

HR 5380 - Medicare Telehealth Parity Act of 2014

Rep. Mike Thompson (D-CA), Rep. Gregg Harper (R-MS),
Rep. Peter Welch (D-VT)

Author Intent: To amend Title XVIII of the Social Security Act to provide for a phased-in expansion of telehealth coverage under the Medicare program and for other purposes.

ORIGINATING SITES

Current Law

Current law requires that for Medicare reimbursement, an eligible beneficiary must be located at an originating site that is in one of a specific list of facilities in certain geographical locations. Current law geographic requirements are that an originating site must:

- Be located in an area that is designated as a rural health professional shortage area under section 32(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));
- Be located in a county that is not included in a Metropolitan Statistical Area; or
- Participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

Current facilities eligible to act as an originating site under Medicare:

- Office of a physician or practitioner
- Federally Qualified Health Center (FQHC)
- Hospital
- Hospital-based or critical access hospital-based renal dialysis center (including satellites)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Skilled Nursing Facility
- Community Mental Health Center

The eligible originating sites may receive a facility fee under the Medicare program.

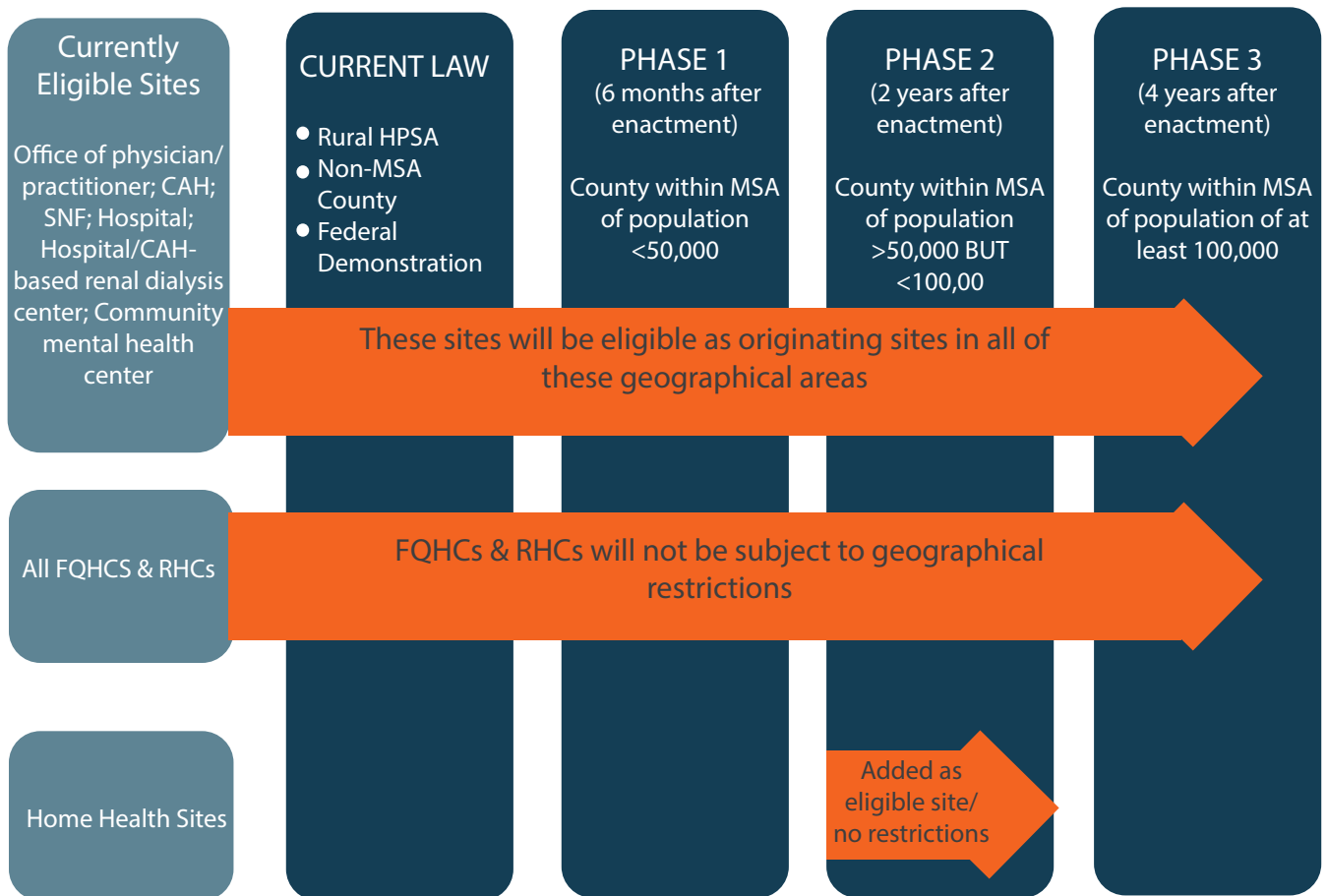
Bill Language

The bill seeks to expand the types of eligible facilities to act as an originating site and not be limited by the existing geographic restrictions imposed in the Medicare program. Each successive phase builds upon the previous stage(s), expanding geographical eligibility for sites while still including the previously approved locations as viable originating sites.

In the first phase, six months after the bill is enacted, any FQHC and RHC, as defined in Section 1861(aa) of the Social Security Act, will be an eligible originating site, regardless of geographical location. Additionally, any facility eligible under current law to be an originating site and is located in a county within an MSA of less than 50,000 will become an eligible originating site. The geographic restrictions currently in Medicare will not apply to these sites, but they also will not receive the originating site facility fee. However, if the currently eligible originating sites do not fall into one of the categories of Phase One, but still would be eligible under current law, those sites will still be qualified to provide telehealth services and receive reimbursement in the Medicare program as well as the originating site facility fee. This will hold true through all three phases of the proposed bill.

Phase Two will take place two years after the enactment of the bill and relax geographic restrictions further by allowing the current list of eligible originating sites to be located in a county within a MSA with a population of at least 50,000, but fewer than 100,000. Additionally home telehealth site, as defined in the bill, would be added as an eligible originating site, but face no geographical restrictions.

The third and final phase of the bill would take place four years after the bill's enactment and would make eligible originating sites located in a county in a MSA with a population of at least 100,000.



IMPACT & ANALYSIS

