RESEARCH DIVISION
LEGISLATIVE COUNSEL BUREAU

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RESEARCH DIVISION STAFF
research@lcb.state.nv.us

TELEHEALTH

in Nevada and the U.S.

The use of telehealth skyrocketed in Nevada and throughout the United States following the outbreak of SARS-CoV-2 and the COVID-19 pandemic. While Nevada law provides a foundation from which such growth could occur, temporary policies at the federal and state levels eliminated barriers to providing and receiving remote care. Most policy changes were provisional, facilitating access to telehealth only for the duration of the public health emergency. However, policymakers at all levels are now considering whether and how to maintain flexibilities and support improved access to care after the pandemic subsides. Telehealth presents numerous opportunities, as well as certain challenges, that policymakers should consider as they determine how best to sustain enhanced access to care while balancing the effects of long-term policy changes on health care quality, cost, privacy, and equity.

WHAT IS TELEHEALTH?

Telehealth involves the use of technology to remotely provide health care services such as disease prevention, diagnosis, and treatment. It also is used to promote public health and provide health-related education to patients and health care professionals.

Nevada law defines telehealth as "the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail" (*Nevada Revised Statutes* [NRS] 629.515[4][c]).

TYPES OF TELEHEALTH

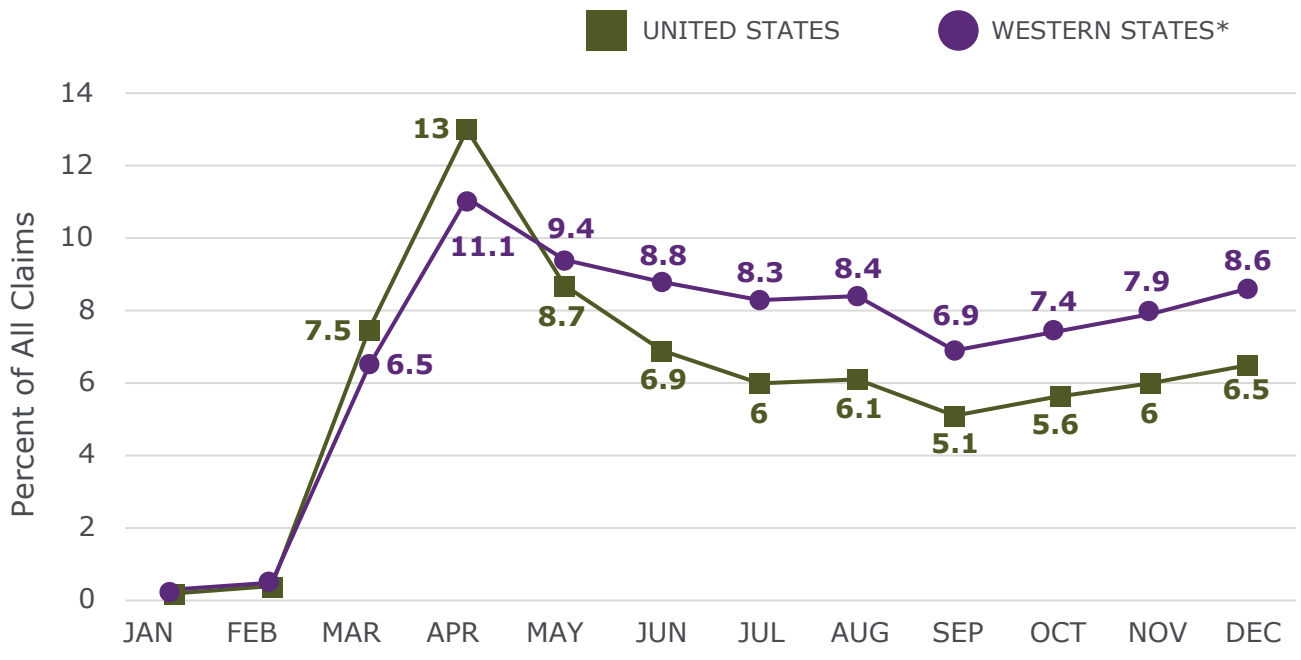
1. **Synchronous:** Real-time, two-way interaction, with the patient and provider communicating from different locations through video, telephone, or live chat.
2. **Asynchronous (store-and-forward):** The transmission of recorded health information—such as an x-ray or a prerecorded video—through electronic communications systems to a provider (often a specialist) who evaluates the information and provides a service at a later time.
3. **Remote patient monitoring:** Using technology to collect personal or health data from a person in one location and transmit it to a health care provider in another location, allowing the provider to track a patient's health status.

