THORN RUN PARTNERS
GOVERNMENT RELATIONS

Background Brief: Telemedicine

October 7, 2015

I. EXECUTIVE SUMMARY

This memorandum explores the reimbursement and regulatory landscape for telemedicine services, particularly those relating to population health. The memo provides a brief definition of telemedicine, in contrast to broader telehealth services (sec. II), before outlining how government and private payers reimburse providers for certain telemedicine services (sec. III). Additionally, the memo identifies alternative sources of telemedicine funding via grant and demonstration projects (sec. V). Finally, the memorandum examines major policy issues that may impact telemedicine (sec. VI).

II. DEFINITIONAL CONTEXT: TELEMEDICINE IN SUPPORT OF POPULATION HEALTH

Telemedicine is considered a subset of telehealth, the latter of which more broadly encompasses health information technology (health IT) and includes "remote *non-clinical* services, such as provider training, administrative meetings, and continuing medical education (CME), in addition to clinical services" (emphasis added).[1]

In contrast to the more expansive term, the Office of the National Coordinator for Health Information Technology Organization (ONC) clarifies that telemedicine "refers specifically to remote *clinical* services" (emphasis added).[2] Telemedicine services "include primary care and specialist referral services involving the use of live interactive video; remote patient monitoring, devices to remotely collect and send data to a provider for interpretation; and medical education, including [CME] for health professionals and special medical education seminars for targeted groups in remote locations."[3]

The use of telemedicine to promote population health has gained traction in recent years, in part due to growing health care costs and the increasing prevalence of chronic disease. An Institute of Medicine (IOM) panel[4] defined population health as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Kindig and Stoddart, 2003)."[5] The IOM

[1] http://allhealth.org/publications/AHR-Telemedicine-Toolkit_June-2015_164.pdf and https://www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine
[2] https://www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine
[3] http://allhealth.org/publications/AHR-Telemedicine-Toolkit_June-2015_164.pdf
[4] For more information, see the IOM Roundtable on Population Health Improvement at: http://iom.nationalacademies.org/Activities/PublicHealth/PopulationHealthImprovementRT.aspx
[5] http://iom.nationalacademies.org/~/media/Files/Activity%20Files/PublicHealth/PopulationHealthImprovementRT/Pop%20Health%20RT%20Population%20Health%20Working%20Definition.pdf

clarifies that "population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors."[6]

III. TELEMEDICINE REIMBURSEMENT LANDSCAPE

A. MEDICARE FEE-FOR-SERVICE

Fee-for-service (FFS) Medicare covers a defined set of outpatient services furnished to an eligible beneficiary via an approved (two-way, real-time) interactive telecommunications system. Beneficiaries are eligible for the services if they receive care from an "originating site" – such as physician offices, hospitals, and rural health clinics (RHCs) – located in:

- A rural Health Professional Shortage Area (HPSA), either located outside of a Metropolitan Statistical Area (MSA) or in a rural census tract, as determined by the Health Resources and Services Administration's (HRSA) Office of Rural Health Policy;
- A county outside of an MSA; or
- Entities that participate in a federal telemedicine demonstration project approved by or receiving funding from the Department of Health and Human Services (HHS) as of December 31, 2000, regardless of geographic location.[7]

According to the American Telemedicine Association (ATA), Medicare "[r]eimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. In addition, the non-metropolitan facility with the patient is eligible to receive a facility fee."[8] Highlighted at Addendum A is the list of Medicare-covered telemedicine services for calendar year (CY) 2015. Additions or deletions to this list are evaluated on an annual basis by the Centers for Medicare and Medicaid Services (CMS) via the Medicare Physician Fee Schedule (MPFS) rule. (Note that additional telemedicine services are proposed for coverage in CY16; final action is anticipated in the forthcoming final rule due around Nov. 1.)

