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Updated May 11, 2017

Telehealth and Medicare

Introduction

Telehealth is a multidimensional set of health care services delivered via a range of telecommunications technologies, including the Internet, video, and telephone, according to the Medicare Payment Advisory Commission (MedPAC). Access to telehealth services involves a broad range of providers, services, settings, modalities, and patients. For example, telehealth providers include physicians, nurses, and psychotherapists who examine and prescribe treatment for patients who are located at home, at a health center, or other location that separates the provider and patient. Telehealth providers may consult with patients via synchronous communication, such as live videoconferencing, or asynchronous communication, such as store-and-forward technologies. "Store and forward" technologies feature a time delay between the capture and evaluation of patient data. Store-and-forward telehealth is used by some providers to assess radiologic images, photos, and videos that are shared among providers for consultative purposes, when a face-to-face visit is not required. For detailed information on telehealth and its applications, see CRS Report R44437, *Telehealth and Telemedicine: Description and Issues*. The rapidly evolving nature of digital medicine raises questions about newer technologies, such as mobile applications and wearable technology systems, which do not always fit with more traditional concepts of health care delivery (both in private and public health insurance systems, including Medicare). Although these and other telehealth modalities have the potential to increase health care access among certain patient populations, not all are paid for under programs such as Medicare. Medicare covers telehealth services to a limited extent.

The Centers for Medicaid and Medicare Services (CMS), within the Department of Health and Human Services (HHS), administers the Medicare program and makes decisions on telehealth coverage and reimbursement. The Medicare program was established in 1965 under Title XVIII of the Social Security Act (SSA, P.L. 74-271, as amended) to pay for benefits in the form of health insurance payments to providers who deliver services to beneficiaries. In 2017, Medicare expects to provide health insurance benefits to more than 58 million seniors and certain individuals with disabilities at an estimated annual cost of $705 million. The program organizes payments for health services mainly through the following parts: Part A (inpatient hospital services, skilled nursing facility services, and hospice care); Part B (physician and non-physician practitioner services, therapy services, preventive services, clinical laboratory and other diagnostic tests, Part B drugs and biologics, and other selected types of outpatient services); Part A and B (home health services and end-stage renal disease); Part C (managed care); and Part D (prescription drugs).

Telehealth Access

Under Medicare Part A, telehealth services may be utilized in the treatment of hospital inpatients, but there is no statutory authority for a separate payment under the hospital Inpatient Prospective Payment System (IPPS). Although no payment is involved, CMS guidance for Part A explicitly identifies "telehealth" as an alternative to face-to-face encounters when a physician writes an order for home health services.

Section 1834(m) of the SSA, which establishes telehealth requirements for Medicare Part B, has been an area of focus of recent telehealth-related legislative activities. Statutory requirements for Part B specify the conditions for payment for telehealth services. Location, provider, technology, and other parameters for telehealth service are defined. A *distant site* is the site where the physician or practitioner is located at the time the service is provided via a telecommunications system. An *originating site* is a site where the eligible telehealth patient is located when the service is furnished via a telecommunications system. The originating site must be located (1) in an area that is designated as a rural health professional shortage area (Section 332(a)(1)(A) of the Public Health Service Act); (2) in a county that is not included in a Metropolitan Statistical Area—or a rural county; or (3) from an entity that participates in a federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of HHS as of December 31, 2000. Distant telehealth providers are physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals and, under current regulation, they are the only providers who are eligible to receive payments as "distant site" providers (42 CFR 410.78(b)(2)).

Telehealth services for Medicare beneficiaries must be delivered via a "telecommunications system." The systems must have an interactive audio and video component that supports real-time (or synchronous) communication between the provider and patient. Asynchronous or "store and forward" technologies, where there is a time delay between the capture and evaluation of patient data, are paid for only by federal demonstration programs taking place in Alaska and Hawaii. Outside of demonstration projects, telehealth visits must take place at qualified facilities in rural locations. Note that location is a significant matter for health centers and rural health clinics because the law or regulations restrict telehealth payments to location.

