Kentucky Passes Telehealth Legislation

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Hooper, Lundy & Bookman's national telehealth practice consists of attorneys licensed across the country, including in Kentucky. This piece focuses on Kentucky SB 112, which will allow Kentucky-licensed providers to establish a physician-patient relationship via telehealth, and outlines coverage and payment parity requirements for telehealth services. SB 112 is effective beginning July 1, 2019.

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Defining Telehealth. SB 112 revises KRS 205.510(15) and KRS 304.17A-005, which define telehealth for purposes of Kentucky Medicaid and commercial insurance in Kentucky, respectively. Both statutes now define "telehealth" as "the delivery of health care-related services" by a provider who is licensed in Kentucky to a patient through a face-to-face encounter with access to real-time interactive audio and video technology or store and forward services that are provided via asynchronous technologies[1] . The requirement for a face to face encounter can be satisfied with the use of asynchronous telecommunications technologies in which the health care provider has access to the patient's or client's medical history prior to the telehealth encounter." The law also provides that "telehealth ... shall not include the delivery of services through electronic mail, text chat, facsimile, or standard audio-only telephone call" and "shall be delivered over a secure communications connection" that complies with HIPAA. See KRS 205.510(15), KRS 304.17A-005(44)(a).

SB 112 does not define what constitutes the "medical history" that providers must review before utilizing asynchronous telecommunications technologies to treat a patient via telehealth. However, since the law specifically carves e-mail, text chat, facsimiles, and audio-only phone calls out of the definition of "telehealth," it seems unlikely that recordings or transmissions in any of these forms alone could be used to satisfy the requirement that a practitioner review a patient's medical history. Providers should assume that reviewing a patient's medical history includes having access to clinical data and/or medical records of some type.

Coverage and Reimbursement Parity. KRS 304.17A-138(1)(a) states that health benefit plans "shall reimburse for covered services provided to an insured person through telehealth ... Telehealth coverage and reimbursement shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit contractually agree to a lower reimbursement rate for telehealth services." KRS 304.17A-138(4)(b) also states that health benefit plans shall not be required to "reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter." In practice, this means that if Insurer A pays Dr. Jones $50 for a consultation provided in her private practice, Insurer A must also pay Dr. Jones $50 for a consultation provided via synchronous audio-

video interaction with her patient (unless Insurer A and Dr. Jones have contractually agreed to a lower rate of, for instance, $40 for consultations that Dr. Jones provides via telehealth). Insurer A does not, however, need to pay Dr. Jones any extra money to cover the cost of the telehealth platform that Dr. Jones used to provide the consultation via telehealth.

New Payer Requirements. KRS 304.17A-138(1)(b) imposes new requirements upon health benefit plans designed to prevent discriminatory treatment of telehealth services and their reimbursement. Specifically, payers may not:

1. Require a provider to be physically present with a patient unless the provider determines it is necessary;
2. Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if the service were rendered in person;
3. Require any demonstration that it is necessary to provide services to a patient via telehealth;
4. Require a provider to be employed by any particular entity where such requirement would not apply if the services at issue were rendered in person;
5. Restrict or deny coverage of telehealth based solely on the communication technology or application used to provide the telehealth services; or
6. Require a provider to be part of a telehealth network.

Once SB 112 takes effect, Kentucky providers should be prepared to push back if payers complicate the process of obtaining reimbursement for services provided via telehealth by requiring a provider to be physically present with a patient, requiring prior authorization, medical review or administrative clearance, or requiring a demonstration to verify that it is necessary for the patient to receive services via telehealth. Kentucky law will prohibit these actions as of July 1, 2019, but some payers unfortunately may not update their practices right away.

Kentucky Licensure Requirement. Kentucky payers, including Kentucky Medicaid, are only required to cover telehealth services rendered by a telehealth provider licensed in the state of Kentucky. KRS 304.17A-138(2); KRS 205.510(15). This means that before treating any patients located in Kentucky via telemedicine, providers must obtain Kentucky licensure. Complicating matters, Kentucky is not currently a party to the Interstate Medical Licensure Compact (the "IMLC"), which creates an expedited pathway to licensure for providers in IMLC-participating states.[2] Thus, obtaining licensure in Kentucky may be a time consuming process, and providers who anticipate wanting to provide services to Kentucky residents via telehealth beginning in July 2019 should consider beginning the process of obtaining Kentucky licensure sooner rather than later.

No Abortion via Telehealth. Kentucky law now provides, "A physician performing or inducing an abortion shall be present in person and in the same room with the patient. The use of telehealth … shall not be allowed in the performance of an abortion." KRS 311.820. Kentucky therefore joins an increasing number of states that have established standards for providing services via telemedicine, but specifically prohibited providers from using telemedicine modalities to perform abortions.

Hooper, Lundy & Bookman will continue to monitor federal and state telehealth developments across the country. For further information, please contact Jeremy Sherer in Boston, Steve Phillips in San Francisco, Robert Miller in Los Angeles, Jennifer Hansen in San Diego, or Bob Roth in Washington, D.C.

[1] Asynchronous technologies do not transmit information in real time. Generally, this means that clinical information – whether it is an x-ray, an MRI or a video-clip in which the patient explains and/or displays their symptoms or ailments – is collected at the site where the patient is located, and then transmitted to a clinician located elsewhere for review. The clinician then reviews the data, and communicates their findings to the patient.

[2] SB 153, which was introduced in the Kentucky Senate in February 2018, calls for Kentucky to join the IMLC. As of May 2018, this legislation has not advanced out of the Kentucky Senate's Licensing, Occupations and Administrative Regulations Committee.

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