In light of the above federal stipulations, roughly 80% of Medicare beneficiaries do not qualify for telemedicine services because they live in a metropolitan area.[9] Additional conditions of payment – including a general prohibition on asynchronous "store and forward" technology and remote patient monitoring of chronic conditions, including in a patient's home, further limit the breadth of Medicare telemedicine coverage.[10] Though videoconferencing technology has been around for decades, a *Kaiser Health News* report from June 2015 indicates that "fewer than 1% of Medicare

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[6] Ibid.
[7] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telemedicinesrvcsfctsht.pdf
[8] http://www.americantelemed.org/docs/default-source/policy/medicare-payment-of-telemedicine-and-telehealth-services.pdf
[9] http://allhealth.org/publications/AHR-Telemedicine-Toolkit_June-2015_164.pdf
[10] Ibid.

beneficiaries use it."[11] In general, telemedicine coverage and reimbursement restrictions have remained in place out of "concern that the service might increase Medicare expenses" due to an increase in beneficiaries' use of services.[12]

B. MEDICARE ADVANTAGE

In the Medicare Advantage (MA) program, reimbursement for telemedicine depends on the private plan. In contrast to Medicare FFS, a number of MA plans as well as Medicare Accountable Care Organizations (ACOs) have turned to telemedicine as a means by which to facilitate greater care management and beneficiary engagement. This is predominantly due to the fact that "[MA] plans have the option to offer telemedicine without the tight restrictions in the traditional Medicare program because they are paid a fixed amount by the federal government to care for seniors. As a result, Medicare is not directly paying for the telemedicine services; instead, the services are paid for through plan revenue."[13] Anthem, for example, provides telemedicine services at no extra charge to its roughly 350,000 MA members across a dozen states, demonstrating its belief that these services lead to improved care and customer satisfaction, as well as cost savings.[14]

C. MEDICAID

As of May 2015, 48 states including D.C. provide some level of Medicaid reimbursement for telemedicine services.[15] While federal Medicaid statute does not explicitly recognize telemedicine as a distinct service, states have considerable flexibility in covering and reimbursing for these activities.[16] As CMS points out:

> *…[S]tates have the option/flexibility to determine whether (or not) to cover telemedicine; what types of telemedicine to cover; where in the state it can be covered; how it is provided/covered; what types of telemedicine practitioners/providers may be covered/reimbursed, as long as such practitioners/providers are 'recognized' and qualified according to Medicaid statute/regulation; and how much to reimburse for telemedicine services, as long as such payments do not exceed Federal Upper Limits [FULs].*[17]

[11] http://khn.org/news/medicare-slow-to-adopt-telemedicine-due-to-cost-concerns/
[12] Ibid.
[13] http://khn.org/news/medicare-slow-to-adopt-telemedicine-due-to-cost-concerns/
[14] Ibid.
[15] http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf
[16] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html
[17] Ibid.

State Medicaid reimbursement for telemedicine services must meet broad federal requirements "of efficiency, economy and quality of care," though states are encouraged to use the flexibility of the program to establish payment methodologies that serve their residents' needs.[18] Due to the inherit flexibility of the program, states do not need to submit a separate State Plan Amendment (SPA) for establishing the coverage of telemedicine services if it reimburses providers the same as a face-to-face service. However, states must obtain approval from CMS if reimbursement differs from the face-to-face service.[19]

D. Private Insurance

State-mandated telemedicine coverage of private insurers has become increasingly prevalent over the past decade.[20] For example, "[c]overage was mandatory in 5 states in 2000, 12 in 2011, and 24 plus D.C. as of May 2015," an Alliance for Health Reform telemedicine toolkit notes.[21] However, only 16 of the 24 states with telemedicine parity laws for private insurance "authorize state-wide coverage, without any provider or technology restrictions."[22] Telemedicine advocates are pushing for more states to pass legislation requiring that telemedicine services be covered to the same extent and in a similar manner as in-person services. Advocates say that parity is most widely adopted in the private insurance market, relative to Medicaid and state-sponsored plans.[23]

IV. Alternative Telemedicine Funding Mechanisms

A. HRSA Grants

The Health Resources and Services Administration (HRSA) works to increase access to care and promote the use of telemedicine services through grants. HRSA has four central telemedicine grant programs, some of which are more broadly focused on telehealth:

- The Evidence-Based Tele-Emergency Network Program (EB TNGP)[24] competitive grant program "seeks to expand capabilities in remote emergency departments and determine the effectiveness of tele-emergency care for rural patients and providers." A list of active grants is available at the HRSA web site.[25]

