Geographic Restrictions for Medicare Telehealth Reimbursement

Issue:

The Medicare requirement mandating that telehealth services be provided outside of a Metropolitan Statistical Area (MSA) in order for health care services to be reimbursed by Centers for Medicare & Medicaid (CMS) should be removed. Additionally, the requirement that patients must live in or receive health care services in a federally designated geographic Health Professional Shortage Area (HPSA) in order for Medicare to reimburse services should be removed. These requirements currently have negative impacts on the access rural residents have to specialized medical services.

Recommendations:

● Expand geographical eligibility to those patients living in or receiving care in -a Metropolitan Statistical Area (MSA) county with less than 30,000 residents.
● Remove the geographical patient requirement of living in or receiving care in a geographic Health Professional Shortage Area (HPSA).

Background:

Telehealth provides rural patients access to primary and specialty care and is considered to be a cost-effective alternative to the more traditional face-to-face model of providing health care. It lowers the cost of care by providing early and timely diagnosis, improving triage, reducing unnecessary transfers and improving management of chronic diseases. The Center for Information Technology Leadership has estimated that telehealth could result in $4.28 billion in annual savings to the US health care system if widely adopted.

Telehealth is needed because of its ability to provide patients with access to the care they need, regardless of the patient or provider geographic location. Telehealth fills an important gap in providing underserved and rural patients with access to many types of specialty care. It can be affordably leveraged to assist underserved patients throughout the United States, regardless of their physical location.

Issue:

Telehealth was originally identified as a solution exclusively for rural patients, and reimbursement has been limited to patients in geographic areas that are federally designated as both rural and as Health Professional Shortage Areas (HPSAs). However, barriers to health care exist independently and regardless of geographical criteria.

The current reimbursement policy outlined by the Centers for Medicare & Medicaid Services requires the telehealth encounter meet the following criteria: the Medicare beneficiary resides in, or utilizes the telehealth system 1) in a county that is not included in an MSA and 2) in a federally designated geographic HPSA.

These limitations were included in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to reduce the cost of telehealth to Medicare. When the bill was passed in 2000, the Congressional Budget Office estimated the telemedicine cost to Medicare to be $150 million over five years. After six years, the true cost has been just 2.6% of what was budgeted, leveling off at approximately $2 million per year. This $2 million, includes both 1) the cost of the professional fees, which are equal to an in person visit and 2) the originating site fee which is currently reimbursed at a rate of $24.10 per visit to the facility in which the patient is located. CMS has worked within its regulatory authority to expand telehealth reimbursement to additional services, which includes adding eligible codes, but not expanding geographic eligibility. Even with the expansion of eligible telehealth codes, CMS does "not anticipate that these proposed [expansions] will have a significant budgetary impact on the Medicare program."

In part, these costs have not been realized because of the limited provider capacity in the United States. Providers in the US already face overburdened schedules and patients face long wait times to see specialists. This limited physician capacity provides a cap on utilization; telehealth does not create provider capacity to care for additional patients, but rather changes the mode of care delivery to reach underserved patients. Even with unrestricted reimbursement, telehealth's cost to Medicare is limited, but its benefits to patients are not.

In short, instead of limiting cost to Medicare, these geographic barriers affectively limit access to care. Both the requirement of occurring outside an MSA and inside a HPSA neglect the realities of access barriers for beneficiaries.

For example, an MSA contains a core urban area of 50,000 people or more and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration. There are two key problems with limiting eligibility to MSAs. The first is that the definition of MSA by county line may result in rural communities more than an hour outside of the city limits being defined as metropolitan. Additionally, there may be many instances where patients living within an MSA lack access to specialists because their sub-specialty is not available locally or the local specialist does not have capacity to take new patients. In many areas of the country there are not enough health care professionals to provide timely access to certain types of specialty care. Telehealth allows patients in need of services to reach providers with capacity and should not be restricted based on rurality.

HPSAs are designated by the Health Resources and Services Administration as having shortages of primary medical care providers in a specific geographic region. HPSAs serve an important role in identifying communities and populations that are underserved by primary care, dental care, and mental health care. However, the HPSA designation is not an appropriate requirement for telehealth reimbursement because access to specialty physicians is not included in the formula. Because of the HPSA eligibility requirement, residents who have access to primary

care, but not needed specialty care, are penalized. Telehealth allows patients in need of specialty services to reach providers with capacity and should not be restricted based on access to primary care. Beneficiaries often require access to many types of specialties, and should not be penalized for having access only to primary care.

Financial Impact of Policy Recommendations:
The proposed policy changes do not negatively impact current levels of anticipated reimbursement for services. As previously noted, due to access barriers related to the current reimbursement policy of linking telemedicine reimbursement eligibility to areas outside of MSAs, and within geographic HPSAs, current reimbursement for services lags at 2.6% of original cost estimates.

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References:

The Center for Information Technology Leadership. "The Value of Provider-to-Provider Telehealth Technologies. 2007. Pg 3. Available online at: http://www.citl.org/*pdf/CITL_Telehealth*Report.pdf. Federal Register. November 25, 2009. Department of Health and Human Services Book 2 of 2 Part II. Centers for Medicare & Medicaid Services, 42 CFR Parts 410, 411, 414, et al. "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Proposed Rule." Federal Register / Vol. 74, No. 132 / Monday, July 13, 2009 / Proposed Rules. Page 33663. Ibid. Ibid. 2009 Survey of Physician Appointment Wait Times, 2009 Merritt Hawkins & Associates.

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