Center for Connected Health Policy
The National Telehealth Policy Resource Center

S. 2484 - Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act

Sen. Schatz (D-HI), Wicker (R-MS), Cochran (R-MS), Cardin (D-MD), Thune (R-SD) and Warner (D-VA)

Author Intent: To amend titles XVIII and XI of the Social Security Act to promote cost savings and quality care under the Medicare program through the use of telehealth and remote patient monitoring services, and for other purposes.

Telehealth and Remote Monitoring Services "Bridge" Demonstration Waivers

The bill requires the Secretary to solicit proposals from and issue telemedicine or remote patient monitoring (RPM) "bridge" demonstration waivers to eligible applicants who, for the duration of time for which the demonstration waiver would apply, are furnishing telehealth or RPM services that are consistent with the goals of the Merit-based Incentive Payment System (MIPS), including goals of quality, resource utilization, and clinical practice improvement (including care coordination and patient engagement) or the incentive payments for participation in eligible alternative payment models (APM).

Eligible applicants are:

- A qualifying APM participant;
- A professional described in 1848(q)(1)(C)(i)(I) which are: physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and a group that includes such professionals;
- Any other professional deemed appropriate by the Secretary and a group that contains such providers.

The bill exempts participating entities under the demonstration waiver from telehealth requirements included in section 1834(m) of the Social Security Act (SSA), including:

- Geographic limitation
- Limitation on what qualifies as an originating site
- Limitation on store and forward or RPM
- Limitation on type of professional who may furnish telehealth

Current Medicare Fee-for-Service Limitations	Entities in Demonstration Waiver & Qualifying APM Participants
Reimbursement for telehealth delivered services limited to rural areas, as defined below: • An area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)); • In a county that is not included in a Metropolitan Statistical Area (MSA); or • From an entity that 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.	Exempt – telehealth services can take place anywhere, whether the patient is located in a rural area or not.

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Current Medicare Fee-for-Service Limitations	Entities in Demonstration Waiver & Qualifying APM Participants
Current facilities eligible to act as an originating site under Medicare: • Office of a physician or practitioner Critical access hospital • Rural health clinic (RHC) • Federally qualified health center (FQHC) (as defined in section 1861(aa)(4)) • Hospital • Hospital-based or critical access hospital-based renal dialysis center (including satellites) • Skilled nursing facility • Community mental health center	Exempt – the patient can be in any location to receive telehealth services, including their home.
Medicare limits the types of health care professionals who can provide telehealth-delivered services. The small group of eligible professionals are: • Physicians; • Nurse practitioners; • Physician assistants; • Nurse midwives; • Clinical nurse specialists; • Clinical psychologists and clinical social workers (these professionals cannot bill for psychotherapy services that include medical evaluation and management services); • Registered dietitians or nutrition professionals.	Exempt – any healthcare provider can deliver services via telehealth that qualifies for Medicare reimbursement.
Services delivered through store and forward and remote patient monitoring technology do not qualify for reimbursement.	Exempt – both store and forward and RPM are modalities that can be used to deliver services and be reimbursed.
Medicare approves a list of CPT codes eligible for reimbursement every year.	Undisclosed – the bill doesn't directly mention an exemption for this restriction.

Participants under the demonstration waiver program would have to submit an application annually that includes an attestation of the intent to use telehealth or RPM and an agreement to:

1) submit data annually on the utilization and expenditures for telehealth or RPM; applicable quality measures and any other information the Secretary deems necessary; data on applicable quality measures during the preceding year; and
2) cooperate in any audit conducted with respect to claims for telehealth or RPM furnished under the waiver.

The Secretary may also require other data to be submitted and may conduct audits of randomly selected claims under the demonstration waiver program.

Unlike the participants in the demonstration waiver program, qualifying APM participants do not need to cooperate in any audit, but if the Secretary determines payment for telehealth or RPM will increase expenditures, the Secretary will make adjustments to such payments to eliminate those increases.

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The demonstration waiver will expire December 31, 2019. However, the Secretary through rulemaking may expand and implement on a nationwide basis the duration and scope of the demonstration waiver program if the Secretary determines the expansion will reduce spending without reducing quality or improve the quality of patient care without increasing spending; the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion would reduce (or not result in any increase in) net program spending; and the Secretary determines that such expansion would not deny or limit the coverage or benefits for individuals.A report to Congress by the Chief Actuary will be submitted on the evaluation of the impact of telehealth and RPM under the demonstration waiver program. This report will be submitted no later than December 31, 2020.

