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FISCAL AND POLICY NOTE
Revised

Senate Bill 198

(Senator Pugh, *et al.*)

Finance

Health and Government Operations

Maryland Medical Assistance Program - Telemedicine

This bill specifies that, to the extent authorized by federal law, coverage of and reimbursement for health care services delivered through telemedicine must apply to Medicaid and managed care organizations in the same manner they apply to health insurance carriers. Subject to the limitations of the State budget and to the extent authorized by federal law, the Department of Health and Mental Hygiene (DHMH) may authorize coverage of a reimbursement for health care services that are delivered through store and forward technology or remote patient monitoring. DHMH may specify by regulation the types of health care providers eligible to receive reimbursement for health care services provided to Medicaid recipients.

Fiscal Summary

State Effect: Medicaid expenditures increase beginning in FY 2015 to expand reimbursement for services delivered by telemedicine. According to DHMH, Medicaid expenditures could increase by between \$525,000 and \$750,000 in FY 2015 (50% general funds, 50% federal funds) and \$700,000 and \$1.0 million (50% general funds, 50% federal funds) annually in future years. Federal matching funds increase correspondingly.

Local Effect: None.

Small Business Effect: Meaningful. Health care providers that deliver services by telemedicine will receive reimbursement for services provided to Medicaid enrollees.

Analysis

Bill Summary: “Health care provider” means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program. “Telemedicine” means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology (1) by a health care provider to deliver a health care service that is within the scope of practice of the health care provider at a site other than the site at which the patient is located and (2) that enables the patient to see and interact with the health care provider at the time the service is provided to the patient. “Telemedicine” does not include an audio-only telephone conversation, electronic mail message, or facsimile transmission between a health care provider and a patient.

Chapter 280 of 2013 requires the Medicaid program to reimburse for telemedicine 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.

Through regulations effective September 30, 2013 (Code of Maryland Regulations 10.09.49.01 *et seq.*), Medicaid established two telemedicine pilot programs – the Cardiovascular Disease and Stroke Telemedicine Program (to implement Chapter 280) and the Rural Access Telemedicine Program. The programs are intended to improve (1) access to outpatient specialty care; (2) patient compliance with treatment plans, health outcomes through timely disease detection, and treatment options; and (3) capacity and choice for outpatient ongoing treatment in underserved areas of the State.

Chapters 579 and 580 of 2012 require insurers, nonprofit health service plans, and health maintenance organizations 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.

Background:

Federal Guidelines: According to the federal Centers for Medicare and Medicaid Services, 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, 43 states (including Maryland) and the District of Columbia provide at least some Medicaid coverage for telemedicine or telehealth. 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 *under certain circumstances*, 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.

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, 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.

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 recommended 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. DHMH noted that this limitation should help ensure that telemedicine is being used to address access-to-care issues 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 in those limited rural jurisdictions only. 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: According to DHMH, Medicaid expenditures could increase by between \$525,000 and \$750,000 (50% general funds, 50% federal funds) in fiscal 2015, which accounts for the bill’s October 1, 2014 effective date, to provide reimbursement for all telemedicine-delivered services offered for Medicaid enrollees statewide. This estimate:

- reflects only the cost of the originating site facility fee (Q3014 CPT code);
- reflects only licensed physicians and does not include other licensed providers;
- does not include reimbursement for provider-to-provider consultations;
- does not assume any increase in utilization of services;
- does not reflect any potential savings from averted transportation costs or hospital emergency room visits; and
- assumes Medicaid conducts prior authorization of telemedicine services, as is currently done by commercial insurers.

The estimate is based in part on actual costs currently incurred by the telemental health pilot program (approximately \$360,493 annually) extrapolated on a statewide basis, and it reflects the fact that Medicaid spending on telemedicine has, to date, been low in other states and among commercial insurers in Maryland. The telemental health program is limited to licensed physicians and does not provide reimbursement for other licensed providers. Full-year costs, beginning in fiscal 2016, are estimated at between \$700,000 and \$1.0 million annually.

A more precise figure cannot be reliably estimated at this time and depends on the number of providers who offer telemedicine services, the amount of patients that utilize such services, and the potential savings in averted costs.

Additional Comments: CareFirst BlueCross BlueShield initiated a reimbursement policy for telemedicine visits across medical disciplines in July 2011. Initial telemedicine visits for new patients are limited to consultations. Subsequent telemedicine visits may be for other types of services. Telemedicine services must meet all the requirements of a face-to-face consultation or contact between a health care provider and a patient for services. Deductibles, copayments, or coinsurance apply to telemedicine services just as they do for face-to-face diagnoses, consultations, or treatment services. According to CareFirst, the company processed 211 claims for telemedicine services in calendar 2013 for 2.1 million members.

Additional Information

Prior Introductions: None.

Cross File: HB 802 (Delegate Lee, *et al.*) – Finance.

Information Source(s): CareFirst BlueCross BlueShield, National Conference of State Legislatures, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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