



H.R. 2550 MEDICARE TELEHEALTH PARITY ACT OF 2017

SPONSORS: *Rep. Mike Thompson (D-CA), Rep. Gregg Harper (R-MS), Black (R-TN), Welch (D-VT)*

INTENT: *To amend Title XVIII of the Social Security Act to provide for an incremental expansion of telehealth coverage under the Medicare program.*

ORIGINATING SITES

CURRENT LAW

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

Current Law Geographic Requirements:

- In 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; 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.

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 (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

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

BILL LANGUAGE

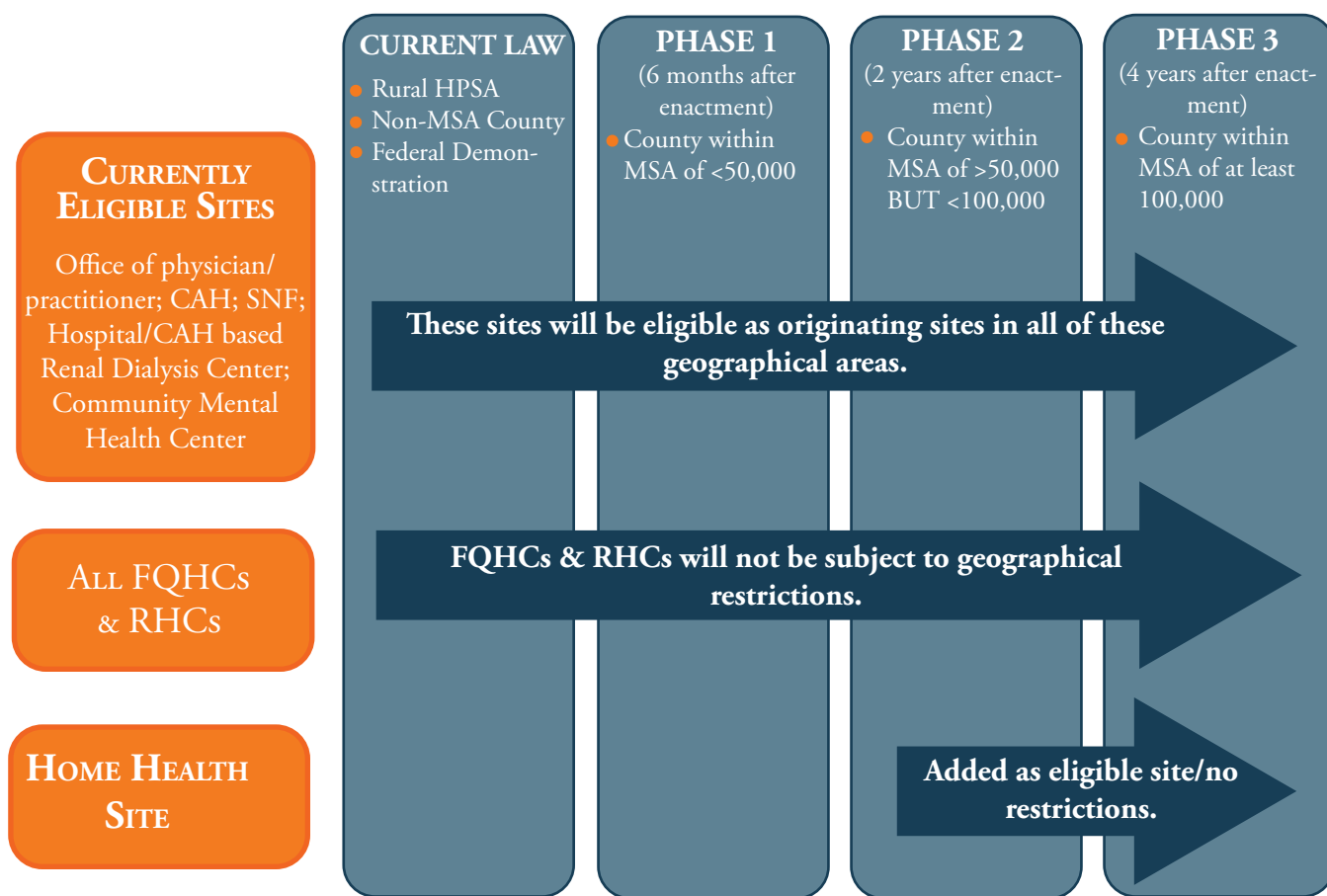
The bill seeks to expand the types of eligible facilities to act as an originating site and not be limited by the existing geographic restrictions imposed in the Medicare program through a phase-in approach. Each successive phase builds upon the previous

stages, 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 site 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 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 I, 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 facility fee for an originating site. 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. Home telehealth sites used to deliver outpatient live video mental or behavioral health, as well as hospice care, home dialysis or home health services, would be added as an eligible originating site, and face no geographical restrictions. Additionally, any site used to treat an acute stroke via telehealth would also qualify.