INCREASE IN TELEHEALTH SERVICES DURING THE COVID-19 PANDEMIC

While telehealth has existed for decades, adoption increased rapidly with the onset of the COVID-19 pandemic. Telehealth is uniquely situated to provide care amid the outbreak of a highly contagious disease as it enables certain services—such as non-urgent care and routine and preventive medical and behavioral health services—to be delivered without direct contact, thus reducing the risk of disease transmission and enabling potentially limited in-person services to be dedicated to COVID-19 patients and patients who require care that cannot be provided remotely.

According to FAIR Health, an independent nonprofit organization focused on transparency, private health insurance claims related to telehealth grew from 0.2 percent of total claims nationwide in January 2020 to 6.5 percent in December—an increase of 3,150 percent. In western states, telehealth claims rose 2,767 percent over the same period—from 0.3 percent in January to 8.6 percent in December. While telehealth claims appear to have peaked in the spring, use remains significantly higher than prior to the pandemic. Similar trends are apparent in Medicaid services provided through telehealth.

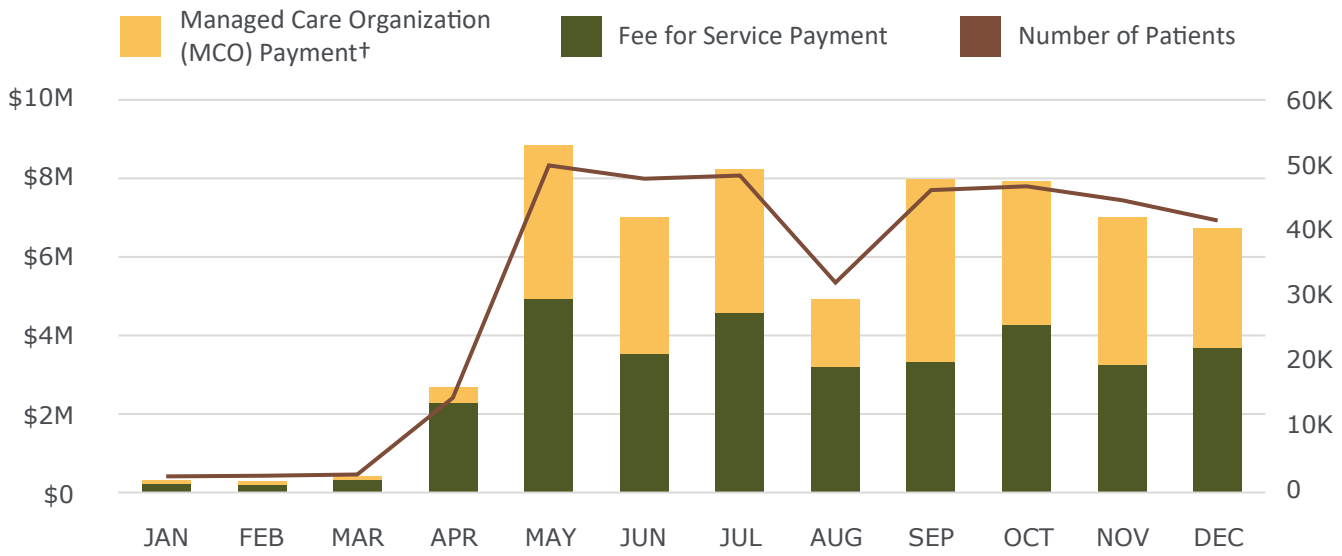
PRIVATE HEALTH INSURANCE CLAIMS RELATED TO TELEHEALTH, 2020



*Western states include Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Source: *Monthly Telehealth Regional Tracker, FAIR Health; Accessed March 2021*

TELEHEALTH USE AND PAYMENTS IN NEVADA: MEDICAID AND NEVADA CHECK UP, 2020*



*Nevada Check Up is the state's Children's Health Insurance Program, which provides low-cost health insurance coverage to eligible low income, uninsured children.