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[18] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html
[19] Ibid.
[20] http://allhealth.org/publications/AHR-Telemedicine-Toolkit_June-2015_164.pdf
[21] Ibid.
[22] Ibid.
[23] http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf
[24] http://www.grants.gov/web/grants/view-opportunity.html?oppId=255433
[25] https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=G01&rs:Format=HTML4.0

- The Licensure Portability[26] competitive grant program supports state professional licensing boards to develop and implement policies that will reduce statutory and regulatory barriers to telemedicine. A list of active grants is available at the HRSA web site.[27]
- The Telehealth Network[28] competitive grant program supports projects that "demonstrate the use of telemedicine networks to improve healthcare services for medically underserved populations in urban, rural, and frontier communities." A list of active grants is available at the HRSA web site.[29]
- Finally, the Telehealth Resource Center (TRC)[30] is a competitive grant program that supports the establishment of TRCs across the country. TRCs assist organizations, "health care networks, and health care providers in the implementation of cost-effective telemedicine programs to serve rural and medically underserved areas and populations." A list of active grants is available at the HRSA web site.[31] [32]

B. USDA GRANTS

The U.S. Department of Agriculture (USDA) provides grants through the Distance Learning and Telemedicine (DLT)[33] Program. The program supports rural communities in "us[ing] the unique capabilities of telecommunications to connect to each other and to the world… [in some cases] link[ing] teachers and medical service providers in one area to students and patients in another."

DLT funding is available to those entities that provide education or health care through telecommunications. Eligible entities include corporations, partnerships, tribes, state or local governments, and private for-profit and not-for-profit corporations. Roughly $19 million in DLT funding was made available this year, although the July 6 application deadline has passed.

Additionally, there is the USDA's Community Facilities[34] direct loan program, through which funds may be provided to eligible borrowers "to develop essential community facilities in rural areas." Examples of an "essential community facility" include health care facilities such as hospitals, medical clinics, dental clinics, nursing homes, and assisted living facilities.

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[26] http://www.telehealthresourcecenter.org/
[27] https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=H1M&rs:Format=HTML4.0
[28] http://www.hrsa.gov/ruralhealth/about/telehealth/telehlthnetworks.html
[29] https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=H2A&rs:Format=HTML4.0
[30] http://www.telehealthresourcecenter.org/
[31] https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=G22&rs:Format=HTML4.0
[32] http://www.hrsa.gov/ruralhealth/about/telehealth/
[33] http://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants
[34] http://www.rd.usda.gov/programs-services/community-facilities-direct-loan-grant-program

C. FCC GRANTS

The Federal Communications Commission (FCC) administers the Rural Health Care Program,[35] which includes the 2013-initiiated Healthcare Connect Fund. The Healthcare Connect Fund provides support to eligible rural and non-rural public/non-profit health care providers (including individual providers and consortia thereof) for broadband connectivity and broadband networks.

Additionally, a three-year Skilled Nursing Facility (SNF) Pilot program, to be funded via the Healthcare Connect Fund, was slated to launch in July 2014 but appears to have been deferred "until the Commission determines whether to use SNF Pilot Program funds for the rural health care broadband experiments."[36]

D. OTHER GRANT OPPORTUNITIES

Through CMS' Center for Medicare and Medicaid Innovation (CMMI), the agency supports various demonstration projects, some of which incorporate specific elements of telemedicine, depending on the scope of the project. Examples include the Frontier Community Health Integration Project,[37] limited initially to participating Critical Access Hospitals (CAHs) in select states, as well as certain Health Care Innovation[38] awardees testing certain innovative payment and delivery service models, some of which include telemedicine components. Furthermore, various CMS Accountable Care Organization (ACO) models, such as the Next Generation ACO Model,[39] aim to enhance care management through additional coverage of telemedicine services.[40]

In October 2014, CMMI sought stakeholder input[41] to inform the future development of health plan-focused initiatives under its broad ACA demonstration authority. It sought input, for example, on "the inclusion of remote access technologies beyond what is covered by Original Medicare in the basic benefit package" under MA coverage, possibly signaling its contemplation of yet-to-be released telemedicine-related demonstration opportunities for MA plans.

