NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

April 25, 2024

To: Medicare Payment Advisory Commission

From: The National Association of Rural Health Clinics (NARHC)

Re: NARHC Comments Regarding the April 11 Public Meeting on Telehealth in Medicare

On behalf of the National Association of Rural Health Clinics (NARHC), representing over 5,400 RHCs providing care to over 60% of rural Americans across the nation, we are pleased to provide the following comments to the Medicare Payment Advisory Commission (MedPAC) regarding the public meeting held on April 11, 2024, discussing Telehealth in Medicare: Status report.

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.

NARHC 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 $96.87, 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. This differs from Medicare fee-for-service providers who receive parity for in-person and telehealth visits.
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.

In the June 2023 *Medicare and the Health Care Delivery System* report to Congress, MedPAC recommended to Congress that if they 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.

NARHC was disappointed by the RHC-specific telehealth recommendations and their rationale provided in this report, as outlined in our July letter to Chairman Chernew.

Since this report, we appreciate MedPAC's continued tracking of available telehealth data amongst fee-for-service providers and safety-net providers such as RHCs and FQHCs and the presentation of it at the most recent public meeting. Telehealth utilization and its fluctuations over time are important components of effective advocacy.

In the most recent meeting, MedPAC made several points that NARHC finds imperative to highlight.

1) The share of claims with a telehealth service has continued to decline for RHCs since the initial spike in 2020. Further, regardless of facility type, "as rurality increases, telehealth utilization decreases."
    a. Limited uptake of telehealth in rural areas is due to many factors, including patient interest in the modality, broadband access, etc. However, as was highlighted by Ms. Barr, the Commission would be remiss to not consider the impact of the lack of reimbursement parity between in-person and telehealth visits that RHCs are subject to.
    b. Importantly, low uptake calls attention to the fact that the sheer existence of a benefit does not mean automatic high utilization, particularly for our rural, medically underserved communities in which many see great potential for telehealth to fill gaps in access.
    c. It is becoming clear that the role of telehealth for the majority of providers is as a complimentary component of care offerings, and protecting in-person access to care for patients and providers that prefer this modality remains essential. **NARHC continues to believe that the strongest way to ensure that clinical considerations and patient choice remain the primary considerations when determining the best modality (in-person care or via telehealth), is to pay parity between in-person and telehealth visits.** Currently, the G2025 policy, and MedPAC's June recommendation to Congress creates a significant financial incentive for our safety-net providers to **not** invest in and recommend telehealth to patients, which we believe is further demonstrated in the latest data presented.
        i. While the utilization data presented currently shows that the share of RHC claims with a telehealth service is .5% higher than in the PFS system, we do not believe that this demonstrates the current G2025 payment system is adequate. We expect that RHC usage will continue to decrease as it has significantly from 2020-2022, an unintended consequence of the special payment rule.
        ii. In traditional fee-for-service settings, particularly those in urban areas with greater access to care to begin with, telehealth is a benefit. In rural, underserved areas, telehealth has the potential to be a significant bridge to any healthcare access. We encourage MedPAC to see these declining utilization rates as another example of why parity for our safety-net providers is critical for utilizing the full potential of these new technologies.

2) The occasional in-person requirement for behavioral health visits done via telehealth "could disrupt established care patterns, but policymakers could consider alternative guardrails."
    a. In its June 2023 report, 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, we would reiterate that 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.

b. We encourage MedPAC to further consider other guardrails to recommend to Congress, if they are deemed necessary, such as "additional scrutiny to outlier clinicians." There are existing mechanisms for determining fraud and abuse within the Medicare program. NARHC encourages utilization of these mechanisms as opposed to assuming that our safety-net providers will abuse a benefit intended to better service their medically underserved populations.

While the data presented at this meeting specifically is not part of an upcoming report to Congress, we implore MedPAC to ensure that these continued findings are part of future recommendations to Congress as they consider the status of Medicare telehealth policy post-2024.

Again, we thank MedPAC for its continued work on telehealth, and we look forward to seeing the future work of the Commission on recommendations to continue these benefits and 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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