



## **NRHA Rapid Response Policy Brief: Telehealth**

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### **I. Introduction**

The Health Resources and Services Administration (HRSA) defines telehealth as, “The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.”<sup>7</sup>

Telehealth is different from telemedicine because it refers to a broader scope of remote health care services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.<sup>2, 7</sup>

Access to telehealth services increased greatly during the coronavirus disease (COVID-19) pandemic. Even though telehealth tools existed prior to the pandemic, demand has grown in response to the public health emergency (PHE), increased patient and provider comfort with virtual visits, and the convenience telehealth services offer. The Centers for Medicare and Medicaid Services (CMS) has approved more than 90 new telehealth services and approximately 250 new billing codes in response to COVID-19 patient and provider demand.<sup>6</sup>

Telemedicine is not a substitute for all clinical interactions, but if used appropriately, it could supplement care provided in rural areas, improve access to important health care services and alleviate travel burdens.<sup>4</sup> The National Rural Health Association (NRHA) supports making permanent and expanding the telehealth regulatory waivers and reimbursement programs enacted during COVID-19 to sustain the telehealth opportunities created for medical providers and patients. This rapid response policy brief is intended to outline NRHA policy statements and recommendations to encourage adoption of telehealth in rural America.

### **II. Policy Statements to Ensure Rural Fairness and Access to Health Care Services**

- Telehealth will remain an important tool for health care delivery long after the COVID-19 PHE has ended. Maintaining telehealth services will require flexibility and standardization to ensure consistency and performance.<sup>1</sup>



- When patients do not show up for their appointments, it can negatively impact their health and contribute significantly to lost revenue for providers. Implementing virtual visits has significantly decreased in patient no-shows, according to Avera eCARE Specialty Clinic.<sup>3</sup> Factors such as improved patient satisfaction and health outcomes, provider cost-savings, and avoided transportation barriers should be considered when evaluating the impact and cost-effectiveness of telemedicine.
- Regulations, reimbursement programs, and protocols/procedures need to distinguish appropriately between an in-person visit and virtual visit. In rural areas, these regulations and reimbursement programs must be conducive to utilization of telehealth services. Consideration should be given to the role of remote monitoring and use of peripheral diagnostic tools as part of telemedicine services.<sup>4</sup>
- All health care professionals/practitioners with approved national provider identification (NPI) numbers should have the ability to bill all payers for telemedicine services as a distant site.<sup>4</sup> Policy makers must evaluate the option for other health care practitioners, such as care coordinators, respiratory therapists, dental hygienists, and dentists, to participate as telehealth services expand in the future.
- Reimbursement rates need to fully cover costs and be adjusted regularly. Telemedicine reimbursement rates should account for time, overhead costs such as cost of equipment, and scope of the visit, such as a virtual visit or a remote patient monitoring encounter.<sup>9</sup>
- Telemedicine should be subject to ongoing evaluations of whether assigned codes match the services provided and new codes should be added when appropriate. Rural programs and medical providers should be afforded the same opportunities for billing and coding telemedicine services as an originating site as other medical organizations and providers.
- Payers should not require telemedicine to incorporate pre-authorization and medical necessity review since it is a component of clinic-based routine care.
- Telehealth training should be incorporated into health professional and medical education.<sup>2</sup> Rural medical and professional education programs should have allocated funding for telehealth training and expanded telemedicine use.
- Patient satisfaction and quality reporting will need to address telemedicine performance.<sup>2</sup> Some clinical situations are may be impacted by telehealth as a



modality, while others are not, and this will need to be considered when measuring clinical performance and outcomes.