†MCO payments are not state expenditures, but rather payments from MCOs to health care providers.

Source: *Office of Analytics, Nevada's Department of Health and Human Services*

TELEHEALTH POLICY IN THE U.S. AND NEVADA

A variety of policies determine who is authorized to provide telehealth and how, where, and to whom, as well as how—and whether—such services are reimbursed. The federal government regulates telehealth policies for Medicare and self-insured health plans; states generally regulate telehealth services provided by other private health insurance plans and Medicaid. Many telehealth policies were relaxed in response to the COVID-19 pandemic, facilitating the increase in utilization nationwide.

FEDERAL TELEHEALTH

While certain federal laws apply to the provision of telehealth nationwide, others relate specifically to health insurance programs provided or regulated by the federal government. For example, the Health Insurance Portability and Accountability Act (HIPAA), which protects personal health information, applies to telehealth services nationwide. This means that the same HIPAA requirements that apply to in-person services also apply to telehealth. In addition, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 prohibits dispensing controlled substances without a valid prescription issued for a legitimate medical purpose, generally through an in-person medical evaluation rather than a telehealth service.

Medicare, the federal health insurance program for individuals 65 years of age and older as well as younger people with certain disabilities, reimburses a limited number of telehealth services that are provided by certain health care professionals and delivered to patients at designated medical facilities in rural or underserved areas. In contrast, the federal government gives states broad authority to determine telehealth policy in Medicaid.

NEVADA TELEHEALTH LAWS

Prior to the COVID-19 pandemic, the Nevada Legislature set a foundation for the provision of telehealth with the passage of Assembly Bill 292 in 2015. The bill declared it the public policy of the state to encourage and facilitate the provision of health care services through telehealth to improve public health and the quality of health care while also lowering the cost of care.

In order to provide telehealth services in Nevada, health care professionals must have a valid Nevada license or certificate, with certain exceptions, though they need not be located in the state to serve Nevada patients. As with all health care services, health professionals may provide telehealth services only within their scope of practice and must meet required standards of care.

Assembly Bill 292 also required Medicaid and any policy of health or industrial insurance to cover telehealth services to the same extent as services provided in person. Insurance plans may not require an insured person to establish a relationship in person with a provider, to obtain prior authorization for telehealth services if it is not required for equivalent in-person services, or to provide any additional consent or reason for obtaining services through telehealth as a condition of paying for services.

TELEHEALTH IN NEVADA MEDICAID

According to the federal Centers for Medicare and Medicaid Services, states have "a great deal of flexibility with respect to covering Medicaid services provided via telehealth." They can determine whether to use telehealth, which services to cover, where and how it is implemented, the types of professionals authorized to deliver services via telehealth, and reimbursement rates.

> **The Division of Health Care Financing and Policy (DHCFP), which administers the Nevada Medicaid program, was classified as having a "progressive" telehealth policy by Manatt Health in 2018.**

In 2018, the Division of Health Care Financing and Policy (DHCFP), which administers the Nevada Medicaid program, was classified as having a "progressive" telehealth policy by Manatt Health. Prior to the COVID-19 pandemic, Medicaid provided telehealth in parity with in-person services, and general requirements such as prior authorization applied to both in-person and virtual services. Telehealth services were required to be delivered using HIPAA-compliant audio-visual telecommunications systems, either through two-way videoconferencing—which allows real-time interaction between a patient and health care provider—or through asynchronous, store-and-forward methods, which occur when health information is transmitted to a provider outside of real-time interaction. The types of providers who could use telehealth were not restricted, as long as the professionals worked within their scope of practice. In addition, Medicaid covered telehealth services provided at a wide variety of health care sites and facilities, schools, and clinics, as well as those provided through a recipient's smartphone or home computer.

TELEHEALTH POLICY CHANGES IN RESPONSE TO THE COVID-19 PANDEMIC

Federal Telehealth Policy Changes

The federal government modified numerous policies to improve access to telehealth nationwide during the national public health emergency.