FQHCs and RHCs are currently eligible originating sites. Should this bill pass, FQHCs and RHCs would not be subject to the geographical restrictions currently in the Medicare program and not subject to any of the population requirements noted in the three phases. In Phase 2, the home will be added as an eligible site with no geographical restrictions, but limited in the types of services that can be received there. All new facilities added by the bill would not receive a facility fee, though those that continue to meet the requirements in current law would presumably still be eligible to receive an originating site facility fee.

The geographic restrictions to telehealth services in Medicare will be relaxed should this bill be enacted and the home becomes eligible as an originating site for a limited set of services. Additionally, the bill language appears to still allow those sites that meet current geographical and facility requirements to collect a facility fee, but those that are eligible under one of the Phases would not. Therefore, one hospital may be eligible to receive a facility fee while another may not. These varying qualifications on sites could cause some confusion, though it would expand the number of eligible originating sites.

INCREASE LIST OF ELIGIBLE PROVIDERS AND SERVICES

Current Law

Medicare will only reimburse a limited list of health care professionals and practitioners for services provided via telehealth:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse Midwives
- Clinical Nurse Specialists
- Clinical Psychologists
- Clinical Social Workers

Currently, a narrow list of specific services are reimbursed under the Medicare program if the services are delivered via telehealth. Each year, CMS considers adding additional services to the telehealth list if certain standards are met. To be approved, services must fall into one of two categories. Category 1 is reserved for services that are similar to professional consultations, office visits and office psychiatry services that are currently on the list of telehealth services. Category 2 (which entails a more extensive qualification process) is for services that are not similar to current telehealth services on the Medicare list.

Bill Language

Six months after the enactment of the bill, the definition for “practitioner” will be amended by adding to the current definition:

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- Certified diabetes educator
 - Licensed audiologist
 - Licensed physical therapist
 - Licensed respiratory therapist
 - Licensed occupational therapist
 - Licensed speech language pathologist

Two years after the enactment of the bill, services added to the list of reimbursable telehealth services in Medicare will include the following outpatient therapy services:

- Speech-language pathology services
- Respiratory services
- Audiology services
- Any additional services specified by the Secretary

Home telehealth services will also be added two years after enactment of the bill. These services are hospice care, home dialysis, home health services or durable medical equipment, but only video conferencing would be reimbursed.

The Comptroller General will conduct a study that includes at a minimum:

- The effectiveness of using telehealth for speech-language pathology, audiology and respiratory services
- Savings to Medicare associated with the aforementioned services
- Potential implications of greater use of telehealth for forms of therapy not described above.