- Health services research to evaluate and improve telehealth interventions should be encouraged and supported. Funding for telehealth research must include rural providers and programs to ensure differences in practicing in rural settings are thoroughly understood and improvements to rural health outcomes are pursued equitably.
- Network adequacy is a major concern for rural providers who could be bypassed by out of state or regional area providers.<sup>8</sup> Telemedicine capabilities must not be substituted for network adequacy insurance coverage for rural counties. Telemedicine services enhance availability and supplement patient care and treatment, but they are not a substitute for in-person clinic encounters. Regulations for payment for virtual visits and remote patient monitoring must require a demonstrated relationship with a primary care provider and/or referral to specialist.
- A national telehealth discussion should address the cost and complexity of multi-state licensing and provide guidelines so that out of state medical care augments and supports the local health care services.
- CMS and commercial payers' telehealth definitions should be consistent to provide clarity regarding covered and non-covered services.<sup>2, 7</sup>
- CMS needs to establish productivity standards for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) that included virtual visits and not left to the Medicare Audit Contractors interpretation. Time and resource allocation are relatively the same for in-person versus virtually. Therefore, RHCs and FQHCs reimbursement for telehealth services should be at their respective All-inclusive Rate (AIR).
- CMS should create a telehealth advisory panel to standardize and refine telehealth services similar to how CMS has established the Outpatient Panel that makes recommendations for rulemaking. The panel should be required to have rural representation.
- CMS should standardize requirements for telehealth software programs, as well as conditions of participation that address privacy and HIPAA.
- Broadband allows for effective telehealth delivery; many rural communities have poor broadband coverage.



- Telephonic consultation is an option when both virtual and in-person are not available. CMS must clarify through rulemaking the difference between a billable versus non-billable virtual contact. For example, circumstances when a practitioner contacts a patient by phone to provide lab results versus a formal telehealth visit.<sup>4</sup>
- Telehealth allows health care professionals to interact with patients in a new innovative way and/or create the opportunity for advance practice practitioners to provide diagnostic procedures under the supervision of a physician virtually.<sup>8</sup>
- Although telehealth has found application in both urban and rural areas, rural providers have unique challenges such as broadband connectivity, financial resources, expertise, equipment, and training that need to be addressed for telehealth use to be a success for rural providers and patients.<sup>9</sup>

### **III. Policy Recommendations to Ensure Rural Fairness and Access to Health Care Services**

- The telehealth waivers enacted during the COVID-19 PHE should be extended through December 2021 or until the waivers can be made permanent.<sup>6</sup>
- CMS should authorize RHCs and FQHCs as distant sites for billing and coding purposes permanently.
- CMS should authorize licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech-language pathologists, and EMS and community paramedics, to furnish the brief online assessment and management services as virtual check-ins and remote evaluation services.
- A national telehealth advisory committee, one which includes rural representation, should develop guardrails that address telehealth/telemedicine definitions for usage and quality for all settings.
- Many rural communities have poor broadband coverage. Policy makers must continue to advance broadband coverage nationally to all rural communities.<sup>8</sup> The Universal Service Administrative Company (USAC) and other rural broadband programs that reduce the higher cost of broadband in rural communities should be made available to all rural providers and properly funded each year to bridge the digital divide and create equitable broadband access.
- Telemedicine payment for remote physiologic monitoring (RPM) services should require an established patient-physician relationship prior to the service and



allow consent to be obtained at the time services are furnished. In addition, a medical device used as part of remote monitoring must be a medical device as defined by Section 201(h) of Federal Food, Drug and Cosmetic Act, that the device must be reliable and valid, and that must be electronically collected and transmitted rather than self-reported. CMS should clarify that RPM services should be considered evaluation and management (E/M) services and that practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions.<sup>5</sup>

- Allowing the virtual presence of a supervising physician or practitioner using interactive audio/video real-time communication technology would increase access to diagnostic services in rural areas where onsite physician supervision is currently required for rural providers.

#### **IV. Conclusion**

Telehealth can improve health care access and create cost savings. Policymakers should advance health care by standardizing telehealth. Additionally, policy makers should modernize national health care coverage and commit additional resources to understanding the costs and benefits of telehealth to improve health care delivery and health outcomes in rural America.



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