NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

September 13, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1751-P
P.O. Box 8010
Baltimore, MD 21244–1850

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 4,900 federally certified Rural Health Clinics (RHC), we are pleased to provide the following comments on the proposed 2022 Medicare Physician Fee Schedule (PFS). Our comments are focused on the following issues:

- RHC Mental Health Services Provided Via Telehealth
- Remote Physiological Monitoring and Remote Therapeutic Monitoring
- Grandfathered RHC Payment Methodologies
- Consolidated Cost Reports
- Payment for Attending Physician Services Furnished by RHCs to Hospice Patients

RHC Mental Health Services Provided Via Telehealth

We are very pleased to see that CMS is proposing to re-define what constitutes an RHC visit in order to address the discrepancies in telehealth regulations between fee-for-service and RHC providers in place prior to the public health emergency. These previous policies unjustly penalized critical safety-net facilities in their provision of care, and NARHC is grateful for the components of the MPFS that ensure RHCs are not left behind and that their services better reflect contemporary medical practice by allowing them to provide mental health services via telehealth beyond the end of the public health emergency.

By including encounters "furnished through interactive, real-time telecommunications technology, but only when furnishing services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder" within the definition of a mental health RHC encounter, CMS is ensuring that RHC patients receive similar access to mental health care as beneficiaries covered by practitioners paid under the PFS.

NARHC is additionally grateful for the inclusion of audio-only communications technology in this provision, taking into account clinical judgement and patient needs. This especially benefits rural patients with poor broadband infrastructure.

We are thankful that the decision to incorporate mental health services provided via telehealth into the definition of a mental health visit allows RHCs to be reimbursed at their normal all-inclusive rate instead of the special temporary payment mechanism, reducing administrative burden and ensuring that providing equitable mental health remains a component of RHC provided care.

NARHC appreciates CMS seeking comment regarding the in-person service requirement associated with the furnishing of telehealth services. We strongly support the proposal that an "in-person service (without the use of telecommunications technology) be provided at least every 6 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, which would be documented in the patient's medical record."

We believe that this requirement protects the integrity of the telehealth benefit. Additionally, it aligns with fee for service provider in-person requirements. Furthermore, these requirements ensure some level of physical proximity between the patient and provider which is valuable in the event of in-person mental health care needs. Ensuring that RHC patients receive mental health care via telehealth in a location reasonably situated to where they receive in-person care would provide the most comprehensive option in meeting patient needs.

Additionally, CMS seeks comments on how to address scenarios when multiple providers within the same practice may need to provide services to eligible telehealth patients. NARHC encourages CMS to allow individuals who become established patients through in-person visits with a provider in an individual RHC to receive mental health services via telehealth from any other, eligible and qualified provider in the same RHC. This would ensure continuity of care for RHC patients, without the requirement that they re-establish themselves with additional providers in the same clinic in order to utilize mental health services provided via telehealth.

Finally, NARHC is appreciative of the ways in which CMS is ensuring the definition of an RHC encounter does not become outdated and looks forward to engaging in continued conversations with CMS as to further expansions of an "RHC visit" as we approach the end of the public health emergency.

NARHC's preferred policy is that RHCs will be reimbursed for visits provided via telehealth at their normal all-inclusive rate as they are for face-to-face visits. The 2022 MPFS proposed rule demonstrates that CMS has the authority to create a new definition of a "visit" via rulemaking and that revising this definition would not require any statutory changes. Therefore, we believe this can be expanded to allow *all* Medicare services provided via telehealth to be reimbursed as a normal, face-to-face visit, as many state Medicaid programs have already established.

Remote Physiological Monitoring and Remote Therapeutic Monitoring

NARHC is pleased that CMS continues to expand the digital health services codes covered under Medicare for fee-for-service providers. Unfortunately, however, Rural Health Clinics continue to lag behind these providers as CMS has not applied these expansions and considerations to RHCs. As safety net providers, RHCs are crucial in providing comprehensive care to underserved populations and to do so, should have equal access to reimbursement of these enhanced digital health services.

In years past, when Medicare has created new non-face-to-face benefits such as Virtual Care Communications and Chronic Care Management, CMS has created mechanisms for RHCs to provide and bill for these services. However, in the case of RPM and RTM services, CMS has not yet created a way for RHCs to provide and bill for these benefit. Unfortunately, on this issue, CMS has left RHCs and the patients they serve behind.