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[35] https://www.fcc.gov/encyclopedia/rural-health-care#HCF
[36] https://www.fcc.gov/encyclopedia/rural-health-care
[37] http://innovation.cms.gov/initiatives/Frontier-Community-Health-Integration-Project-Demonstration/
[38] http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/
[39] http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
[40] http://blog.cms.gov/2015/03/10/building-on-the-success-of-the-aco-model/
[41] http://innovation.cms.gov/Files/x/HPI-RFI.pdf

V. POLICY CONSIDERATIONS AND DEVELOPMENTS

A. EXPANDING TELEMEDICINE ADOPTION

According to Adler-Milstein et al., states that wish to promote the use of telemedicine should explore private payer reimbursement and relax licensure requirements.[42] By late 2012, 42 percent of U.S. hospitals had adopted telemedicine, but adoption rates vary significantly by geography. Alaska was the highest with 75 percent, while Rhode Island had minimal adoption. Factors that positively influence adoption rates include serving as a teaching hospital, being part of a larger system, having greater technological capacity, and being located in a rural area. Factors negatively affecting adoption include high population density, holding for-profit status, and operating in a less competitive market.[43]

Trade groups and ACOs are pushing CMS to modify the ACO program to better accommodate telemedicine and remote patient monitoring. They assert that that existing policies create a disincentive to use telemedicine by not providing reimbursement for connected care services.[44] As noted above, CMS' latest Next Generation ACO model aims to improve beneficiary engagement, in part through telemedicine. Though Round 1 Next Generation ACO applications were due last June, Round 2 letters of intent (LOIs) and applications are expected to be made available sometime next March with LOIs dueby May 1, 2016 and applications due by June 1, 2016.[45]

Furthermore, state legislatures have been active in the telemedicine policy realm. As of last September, 29 states and DC adopted legislation mandating coverage of telemedicine.[46]

B. LICENSING ISSUES ACROSS STATE LINES

States typically require physicians to be licensed to practice in the "originating" site, i.e., the patient must be in the same state in which the attending physician is licensed to practice. Some states require that providers maintain a license with the board where the patient is located, which can lead to extra costs and paperwork for the providers.[47] Additionally, certain providers, such as nurse practitioners, who can deliver care autonomously in one state may not be able to treat patients in states that do not offer the same privileges.

Last year, the American Medical Association (AMA) adopted telemedicine principles that "aim to help foster innovation in the use of telemedicine, protect the patient-physician relationship and

[42] http://content.healthaffairs.org/content/33/2/207.full.pdf
[43] Ibid.
[44] http://www.modernhealthcare.com/article/20140610/NEWS/306109921
[45] http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
[46] http://atawiki.org.s161633.gridserver.com/wiki/index.php?title=State_law
[47] http://www.healthit.gov/providers-professionals/faqs/are-there-state-licensing-issues-related-telehealth

promote improved care coordination and communication with medical homes."[48] Some of these recommendations may present challenges to rapid telemedicine adoption. The Federation of State Medical Boards (FSMB) has been active in the development of model legislation[49] that states may use to advance the concept of multi-state compacts for cross-state physician licensures.[50]

C. UPCOMING TELEMEDICINE REFORMS

The Medicare Access and CHIP Reauthorization Act (MACRA),[51] signed into law in April 2015, contained various provisions aimed at expanding the use of telemedicine. It included a provision that limits restrictions on telemedicine only to FFS as opposed to the alternative payment models (APMs) established under the law.[52] Another provision directs the Government Accountability Office (GAO) to study specified telemedicine and remote patient monitoring services. A third stipulation incorporates telemedicine into the care coordination elements of clinical practice improvement activities the law promotes.[53]

In addition, providers and stakeholders are staying closely attuned to the ongoing 21st Century Cures deliberations in Congress that relate to telemedicine. The House-passed version of the bill (H.R. 6) requires CMS and the Medicare Payment Advisory Commission (MedPAC) to provide detailed information to Congress regarding telemedicine.[54]

VI. CONCLUSION

We hope that you find this memorandum useful in your ongoing assessment of the dynamic telemedicine policy and reimbursement landscape, particularly as a vehicle through which to improve population health.

