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What Does the Cures Act Mean for Medicare Telehealth Coverage?

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The 21st Century Cures Act (Cures Act or Act), passed with broad bipartisan support and signed into law on December 13, 2016, contains several telehealth provisions that may signal a new willingness by Congress to expand Medicare's telehealth benefit.[1] Currently, Medicare lags behind commercial payers in coverage of telehealth services largely due to statutory restrictions and the Centers for Medicare and Medicaid Services (CMS) historically cautious and incremental approach to approving new telehealth services. In contrast, commercial payers and even Medicaid have been quicker to embrace telehealth and have been the primary drivers of the rapidly increasing use of telehealth services in the United States.

Medicare coverage of telehealth is limited to patients seen at certain clinical facilities, so-called "originating sites," located in health professional shortage areas (HPSAs) or outside of Metropolitan Statistical Areas (MSAs).[2] Originating sites do not include the patient's home, and telehealth services are primarily limited to professional consultations, psychiatry services, and certain end-stage renal disease (ESRD) services. Medicare coverage does not include remote patient monitoring either in the home or other care settings.[3] Although the statute allows the Department of Health and Human Services (HHS) Secretary to expand coverage to other services, CMS has been very cautious in adopting new telehealth codes.[4]

Section 4012 of the Cures Act makes no change to current Medicare coverage of telehealth. Instead, it requires the Medicare Payment Advisory Commission (MedPAC) and CMS to study the issue and submit information to the congressional committees of jurisdiction. CMS must identify and report, within one year of enactment, on those populations of Medicare beneficiaries whose care may be most improved through telehealth expansion, including dual-eligibles and those with chronic conditions. It must also report on telehealth activities taking place in the Center for Medicare and Medicaid Innovation (CMMI) and those funded through Section 1115A of the Social Security Act.

The Act charges MedPAC with recommending ways in which those telehealth services covered by private payers could be included in the Medicare fee-for-service program. Finally, to the extent there was still doubt as to its intent, the Act includes the following "Sense of Congress" language:

> It is the sense of Congress that –
>
> > 1) eligible originating sites should be expanded beyond those originating sites [described in 42 U.S.C. 1395m(m)]; and
> >
> > 2) any expansion of telehealth services under the Medicare program . . . should –
> >
> > > A) recognize that telemedicine is the delivery of safe, effective, quality health care services, by a health care provider, using technology as the mode of care delivery;

> B) meet or exceed the conditions of coverage and payment with respect to the Medicare program if the service was furnished in person, including standards of care . . . [5]

Despite this seemingly positive language, opinions differ as to whether the Cures Act holds a real promise for expanding Medicare coverage of telehealth services. At least some telehealth advocates view the Act's request for further studies as simply paying lip service to the issue with no real commitment to meaningful expansion anytime soon.[6] They doubt whether there is a congressional appetite for real change. Significantly, Congress did not specify whether expansion of originating sites includes both geographic expansion (e.g., elimination of the rural limitation) and expansion of the types of sites that qualify as originating sites (e.g., the patient's home) or is intended to be interpreted more narrowly. It is certainly plausible that that this provision is simply to buy time while services provided under Medicare Part B transition away from fee-for-service to other payment models thereby allowing increased use of telehealth without putting Medicare dollars at risk.

On the other hand, a bipartisan proposal released last fall by the Senate Finance Committee includes a number of specific steps to expand Medicare coverage of telehealth services including waiver of originating site and geographic limitations for Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program, monthly assessment visits for dialysis patients, and remote stroke diagnosis.[7] The proposal would also ease Medicare Advantage (MA) rules for including telehealth services in benefit packages.

The recently passed Expanding Capacity for Health Outcomes (ECHO) Act[8] is another indicator of Congress' broad support for telehealth, especially when it does not require new spending. The ECHO Act's quick passage at the end of 2016, driven in large part by the opioid epidemic, requires HHS to study and report on telehealth long-distance care models that allow for collaboration among health professionals.

Perhaps the major obstacle to more rapid expansion of Medicare telehealth coverage has been the lack of data available to the Congressional Budget Office (CBO) to project how expanding coverage would affect program costs.[9] However, the Cures Act report due from CMS on CMMI and other innovative Medicare and Medicaid uses of telehealth may help close the information gap. There are several CMMI payment models that permit, if not require, expanded use of telehealth. Both the Comprehensive Care for Joint Replacement and Next Generation ACO programs waive Medicare's rural restriction and also allow patients to receive telehealth services in their homes. The Bundled Payment for Care Initiative (BPCI) waives the rural restriction although it does not allow coverage in the patient's home. CMS just issued final rules for three new episode payment models (EPMs) for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment that also waive statutory limitations on telehealth benefits.[10] The agency stated that the waiver is "essential to maximize the opportunity to improve the quality of care and efficiency . . ."[11] The government has also made Health Care Innovation Awards (HCIA) to a number of providers who are incorporating use of telehealth beyond what Medicare would normally cover.[12]