Originating sites may include Federally Qualified Health Centers (FQHCs) and rural health clinics. FQHCs must serve a Medically Underserved Area (MUA) or Medically Underserved Population (MUP) as well as meet other statutory requirements for Medicare payment (in Section 1861(aa)(4) of the SSA). FQHCs are located in rural and urban locations. Rural health clinics, on the other hand, must be located in a non-urbanized area, and be designated as a Health Professional Shortage Area (HPSA), a MUA, or a governor-designated and Secretary-certified shortage area. Section 1834(m)(4)(F) requires the Secretary of HHS to provide by regulation a process for adding or deleting telehealth services (and payment codes) that are authorized for telehealth payment. As of November 2016, CMS published nearly 100 types of telehealth services that are covered under Medicare Part B. End-stage renal disease, smoking cessation, and advanced care planning are some examples of those services. Regulations further specify requirements for telehealth providers, services, facilities, and payments, but the requirements in both statute and regulation are restrictive in some instances, such as the location of the service or the type of technology that is covered. In 2014, the Medicare Part B telehealth program served approximately 68,000 beneficiaries (0.2% of all Part B Medicare beneficiaries). This calculation excludes telehealth payments made through the Center for Medicare and Medicaid Innovation (CMMI), such as Accountable Care Organizations (ACOs).

Regulations for Medicare Advantage (MA) require plans to cover telehealth services as part of their basic coverage, as well as any telehealth services covered under Part B. As an added option for enrollees, MA plans may offer telehealth technologies as part of a supplemental benefit. Requirements for the supplemental telehealth benefit are found in the Medicare Managed Care Manual. Telehealth technologies included in MA plans include remote patient monitoring, teleconferencing, and nursing hotlines. In 2014, up to 70% of 2,576 health plans (non-employer MA plans) offered enrollees one or more of the following telehealth technologies: 1,799 plans offered nursing hotlines, 200 plans offered remote patient monitoring, and 94 plans offered web- and/or phone-based technology.

Medicare Medication Therapy Management (MTM), authorized in Part D, allows participating pharmacists to use "telehealth technologies" (undefined in the law) to conduct an annual comprehensive medication review (CMR) in-person or via telehealth. Telephones or interactive video conferencing are among the telehealth options the MTM plans are offering to enrollees to complete the MTM annual assessment. CMS reports that in 2016, there were 623 Part D contracts: all programs offer CMRs via telephone consultations, and 36.1% of programs offered CMRs through telehealth technologies. Section 10328 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) amended Section 1860D–4(c)(2) of the SSA to strengthen requirements for the MTM program, and to add the telehealth option.

Established in the ACA, CMMI funds health care payment and service delivery models, some of which incorporate telehealth into their design, such as ACOs and Health Plan Innovation Initiative models. Following the ACA, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) repealed the Sustainable Growth Rate formula and replaced it with the Quality Payment Program (QPP), which rewards providers for delivering high-quality patient care through Alternative Payment Models and (APMs) and the Merit-based Incentive Payment System (MIPS). APMs such as ACOs may incorporate telehealth systems or modalities, as specified in MACRA (and in a November 2016 regulation). For information on QPP models and systems, see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10).* Between 2010 and 2016, CMS supported telehealth demonstrations that expand telehealth beyond current limits, and designed payment models that incorporate telehealth. For example in 2016, CMMI announced that telehealth benefits are expanded under the Next Generation ACO model. Those expansions permit beneficiaries associated with a participating doctor to receive telehealth from their homes regardless of geographic (rural or urban) location. A second model, the MA Value-Based Insurance Design (MA-VBID), which began in January 2017 and will run through 2022, authorizes CMS to makes payments to telehealth providers who use telehealth technologies to deliver health services (in the form of supplemental benefits) to specific beneficiaries who are diagnosed with specific clinical conditions (such as diabetes, chronic obstructive pulmonary disease, and heart failure).

In 2015, the Congressional Budget Office cited two issues that make it difficult to predict the impact on federal spending if coverage of telehealth services were changed under Medicare—one is the uncertainty over payment rates for those services and the second is whether such services would substitute for existing coverage or be in addition to existing coverage. In 2017, the Government Accountability Office investigated remote monitoring under Medicare and found that providers and patients stated that the potential that telehealth and remote patient monitoring have to improve or maintain quality of care is a "significant factor" that encourages utilization. According to a 2016 MedPAC report, different payment models (e.g., managed care/bundled payments versus fee-for-service) impact who bears responsibility for the cost of services such as telehealth (one model may absorb the costs, another may amount to additional spending for the program).

Legislation in the 115th Congress

Among proposals that have been introduced thus far in the 115th Congress, some seek to ease or remove restrictions on telehealth utilization under Medicare. For example, some proposals would amend the SSA to authorize CMS and/or CMMI to explore the use of telehealth modalities through demonstration programs or models under Medicare. Other proposals would expand the list of diseases or conditions covered under Medicare Part B and evaluate the overall impact of such coverage on the program.

Victoria L. Elliott, Analyst in Health Policy

IF10649

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