The third and final phase would take place four years after the bill's enactment and would make originating sites located in a county in a MSA with a population of at least 100,000 eligible for Medicare reimbursement. Just as in phase 1, none of the sites added in phase two or three would qualify for the originating site facility fee.



IMPACT AND 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 two, any site administering acute stroke care as well as 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. 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.

DISTANT SITES

CURRENT LAW

A distant site is defined as the site at which the physician or practitioner is located at the time the service is provided via telehealth.

BILL LANGUAGE

The bill would make it clear that a rural health clinic (RHC) and federally qualified health center (FQHC) do qualify as an eligible distant site. It specifies that any telehealth service rendered from an RHC or FQHC to an eligible telehealth individual will not be treated as an RHC or FQHC service, and payment may not otherwise be made under this title with respect to such service provided to such individual.

IMPACT AND ANALYSIS

This section would allow FQHCs and RHCs to be reimbursed by Medicare for acting as a distant site. Currently, CMS does not allow this because only a physician or practitioner can currently bill as a distant site, and since FQHCs and RHCs bill as a facility, they are ineligible. This has been an issue for many FQHCs and RHCs who contract with, and bill Medicare on behalf of distant site providers. This provision would resolve this issue.

INCREASE LIST OF ELIGIBLE PROVIDERS AND SERVICES

CURRENT LAW

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

- Physicians
- Nurse Practitioners
- Physicians 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

To take effect six months after enactment, the bill would replace the definition of “practitioner” with a definition for “professional”, which includes the providers eligible under current law (listed above), as well as the following:

- Certified Diabetes Educator
- Respiratory Therapist
- Audiologist
- Occupational Therapist
- Physical Therapist
- Speech Language Pathologist

This bill would also add respiratory services, audiology services, and outpatient therapy services including physical therapy, occupational therapy and speech-language pathology services to the list of reimbursable telehealth services in Medicare.

Home telehealth services will also be added two years after enactment of the bill. These services would only be reimbursed if they were related to outpatient mental or behavioral health delivered via live video or for hospice care, home dialysis, or home health services.

The Comptroller General would also be required to conduct a study and produce a report two years after the date of enactment 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 AND ANALYSIS

This bill would allow for the expansion of eligible Medicare physicians and professionals, as well as services. The bill would keep physicians and practitioners as eligible providers, but also add certified diabetes educators, respiratory therapists, audiologists, occupational therapists, physical therapists and speech language pathologists to the list. The bill’s current language does not amend other parts of the telehealth section of the Social Security Act, where the term “physician and practitioner” is still used, excluding the professionals added by this provision. This is most notable in the definition of the “Distant Site” (Section 1834(m)(2)(A)). However, the author’s office has informed CCHP that this was not the intent.

RPM COVERED CONDITIONS

CURRENT LAW

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

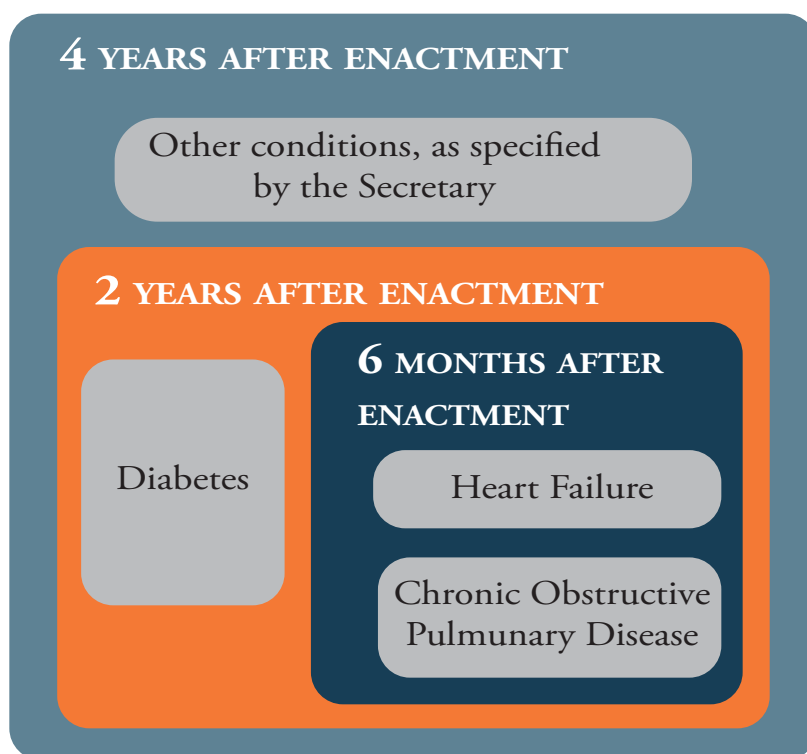
BILL LANGUAGE

To take place six months after enactment of the bill, applicable remote patient monitoring services for specific chronic health conditions (see chart below) would be added to the definition of “medical and other health services” of the Social Security Act. The definition of applicable remote patient monitoring services is the monitoring, evaluation, and management of an individual for a covered chronic condition. Payment is made for up to 90 days, which can be renewed by the physician if they decide the individual continues to qualify for such management. Remote patient monitoring technology would include a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmits vital sign data or information on activities of daily living and may include responses to assessment questions, conducted as part of an established plan of care for the patient, which includes a review and interpretation of the data by a health care professional.

