NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

July 10, 2023

Michael E. Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
25 I Street N.W., Suite 701
Washington, D.C. 20001

Dear Chairman Chernew:

On behalf of the 5,300 Rural Health Clinics (RHC), providing care to over 60% of rural Americans across the nation, the National Association of Rural Health Clinics (NARHC) thanks MedPAC for its work on the June 2023 *Medicare and the Health Care Delivery System* report to Congress.

Since the passage of the CARES Act in 2020, RHCs have benefited from the expanded flexibilities to serve as a distant site provider of telehealth services, currently in place through December 31, 2024, and their patients see continued value in the increased access to care via different modalities that best fit their needs.

The National Association of Rural Health Clinics strongly supports permanent Medicare coverage of telehealth services provided by RHCs and is working with Congress to achieve this priority. However, the current "Special Payment Rule," established as code G2025 reimbursing at a rate of $98.27 presents three primary challenges to RHCs in offering telehealth services:

1) The payment rate is lower than a RHCs all-inclusive rate, which disincentivizes investment in telehealth technologies.
2) The single billable code for over 200 services obscures and distorts claims data.
3) The entirely new billing and cost reporting rules generate a significant administrative burden for safety-net providers.

We were disappointed by the RHC-specific telehealth recommendations provided in the June 2023 report. MedPAC recommends that if Congress decides to permanently cover distant-site telehealth services in RHCs and FQHCs that they continue to reimburse at the rate "based on PFS rates for comparable telehealth services," which is effectively an endorsement of the current G2025/special payment rule.

First, MedPAC states that "paying FQHCs and RHCs their standard rates for all telehealth services would increase costs for the program and beneficiaries…Depending on beneficiaries' supplemental insurance coverage, these high payment rates (especially for RHCs) could discourage access because of high out-of-pocket spending." MedPAC reported that RHC Medicare spending for telehealth was just 3% and 2% of total Medicare spending for RHCs in 2020 and 2021, respectively. Even if granted payment parity, we believe it is highlight unlikely that this would significantly increase overall Medicare program spending, despite the significant potential benefits for safety net providers and patients.

Secondly, MedPAC raises the concern that "practitioners who furnish telehealth services do not need to be physically located in an underserved area, so the higher rates for FQHC- and RHC-provided telehealth services would not be necessary to ensure access." NARHC agrees with MedPAC that there are currently no limitations as to where a provider offering telehealth services can be located, but if telehealth flexibilities are to continue long-term, Congress would likely institute some type of guardrails to protect the integrity of the benefit. Those guardrails could include requiring the provider to be in the clinic, some type of service area requirement, or an occasional in-person visit. Further, the MEDPAC recommendation would disincentivize rural providers from investing in telehealth technologies and services due to low reimbursement, while incentivizing urban and suburban providers to offer telehealth services to rural patients with no physical proximity to them.

Third, MedPAC states that "Paying standard rates for telehealth visits could also be a disincentive to furnish in-person care since telehealth visits likely cost less than in-person visits due to reduced facility costs. Providers should make decisions about what mode of care is most beneficial to the patient based on clinical considerations, not on what is most financially advantageous." NARHC is not confident that there is strong evidence, particularly in rural areas, clearly demonstrating that telehealth costs less to provide than in-person services. While we also disagree with the assumption that RHC providers would choose a less clinically advantageous mode of care for their patients based on reimbursement, the fact remains that **the strongest way to ensure that clinical considerations remain the primary consideration is to pay parity between in-person and telehealth visits.** In its efforts to avoid an incentive to focus on telehealth, MedPAC's recommendation here is creating a significant financial incentive to not invest in and recommend telehealth.

Finally, MedPAC provides the rationale that, "Because telehealth services can be delivered to beneficiaries outside FQHCs' or RHCs' local service areas, paying these providers rates far above PFS rates could increase costs for the Medicare program and beneficiaries (without improving access) in areas that are not underserved and could undermine competition (as clinicians compete to bill under the highest-paid facility as opposed to competing for patients based on quality and service)." MedPAC is raising the concern that if RHCs received payment parity for telehealth and in-person visits, there would be a financial incentive for RHC providers to provide telehealth services to non-rural, medically underserved patients and yet still receive a higher reimbursement than fee-for-service rates. NARHC agrees that with no guardrails there is the potential for abuse of the benefit. **However, simply offering lower reimbursement to safety net providers through a crude special payment rule is not an appropriate guardrail. This continues to limit safety net providers' ability to invest in these important technologies.** MedPAC should instead consider other guardrails, for example, the occasional in-person visit requirement established by Congress for mental health services provided via telehealth.

Again, we thank MedPAC for its work on this report, and we look forward to seeing the future work of the Commission on other options to protect the integrity of the program without disadvantaging the country's safety net providers. Should the Commission have any questions, the National Association of Rural Health Clinics remains available to serve as a resource, you may reach us by phone at (202) 543-0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.

Sincerely,

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