IMPACT & ANALYSIS

While there will be an expansion of eligible Medicare providers and practitioners, the services provided by those additional practitioners will not be reimbursed under the Medicare program until two years after the bill has been adopted. The inclusion of the additional practitioners occurs six months after passage of the bill.

The Secretary will also be allowed to add additional services two years after the enactment of the bill. There is no mention that this specific power would require the Secretary to follow what is in current law regarding the addition of services to the telehealth list. Therefore, it is uncertain whether the Secretary would need to continue utilizing the already in place decision-making process of adding new services to be reimbursed in the Medicare program.

REMOTE PATIENT MANAGEMENT

Current Law

Currently, there is no remote patient management laws related to telehealth as it is applied in the Medicare program.

Bill Language

To take place six months after enactment of the bill, remote patient management services for

specific chronic health conditions (congestive heart failure, chronic obstructive pulmonary disease, and in the case of an FQHC, also diabetes) would be added to the definition of “medical and other health services” of the Social Security Act. The definition of remote patient management services is the remote monitoring, evaluation, and management of an individual with a covered chronic condition. A system of technology that allows a remote interface to collect and transmit clinical data between individual and responsible physician or supplier will be used. Services will include in-home technology-based professional consultations, patient monitoring, patient training services, clinical observation, assessment, treatment and any other services that utilize technologies specified by the Secretary, but does not include systems that only use telephone, facsimile or electronic text mail. The Secretary of Health will develop guidelines on billing for remote patient management and determine the amount of reimbursement for it. In determining the relative value for remote patient management services, the Secretary must consider physician resources, practice expense costs associated with the service and malpractice expense resources.

No later than two years after the enactment of the bill, the Secretary will develop standards on qualifications of personnel and maintenance of equipment for remote patient management services for covered chronic health conditions.

The Comptroller General will conduct a study that will be submitted to Congress not later than two years after enactment of this bill that includes at a minimum:

- The effectiveness of remote patient monitoring on decreasing hospital readmissions for the chronic conditions noted earlier.
- Savings to Medicare associated with remote patient monitoring use with respect to such chronic conditions.
- The potential for greater use of remote patient monitoring for other chronic conditions.
- Potential implications of greater use of remote patient monitoring with respect to payment and delivery system transformations under Medicare.

IMPACT & ANALYSIS

Due to the fact that this section on remote patient management services will be placed in Section 1861(s)(2) of the Social Security Act, it does not have the other restrictions such as geographic limitations that telehealth services currently face (and would still be limited by other sections in this bill). This would allow remote patient management services greater flexibility than other telehealth services. However, the services will be limited to specified chronic conditions, of which diabetes will be limited to FQHCs.

In setting rates, the Secretary will have to take into consideration the costs the physician or practitioner incurs in providing the service. One of the main concerns about reimbursement rates is that they do not adequately cover the costs of providing services via telehealth. By including those costs in calculating reimbursement for remote patient management, this concern appears to be addressed.

STORE-AND-FORWARD

Current Law

Medicare reimburses for store-and-forward services provided only in demonstration programs in Hawaii or Alaska.

Bill Language

Six months after the enactment of the bill, store-and-forward may be used for delivery of eligible services in Medicare. Current restrictions on the use of store-and-forward in Medicare will be eliminated, allowing other locations beyond Alaska and Hawaii to take advantage of the technology.

IMPACT & ANALYSIS

By allowing reimbursement for store-and-forward, providers could handle cases more effectively and decrease wait times for patients. However, under the bill, store-and-forward cannot be used in a home telehealth setting (all services must be video conference).

SECRETARY'S OPTION TO EXPAND SERVICES TO NON-ELIGIBLE ORIGINATING SITES

Current Law

N/A

Bill Language

Four years after the enactment of the bill, the Secretary of Health would have the option to expand services to non-eligible originating sites.

IMPACT & ANALYSIS

This language would provide the Secretary with the option to expand the list of eligible originating sites without the need for legislative action/approval.

The Center for Connected Health Policy (CCHP) is a non-profit, nonpartisan organization that develops and advances telehealth policy solutions that promote improvements in health and health care systems. CCHP is the federally designated National Telehealth Policy Resource Center (NTRC-P), providing technical assistance to twelve Regional Resource Centers nationwide, and serves as a national resource on telehealth policy. The NTRC-P project is made possible by Grant #G22RH24746 from the Office of the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services. CCHP was created in 2008 by the California HealthCare Foundation, who remains its lead funder. CCHP is a program of the Public Health Institute.