For example, federal agencies authorized:

- Health care professionals to provide telehealth services through common communication mechanisms, such as FaceTime and Skype, that do not comply with HIPAA patient privacy requirements—as long as they serve patients "in good faith";[1]
- Prescribers to use telehealth to issue controlled substance prescriptions without conducting an in-person evaluation or having established a patient-provider relationship; and
- Health care professionals who provide certain qualifying COVID-19-related telehealth services to practice across state lines without complying with state licensure laws.[2]

Further, the federal Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Public Law 116-123), waived certain telehealth restrictions under traditional Medicare. These include:

- Eliminating the requirement that patients must live in a rural area to receive telehealth services—effectively allowing beneficiaries living anywhere to receive remote care;
- Authorizing beneficiaries to receive telehealth from their home;
- Permitting telehealth to be provided through a smartphone and certain services to be provided through audio-only telephone;
- Removing the requirement that the patient and provider have a preexisting relationship; and
- Expanding the types of health care professionals authorized to provide telehealth.

In addition, the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136) authorized federally qualified health centers and rural health clinics to provide telehealth services to Medicare beneficiaries during the COVID-19 public health emergency. It also waived the requirement that providers must be licensed in the state in which they provide services, though it did not exempt them from similar state-level restrictions.

Among other items, federal and state policy changes to expand telehealth access during the COVID-19 pandemic include:

- **Authorizing health care professionals to practice across state lines;**
- **Authorizing telephonic visits;**
- **Waiving preexisting patient-provider relationship requirements;**
- **Relaxing regulations related to privacy; and**
- **Authorizing Medicare patients to access telehealth services from home.**

[1] See notice and guidance issued by the Office for Civil Rights of the U.S. Department of Health and Human Services (DHHS).

[2] Authorized by the U.S. DHHS in December 2020.

Nevada Telehealth Policy Changes

Policy changes were made at the state level in response to the COVID-19 pandemic, as well.

Executive Declarations

On April 1, 2020, Governor Steve Sisolak issued Declaration of Emergency Directive 011, requiring health professional licensing boards to temporarily waive certain licensing requirements for health care professionals during the COVID-19 crisis. The waiver authorizes any provider who is licensed in good standing in another state, whose license is suspended for certain reasons, or who retired with a license in good standing to practice in Nevada without a Nevada license if the appropriate board is notified.

Health Insurance

In early 2020, Nevada's Division of Insurance adopted emergency regulations requiring health insurers to provide information to those they insure and health care providers in their network regarding available benefits, medical advice and treatment through telehealth, and preventive measures related to COVID-19, among other provisions.

In addition, certain health insurance companies voluntarily expanded telehealth coverage in response to the pandemic. Others reduced or eliminated cost sharing (such as co-pays and deductibles) for telehealth, though typically for a limited amount of time. Such changes vary by insurance provider, and while some apply only to COVID-19-related services, others took effect for all services.

Nevada Medicaid

To enhance access to care during the pandemic, Nevada Medicaid expanded the services for which telehealth is authorized and permitted telehealth to be delivered via audio-only telephone. These changes are effective through the end of the federal COVID-19 public health emergency; however, it is unclear whether any will become permanent after the emergency ends.

MEDICAID SERVICES THAT MAY BE PROVIDED VIA TELEHEALTH

Nevada Medicaid authorized the following services to be delivered through telehealth for the duration of the public health emergency:

- **Certain applied behavior analysis services;**
- **Group therapy;**
- **Initial and recertification assessments for home health agencies and hospice agencies;**
- **Certain services related to long-term services and supports;**
- **Maternity care;**
- **Physical, speech, and occupational therapy; and**
- **Psychosocial rehabilitation services for children.**

Additional information regarding COVID-19 coverage changes is available from DHCFP.

THE FUTURE OF TELEHEALTH: POLICY OPTIONS

Because many policy changes that reduced barriers to telehealth during the COVID-19 pandemic expire at the end of the public health emergency, policymakers are considering how to maintain improved access to care while balancing the effect of long-term policy changes on health care quality, cost, privacy, and equity.

States are pursuing a range of policy options, such as:

- Requiring parity in telehealth coverage and/or payment;
- Mandating coverage for audio-only telehealth;
- Focusing on mental health services;
- Streamlining health professional licensure;
- Revising scope of practice; and
- Addressing technology access and other health equity concerns.

