F I S C A L I M P A C T R E P O R T

SPONSOR Padilla **ORIGINAL DATE** 2/9/20 **LAST UPDATED** **HB**

SHORT TITLE Gross Receipts on Remote Patient Monitoring **SB** 242

ANALYST Graeser

APPROPRIATION (dollars in thousands)

Appropriation			Recurring or Nonrecurring	Fund Affected
FY20	**FY21**	**FY22**		
	3,400.0		Nonrecurring (reverting)	General Fund (develop and implement pilot project)
	300.0		Nonrecurring (reverting	General Fund (develop strategic plan and report)
	6,500.0		Nonrecurring (reverting	General Fund (purchase equipment for pilot project

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue					Recurring or Nonrecurring	Fund Affected
FY20	**FY21**	**FY22**	**FY23**	**FY24**		
	195.0				Nonrecurring	General Fund – 3% excise tax
					Recurring	
					Recurring	
					Recurring	

Parenthesis ( ) indicate revenue decreases

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY20	FY21	FY22	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
State	$0.0	$1,890.0	$0.0	$1,890.0	Nonrecurring	SGF
Federal	$0.0	$5,233.0	$0.0	$5,233.0	Nonrecurring	Federal Medicaid Admin Matching Funds
Total	$0.0	$7,124.0	$0.0	$7,124.0	Nonrecurring	General Fund and Federal Medicaid Matching Funds

Parenthesis ( ) indicate expenditure decreases

SOURCES OF INFORMATION
LFC Files
Responses Received From
Human Services Department (HSD)

No Response Received
Taxation and Revenue Department (TRD)

SUMMARY

Synopsis of Bill

Senate Bill 242 proposes to establish a pilot program for remote patient monitoring (RPM) by adding a new section to the Department of Health Act requiring the Department of Health (DOH) to develop and implement a RPM pilot program beginning in FY21 for two counties with significant populations of eligible remote patients who have increased health risks due to chronic illness as well as alcohol or substance abuse.

SB242 contains a $10.2 million appropriation to DOH, which would be allocated as follows:

- $3.4 million to develop and implement a RPM pilot program in two counties,
- $300,000 for strategic planning and reporting,
- $6.5 million to purchase equipment.

An excise tax of 3 percent of remote patient monitoring equipment gross receipts on the sale of remote patient monitoring equipment is imposed on any person engaging in business in New Mexico.

Any unexpended or unencumbered balance at the end of FY21 would revert to the state general fund.

If SB242 is enacted, DOH would be required to

1. Develop and implement a pilot program to provide remote monitoring of vital health indicators for “at-risk patients” that can be addressed with significant benefits to the patient through intermittent remote reporting of vital health indicators to the patient's health care provider;
2. Establish by rule
    a. A definition of “at-risk patients” based on health conditions, including substance use disorders;
    b. A definition of "remote patient" based on the physical distance of a patient's residence from healthcare facilities or other factors that physically limit a patient's access to health care services;
    c. A definition of "eligible remote patient" based on a patient's physical access to healthcare services and the patient's level of at-risk health conditions;
    d. A list of vital health indicators that may be determined by an average person without medical training through the use of electronic or mechanical equipment and that would allow a medical professional to determine if a remote patient needs to visit a healthcare facility; and
    e. The requirements for equipment that could be used by a patient in the patient's home to determine vital health indicators and to transmit those indicators to a

healthcare provider;

3. Develop a statewide strategic plan to provide remote monitoring of vital health indicators for at-risk patients who live in remote locations or who otherwise lack immediate access to healthcare services. DOH would be required to provide a report summarizing the plan to the Legislative Finance Committee and the Legislative Health and Human Services Committee by November 30, 2020.

The effective date of this bill is July 1, 2020. The appropriation and the planning are essentially nonrecurring so that no delayed repeal seems to be necessary.

FISCAL IMPLICATIONS

An excise tax of three percent of remote patient monitoring equipment gross receipts on the sale of remote patient monitoring equipment is imposed on any person engaging in business in New Mexico. The $6.5 million portion of the appropriation would be subject to this tax. This would amount to about $195 thousand in FY21.

There would be no gross receipts tax imposed, because of the action of 7-9-54 NMSA 1978 that provides for a deduction for sale of tangible personal property to a government entity. Even if DOH contracted this pilot to a nonprofit agency, there would be no gross receipts tax liability pursuant to 7-9-60 NMSA 1978.

This is a special excise tax that might be considered a provider tax. HSD (commentary below), which would administer the Medicaid match, does not expect this pilot project to generate a Medicaid match. If there were a Medicaid match, then the 3 percent excise tax would be imposed on equipment purchased with the match funds.

HSD provides extensive commentary:

> Currently, Medicaid does not reimburse for RPM services. The bill does not discuss reimbursement, so it is unclear whether payment for Medicaid patients receiving RPM services would be a consideration or expectation under SB242.
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> If there is an expectation of reimbursement from Medicaid for RPM services, then there would be a fiscal impact to HSD in FY22, presuming MAD (Medical Assistance Division) receives approval from the federal Centers for Medicare and Medicaid Services (CMS). Because the bill does not specify, and it is not clear which counties/populations would receive RPM service through the pilot program, $7.124 million was calculated with the assumption that the two counties selected for the pilot would be San Juan and McKinley based on SB242 stating the counties to be those with "significant populations of eligible remote patients who have increased health risk due to chronic illness as well as alcohol or substance abuse." (The Behavioral Health Services Division) BHSD provided a client count of 4,632 individuals in McKinley County and 7,378 individuals in San Juan County with the ICD (International Classification of Diseases) 10 diagnosis codes for alcohol/substance abuse. The monthly cost of $49.43 was assumed for these individuals based on Medicare reimbursement rate for procedure code 99457 which describes chronic care remote physiologic monitoring. The $7.124 million under "estimated additional operating budget impact" was split as 26.54 percent state funds for a total of $1.891 million with the remaining $5.233 million as federal funds based on the FFY22 federal match of 73.46 percent.

