH and SUD care to the extent patients and providers agree that it is an appropriate service delivery mode. **We urge a favorable report on SB393 to ensure appropriate standards for the implementation of telehealth service delivery of MH and SUD care in Maryland on a permanent basis.**

Thank you for considering our views.

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ATTACHMENT 1

Legal Action Center: State Survey Telehealth Standards: Audio-Only and Payment Parity

States	Medicaid		Private Insurance	
	Audio-Only	**Payment Parity[1]**	**Audio-Only**	**Payment Parity**
Alabama				
Alaska		Yes[2]		
Arizona				
Arkansas		Yes[3]		Yes[4]
California		Yes[5]		Yes[6]
Colorado	Yes[7]	Yes[8]	Yes[9]	Yes[10]
Connecticut				
Delaware		Yes[11]	Yes[12]	Yes[13]
District of Columbia	Yes[14]	Yes[15]	Yes[16]	
Florida				
Georgia			Yes[17]	Yes[18]
Hawaii		Yes[19]		Yes[20]
Idaho		Yes[21]		
Illinois				
Indiana		Yes[22]		
Iowa		Yes[23]		
Kansas		Yes[24]		
Kentucky		Yes[25]		
Louisiana		Yes[26]		
Maine		Yes[27]		
Maryland		Yes[28]		
Massachusetts[29]	Yes[30]	Behavioral Health permanently and other services for 2 years[31]	Yes[32]	Behavioral Health permanently and other services for 2 years[33]
Michigan		Yes[34]		
Minnesota		Yes[35]		Yes[36]
Mississippi		Yes[37]		
Missouri		Yes[38]		
Montana				
Nebraska		Yes[39]		
Nevada		Yes[40]		
New Hampshire	Yes[41]	Yes[42]	Yes[43]	Yes[44]
New Jersey		Yes[45]		Yes[46]
New Mexico		Yes[47]		Yes[48]
New York	Yes[49]	Yes[50]		
North Carolina		Yes[51]		

North Dakota				Yes[52]
Ohio	Yes[53]	Yes[54]		
Oklahoma				
Oregon	Yes[55]	Yes[56]		
Pennsylvania				
Rhode Island				
South Carolina		Yes[57]		
South Dakota		Yes[58]		
Tennessee		Yes[59]		
Texas		Yes[60]		
Utah		Yes[61]		
Vermont		Yes[62]		Yes[63]
Virginia				Yes[64]
Washington		Yes[65]		Yes[66]
West Virginia				
Wisconsin		Yes[67]		
Wyoming		Yes[68]		

[1] This chart cites to Medicaid statutes, regulations, manuals, or websites that explicitly require payment parity for telehealth. Federal Medicaid regulators (Centers for Medicaid and Medicare Services) view telehealth as a mode of service delivery, rather than a separate service, and do not require States "to submit a (separate) SPA [State Plan Amendment] for coverage or reimbursement of telemedicine services, if they decide to reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations." Telemedicine, Medicaid.gov, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. No such State Plan Amendments were found in this review. Therefore, it is likely that more, if not all, state Medicaid programs reimburse telehealth services at the same rate as in-person services.

[2] Alaska Dep't. of Health & Social Services, Division of Public Health, Telehealth in Alaska & Telemedicine, http://dhss.alaska.gov/dph/HealthPlanning/Pages/telehealth/default.aspx.

[3] Ark. Code §§ 23-79-1602(a)(2), 23-79-1602(d)(2).

[4] Ark. Code § 23-79-1602(d)(2).

[5] Cal. Dep't. of Health Care Services, Telehealth Frequently Asked Questions (Sept. 23, 2020), https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx.

[6] Cal. Ins. Code § 10123.855(a)(1).

[7] Colo. Rev. Stat § 25.5-5-320(1).

[8] Colo. Rev. Stat. § 25.5-5-320(1) – (2.5).

[9] Colo. Rev. Stat. § 10-16-123(4)(e).

[10] Colo. Rev. Stat § 10-16-123(2)(b)(I).

[11] Del. Health & Social Services, Division of Medicaid & Medical Assistance, Delaware Medical Assistance Program, Practitioner Provider Specific Policy Manual § 16.4.1.5 (Aug. 2019)