The experience of private payers will also be instructive as Congress considers expansion of telehealth coverage under Medicare. The Cures Act specifically asks MedPAC for recommendations as to how telehealth services covered by commercial payers could be incorporated into the Medicare fee-for-service program.[13] MedPAC in its June 2016 Report to Congress found that most commercial plan use of telehealth is for basic medical care, especially primary care and psychiatric care. It concluded that the research is mixed on whether telehealth services reduce costs of care, although MedPAC found positive evidence in the areas of telestroke and store-and-forward teleretinal scanning. For other services, MedPAC cautioned that expanding coverage may result in new utilization thus driving up costs. Given the lack of evidence MedPAC found of the efficacy for

telehealth services both in terms of quality and cost savings, it suggested that an expansion should be through partial capitation payment models.

In fact, partial capitation, other CMMI initiatives, and alternative payment models (APMs) developed under the Medicare Access and CHIP Reauthorization Act (MACRA) can serve as incubators for development of new and cost effective uses of telehealth services while holding Medicare harmless for increased costs. MACRA, which took effect January 1, 2017, incentivizes physicians to participate in APMs that could allow for expanded use of telehealth services. MACRA establishes a process for physicians to develop new physician-focused payment models (PFPMs), which can be submitted for review to the Physician-focused Technical Advisory Committee (PTAC). These models are free to incorporate use of telehealth services without the restrictions that apply to Medicare fee-for-service but require the provider to bear risk if costs exceed certain thresholds or target amounts.[14] MACRA's Merit-based Incentive Payment System (MIPS) also gives points to clinicians that make use of telemedicine in clinical improvement activities.

Although MedPAC and CBO both take a cautious approach to telehealth expansion, many commercial payers that offer MA plans are eager to see Congress break down the barriers to telehealth access. Currently, MA plans can only offer telehealth services as a supplemental benefit that cannot be included in the plan's bid. In a recent letter to CBO, 11 private payers urged CBO to consider non-Medicare sources of data in scoring congressional proposals for expanding Medicare coverage of telehealth.[15] They claim that data supports the value proposition of telehealth visits, which reduce the need for urgent care and emergency department services. How well this data will support expansion of telehealth in the Medicare fee-for-service system is unclear. Private payers have more flexibility than Medicare when it comes to provider networks, fee schedules, and enrollee cost-sharing, all of which can be used to control utilization.

To the extent that Medicare fee-for-service telehealth benefits will be expanded in the future, indicators suggest Congress will take an incremental approach allowing for expansion for those telehealth services that have proven to enhance quality and reduce costs in specific population groups. Prime targets would seem to be telestroke, dialysis visits, and lifting the barrier on the patient's home as an originating site for patients with certain chronic conditions along with removing obstacles for use by MA plans and ACOs. At the same time, Congress may opt to wait and see what can be learned from the CMMI and other alternative payment models currently underway.

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[1] 21st Century Cures Act, Pub. L. No. 114-255.
[2] 42 U.S.C. § 1395(m)m.
[3] Medicare does cover certain diagnostic tests performed remotely including certain cardiac tests and sleep testing.
[4] For example, for 2017, CMS approved three new telehealth services but turned down requests for several others. (Medicare 2017 physician fee schedule rule, 81 Fed. Reg. 80199 (Nov.15, 2016)).
[5] 21st Century Cures Act, § 4102,
[6] *See, e.g.,* statement of American Telemedicine Association CEO, *available at* https://www.globalmed.com/telehealthanswers/21st-century-cures-only-touches-on-telehealth
[7] CONNECT for Health Act (S.2484/H.R. 4442), http://www.finance.senate.gov/download/chronic-care-section-by-section.
[8] Pub. L. No. 114-270.
[9] *See* Answers to Questions for the Record Following a Hearing by the House Committee on the

Budget on the Work of the Congressional Budget Office, June 2, 2015, *available at* https://www.cbo.gov/publication/50416
[10] Advancing Care through Episode Payment Models (EPMs), Cardiac Rehabilitation Incentive Payment Model and Changes to the Comprehensive Care for Joint Replacement Model, 82 Fed. Reg. 180 (Jan. 3, 2017).
[11] *Id*. at 492.
[12] There are at least eight awards incorporating telepharmacy, ICU telemonitoring, nutrition counseling, ESRD services and others, *see* https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/
[13] Although the provision makes no mention of expansion of telehealth in the Medicare Advantage (MA) program, any expansion of telehealth in Medicare FFS would automatically apply to MA plans.
[14] One of the two APMs currently under review by PTAC is for use of telehealth and telemonitoring of patients with COPD and asthma, *see* https://aspe.hhs.gov/sites/default/files/pdf/253406/TheCOPDandAsthmaMonitoringProject-PMA.pdf.
[15] *See* Insurers October 18, 2016 letter to Keith Hall, Director, CBO, *available at* http://assets.fiercemarkets.net/public/004-Healthcare/internal/insurerletterontelemedicine.pdf.