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[48] http://www.ama-assn.org/ama/pub/news/news/2014/2014-06-11-policy-coverage-reimbursement-for-telemedicine.page

[49] https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

[50] www.modernhealthcare.com/article/20140905/NEWS/309059956 and https://www.fsmb.org/Media/Default/PDF/Publications/senate_compact_letter_release1012015.pdf

[51] See P.L. 114-10: https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf

[52] http://allhealth.org/publications/AHR-Telemedicine-Toolkit_June-2015_164.pdf

[53] Ibid.

[54] https://www.congress.gov/bill/114th-congress/house-bill/6?q={%22search%22%3A[%22\%22hr6\%22%22]}&resultIndex=1

ADDENDUM A: LIST OF CY15 MEDICARE TELEMEDICINE SERVICES

Code	Short Descriptor	Code	Short Descriptor
90791	Psych diagnostic evaluation	99231	Subsequent hospital care
90792	Psych diag eval w/med srvcs	99232	Subsequent hospital care
90832	Psytx pt&/family 30 minutes	99233	Subsequent hospital care
90833	Psytx pt&/fam w/e&m 30 min	99307	Nursing fac care subseq
90834	Psytx pt&/family 45 minutes	99308	Nursing fac care subseq
90836	Psytx pt&/fam w/e&m 45 min	99309	Nursing fac care subseq
90837	Psytx pt&/family 60 minutes	99310	Nursing fac care subseq
90838	Psytx pt&/fam w/e&m 60 min	99354	Prolonged service office
90845	Psychoanalysis	99355	Prolonged service office
90846	Family psytx w/o patient	99406	Behav chng smoking 3-10 min
90847	Family psytx w/patient	99407	Behav chng smoking > 10 min
90951	Esrd serv 4 visits p mo <2yr	99495	Trans care mgmt 14 day disch
90952	Esrd serv 2-3 vsts p mo <2yr	99496	Trans care mgmt 7 day disch
90954	Esrd serv 4 vsts p mo 2-11	G0108	Diab manage trn per indiv
90955	Esrd srv 2-3 vsts p mo 2-11	G0109	Diab manage trn ind/group
90957	Esrd srv 4 vsts p mo 12-19	G0270	Mnt subs tx for change dx
90958	Esrd srv 2-3 vsts p mo 12-19	G0396	Alcohol/subs interv 15-30mn
90960	Esrd srv 4 visits p mo 20+	G0397	Alcohol/subs interv >30 min
90961	Esrd srv 2-3 vsts p mo 20+	G0406	Inpt/tele follow up 15
96116	Neurobehavioral status exam	G0407	Inpt/tele follow up 25
96150	Assess hlth/behave init	G0408	Inpt/tele follow up 35
96151	Assess hlth/behave subseq	G0420	Ed svc ckd ind per session
96152	Intervene hlth/behave indiv	G0421	Ed svc ckd grp per session
96153	Intervene hlth/behave group	G0425	Inpt/ed teleconsult30
96154	Interv hlth/behav fam w/pt	G0426	Inpt/ed teleconsult50
97802	Medical nutrition indiv in	G0427	Inpt/ed teleconsult70
97803	Med nutrition indiv subseq	G0436	Tobacco-use counsel 3-10 min
97804	Medical nutrition group	G0437	Tobacco-use counsel>10min
99201	Office/outpatient visit new	G0438	Ppps, initial visit
99202	Office/outpatient visit new	G0439	Ppps, subseq visit
99203	Office/outpatient visit new	G0442	Annual alcohol screen 15 min
99204	Office/outpatient visit new	G0443	Brief alcohol misuse counsel
99205	Office/outpatient visit new	G0444	Depression screen annual
99211	Office/outpatient visit est	G0445	High inten beh couns std 30m
99212	Office/outpatient visit est	G0446	Intens behave ther cardio dx
99213	Office/outpatient visit est	G0447	Behavior counsel obesity 15m
99214	Office/outpatient visit est	G0459	Telehealth inpt pharm mgmt
99215	Office/outpatient visit est		

Source: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html