Improving Telehealth for Underserved Communities Act of 2020

U.S. Senators Cindy Hyde-Smith (R-Miss) & Angus King (I-Maine)

Summary: Without Congressional action, most rural health clinics (RHCs) and all federally qualified health centers (FQHCs) will owe money back to Medicare in July for every telehealth visit provided during the COVID-19 pandemic. This legislation would prevent this clawback from occurring by allowing RHCs and FQHCs to provide and bill for telehealth visits through their normal reimbursement mechanisms through the end of the COVID-19 public health emergency.

Background: The CARES Act allowed RHCs and FQHCs to bill Medicare as distant site providers during the COVID-19 public health emergency. However, CMS insisted on authorization to create a new payment methodology for these distant site services instead of paying RHCs and FQHCs for telehealth through its normal reimbursement mechanisms. In rulemaking following the CARES Act, CMS determined it would reimburse RHCs and FQHCs with a flat fee of $92.03 for any of the 200+ different telehealth services covered by Medicare, regardless of the complexity or length of the visit.

Even though CMS requested this new methodology, CMS has since stated that technical problems have prevented it from paying RHCs and FQHCs under the new methodology until July 1. Therefore, until June 30, Medicare will pay RHCs and FQHCs for telehealth under its normal reimbursement mechanisms. However, beginning in July Medicare will recoup the difference between the normal rate and $92.03 for every telehealth visit provided. This clawback not only creates a major administrative burden for RHCs and FQHCs but also diminishes the incentive to use of telehealth during the COVID-19 pandemic, when telehealth is especially important to allow patients to stay home and avoid infection.

Current Policy:

- RHCs and FQHCs bill all telehealth visits under one code (G2025) for which payment is $92.03 for all telehealth visits no matter what service was provided
- Creates administrative burden on RHCs and FQHCs because all costs associated with telehealth must be "carved out" of the annual cost report
- Telehealth visits do not count toward the productivity standard for RHCs
- Claims data is inaccurate because G2025 represents at least 238 different services
- Recoupment period in July creates financial strain and disincentivizes telehealth adoption by RHCs and FQHCs

Proposed Policy:

- RHCs and FQHCs bill telehealth visits through their normal reimbursement mechanisms throughout the COVID-19 public health emergency
- Costs associated with telehealth are incorporated into annual cost reporting
- Telehealth visits count toward RHC productivity standards
- Claims data is accurate because accurate coding would be used rather than the single G2025 code.
- No recoupment period in July