https://www.matrc.org/wp-content/uploads/2019/08/DE-Provider-Manual.pdf?9b3fb7&9b3fb7.
[12] Del. Code §§ 3370(a)(4), 3571R(a)(4).
[13] Del. Code §§ 3370(e), 3571R(e).
[14] D.C. Fiscal year 2021 Budget Support Act of 2020, Telehealth Reimbursement Amendment Act of 2020, Sec. 5042 (Oct. 1, 2020), https://lims.dccouncil.us/downloads/LIMS/45028/Meeting4/Enrollment/B23-0760-Enrollment17.pdf.
[15] D.C. Code § 31-3863.
[16] D.C. Fiscal year 2021 Budget Support Act of 2020, Telehealth Reimbursement Amendment Act of 2020, Sec. 5042 (Oct. 1, 2020).
[17] Off. Code of Ga. Ann. § 33-24-56.4(b)(6).
[18] Off. Code of Ga. Ann. § 33-24-56.4(f).
[19] Haw. Rev. Stat. § 346-59.1(b).
[20] Haw. Rev. Stat. § 431:10A-116.3(c).
[21] *See* CMS, State Medicaid & CHIP Telehealth Toolkit, Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1 61 (Oct. 14, 2020), https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.
[22] Ind. Health Coverage Programs, Provider Reference Module, Telemedicine and Telehealth Services 10 (Feb. 6, 2020, https://www.in.gov/medicaid/files/telemedicine%20and%20telehealth%20services.pdf.
[23] Iowa Admin. Code § 441.78.55.
[24] Kan. Dep't. of Health & Environment, Division of Health Care Finance, Kansas Medical Assistance Program, Fee-for-Service Provider Manual 33 (Jan. 2020), https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Gen%20benefits_19203_19079.pdf.
[25] Ky. Rev. Stat. § 205.5591(5).
[26] La. Dep't. of Health, Professional Services Provider Manual, Chapter Five of the Medicaid Services Manual 153 (Nov. 6, 2020), https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf.
[27] MaineCare Benefits Manual, 10-144 ch. 101 § 4.07-1(A) (June 15, 2020), https://www.maine.gov/sos/cec/rules/10/ch101.htm.
[28] Md. Health Care Commission, Reimbursement for Telehealth Services (Mar. 2019), https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Telehealth_Reimbursement_Flyer_20200330.pdf.
[29] Massachusetts also includes requirements that Medicaid plans and commercial insurance plans "shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request." Mass. Gen. Law ch. 118E § 79(b); Mass Gen. Law ch. 175 § 47MM(b) (2020), https://malegislature.gov/Bills/191/S2984.
[30] Mass. Gen. Law ch. 118E § 79(a) – (b) (2020).
[31] Mass. Gen. Law ch. 118E § 79(g) (behavioral health services); Mass. Ch. 260 of the Acts of 2020 § 68 (all other services, but only for two years), https://malegislature.gov/Bills/191/S2984.
[32] Mass Gen. Law ch. 175 § 47MM(a) – (b) (2020).

[33] Mass. Gen. Law ch. 175 § 47MM(g) (behavioral health services), Mass. Ch. 260 of the Acts of 2020 § 68 (all other services, but only for two years), https://malegislature.gov/Bills/191/S2984.
[34] Mich. Medicaid Provider Manual, § 6.22.A, http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.
[35] Minn. Stat. § 256B.0624(3b)(a).
[36] Minn. Stat. § 62A.672(b)(3).
[37] Miss. Admin. Code tit. 23 part 225 ch. 1, Rule 1.5(B) (Aug. 1, 2020), https://www.sos.ms.gov/adminsearch/ACCode/00000608c.pdf.
[38] Mo. Rev. Stat. § 208.670(2).
[39] Neb. Rev. Stat. § 71-8506(1) – (2).
[40] Nev. Rev. Stat. § 422.2721(1),
[41] N.H. RSA 167:4-d, III(e) (2020).
[42] N.H. RSA 167:4-d, III(b) (2020).
[43] N.H. RSA 415-J:2, III (2020).
[44] N.H. RSA 415-J:3, III (2020).
[45] N.J. Rev. Stat. § 30:4D-6k(7)(a).
[46] N.J. Rev. Stat. § 26:2S-29(a).
[47] N.M. Admin. Code § 8.310.2.12(M).
[48] N.M. Stat. Ann. § 59A-22-49.3(I) (2019).
[49] N.Y. Pub. Health Art. 29-G § 2999-CC(4) (2020), https://legislation.nysenate.gov/pdf/bills/2019/S8416.
[50] N.Y. Pub. Health Art. 29-G § 2999-DD(1). However, reimbursement of audio-only telehealth is contingent upon federal financial participation. *Id.*
[51] N.C. Division of Medical Assistance, Medicaid and Health Choice Clinical Coverage Policy No. 1H, Telemedicine and Telepsychiatry 15 (Jan. 1, 2018), https://files.nc.gov/ncdma/documents/files/1-H.pdf.
[52] N.D. Century Code § 26.1-36-09.15(3).
[53] Ohio Admin. Code § 5160-1-18(A)(3)(b)(i) (2020).
[54] Ohio Admin. Code §§ 5160-1-18(E)(4), (8).
[55] Or. Admin. Rule § 410-120-1990(1)(b) (effective Jan. 1, 2021), as amended by DMAP 64-2020, available for download at https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=275177.
[56] Or. Admin. Rule § 410-120-1990(6)(b) (effective Jan. 1, 2021), as amended by DMAP 64-2020.
[57] S.C. Department of Health and Human Services, Physicians Services Provider Manual 215 (July 1, 2020), https://provider.scdhhs.gov/internet/pdf/manuals/Physicians/Manual.pdf.
[58] S.D Medicaid, Billing and Policy Manual, Telemedicine Services 12 (Jan. 2021), https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Telemedicine.pdf.
[59] Tenn. Code Ann. § 56-7-1002(f).
[60] Tex. Code tit. 4 § 531.0217(d).
[61] Utah Code § 26-18-13.5(3).
[62] 8 Vt. Stat. Ann. § 4100k(a)(2)(A), 4100k(i)(2).
[63] 8 Vt. Stat. Ann. § 4100k(a)(2)(A).
[64] Va. Code § 38.2-3418.16(D).

[65] Rev. Code Wash. § 74.09.325(1)(b)(i); Washington Apple Health (Medicaid), Physician-Related Services/Health Care Professional Services Billing Guide 88 (Feb. 1, 2020), https://www.hca.wa.gov/assets/billers-and-providers/physician-related-servs-bg-20200201.pdf.
[66] Rev. Code Wash. § 48.43.735(1)(b)(i) (2020).
[67] Wis. Stat. 49.45(61)(e)(1).
[68] Wyo. Dep't. of Health, Division of Healthcare Financing, "CMS 1500 ICD-10" 121 (Jan. 1, 2018), https://wymedicaid.portal.conduent.com/manuals/Manual_CMS1500_1_1_18.pdf.