

Department of Legislative Services
Maryland General Assembly
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FISCAL AND POLICY NOTE
Revised

Senate Bill 496

(Senator Pugh, *et al.*)

Finance

Health and Government Operations

Maryland Medical Assistance Program - Telemedicine

This bill requires the Medicaid program, unless otherwise specifically prohibited or limited by federal or State law, to reimburse a health care provider for a health care service delivered by telemedicine in the same manner as the same health care service is reimbursed when delivered in person. Reimbursement is required only for a health care service that is medically necessary and is provided (1) for the treatment of cardiovascular disease or stroke; (2) in an emergency department setting; and (3) when an appropriate specialist is not available. The Department of Health and Mental Hygiene (DHMH) must adopt regulations to carry out the requirements of the bill.

Fiscal Summary

State Effect: Medicaid expenditures (50% general funds, 50% federal funds) increase beginning in FY 2014 as discussed below to provide reimbursement for specified services delivered by telemedicine. Federal matching funds increase correspondingly. Regulations can be promulgated using existing resources.

Local Effect: None.

Small Business Effect: Potential meaningful. Specialist physicians that deliver services for the treatment of cardiovascular disease and stroke by telemedicine may receive reimbursement for services provided to Medicaid enrollees.

Analysis

Current Law: “Telemedicine” is the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver

a health care service within the scope of practice of the provider at a site other than the site at which the patient is located. “Telemedicine” does not include audio-only telephone calls, email messages, or communications via fax.

Chapters 579 and 580 of 2012 (SB 781/HB 1149) require insurers, nonprofit health service plans, and health maintenance organizations (HMOs) to cover and reimburse for health care services appropriately delivered through “telemedicine.” Carriers may impose cost-sharing requirements for services delivered through telemedicine. Carriers may also undertake utilization review, including preauthorization, to determine the appropriateness of a health care service – whether delivered in person or through telemedicine – if the appropriateness of the service is determined in the same manner.

Chapters 579 and 580 also required DHMH to conduct a review of, among other things, literature and evidence regarding telemedicine, other payors’ and other state Medicaid agencies’ telemedicine policies and procedures, and the potential fiscal effect of Medicaid coverage of telemedicine. DHMH was required to submit a report on its findings and recommendations to specified committees of the General Assembly by December 1, 2012.

Background:

Federal Guidelines: According to the federal Centers for Medicare and Medicaid Services (CMS), for purposes of Medicaid, telemedicine seeks to improve a patient’s health by permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the distant site. Telemedicine is viewed as a cost-effective alternative to more traditional face-to-face consultations or examinations. Telemonitoring, which includes such technologies as remote patient monitoring, does not meet the Medicaid definition of telemedicine; however, such services may be covered and reimbursed as part of a Medicaid coverable service.

States have the option to determine whether to cover telemedicine, what types of telemedicine to cover, where in the state telemedicine will be covered, how it will be provided and covered, what types of telemedicine practitioners may be covered, and how much to reimburse for telemedicine services. If a state covers telemedicine but does not cover certain practitioners or providers, the state is responsible for assuring access and covering face-to-face visits and/or examinations by those practitioners or providers. Furthermore, if a state covers telemedicine but limits coverage to certain parts of the state, the state must ensure access and cover face-to-face visits and/or examinations in those parts of the state where telemedicine is not available.

Medicaid Coverage of Telemedicine in Other States: According to the National Conference of State Legislatures, 42 state Medicaid programs now provide some

coverage of telemedicine or telehealth services. State reimbursement varies widely among states: at least 14 states cover all or nearly all medically necessary Medicaid services that can feasibly be provided via telemedicine, 35 cover physician consultations, 26 cover at least some mental health services (including Maryland's telemental health pilot program), 16 cover some store-and-forward technology, and 15 cover remote patient monitoring. Medicaid programs in Delaware, Pennsylvania, Virginia, and West Virginia all provide coverage of telemedicine. Delaware and Pennsylvania adopted such coverage in fiscal 2013. West Virginia reimbursement is limited to services provided outside of metropolitan statistical areas (MSAs).

Medicaid Telemedicine Spending in Other States: Medicaid programs cannot be easily compared among states due to differences in the populations covered, services provided, and geographic considerations. *For illustrative purposes only*, according to the Virginia Department of Medical Assistance Services, which has covered telemedicine statewide since 2003, telemedicine billing in Virginia has been low (in fiscal 2012, 5,854 claims and a total of \$258,000 in payments). The department reports this has also been the experience of other states that provide Medicaid coverage of telemedicine services. In Texas, utilization of Medicaid telemedicine services has steadily increased since coverage began in 1998; however, total expenditures in 2011 were only \$1.2 million for services provided to 9,748 patients.

Potential Cost Savings from Telemedicine: Research on the long-term fiscal impact of telemedicine is lacking, and there is no consensus among researchers with respect to the cost-effectiveness of telemedicine or telehealth overall. However, some initial studies indicate that telemedicine has *the potential* to reduce overall costs to health and related systems due to better management of chronic diseases, reduced inpatient hospitalization, and lower transportation costs, particularly through management of chronic diseases. For example:

- A 2006 study on the impact of telehealth on health care utilization by congestive heart failure (CHF) patients enrolled in Medicare found that patients managing their CHF via telehealth technology decreased utilization of physician office visits by 42%, emergency room department visits by 33%, and inpatient admissions by 29%.
- In 2008, the Veterans Health Administration implemented a national home telehealth program to support veterans with chronic conditions such as diabetes, hypertension, and CHF. Serving 17,025 patients, the program identified a 25% reduction in the number of bed days of care and a 19% reduction in inpatient admissions. The program cost \$1,600 per patient annually compared with \$13,121 per year for home-based primary care services.

