Telehealth Services

RHCs that are located in a rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA) are authorized by law to be telehealth originating sites (the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs).

However, RHCs are not authorized to be distant site providers (practitioners furnishing covered telehealth services).

Authorized distant site providers include physicians, NPs, PAs, CNMs, clinical nurse specialists (CNSs), CPs, CSWs, and registered dietitians or nutrition professionals. Although RHC practitioners are eligible to furnish and bill for telehealth distant site services when they are not working at the RHC, they cannot furnish and bill for telehealth services as an RHC practitioner because RHCs are not authorized distant site providers. Also, these practitioners cannot bill Medicare Part B while they are working for a Medicare RHC since Medicare is paying the RHC through the Medicare RHC cost report an all-inclusive rate per visit that includes all direct and indirect costs, such as the practitioner's services, space to provide those services, support staff services, related supplies, records costs, and other services. To allow separate Medicare Part B physician fee schedule payment to a practitioner while that practitioner is working for the RHC would result in duplicate Medicare payment for the telehealth service; once through the Medicare RHC cost report and again through the Medicare Part B physician fee schedule payment.

We are interested in exploring ways to allow RHC practitioners to furnish distant site telehealth services in a way that will not result in duplicate payment, especially for services such as mental health services, which are particularly limited in rural areas.

Therefore, we are requesting comments on potential changes we could make to Medicare Provider Reimbursement Principles contained in Health Insurance Manual 15–1, Medicare RHC cost report/instructions contained in Health Insurance Manual 15–2, and other Medicare policies that would allow RHCs to furnish telehealth services. Commenters should address how any suggestions for changes or exceptions would prevent duplicate payment—that is, ensure Medicare is not paying for the same costs to the RHC on the basis of allowable cost and the physician fee schedule under the telehealth benefit. We are particularly interested in comments that address these concerns without adding undue additional cost

reporting and compliance burdens on RHCs to ‘‘carve out’’ or separate those costs that would otherwise be paid under the RHC benefit when Medicare is making physician fee schedule payments. Given the interest in encouraging the provision of mental health services in rural areas, we are interested in comments addressing whether changes should apply to all services that could potentially be provided through telehealth or only specific services such as mental health. If commenters believe these changes should only apply to specific services, we are interested in which services should be subject to these special rules and a policy justification for why these services are different than other services that could potentially be subject to special commingling rules.

Hospice Services

The hospice statute (section 1861(dd) of the Act) authorizes physicians and NPs to be attending physicians for Medicare beneficiaries that elect the Medicare hospice benefit. RHCs are not statutorily authorized to be hospice providers, and can only treat hospice beneficiaries for medical conditions not related to their terminal illness.

In some rural areas, the RHC may be the only source of health care in the community, and there may be no other providers available during RHC hours to provide services that are related to a beneficiary's terminal illness. While RHC practitioners are eligible to furnish and bill for hospice services when they are not working at the RHC, they cannot furnish and bill for hospice services as an RHC practitioner because RHCs are not authorized to be attending physicians for hospice. Also, these practitioners cannot bill Medicare Part B while they are working for a Medicare RHC since Medicare is paying the RHC through the Medicare RHC cost report an all-inclusive rate per visit that includes all direct and indirect costs, such as the practitioner's services, space to provide those services, support staff services, related supplies, records costs, and other services. To allow separate Medicare Part B physician fee schedule payment to a practitioner while that practitioner is working for the RHC would result in duplicate Medicare payment for the hospice service; once through the Medicare RHC cost report and again through the Medicare Part B physician fee schedule payment.

We are interested in exploring ways to allow RHC practitioners to furnish hospice services in a way that will not result in duplicate payment, especially in areas with limited hospice providers.

Therefore, we are requesting comments on potential changes we could make to Medicare Provider Reimbursement Principles contained in Health Insurance Manual 15–1, Medicare RHC cost report/instructions contained in Health Insurance Manual 15–2, and other Medicare policies that would allow RHCs to furnish hospice services.

Commenters should address how any suggestions for changes or exceptions would prevent duplicate payment—that is, ensure Medicare is not paying for the same costs to the RHC on the basis of allowable cost and the physician fee schedule under the hospice benefit. We are particularly interested in comments that address these concerns without adding undue additional cost reporting and compliance

burdens on RHCs to ‘‘carve out’’ or separate those costs that would otherwise be paid under the RHC benefit when Medicare is making hospice payments.