

HR 3306 - Telehealth Enhancement Act of 2013

Rep. Gregg Harper (R-MS)

Purpose: To promote and expand the application of telehealth under Medicare and other Federal health care programs.

BILL DRAFT	CURRENT LAW
<p>Positive Incentives for Medicare’s Hospital Readmissions Reduction Program Provides hospitals, under Medicare’s Hospital readmissions reduction program, with an additional payment that would be made to a hospital from the sharing in the savings achieved from a better-than-expected performance in reducing hospital readmissions.</p>	<p>Hospitals are subject to the hospital readmission payment adjustment factor for excess readmissions. No additional positive incentive exists.</p>
<p>Medicare Health Homes for Individuals with Chronic Diseases The Secretary may contract with the appropriate State Medicaid agency for those states which have opted, under its State Plan, to provide coordinated care through a health home for individuals with chronic conditions.</p> <p>As a quality measure and condition for provider payment, there must be included a plan for the use of remote patient monitoring (RPM). Entities under this program shall follow evidence based guidelines.</p> <p>Limitations on telehealth under 1834(m), such as restrictions on the geographic location and facility type of the originating site, shall not apply.</p>	<p>A State has the option to make a State plan amendment to provide for medical assistance to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals operating with such a provider, or a health team as the individual’s health home through its Medicaid program.</p>
<p>Specialty Medical Homes The Secretary may contract with a national or multi-state regional center of excellence with a network of affiliated local providers to provide through one or more medical homes for targeted accessible, continuous and coordinated care to individuals with a long-term illness or medical condition that requires regular medical treatment, advising and monitoring.</p> <p>The Medical Home must have a plan for using health information technology in providing services, including the use of wireless patient technology and RPM. They also must have a health assessment tool to identify individuals most likely to benefit from RPM.</p> <p>Limitations on telehealth under 1834(m) shall not apply.</p>	<p>N/A</p>
<p>Flexibility in Accountable Care Organizations Coverage of Telehealth An ACO may include coverage of <i>telehealth and RPM services</i> as supplemental health care benefits to the same extent as a Medicare Advantage plan is permitted to provide coverage of such services as supplemental health care benefits.</p> <p>An ACO may include payments for RPM and home-based video conferencing in connection with the provision of home health services.</p>	<p>An ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care, such as through the use of telehealth, remote patient monitoring and other such enabling technologies.</p>

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<p>National Pilot Program on Payment Bundling Telehealth and RPM are added into the National Pilot Program on Payment Bundling.</p>	N/A
<p>Additional Telehealth Originating Sites Adds the following telehealth originating sites, which qualify for Medicare payment, whether or not they are located in a rural HPSA, MSA or a demonstration program.</p> <ul style="list-style-type: none"> • Critical Access Hospital • Sole Community hospital • Home Telehealth site • Any other originating site in current law that is located in a county with a population of less than 25,000, according to the most recent decennial census or in an area that was not included in a Metropolitan Statistical Area on any date in 2000. • Any other originating site in current law, with respect to services related to the evaluation or treatment of an acute stroke. <p>The additional originating sites are not eligible for a site facility fee.</p> <p>Definitions “Home Telehealth Site” is a telehealth service furnished to an individual in their place of residence.</p> <p>“Telehealth service” [as used in the definition of home telehealth site] is related to the provision of hospice care or home dialysis or furnished to an individual who is determined to be homebound.</p>	<p>Eligible patient must be located in a rural HPSA, MSA or in a demonstration program and also must be in an eligible originating site facility, which include:</p> <ul style="list-style-type: none"> • Office of a physician or practitioner • Critical Access hospital • Rural health clinic • FQHC • Hospital • Hospital based or critical access hospital based renal dialysis center • A skilled nursing facility • A community mental health center
<p>The Secretary will pay for telehealth services furnished or received at a critical access hospital or a sole community hospital to include store and forward technologies.</p>	<p>Store and forward is only covered for federal telemedicine demonstration programs in Alaska or Hawaii.</p>
<p>For liability purposes, the providers of the telehealth service are considered to be furnishing their services at their location and not at the originating site.</p>	<p>Currently the service is considered where the patient is located, requiring providers to be subject to the laws of the patient’s state.</p>
<p>Medicaid Option for High Risk Pregnancies and Births Within its state plan, states may provide medical assistance to eligible individuals for maternal-fetal and neonatal care who select a designated provider, a team of health care professionals operating with such a provider or a health team as her birthing network for purposes of providing pregnancy related services. The “team of health care professionals” may be virtual.</p> <p>When appropriate and feasible, providers shall use health information technology when fulfilling their obligation to report monthly to the state on measures determining quality of service.</p>	N/A