- A 2010 Massachusetts study of the use of telemedicine in the intensive care unit (ICU) setting noted that patient ICU stays and transfers from community hospitals were reduced, thereby saving health insurers an estimated \$2,600 to \$10,000 per patient.
- A 2011 analysis of legislation proposed in California (AB 415) to expand coverage of telehealth to include remote patient monitoring *projected* that potential savings for California’s Medi-Cal program could be as much as \$929 million per year (in total funds) from heart failure monitoring and \$417 million per year (in total funds) from diabetes monitoring.

Maryland Medicaid Report on Telemedicine: In response to Chapters 579 and 580, DHMH submitted its *Report on Telemedicine Policies and Fiscal Impact of Maryland Medical Assistance Coverage of Telemedicine* in December 2012. The report notes that the most commonly used modality through which telemedicine services are provided is “hub-and-spoke” video conferencing, in which a patient in a remote location (spoke) interacts with a physician at a larger health facility (hub). Based on a literature review, DHMH found that several studies indicate that “hub-and-spoke” telemedicine is less costly than regular health care delivery. While utilization may increase among patients with poor access to care, there are cost savings from more timely access to care and a reduction in utilization of emergency department visits, transportation, and services from other high-cost providers.

The report recommends that Medicaid cover medically necessary services that can reasonably be provided via “hub-and-spoke” telemedicine. However, such coverage should be limited to rural geographic areas and conform to the restrictions developed for Medicaid coverage of telemental health services. More specifically, the originating (“spoke”) provider must be located in one of the following counties: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Garrett, Kent, Queen Anne’s, St. Mary’s, Somerset, Talbot, Washington, Wicomico, or Worcester, while the “hub” provider can be located anywhere in the State. DHMH notes that this limitation should help ensure that telemedicine is being used to address access-to-care issues stemming from specialists being located a long distance from patients and not as a replacement for in-person care.

To provide a fiscal estimate of the cost of this level of coverage, DHMH contracted with the Hilltop Institute. The increase in Medicaid expenditures was predicted to be between \$500,000 and \$700,000 (50% federal funds, 50% general funds) for all specialties. This estimate did not reflect any potential cost savings from reductions in emergency department visits, transportation services, or decreased utilization due to improved health status over the long term.

State Fiscal Effect: Medicaid expenditures (50% general funds, 50% federal funds) increase beginning in fiscal 2014 to provide reimbursement for medically necessary health services delivered to Medicaid enrollees via telemedicine (1) for the treatment of cardiovascular disease and stroke; (2) in an emergency department setting; and (3) when an appropriate specialist is not available. The exact amount of such expenditures cannot be reliably estimated at this time but is not anticipated to be significant.

DHMH advises that, in calendar 2011, Medicaid enrollees had a total of 11,179 cardiovascular disease or stroke-related emergency department visits. Assuming a similar level of visits in future years, if *all* such visits use telemedicine for evaluation of the patient using the Medicare rate of \$142.50 (G0426 – telehealth consultation, emergency department of initial inpatient, typically 50 minutes communicating with the patient via telehealth), Medicaid costs would increase by as much as \$1,194,756 (50% federal funds, 50% general funds) in fiscal 2014, which reflects the bill’s October 1, 2013 effective date. However, because only a percentage of these visits would actually use telemedicine, *actual expenditures would be lower* (and potentially significantly lower) depending on utilization. For example, if 50% of such visits use telemedicine, the impact on the general fund would be \$298,689, while if 10% of visits use telemedicine, the impact on the general fund would be \$59,738.

Furthermore, to the extent that the use of telemedicine results in earlier diagnosis and treatment of cardiovascular disease and stroke and improves patient outcomes, Medicaid may experience a reduction in expenditures for such patients for nursing home and personal care services. Any such impact cannot be reliably estimated; however, *for illustrative purposes only*, the current daily nursing home rate for a Medicaid enrollee is \$201.42. This daily rate is greater than the likely charge for a telemedicine consultation.

Additional Comments: CareFirst BlueCross BlueShield initiated a reimbursement policy for telemedicine visits across medical disciplines effective July 15, 2011. Initial telemedicine visits for new patients are limited to consultations. Subsequent telemedicine visits may be for other types of services. Documentation in the medical record must support the services rendered. Deductibles, copayments, and coinsurance apply to telemedicine services just as they do for face-to-face diagnoses, consultations, and treatment services.

Additional Information

Prior Introductions: None.

Cross File: HB 931 (Delegate Lee, *et al.*) - Health and Government Operations.

Information Source(s): American Telemedicine Association, Center for Connected Health Policy, Centers for Medicare and Medicaid Services, The Children's Partnership, National Conference of State Legislatures, Texas Health and Human Services Commission, Virginia Department of Medical Assistance Services, Department of Health and Mental Hygiene, University of Maryland Medical System, Department of Legislative Services

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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510