The amendment to the APM participants will apply to services furnished on or after January 1, 2017.

Analysis

The bill does not state what payment for these services will be based upon, whether the physician fee schedule or some scale created by the Secretary. This section of the bill also doesn't specifically list the requirements of complying with the telehealth approved CPT codes as being waived, as it does for the other restrictions. This may still persist as a barrier as reimbursement will only be made for a limited list of services.

Medicare Coverage of Telehealth and Remote Patient Monitoring Services

Medicare currently does not reimburse for remote patient monitoring services. The bill would allow for RPM reimbursement for certain chronic health conditions under Medicare. This bill would also allow Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to act as an eligible provider of RPM services for individuals with certain chronic care conditions. An eligible recipient of RPM services must have two or more covered chronic conditions and have a history of two or more hospitalization or emergency room visits related to covered chronic conditions in the preceding 12 months.

The Secretary shall establish procedures which will require providers who furnish RPM services to annually submit data on applicable quality measures. If the Chief Actuary of CMS determines that a condition in the inclusion of "covered chronic condition" will result in increased expenditures, the Secretary will need to make adjustments to the definition to eliminate the increased expenditures.

Restrictions under the bill include:

Applicable Individual	Health Care Provider	Covered Chronic Condition	RPM Services Duration
• Must have two or more covered chronic diseases. • Must have been hospitalized two or more times in previous 12 months.	Only a physician, practitioner, RHC or FQHC is eligible to receive reimbursement.	Defined as anything qualifying for chronic care management under section 1848(b)(8) of the Social Security Act or any condition the Secretary may specify.	Provides for reimbursement for up to 90 days, with possibility for renewal if the participant has had one or more hospitalizations related to the covered chronic conditions (emergency room visits do not count).

Payment for RHCs and FQHCs will be an amount equal to the national average payment amount for such services as determined by the Secretary. These changes will apply to services furnished on or after January 1, 2017.

Analysis

The bill defines remote patient monitoring services as distinct from telehealth services. This distinction allows RPM services to avoid the restrictions on telehealth services (location, facility type, eligible providers, etc.) that currently exist in the Medicare program. At the same time, the bill lays out restrictions of its own on RPM, such as limiting it to certain individuals with chronic diseases, limiting the health care providers eligible for reimbursement and limiting the duration of time RPM services can be utilized. Additionally, as in previous sections, providers of RPM will be required to submit annual data on quality measures as well as requiring the Secretary to make adjustments to ensure cost neutrality.

Allowing for Stroke Evaluation Sites and Native American Health Service Facilities as Sites Eligible for Telehealth Reimbursement

As mentioned previously, current law restricts Medicare reimbursement for telehealth services to a narrow list of sites in specific geographic areas. The bill would allow any site the patient is located in to serve as an originating site for purposes of acute stroke evaluation or management regardless of geography. It also allows any site to be reimbursed if it is a facility of the Indian Health Service (whether operated by such Service or by an Indian tribe, tribal organization, or a facility of the Native Hawaiian health care system authorized under the Native Hawaiian Health Care Improvement Act), regardless of geography. There would be no originating site facility fee for these new sites. The amendments apply to services on or after January 1, 2017.

Analysis

The SSA restricts reimbursement for telehealth services to a list of CPT codes reviewed and released by CMS on a yearly basis. The bill would not mandate additional CPT codes be added to this list for the treatment of acute stroke. The most common codes used to bill for stroke (99291 and 99292) are currently not reimbursable telehealth codes. Thus the impact of alleviating the originating site restrictions may be limited without adding the additional CPT codes, if the purpose is to provide for reimbursement for acute stroke care.

Other Changes Made By the CONNECT for Health Act:

- Allows for telehealth to meet the monthly in-person visit requirement for individuals who have end stage renal disease receiving home dialysis if the person receives an in-person examination once every three months. The originating site must be a dialysis facility.
- FQHCs and RHCs would be authorized to act as distant site providers (to go into effect January 1, 2017).
- Clarifies that Medicare Advantage plans (under Medicare Part C) can utilize telehealth or RPM without application of any of the restrictions on what constitutes an originating site, geographic limitations, the use of store and forward, or type of health care provider. If plans make the election to use telehealth or RPM services, these services will be considered part of the provision of benefits under the original Medicare fee-for-service program. Plans that make such an election must provide data on expenditures and utilization to the Secretary.