The Secretary of Health will develop guidelines on billing for remote patient monitoring and determine the amount of reimbursement for it. In determining the relative value for remote patient monitoring services, the Secretary must consider physician resources, practice expense costs associated with the service and malpractice expense resources. The Secretary will be required to provide separate payment for applicable remote monitoring services and must promptly evaluate existing codes and make additional codes available in order for providers to accurately report and bill for the services. The bill also exempts the extra expenditures spent on the new RPM services from being counted toward the maximum annual adjustment of expenditures (\$20,000,000) in determining the relative value for physician services.

RPM COVERED CONDITIONS

- Six months after enactment: applicable conditions relating to heart failure and chronic obstructive pulmonary disease and related chronic co-morbidities when under chronic care management HCPCS code 99490.
- Two years after enactment: Diabetes and related chronic co-morbidities and related chronic co-morbidities when under chronic care management code 99490.
- Four years after enactment: Other conditions that could be specified by the Secretary that qualify for chronic care management and related chronic co-morbidities when under chronic care management code 99490.



IMPACT AND 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 monitoring services greater flexibility than other telehealth services. However, the services will be limited to specified chronic conditions.

In setting rates the Secretary will have to take into consideration the costs the physician incurs in providing the service. One of the main concerns about reimbursement rates from Medicare 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, the concern for this service 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

This bill would allow store-and-forward to be used in the 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 AND ANALYSIS

This language would open up reimbursement for store-and-forward within the Medicare program, although other restrictions that also limit the use of live video telehealth, such as restrictions on originating sites, providers and services would still apply. Although these restrictions are eased by the language in this bill, they would still persist to a lesser degree. Additionally, it appears that this change will be effective immediately rather than in a phased in approach like other elements of the legislation.

Presumably, store and forward technology could be utilized for remote patient monitoring services, however, only a limited list of chronic conditions are eligible for those services. Beneficiaries with other chronic conditions, would not be able to send their information (via store-and-forward) to their practitioner from home and that practitioner be reimbursed under the current parameters of the bill unless added by the Secretary four years after the enactment of the Act.

HOME DIALYSIS

CURRENT LAW

N/A

BILL LANGUAGE

Beginning Jan. 1, 2018, the bill allows physicians, clinical nurse specialists, nurse practitioners, or physician's assistants to request a waiver for the face-to-face visit requirement for home dialysis for individuals with end stage renal disease, as long as there is documentation that supports active and adequate care. Individuals receiving home dialysis under such waiver would still be required to receive a face-to-face examination at least once every three consecutive months, and in intervening months, a monthly clinical assessment which may be furnished via remote monitoring.

IMPACT AND ANALYSIS

CMS currently requires at least one face-to-face patient visit per month for home dialysis for physicians or practitioners to receive their monthly capitation rate. This provision would allow eligible providers to request a waiver of this requirement (although a face-to-face visit would still be required once every three months). It is unclear under what conditions CMS may accept or reject such a request.

REMOTE DIAGNOSTIC TESTS

CURRENT LAW

N/A

BILL LANGUAGE

In determining the relative value of diagnostic x-ray tests, laboratory tests and other tests, the Secretary must include (in a budget neutral way) the direct costs of supplies and equipment, the costs of the diagnostic device, clinical systems, information transmission and device delivery installation.

IMPACT AND ANALYSIS

This language would ensure that the cost of needed equipment used for diagnostic testing is incorporated within the relative value determination, as implemented by the Secretary.

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 the list of non-eligible originating sites. To expand the list of eligible originating sites is optional and left to the Secretary's discretion.

IMPACT AND 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.

SENSE OF CONGRESS REGARDING THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

CURRENT LAW

The Medicare Access and CHIP Reauthorization Act of 2015, passed in 2015, addressed telehealth in several ways, including incentives to use telehealth or remote monitoring as a means of care coordination, and required a GAO study and report on the use of telehealth and remote patient monitoring (RPM) in federal programs. The Act also states that it does not preclude alternative payment models from furnishing telehealth services for which payment is not made under 1834(m) of the Social Security Act.

BILL LANGUAGE

The bill states that it is the sense of congress that the telehealth expansion efforts initiated by the studies and reports on telehealth and RPM in the Medicare Access and CHIP Reauthorization Act of 2015 are boosted through the incremental expansion of telehealth and RPM services, as this bill proposes to do.

IMPACT AND ANALYSIS

This language points out how the telehealth provisions in the previously passed Medicare Access and CHIP Reauthorization Act of 2015 would be strengthened by the passage of this bill.

Prepared by:

