September 6, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244–8016

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 5,200 federally certified Rural Health Clinics (RHC), we are pleased to provide the following comments on the proposed 2023 Medicare Physician Fee Schedule (PFS). Our comments are focused on the following issues:

- New Care Management Codes Billable in RHCs
- Telehealth
- Grandfathered RHC Payment Methodology
- Medicare Economic Index (MEI) Rebasing

**New Care Management Codes Billable in RHCs**

Since 2016, RHCs have been able to bill for Chronic Care Management (CCM) services through a consolidated care management code: G0511. Over the last several years the services eligible for reimbursement through G0511 have expanded. As safety net providers, RHCs have long been providing comprehensive care beyond the confines of a standard visit, and NARHC commends CMS for retaining a mechanism for RHCs to provide and bill for these services that would not fit our traditional definition of a reimbursable encounter.

During CY 2022, RHCs bill HCPCS code G0511 for any of the services described by codes 99484, 99487, 99490, 99491, 99424, and 99426. G0511 pays a consolidated fee schedule amount, $79.25 in 2022, which is the average of the Physician Fee Schedule (PFS) rates for these CCM and principal care management (PCM) services furnished by a physician or other qualified health care professional.
In this proposed rule, CMS aims to establish new care management codes for Chronic Pain Management (CPM) and General Behavioral Health Integration (GBHI) described as the following:

General Behavioral Health Integration

> *"Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;*

*facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare law to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team."*

Chronic Pain Management

*"(1) HCPCS codes GYYY1: Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, and community based care, as appropriate.* ***Required face-to-face visit at least 30 minutes provided by a physician or other qualified health professional;*** *first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using GYYY1, 30 minutes must be met or exceeded.)*

*and (2) HCPCS code GYYY2: Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month)."*

NARHC is pleased that CMS continues to expand the care management services billable under the G0511 code. As a general rule of thumb, we believe that providers should be able to provide the same suite of services in the RHC setting as fee-for-service providers are able to provide in a traditional office setting.

However, adding CPT codes to the suite of care management services billed through G0511 is only necessary when the services do not meet the definition of an RHC encounter. GYYY1 and GYYY2 clearly meet the definition of an RHC encounter: a face-to-face encounter between a patient and an RHC practitioner during which a qualified service is furnished. **Therefore, Chronic Pain Management should be billed as an RHC encounter and reimbursed at the RHC's All-Inclusive Rate (AIR), not billed through the G0511 payment system**.

As we mentioned above, NARHC is generally supportive of the addition of care management codes for those services that do not meet the current definition of a RHC encounter yet are beneficial to the provision of comprehensive care for RHC patients, such as care coordination services. However, as these services continue to expand, it raises a few points for consideration.

RHCs are paid based on a cost-per visit methodology subject to certain upper payment limits. Once the RHC files their cost report, an "All-Inclusive Rate" or AIR is established and the RHC is reimbursed at this rate for every single RHC encounter they provide throughout the next year. However, over the years, RHC reimbursement policy has evolved to include a variety of different methodologies and systems cobbled together. Unfortunately, this evolution has made RHC billing and coding rules more complicated than necessary.

CMS seeks comments on potential methodologies as the number of care management services continues to grow. NARHC encourages the consideration of a more sustainable policy, reiterating our comments from the 2021 MPFS proposed rule where we argued that care management services (and telehealth services) could all be reimbursed through the All-Inclusive Rate payment methodology if CMS agreed to revise the definition of an RHC medical visit.

Since 2016, G0511 has come to represent a wider and wider array of services and CMS has created other G-codes to bundle together different groups of services that do not meet the RHC definition of an encounter.

NARHC continues to be appreciative of the ways in which CMS allows for RHCs and FQHCs to bill for these innovative services, however, we remain concerned that this bundled approach (i.e., G50011, G5012, G0071, and G2025) serves as a band-aide solution to the core problem: an outdated definition of a "medical visit."

The following table breaks down the current bundled payment policy. In some cases, CMS has created a way for RHCs to bill for such services, in other cases there is not a billing mechanism for RHCs. As more and more services are added to this list and new bundles are created, the reimbursement rules for RHCs only get more confusing.

**Non-Face-to-Face Services CPT Codes and Corresponding RHC Codes Crosswalk Table**

| **Services** | **PFS CPT Code(s)** | **RHC Code** |
|---|---|---|
| Virtual Care Communications, Virtual Check-in | G2010, G2012 | G0071 |
| Digital E-visits (during the PHE) | 99421, 99422, 99423 | G0071 |
| General Care Management Chronic Care Management | 99490, 99487, 99484, 99491 | G0511 |
| Principal Care Management | 99424, 99425 | G0511 |
| Psychiatric collaborative care model | 99492, 99493 | G0512 |
| Diabetes Prevention Program | G9873, G9874, G9875 etc. | **N/A** |
| Remote Patient Monitoring | 99453, 99454, 99457, 99091 | **N/A** |
| Distant Site Telehealth Visit | 278 different CPT codes | G2025 |

The current definition of an RHC encounter was appropriate and adequate in 1977 when health care was largely provided via traditional in-person, face-to-face office visits. However, as healthcare delivery evolves, the strict definition of an RHC visit becomes increasingly outdated.

CMS defines a Rural Health Clinic "visit" in 42 CFR 405.2463 as:

**§ 405.2463 What constitutes a visit.**

**(a)** ***Visit - General.***

**(1)** For RHCs, a visit is either of the following:

**(i)** Face-to-face encounter between a RHC patient and one of the following:

**(A)** Physician.
**(B)** Physician assistant.
**(C)** Nurse practitioner.
**(D)** Certified nurse midwife.
**(E)** Visiting registered professional or licensed practical nurse.
**(G)** Clinical psychologist.
**(H)** Clinical social worker.

**(ii)** Qualified transitional care management service.

**(b)** ***Visit - Medical.***

**(1)** A medical visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

**(i)** Physician.
**(ii)** Physician assistant.
**(iii)** Nurse practitioner.
**(iv)** Certified nurse midwife.
**(v)** Visiting registered professional or licensed practical nurse.

**(3)** ***Visit - Mental health.*** A mental health visit is a face-to-face encounter or an encounter where services are furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio/video interaction for the purposes of diagnosis, evaluation or treatment of a mental health disorder between a RHC or FQHC patient and one of the following:

**(i)** Clinical psychologist.
**(ii)** Clinical social worker.
**(iii)** Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

NARHC and the RHC community were elated by the 2022 MPFS final rule which changed the definition of an RHC *mental health* encounter to include visits performed via telecommunications or audio-only technology. We believe this sets a promising precedent that CMS can update the definition of an encounter as care delivery evolves over time.

However, the current definition of a medical visit in an RHC continues to be prohibitive as it often does not mesh well with new healthcare services such as the diabetes prevention program, care management services, telehealth services, virtual communications services, and medical telehealth visits. Due to the definition of an encounter, none of these "new" healthcare services generate billable RHC visits.

We recognize that some may argue that RHCs are already paid for these new healthcare models and services through the All-Inclusive Rate. One might theorize that because the RHC would have higher allowable costs delivering these services, and thus a higher AIR, they are paid for services they cannot bill through a higher reimbursement rate on those services that are billable. However, this argument does not take into consideration that all RHCs are subject to a cap on their cost-based reimbursement, either the national statutory cap or a clinic-specific upper payment limit nor does the argument account for the methodology that sets each clinic's AIR. Most RHCs have costs per visit that are above or at their upper

payment limit and therefore for most RHCs, adding costs without generating additional visits, leaves these RHCs with no additional reimbursement.

However, if the definition of an RHC visit was amended to allow for additional services to be counted as encounters, the RHC's total cost would be divided by a greater number of visits, resulting in a lower ultimate cost per visit and payment. If CMS made the All-Inclusive Rate truly all-inclusive of any service that is otherwise billable by a traditional office on the fee schedule, it would mean that all of these services would be billable in an RHC setting as well.

Ultimately, it is critical that safety net providers continue to see the same opportunities to expand services and methods of care as fee-for-service providers. Unfortunately, in the case of certain digital health services codes such as Remote Physiological Monitoring (RPM) and Remote Therapeutic Monitoring (RTM), RHCs and FQHCs lag behind as CMS has not either re-redefined the RHC visit definition to include these services or created a separate G-code as was done with other digital services. Furthermore, Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) sessions furnished by a certified DSMT or MNT program may also be considered FQHC visits for Medicare payment purposes, while not considered RHC visits. NARHC strongly believes that if FQHCs have a way to provide and bill for DSMT and MNT, so too should RHCs. RHCs remain essential in providing comprehensive care to underserved populations and to do so, should have equal access to reimbursement of these enhanced digital health services.

**For these reasons, NARHC urges CMS to create a new definition of an RHC medical visit. We believe that the AIR payment model can and should be used to pay RHCs for these new services. Such a change would greatly simplify RHC billing, reimbursement and cost reporting and would make it easier for RHCs to recoup their Medicare costs, as the RHC program was designed.** We would reiterate that the statute does allow CMS to create a new definition of a "visit" via rulemaking, as evidenced by the 2022 MPFS, and that rethinking this definition would NOT require any statutory changes.

***Annual Wellness Visit as Separate Medical Visit***

For preventive services furnished in RHCs on the same day as another medical visit, other than initial preventive physical examinations (IPPEs), RHCs receive their all-inclusive rate for a single billable visit as these services are not eligible for same day billing, i.e. two visits billed on the same day and separately reimbursed. This stipulation results in disparities between preventive care eligible for adequate reimbursement in the RHC versus fee-for-service provider settings.

As CMS continues to make significant strides towards increasing access to preventive care for Medicare beneficiaries, it is essential that RHCs are adequately reimbursed when these services are provided to their patients. **NARHC encourages CMS to further amend the definition of an RHC medical visit, section (c) Visit-Multiple to the following:**

**(c)** ***Visit—Multiple***.

**(1)** For RHCs and FQHCs that are authorized to bill under the reasonable cost system, encounters with more than one health professional and multiple encounters with the same

health professional that take place on the same day and at a single location constitute a single visit, except when the patient—

> **(i)** Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;
> **(ii)** Has a medical visit and a mental health visit on the same day; or
> **(iii)** Has an initial preventive physical exam visit, **or annual wellness visit, when provided by a qualified RHC practitioner,** and a separate medical or mental health visit on the same day.

**Telehealth**

NARHC appreciates the continued telehealth flexibilities granted by Congress in the Consolidated Appropriations Act of 2022, extending RHCs ability to provide telehealth services until the 152nd day after the conclusion of the Public Health Emergency, and for the conforming technical changes made by CMS in this proposed rule to reflect the policies.

We remain grateful that mental health services provided via telehealth were incorporated into the definition of a mental health RHC visit, allowing 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. However, the positive steps made are currently hindered by the lack of clarity.

CMS has yet to provide critical guidance which greatly limits RHC's confidence in offering these important services to their patients. **NARHC continues to seek clarity for the RHC community on the following:**

- Beginning on the 152nd day after the end of the PHE when the in-person mental health via telehealth requirements begin, it is unclear whether the RHC provider providing the telehealth services needs to be the same provider the patient sees in-person, or if it may be another provider within the RHC. NARHC encourages CMS to allow patients the flexibility to see a different provider for their in-person visit than their telehealth visit, when appropriate, to ensure continuity of care for RHC patients.
- It remains unclear which telehealth eligible services should be billed as mental health services reimbursed at the RHC's AIR versus billed G2025. There are seven behavioral health qualified visits on the Rural Health Clinic Qualifying Visit List (QVL). While this list has not been updated by CMS since 2016, it remains a resource for many RHCs as a list of services which meet the definition of an RHC encounter and are billable as such. Of the 278 CPT codes billable under G2025, more than 7 appear to fit the behavioral health category and also meet the definition of an RHC visit.

The billing challenges outlined above emphasize one of many benefits in further expanding the definition of an RHC visit to allow for all telehealth services to be RHC encounters. NARHC is appreciative of the ways in which CMS is ensuring the definition of an RHC encounter does not become further 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 and its associated telehealth flexibilities.

If CMS is forced by Congress to continue the "special payment rule" for RHC and FQHC telehealth reimbursement, NARHC believes that CMS should use normal CPT coding, instead of G2025. NARHC argues that the special payment can be indicated through a modifier code (95) and such a change would allow services like Annual Wellness Visits to be properly counted. Furthermore, NARHC believes that CMS should consider valuing the composite payment for telehealth services on a weighted average of telehealth services provided by fee-for-service providers. The current methodology may disadvantage RHC and FQHC telehealth visits by not factoring in the true average reimbursement received by fee-for-service providers for telehealth services. The composite payment should not be worse than the average reimbursement actually received by traditional fee-for-service providers for telehealth services.

**Grandfathered RHC Payment Methodology**

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 statutory payment cap, will rise by $13 until it reaches $190 in 2028. All RHCs that previously received fully uncapped reimbursement 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 has provided throughout the implementation of these new payment methodologies and the ways in which the agency has been responsive to stakeholder comments on the issue. NARHC is supportive of the ways that various aspects of the policy were finalized in the 2022 MPFS such as clarifying the use of *final* cost settled rates instead of interim rates, change of ownership implications, and allowing for consolidated cost report filing, so long as the RHCs fall within the same national statutory payment limit.

CMS now proposes that in setting clinic-specific upper payment limits for RHCs which had an All-Inclusive Rate (AIR) established for services furnished in 2020, MACs should use the cost report ending in 2020 that reports costs for **12 consecutive months**. In the event that the RHC does not have a cost report ending in 2020 that reports on 12 consecutive months of cost data, MACs should use the next most-recent final settled cost report that reports costs for 12 consecutive months. For those RHCs that did not have an AIR established for services furnished in 2021, MACs are directed to use the cost report ending in 2021 (or the next most-recent final settled cost report) that again, reports costs for 12 consecutive months.

**NARHC strongly supports this proposal as it will ensure that grandfathered RHCs have the most accurate payment limit base moving forward.**

**Medicare Economic Index (MEI) Rebasing**

NARHC acknowledges and appreciates the proposal to rebase the MEI for CY 2023. As the MEI is used to adjust RHC upper payment limits, it is critical to RHC providers that this metric is appropriately reflective of current market conditions.

Ultimately, however, the percent change of the proposed 2017-based MEI for CY 2023 is an increase of 3.8 percent, while the 2006-based MEI would result in a 3.7 percent increase. This increase still remains significantly behind the high inflation rates impacting providers today.

**NARHC encourages CMS to remain attentive to the inflationary impacts on providers now and over the coming years and address the MEI formula accordingly.**

**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 Nathan Baugh or Sarah Hohman at (202) 544-1880.

Sincerely,


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