HSD did not consider the costs of the equipment, set-up, and service related to this system in the $7.124 million impact above. However, there is some indication from the CMS that these RPM-related costs may qualify as a Medicaid administrative cost, but not as a medical cost. This would lower the federal financial participation (FFP) match rate that could be received to 50 percent rather than the regular FMAP rate (72.71 percent from July through September 2020 and 73.46 percent from October 2020 to September 2021). See "Other Substantive Issues," below.

SIGNIFICANT ISSUES

The 3 percent excise tax mirrors the gross receipts and compensating tax act. In particular, certain receipts (transactions) that are exempt from the GRT are exempt from this excise tax:

Statutory Citation	Title
7-9-13	Exemption for receipts of government agencies
7-9-13.1	Exemption for services performed outside the state the product of which is initially used in New Mexico.
7-9-18.1	Receipts from food stamps
7-9-28	Occasional sale of property
7-9-29	Exemption for receipts of 501(C)(3) organizations
7-9-41.3	Exemption for receipts of disabled street vendors.

The 3 percent excise tax imposition does not provide deductions for sales of tangible personal property to government entities or non-profit organizations.

PERFORMANCE IMPLICATIONS

Although TRD will be collecting and distributing the 3 percent excise tax, the agency has no additional reporting requirements. Because this is a pilot project, and the data on effectiveness will be with DOH, some consideration could be given to assign a reporting requirement to the agency administering the operation of the pilot project.

ADMINISTRATIVE IMPLICATIONS

If there would be an expectation of Medicaid reimbursement for services provided under the RPM pilot program, then HSD would have to design the reimbursement methodology and payment parameters and seek federal approval for implementation. It is unclear whether CMS would approve reimbursement of RPM as a direct medical service at this time. See "Other Substantive Issues" below.

TECHNICAL ISSUES

Last year's SB246 (Laws 2019, Chapter 53) enacted an innovative nursing home quality surcharge. Although the act was passed and signed, there was a major contingency whether CMS would approve this as essentially a provider tax. The current proposal should also be contingent on CMS approval.

The excise tax would be administered under the provisions to the Tax Administration Act (7-1-2 NMSA 1978). However, because there is no earmarked distribution to a dedicated fund, the revenue from the 3 percent excise tax would be, by default, distributed to the general fund.

OTHER SUBSTANTIVE ISSUES

HSD has provided extensive background on this proposal:

> Medicaid-covered telemedicine services include the use of electronic information, imaging and communication technologies (including interactive audio, video and data communications as well as store-and-forward technologies) to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education. To be paid for by Medicaid, a telemedicine origination-site can be any medically warranted site. An interactive telemedicine communication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant sites; however, the distant site must be a consulting telemedicine provider.
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> Unlike currently covered telemedicine services, the RPM pilot program described in SB242 would be a healthcare delivery method that uses technology to monitor patient health outside of a traditional clinical setting. An RPM device is the specific technology used to electronically transmit information between patients and physicians. Common examples include voice apps that remind diabetic patients to take their insulin, while allowing their physician to monitor the disease, and digital blood pressure cuffs that enable patients to remotely send physicians their blood pressure and pulse readings. RPM services do not require interactive audio-video, they simply require technology that collects and interprets physiologic data. [https://www.businessinsider.com/remote-patient-monitoring-industry-explained]
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> One example of the application of RPM in the management of substance use disorder is the use of text-message "hovering" from a clinical social worker as a mobile interventionist to assess medical adherence and clinical status of patients with dual diagnosis of serious mental illnesses and substance abuse problems. A 12-week, small clinical trial of 17 participants with such dual diagnosis showed that over 90 percent of participants thought the intervention was useful and rewarding, and that it helped them be more effective and productive in their lives.
> [*J Dual Diagn*. 2014; 10(4): 197–203. doi:10.1080/15504263.2014.962336. Available on-line at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4231298/]
>
> Another established application for RPM is its utilization by a home health agency. On November 13, 2018, the Centers for Medicare and Medicaid (CMS) issued a Federal Register finalizing regulatory changes regarding certifying and recertifying patient eligibility for Medicare home health services and finalizing the definition of "remote patient monitoring" and the recognition of the costs associated with it as allowable administrative costs. This would be distinct from covering RPM as a medical service and would mean that the FFP match rate would be 50 percent from the federal government and 50 percent from the state general fund.
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> CMS acknowledged the potential benefit of the use of RPM to augment a patient's home health plan of care. For example, in cases where a home health patient is admitted for skilled observation and assessment of the patient's condition due to a reasonable potential for complications or an acute episode, RPM could augment home health visits until the patient's clinical condition stabilized. Particularly for patients with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF), research indicates that RPM has been successful in reducing readmissions and long-term acute care utilization. [42

C.F.R. §409.46(e) Allowable administrative costs https://www.law.cornell.edu/cfr/text/42/409.46 and Section III.H of the Federal Register rules and regulations document # 2018-24145 https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf]

ADMINISTRATIVE IMPLICATIONS

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