Statement for the Record

of the

National Association of Rural Health Clinics
1009 Duke Street
Alexandria, VA 22314

to the

United States Senate
Committee on Finance
Subcommittee on Health Care

Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency
November 14, 2023

On behalf of the over 5,400 Rural Health Clinics (RHC) across the nation, we sincerely appreciate the opportunity to provide a statement for the record.

The RHC program, first created in 1977, provides outpatient care for over 60% of rural America and 11% of the entire country (approximately 37 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America.

Telehealth represents a massive opportunity to improve access to care in rural areas, and we appreciate the Committee's continued efforts to best understand its impact and value as we consider post-2024 Medicare telehealth policy.

Rural Health Clinics and FQHCs were not included in HHS' emergency expansion of telehealth policy. For a few weeks at the beginning of the COVID-19 pandemic, fee-for-service providers were able to offer telehealth services to their patients, while RHC and FQHC patients were forced to come in-person to receive a Medicare-covered healthcare service. The CARES Act rectified this issue and allowed RHCs and FQHCs to serve as distant site providers but that legislation did not allow RHCs and FQHCs to bill for telehealth normally. Instead, the CARES Act created a "special payment rule" that paid RHCs outside their normal All-Inclusive Rate methodology at a level that is significantly less than what RHCs receive for in-person services. This stands in stark contrast to traditional physician offices which receive payment parity between in-person and telehealth services.

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, billed whenever an RHC provides one of the 200+ telehealth services reimbursable by Medicare, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth properly, which hinders their ability to properly participate in Accountable Care Organizations and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that telehealth should work this way for all services, not just mental health services.

In the 2023 report on *Medicare and the Health Care Delivery System,* MedPAC provided RHC-specific telehealth recommendations. Their RHC recommendations, and NARHC's responses are below.

Ultimately, 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 stated 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 highly unlikely that this would significantly increase overall Medicare program spending, despite the significant potential benefits for safety net providers and patients.
- Secondly, MedPAC raised 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, NARHC believes that some guardrails may need to be created to ensure that **only safety-net providers serving safety-net patients may receive the enhanced reimbursement rates**. We do not want to create a loophole that allows patients and clinicians in well-served suburban or urban areas to route their telehealth billing through the RHC and take advantage of the RHC reimbursement methodology. 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.
    - Potential guardrails could include requiring the provider to be in the clinic, some type of service area requirement, or an occasional in-person visit and we look forward to continued engagement with the Committee as to additional options.
- Third, MedPAC stated 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 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 provided 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. by Congress for mental health services provided via telehealth.

We are pleased that the CONNECT for Health Act and other pieces of legislation introduced this Congress would eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs and we urge Congress to rectify this issue, at the latest, as part of any telehealth extension legislation.

Conclusion

The National Association of Rural Health Clinics thanks the Senate Finance Subcommittee on Health for organizing this hearing. We hope that the above statement helps illuminate the unique telehealth policy position of the 5,400 Rural Health Clinics across the country. Should the Committee have any questions, the NARHC is happy 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.