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118TH CONGRESS
1ST SESSION

H. R. 5394

To ensure appropriate access to remote monitoring services furnished under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 2023

Mr. BALDERSON (for himself, Ms. PORTER, Mr. DUNN of Florida, and Mr. MURPHY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To ensure appropriate access to remote monitoring services furnished under the Medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Expanding Remote Monitoring Access Act''.

SEC. 2. FINDINGS.

The Congress finds the following:

(1) Remote monitoring is an option that can help patients manage their health conditions from their homes with oversight from their health care providers, which can improve patient health outcomes, reduce long-term health costs, and increase care options for patients.

(2) The Department of Veterans Affairs (VA) saw such results in a 2019 report. Veterans enrolled in remote patient monitoring had a 53 percent decrease in VA bed days of care and a 33 percent decrease in VA hospital admissions.

(3) Providers are currently required by Medicare to collect 16 days of patient data over a 30-day period in order to bill Medicare for remote monitoring services, even in cases where this full duration is not medically necessary to ensure the health and safety of the patient. This can limit the use of remote monitoring in instances where it can promote patient health and safety and where it can reduce the overall cost on the health system.

(4) In the 2021 Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) issued an interim policy to lower the duration required by Medicare to bill for remote monitoring services from 16 days to 2 days within a 30-day pe-

riod, but only for individuals who had been diagnosed with, or were suspected of having, COVID–19. This short-term flexibility called attention to the long-term need to reassess the minimum duration required for providers to bill for remote monitoring.

(5) As part of issuing the 2021 Physician Fee Schedule, CMS studied comments in support of permanently lowering the minimum required duration of remote monitoring for all patients, not just those with COVID–19.

(6) CMS concluded that ''we agree that a full 16 days of monitoring may not always be reasonable and necessary'' but did not revise the 16 day per 30-day period minimum duration for all patients because CMS did not believe they had received ''specific clinical examples'' to allow for ''understanding under what clinical circumstances fewer days of monitoring would be medically reasonable and necessary and allow a practitioner to establish clinically meaningful care''.

(7) Clinical evidence shows numerous instances in which fewer than sixteen days of monitoring within a 30-day period establishes clinically meaningful care. These include:

(A) Sixteen days of monitoring per 30-day period may not be required to establish that a patient has sleep apnea.

(B) A patient prescribed a narcotic for pain may require their breathing to be monitored only while on the medication.

(C) A patient with a chronic condition like diabetes, congestive heart failure, or obesity may have their weight monitored over a longer period of time, but it is not clinically appropriate to have such patient step on a scale 16 or more times in each 30-day period.

(D) A patient whose blood pressure or oxygen levels are monitored during physical therapy may not necessitate 16 days of monitoring in each 30-day period given physical therapy is often ordered twice weekly.

(E) A patient who wears a heart monitor to measure palpitations may wear the monitor continuously, but the data only needs to be collected when the individual is experiencing symptoms.

(F) A patient with hypertension is often monitored for long-term management of this condition on more of a weekly basis, only need-

ing more frequent data collection for active monitoring with changes in medication or dosages.

(G) A patient who suffers from Muscular Sclerosis or Muscular Dystrophy may benefit from a provider tracking the patient's exercise between visits to monitor certain physiologic parameters such as muscle movement but may not produce 16 days of data in a 30-day period.

(H) A patient who needs a total joint replacement may simply need pre-testing for surgery baselines, including to establish gait, force, activity, heart rate and other factors and then compare pre-surgery and post-surgery function.

(I) For a patient with urologic dysfunction, male urine flow data obtained from the patient can be collected in two to four consecutive days.

(J) Remote monitoring may allow a provider to assess a patient's adherence, range of motion, and response to physical therapy and occupational therapy regimens even though many such regimens are less than 16 days per month.

(K) Monitoring cognitive behavioral therapy for less than 16 days in a 30-day period

may provide clinically meaningful care while moderating a patient's anxiety and other symptoms.

(L) A patient with respiratory issues may not require a full 16 days of monitoring of inhaler usage to get clinical benefits from remote monitoring.

(8) A two-day minimum duration would permit Medicare coverage of the full range of remote monitoring services that can be beneficial to a patient without precluding the differential reimbursement of individual remote monitoring services based on patient acuity and cost.

SEC. 3. ENSURING APPROPRIATE ACCESS TO REMOTE MONITORING SERVICES FURNISHED UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall ensure that remote monitoring services furnished under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) during the period beginning on the date of the enactment of this Act and ending on the date that is 2 years after such date of enactment are payable for a minimum of 2 days of data collection over a 30-day period, regardless

of whether the individual receiving such services has been diagnosed with, or is suspected of having, COVID–19.

(b) REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall, after consulting with entities specified in paragraph (2), submit to Congress a report that includes the following:

(A) A summary and analysis of previous experience with such remote monitoring services being payable under such title for a minimum of 2 days of data collection over a 30-day period.

(B) Recommendations for implementing a reimbursement model that takes into account patient acuity and cost of providing remote monitoring services, including potentially creating differential reimbursements for periods with different durations, such as fewer than and more than 16 days.

(C) An analysis and justification for the appropriate place of service and supervision requirements for non-clinical staff reviewing and escalating patient data and provide recommendations.

(D) An analysis of the estimated savings resulting from earlier interventions and fewer days of hospitalizations among patients furnished remote monitoring services.

(2) SPECIFIED ENTITIES.—For purposes of paragraph (1), the entities specified in this paragraph are the following:

(A) Relevant agencies within the Department of Health and Human Services (including, with respect to issues relating to waste, fraud, or abuse, the Inspector General of such Department).

(B) The Department of Veterans Affairs (including the Office of Connected Care of such Department).

(C) Licensed and practicing osteopathic and allopathic physicians, anesthesiologists, physician assistants, and nurse practitioners.

(D) Hospitals, health systems, academic medical centers, and other medical facilities, such as acute care hospitals, cancer hospitals, psychiatric hospitals, hospital emergency departments, facilities furnishing urgent care services, ambulatory surgical centers, Federally qualified health centers, rural health clinics,

and post-acute care and long-term care facilities.

(E) Medical professional organizations and medical specialty organizations.

(F) Organizations with expertise in the development of or operation of innovative remote physiologic monitoring services technologies.

(G) Beneficiary advocacy organizations.

(H) The American Medical Association Current Procedural Terminology Editorial Panel.

(I) Commercial payers.

(J) Any other entity determined appropriate by the Secretary.

(c) DEFINITIONS.—In this section:

(1) REMOTE MONITORING.—The term ''remote monitoring'' means remote physiologic monitoring and remote therapeutic monitoring.

(2) REMOTE PHYSIOLOGIC MONITORING.—The term ''remote physiologic monitoring'' means non-face-to-face monitoring and analysis of physiologic factors used to understand a patient's health status, including the collection and analysis of patient physiologic data that are used to develop and manage a

treatment plan related to chronic or acute conditions.

(3) REMOTE THERAPEUTIC MONITORING.—The term ''remote therapeutic monitoring'' means the use of medical devices to monitor a patient's health or response to treatment using non-physiological data.

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