TELEHEALTH COVERAGE AND PAYMENT PARITY

Coverage Parity

Nevada law currently requires state-regulated health insurance plans, including Medicaid, to provide telehealth "coverage parity," meaning they must cover telehealth services to the same extent as services provided in person or by other means. According to an analysis of information compiled by the Center for Connected Health Policy, at least 29 states have similar requirements for private health insurance. States with coverage parity laws generally maintain that such policies increase access to health care for patients and provide an incentive for health care professionals to offer telehealth services. Other states limit telehealth coverage parity requirements to medically necessary services and/or to specific types of telehealth—such as synchronous technology.

Payment Parity

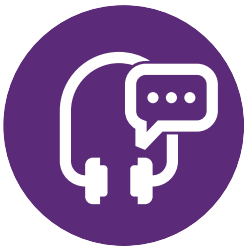
Historically, services provided through telehealth were reimbursed at lower rates than when the same services were provided in person. However, states are increasingly passing laws requiring health insurance companies to reimburse telehealth services at the same rate as in-person services, a policy known as "payment parity." According to an analysis of information compiled by the Center for Connected Health Policy, at least 15 states require payment parity for private health insurance; Nevada currently does not require telehealth payment parity.

Proponents argue payment parity expands access to services for patients by creating an incentive for health care professionals to offer telehealth services. However, certain experts caution that broad payment parity policies can significantly increase the cost of health care—especially if telehealth is used unnecessarily or in addition to, rather than as a substitute for, in-person services. Some suggest that the efficiencies of telehealth make it a lower cost service to provide and that mandating payment parity eliminates an opportunity for competition between providers. Still others express concern that telehealth payment parity may hinder outcome- or value-based

payment models that reimburse health care professionals for providing quality care, rather than for each individual service.

While many states have enacted blanket payment parity laws, others are slightly more nuanced. For example, Kentucky requires reimbursement for telehealth and in-person services to be equivalent unless the telehealth provider and health insurance company contractually agree to a lower reimbursement rate for telehealth services. Washington requires payment parity, but allows hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more providers to elect to negotiate a reimbursement rate for telemedicine services that differs from the reimbursement rate for in-person services. Massachusetts' law mandates permanent payment parity for behavioral health services provided through telehealth and requires payment parity for primary care and disease management services for two years.

AUDIO-ONLY TELEHEALTH SERVICES



Many states exclude audio-only services from the statutory definition of telehealth services, or from the types of telehealth services that health insurance plans must cover. For example, Nevada law explicitly excludes services provided through "standard telephone" from the definition of telehealth. However, in response to the pandemic, multiple states—such as Delaware, New Hampshire, and New York—passed laws expanding telehealth to include audio-only services. New York's law does not require the state Medicaid program to cover audio-only telehealth unless adopted in regulation by the state's health commissioner.

Expanding telehealth to audio-only can help increase access to care and may be particularly beneficial to those who lack Internet or are otherwise unable to use live-video technology. However, experts indicate it is important to ensure audio-only services are clinically appropriate and held to the same standards of care as services provided in person.

COVERAGE FOR MENTAL HEALTH SERVICES

A few states have focused new legislation on expanding access to mental health care services through telehealth. For example, Alaska requires health insurers that provide coverage for in-person mental health benefits to cover the same benefits via telehealth. Maryland requires the state Medicaid program to provide "appropriately delivered" mental health services through telehealth to a patient in the patient's home.

Nevada laws requiring telehealth coverage parity do not distinguish between physical and mental health care, meaning any physical or mental health services covered by state-regulated health insurance plans must be covered to the same extent regardless of how they are provided.

HEALTH CARE PROFESSIONAL LICENSING AND SCOPE OF PRACTICE

States are also pursuing legislation to facilitate licensure for health professionals and expand the services some are authorized to provide. Such policy changes can improve access to telehealth by increasing the number of providers licensed to practice in the state and enabling providers to "practice at the top of their license"—that is, to use the full extent of their education, training, and experience.

