CONFIDENTIAL

LEGISLATIVE BILL REVIEW FORM: 2014

Bill Number: S. 234
Name of Bill: MEDICAID COVERAGE FOR HOME TELEMONITORING SERVICES
http://www.leg.state.vt.us/docs/2014/bills/Intro/S-234.pdf

Agency/ Dept:__DVHA_____ **Author of Bill Review:**_Selina Hickman_____

Date of Bill Review:_2/12/14_____ **Status of Bill: (check one):**

__X___Upon Introduction **_____ As passed by 1st body** **_____As passed by both bodies**

Recommended Position:

_____Support **_____Oppose** **_____Remain Neutral** **__X___Support with modifications identified in #8 below**

Analysis of Bill

1. Summary of bill and issue it addresses.

This bill proposes to amend Medicaid coverage criteria to provide reimbursement for Home Health Agencies to provide home telemonitoring services under certain conditions:

i. After-care following surgery
ii. For certain dx specific chronic conditions
iii. When certain risk factors are present

The bill additionally requires that the home health agency share any clinical information gathered with the patient's treating health care professionals.

Issues addressed are:

- Increased capacity of Home health agencies
- Increased patient access to needed monitoring services
- Potential for decreased ED and ER utilization

2. Is there a need for this bill?

Currently, Medicaid does not have a budget for home telemonitoring services or authority from CMS to reimburse for home telemonitoring services. Legislative action is required to appropriate funding for this new service. DVHA may seek approval from CMS to offer telemonitoring services without legislation.

3. What are likely to be the fiscal and programmatic implications of this bill for this Department?

Fiscal Impact:
Research conducted in coordination with the Vermont Association of Home Health Agencies (VAHHA) estimates the fiscal impact of this bill to be at $315,000 based on a $350 PMPM and utilization of 75 individuals annually.

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DVHA worked with VAHHA to look at current utilization and practices among Medicare patients. They provided our reimbursement unit with costs for staffing and equipment. Reimbursement also looked at current rates under BCBS prior to coming up with their estimates. We extrapolated those costs to the Medicaid-only population and made a bump up in the # of potential eligibles based on an expectation of expanded access to monitoring services. We settled on a PMPM of $350 and 75 people per year, but considered a broader range of potential utilization based on some of the questions below about how to define service eligibility.

This table shows the full potential range of utilization and federal/state share breakout:

# of Beneficiaries		**Low**	**Middle**	**High**
		50	75	100
PMPM Rate 1	$350	$210,000	$315,000	$420,000
	Fed*	$118,524	$177,786	$237,048
	State*	$91,476	$137,214	$182,952

*Assumed FMAP: Fed 0.5644 and State 0.4356

Potential for Cost savings:
A literature review of the potential for cost savings reveals that most published studies are small, some are contradictory, and there is still a need for large, well-controlled trials. However, the preponderance of evidence supports that cost savings may be realized on hospitalizations. In short, while individuals receiving telemonitoring may still be hospitalized as frequently as other home health patients, they will likely be admitted sooner and in better condition than their counterparts without telemonitoring, thereby resulting in reduced length of stay.

Data provided by VAHHA show general hospitalization rates as low as 7 or 8% for patients with Medicare. We are currently running a query of Medicaid patients receiving home health to determine current hospitalization rates so that they can be compared to the VAHHA data for potential savings. An initial look at the data, which still needs to be validated, shows that the rate of re-hospitalization for Medicaid patients within 30 days of receiving home health services is quite high, running at about 45% for ER visits and 50% for inpatient admissions.

Programmatic implications:
- Telemonitoring best practices are still evolving and criteria described in the bill may not coincide with what is feasible or appropriate for this service.
    - Dx- not all diagnoses listed may require or benefit from telemonitoring depending on severity of the disease.
    - Risk factors- not all risk factors listed are easy to ascertain in a systematic way, nor are they related to medical necessity (i.e. living alone and limited or absent informal supports). It would be difficult to monitor appropriate authorization of telemonitoring benefits based on these criteria.
- The fiscal impact estimate assumes federal financial participation. We will need CMS approval of a State Plan amendment in order to receive FMAP.
- Implementation considerations: need to further define the service* in relation to:
    - Medical necessity- severity of disease and risk factors,
    - How/if telemonitoring would be balanced by conventional visits
    - How/if beneficiary would be evaluated for the ability to use technology.

  Note*. The expenditure table shows a range of potential utilization due to the above TBD service criteria. If the bill were to be passed under the amended language, DVHA will be able to appropriately complete the benefit design within the fiscal parameters noted ($350 PMPM, 75 beneficiaries).
- Build in ability for program to appropriately monitor new services- could mean additional FTE.

4. **What might be the fiscal and programmatic implications of this bill for other departments in state government, and what is likely to be their perspective on it?**
   No impact expected.

5. **What might be the fiscal and programmatic implications of this bill for others, and what is likely to be their perspective on it?** (f*or example, public, municipalities, organizations, business, regulated entities, etc)*
   Concept is overall favorable.

6. **Other Stakeholders:**

   6.1 Who else is likely to support the proposal and why?
   VAHHA- expands scope of services and provider capacity to service additional patients.

   6.2 Who else is likely to oppose the proposal and why?
   None known at this time.

7. **Rationale for recommendation:** *Justify recommendation stated above.*
   - DVHA is supportive of more efficient and effective service delivery. Telemonitoring has high potential to fit in that category. This bill has the additional recommendation of being supported by the provider group that would be asked to provide the new service.
   - DVHA's primary concern is regarding the as yet to be determined elements of an effective delivery model for this new service.

8. **Specific modifications that would be needed to recommend support of this bill***:*
   Amend bill language to remove coverage criteria and allow this to be determined by the Agency of Human Services according to evidence based best practices.
   See attached for a track changes version of the bill. See below for resultant bill language:

Sec. 1. MEDICAID COVERAGE FOR HOME TELEMONITORING SERVICES

(a) The Agency of Human Services shall provide Medicaid coverage for services performed by home health agencies using home telemonitoring for Medicaid beneficiaries who have serious or chronic medical conditions that can result in frequent or recurrent hospitalizations and emergency room admissions. Evidence based best practices will be used to determine the conditions or risk factors that shall be covered.

(b) The Home Health Agency shall ensure that clinical information gathered by a home health agency while providing home telemonitoring services is shared with the patient's treating health care professionals and may impose other reasonable requirements on the use of home telemonitoring services.

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(c) As used in this section:

(1) "Home health agency" means an entity that has received a certificate of need from the State to provide home health services and is certified to provide services pursuant to 42 U.S.C. § 1395x(o).

(2) "Home telemonitoring service" means a health service that requires scheduled remote monitoring of data related to a patient's health, in conjunction with a home health plan of care, and access to the data by a licensed home health agency.

Sec. 2. EFFECTIVE DATE

This act shall take effect on July 1, 2014.

Secretary/Commissioner has reviewed this document: _____ Date: _2/6/14_____

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