We urge CMS to either re-define an RHC visit to include RPM and RTM services (as was done with mental health services provides via telehealth) or to create a separate G-code to allow RHCs to bill for RPM and RTM services as was done with G0071 (Virtual Care Communication) and G0511 (Chronic Care Management).

Grandfathered RHC Payment Methodologies

The Consolidated Appropriations Act of 2021 contained significant reforms to the way RHCs are reimbursed by Medicare. As a result of this legislation, the RHC upper payment limit, or cap, will rise to $190 by 2028. All RHCs that were previously uncapped are considered "grandfathered-in" and receive clinic-specific upper-limit payment rates based on their 2020 rates.

NARHC is appreciative of the direction that CMS provided in both guidance and rulemaking related to the operationalization of these significant RHC payment reforms.

CMS proposes that grandfathered RHCs use the cost reporting period that ends in calendar year 2020 to establish the clinic-specific upper payment limit. CMS explains the intended process as the following:

> Therefore, with regard to "services furnished in 2020" we interpret this to mean the period at which the services were furnished in 2020 and that costs for those services were reported. We understand that there may be more than one cost report that reports costs for services furnished in calendar year 2020. However, since section 130 of the CAA 2021 states that the "per visit payment amount" is to be increased by the CY 2021 MEI, if a provider has a cost reporting period that differs from a calendar year time-period then the MACs should use data based on the relevant cost report period ending in 2020.

While it is clear that CMS is proposing to use the cost report period ending in 2020, CMS does not specify whether the clinic specific upper payment limit will be adjusted when the cost report period ending in 2020 is settled. NARHC strongly suggests that the clinic specific upper payment limits should be based on the **final** cost-settled rates for cost report periods ending in 2020, not an **interim** rate.

CMS explains that they "interpret 'per visit payment amount' to align with the interim rate process the MACS use in determining an RHC's AIR." However, the use of "align" in this context is unclear. Interim rates determined for RHCs during 2020 would be based on cost report periods ending in primarily 2019, not 2020.

To be appropriately reflective of individual clinic's true costs, NARHC believes that grandfathered, clinic specific, upper payment limits should be based on the **final** cost settled amount for cost reporting periods that end in 2020, or 2021 (for grandfathered RHCs that do not have cost reporting period that end in 2020). If an interim final rate is necessary for the time period before final cost settled rates are adjudicated, NARHC suggests that CMS set interim clinic specific upper limits only until such time that a final rate is established.

Lastly, in the proposed rule CMS provided no guidance regarding grandfathering status following an RHC change of address or change of ownership. The statute is clear that these RHCs should maintain their grandfathered status and clinic specific upper payment limit in these scenarios. NARHC requests

that these policies be explicitly addressed in CMS guidance as RHC business decisions are currently stalled due to a lack of clarity on these issues.

Consolidated Cost Reports

CMS recognized the advantages in RHCs filing consolidated cost reports; however, in the proposed rule determined that it will "no longer allow new RHCs to file consolidated cost reports" due to the national statutory payment limit that all new RHCs now face.

NARHC strongly implores CMS to revise this proposal. While we agree that non-grandfathered and grandfathered RHCs should not be permitted to file a consolidated cost report, new RHCs should be able to continue filing consolidated cost reports with other RHCs also subject to the national statutory payment limit.

Due to the benefits that CMS itself recognizes such as consolidated cost reports allowing "RHCs to take advantage of administrative efficiencies and economies of scale that do not exist otherwise," CMS should revise the proposal to only prohibit consolidated cost reports when grandfathered and non-grandfathered RHCs are combined.

Payment for Attending Physician Services Furnished by RHCs to Hospice Patients

NARHC is pleased to see that beginning January 1, 2022, RHC clinicians will be able to provide attending physician services to hospice patients and be reimbursed for these as traditional RHC encounters.

CMS did not specify in the proposed rule which revenue code(s) RHCs can use when billing for these encounters and NARHC requests that CMS provide this clarity in the PFS final rule.

Finally, NARHC encourages CMS to allow RHC patients to change their attending hospice provider after they have made their initial election to receive hospice benefits, not only at hospice benefit enrollment. This would allow flexibility for the patient and further align this policy with fee for service providers.

Conclusion

Your consideration of these comments/questions is appreciated. Should you have any questions or need any additional information, please do not hesitate to contact Bill Finerfrock or Nathan Baugh at (202) 544-1880.

Sincerely,

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