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<p>Medicaid Option for High Risk Pregnancies and Births (cont.) Birthing Network Services includes:</p> <ul style="list-style-type: none"> • Comprehensive care coordination • Health promotion • A call center to offer 24 hour physician support for consultations with maternal-fetal medicine specialists • Newborn screening • Patient and family support • Referral to community and social support services; and • Use of health information technology to link services and provide monitoring as feasible and appropriate <p>A state shall include in its state plan amendment a proposal to use health information technology in providing birthing network services and improving service delivery and coordination across the care continuum including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations by the provider.</p>	
<p>Universal Service Support Adds to the definition of a “health care provider” for purposes of Universal Services Support rural health discounts (including eligibility for the Healthcare Connect Fund) the following:</p> <ul style="list-style-type: none"> • Ambulance providers and other emergency medical transport providers • Health clinics of elementary and secondary schools and post-secondary educational institutions • Sites where telehealth services are provided under 1834(m) of the Social Security Act or under a State plan under title XIX. <p>The Commission will establish competitively neutral rules for healthcare providers regardless of the location of the providers.</p>	<p>“Health Care Providers” eligible for Universal Services Support are:</p> <ul style="list-style-type: none"> • Post secondary educational institutions offering health care instruction, teaching hospitals, and medical schools • Community health centers or health centers providing health care to migrants • Local health departments or agencies • Community mental health centers • Not-for-profit hospitals • Rural health clinics • Consortia of any of the above.

Impact and Analysis

HR 3306 creates an opportunity to optimize the use of remote patient monitoring (RPM) and enhance care coordination, but there is no obligation for this to take place.

1. CMS is given authority (but not required) to contract with State Medicaid agencies to provide coordinated care through a health home for individuals with chronic conditions and requires a provider in such an arrangement to report a plan for the use of remote patient monitoring for quality control purposes. It is important to note that this only applies to states that have opted in their State Plan to provide for medical assistance to eligible individuals with chronic conditions.

Impact and Analysis (cont.)

2. CMS is given authority (but not required) to contract with national or multistate regional centers of excellence to provide coordinated care through medical homes to individuals with long term illness or medical conditions that require regular medical treatment, advising or monitoring. The bill requires these medical homes to have a plan for the use of health information technology in providing services, which includes remote patient monitoring.
3. Centered on the success of the Arkansas ANGELS program, HR 3306 gives states the option (but does not obligate them) to amend their state plan to set up “birthing networks” for maternal-fetal and neonatal care. Birthing network services include the use of health information technology to link services and provide monitoring, when feasible and appropriate.
4. ACOs are given the flexibility (but not required) to cover telehealth and RPM services as supplemental health care benefits to the extent a Medicare advantage plan is permitted to provide coverage of supplemental benefits.

In all four of the sections mentioned above, the new allowances will only have an impact if the key stakeholders in each of the programs choose to take advantage of them.

The manner in which RPM is referred to separately from telehealth in many of the previously mentioned sections gives the appearance that it does not fall under telehealth. Additionally, there is no indication that store and forward is being considered under telehealth in these sections, and it is unclear if this delivery mode would be available in these new programs.

HR 3306 also makes additions to the list of current telehealth originating sites which qualify for Medicare reimbursement, and would exempt them from the requirement that they are located in a rural HPSA, MSA or a demonstration project. This would remove a significant barrier to the practice of telehealth in these originating sites, as it would allow for reimbursement of urban critical access hospitals, sole community hospitals, home telehealth sites and any originating site in current law for the treatment of acute stroke.

A notable addition to the list of telehealth originating sites in the bill is a “home telehealth site”. However, a home would only qualify as a home telehealth site, according to the bill, if the service rendered relates to the provision of hospice care or home dialysis or furnished to an individual who is homebound. Additionally, Medicare does not currently reimburse for RPM, which lends itself to use in the home. Therefore, the impact would be narrowly confined to live video services for the provision of hospice care, home dialysis or to patients who are homebound. This is also the only place a “Telehealth service” is defined in the bill, and the definition only applies to this particular section.

Current law restricts Medicare reimbursement of services delivered through store and forward to demonstration projects in Alaska and Hawaii. HR 3306 would expand store and forward reimbursement to critical access hospitals or sole community hospitals, cementing store and forward as a viable method for delivering services. Store and forward would not be available to other originating sites.

For purposes of health care liability, services would be considered furnished from the site of the provider. This means that when telehealth is used by a patient and provider in different states, the provider would no longer need to comply with the laws of the patient's state, as is current law. If a malpractice suit were to arise, it would need to be filed in the state of the provider, not the patient. This would prevent providers from worrying about becoming acquainted with different state laws and ensuring their liability insurance covers them in the applicable state, every time they treat an out of state patient.

Additional changes made by HR 3306 include:

- The addition of ambulance providers, health clinics of elementary and secondary schools and post secondary education institutions and sites where telehealth services are provided to the list of health care providers eligible to receive Universal Service Support rural health discounts, including Healthcare Connect Fund grants.
- The creation of a positive incentive for Medicare's hospital readmissions reduction program. This incentive would be derived from the additional payment that would be made from the shared savings achieved from a better than expected performance in reducing hospital readmissions. This provision is a mandate.
- The addition of telehealth and RPM to the National Pilot Program on Payment Bundling.