Common legislative trends include:

- ***Interstate licensure compacts.*** Compacts facilitate licensure across state lines by providing an expedited licensure application process, licensure reciprocity, or mutual license recognition. Five compacts are currently active in the United States.[3] Nevada is a member of the Interstate Medical Licensure Compact for physicians and the PSYPACT for psychologists. Other active compacts include the Nurse Licensure Compact, Recognition of Interstate EMS Personnel Licensure Interstate Compact (REPLICA), and Physical Therapy Licensure Compact. Additional information regarding interstate compacts is available in the Research Division's publication *Occupational Licensing: Interstate Licensing Compacts*.
- ***Universal licensing recognition.*** These laws require a license granted in one state to be recognized as valid in another state. Typically, applicants must meet minimum requirements and pay applicable fees to practice in the new state. More information on recent legislation is available from the National Conference of State Legislatures (NCSL).
- ***Border-state license reciprocity.*** States are also working to facilitate licensure specifically for health care professionals licensed in border states. For example, a law in Virginia requires the Department of Health Professions to pursue reciprocal licensure agreements for certain primary care practitioners in contiguous states.
- ***Scope of practice.*** During the pandemic, states relaxed requirements or expanded policies related to scope of practice. For example, many states are revising scope of practice laws for dentists and pharmacists—health care providers whose education, training, and experience could be used to help administer COVID-19 vaccines and assist in other ways during public health emergencies.

Streamlining licensure processes could facilitate licensure application for providers, decrease licensure costs for health care professionals if they are not required to pay licensing fees in every state, improve interstate mobility, and increase access to care. However, many licensing boards maintain that their state-specific licensing requirements are necessary to maintain public health and safety.

IMPROVING BROADBAND AND ADDRESSING HEALTH EQUITY

Many forms of telehealth require access to broadband, high-speed Internet, digital devices, and knowledge of how to use the devices and telehealth software. Certain populations are less likely to have access to these key elements and face barriers accessing telehealth. In Nevada and elsewhere, rural and low-income residents are less likely to have broadband Internet. Access to technology—whether computer or smartphone—can be a barrier for older individuals, minority groups, low-income households, and individuals with a disability. Further, owning a computer does not ensure access to telehealth. According to the National Center for Education Statistics, 31.8 million Americans do not know how to use their computer. These individuals tend to be older, less educated, and/or black or Hispanic. If policies do not address the needs of different populations, expanding telehealth may exacerbate existing health disparities.

Thus, states across the nation are exploring options to improve and invest in telecommunications infrastructure, increase access for patients in underserved areas, and evaluate how telehealth policies affect health equity.

[3] Two additional compacts have been established but do not have enough member states to be active. These are the Advanced Practice Registered Nurse Compact and the Audiology and Speech-Language Pathology Interstate Compact.

KEY TELEHEALTH POLICY CONSIDERATIONS

As policymakers think about the future of telehealth and whether to pursue certain policies, it is important to consider potential tradeoffs—how policies affect health care access, quality, cost, and privacy, and the potential impact on diverse populations—and to craft policies that capitalize on the opportunities of this service delivery model while reducing negative or unintended consequences.

OPPORTUNITIES

Telehealth provides significant opportunities to expand access to care. It is convenient—providing access to health care professionals from the comfort and safety of home; saving travel time, money, gas, and lost wages; and often offering an earlier appointment. Telehealth can also improve access to care for individuals in rural regions and other medically underserved areas. It can be used to monitor patients remotely and is particularly helpful in treating individuals with chronic conditions like asthma, diabetes, heart disease, and behavioral health conditions.

LIMITATIONS

On the other hand, telehealth has limitations and is not appropriate in every situation—especially when a health care provider needs to touch or use specialized tools to closely examine a patient, or when medication or a vaccination needs to be administered. Experts caution that without appropriate safeguards, telehealth may be used to provide services that are not medically necessary or clinically appropriate.

Telehealth's convenience may also encourage excessive care if used in addition to in-person care rather than as a substitute. Unnecessary use may result in increased health care spending. Finally, while the federal government temporarily waived HIPAA privacy requirements for telehealth, there are clear disadvantages to reducing privacy protections.

Research Division
Legislative Counsel Bureau

401 South Carson Street
Carson City, NV 89701-4747

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