NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

September 9, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1807-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 5,500 federally certified Rural Health Clinics (RHC), we are pleased to provide the following comments on the proposed 2025 Medicare Physician Fee Schedule (PFS). NARHC serves as the only national organization exclusively dedicated to improving the delivery of quality, cost-effective health care in rural, medically underserved communities through the Rural Health Clinics (RHC) Program.

We commend CMS for many significant ways that the CY25 proposals support RHCs and focus our comments on the following issues in order to provide additional color to their implications for clinics across the country.

- Care Management
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    - *Registered Nurses Performing Annual Wellness Visits*
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Care Management

Since 2016, RHCs have been able to bill for care management services through a consolidated care management code: G0511. Over the last several years, the services eligible for reimbursement through G0511 have expanded and now include Chronic Care Management (CCM), Principal Care Management (PCM), General Behavioral Health Integration (GBHI), Chronic Pain Management (CPM), Remote Physiologic Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community Health Integration (CHI), and Principal Illness Navigation (PIN). 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.

However, as NARHC has shared with CMS in the last few years, this increasingly complex consolidated system has evolved into something that creates a myriad of problems. While we were pleased that CMS changed guidance in 2024 to allow RHCs to bill for more than one G0511 code per patient per month, feedback from our community indicates that this policy was being operationalized differently by various MACs, and the operational complexities of the consolidated system led many RHCs to simply not participate.

Therefore, in alignment with CMS thinking on the value of these care management services and the complexities of patient care that go well beyond a traditional office visit, we support the proposal to eliminate the G0511 consolidated code and instead allow RHCs to bill, on the UB-04 claim form, for the individual fee schedule codes in the care management suite of codes (found in Table 24 of the proposed rule).

We believe that the benefits of this proposal, increased transparency as to the specific services being provided by RHCs, the ability for RHCs to bill for add-on/time-based codes, and the reduced administrative complexity of the system overall, outweigh the potential for a slight decrease in reimbursement for certain clinics.

If this proposal is finalized, we strongly encourage CMS to ensure that all guidance documents, directions to MACs, etc. are issued as soon as possible to avoid disruptions in reimbursement for the RHCs and disruptions in care for patients receiving care management services.

We look forward to seeing the expanded opportunities for RHCs to participate in care management services under this new system that better aligns with the opportunities available to their fee-for-service peers.

Care Management Co-Insurance Clarification

Rural Health Clinic care management co-insurance is currently set at the lesser of patient charges or the G0511 amount. We are **requesting clarification** as to what co-insurance will be based on under the new system.

New Codes for Advanced Primary Care Management (APCM) Services
On behalf of the RHC community, NARHC appreciates the continued recognition by CMS as to the immense value of and the development of new opportunities for investment in primary care. Further, we appreciate CMS proposing to grant RHCs the ability to bill for APCM services at the same time as the opportunity was created for FFS providers, unlike certain CMS Innovation Center models that RHCs are precluded from participating in.

These new codes will likely give RHC providers flexibility in choosing the most appropriate care management option for their patients and the clinic's capacity – whether they elect to perform and bill for individual care management services, *or* the consolidated codes based on complexity of patient conditions.

We support CMS's proposal that these services can be provided by auxiliary personnel under the general supervision of the billing practitioner and appreciate the clarity as to which care management services can be billed simultaneously with APCM codes versus those that are considered duplicative.

CMS specifically asked whether a provided template would be beneficial to facilitate patient consent, and we encourage CMS to provide as many templates and other resources as possible to encourage uptake of these expanded care management opportunities.

We request confirmation that if a beneficiary received a G0511 service within the previous year with the practitioner or another practitioner in the same practice, that they would **not** require an initiating visit for APCM services. CMS is clear that patients who previously received CCM and PCM services in the last year would not require an initiating visit but given distinct RHC billing this confirmation is important.

If the APCM codes are finalized as proposed, the RHC community looks forward to additional sub-regulatory guidance to help implement these services, where appropriate. In particular, we do have concerns that not all small, rural providers may have the capacity to meet all APCM billing requirements, specifically in analyzing patient population data, risk stratifying the practice population, etc. *Advanced* primary care management may be considerably different in an underserved, rural area than in an urban or suburban setting. Thus, requiring similar levels of technological and other capacity to provide these services may not be appropriate. We encourage CMS to consider some flexibility on these high-capacity requirements for safety-net providers. Finally, we are **requesting clarification** as to what co-insurance will be based on for RHCs providing APCM services.

Request for Information Aligning with Services Paid Under the PFS / Request for Information for Services Addressing Health-Related Social Needs
NARHC appreciates CMS seeking comment on improving transparency and predictability regarding which codes are considered care coordination services and how they can apply to RHCs in a more streamlined and seamless way when granted to fee-for-service providers. Additionally, we appreciate CMS encouraging comment on specific new health-related social needs codes billable in 2024. Given the overlap in these RFIs, we are commenting on both below.

Firstly, **NARHC again urges CMS to permit RHCs to bill for and generate an additional reimbursement for the Social Determinants of Health (SDOH) Risk Assessment (G0136) and the Complex E/M add-on code (G2211), as FFS providers can.** Over 60% of people living in rural America are served by RHCs, and many face these economic and social conditions that CMS is aiming to mitigate by incorporating these services into primary care delivery, such as food insecurity, transportation insecurity, and housing insecurity.

Part of the reason why NARHC is supportive of CMS' proposal to eliminate G0511 consolidated billing and instead allow RHCs to bill for the individual care management services is because we hope that it will lead to RHCs gaining access to the same innovate opportunities to better care for their patients. For example, in this year's proposed rule CMS proposed payment for Digital Mental Health Treatment (DMHT) devices. As is recognized in this rule, RHCs are very much engaged in the treatment of behavioral health conditions, yet they are not granted the ability to bill for these new codes as they are not included in the list on page 444.

CMS also did not propose to allow RHCs to bill for six new G codes associated with interprofessional behavioral health consultations. There is a significant opportunity for this to be utilized in Rural Health Clinics as many of these providers integrate other specialty providers in their provision of comprehensive care. We urge CMS to provide RHCs with the same opportunities to bill for these types of services that do not meet the traditional definition of a face-to-face encounter, in recognition of the broader set of services provided in the primary care setting.

Telehealth

Direct Supervision via Use Two-Way Audio/Video Communications Technology
CMS proposes to allow for direct supervision of incident-to services (presence and immediate availability) via telecommunications technology through December 31, 2025. NARHC is **supportive** of this flexibility, and we have no program integrity/patient safety concerns regarding this policy. Auxiliary personnel would never be providing clinical care to patients without a qualified RHC provider on-site for compliance with a separate requirement; however, this flexibility for virtual direct supervision may decrease inefficiencies when the on-site provider is unable to supervise that particular service.

Medical Telehealth Flexibilities Alternative Proposal
NARHC appreciates CMS proposing to utilize their authority to ensure that disruptions in care are not experienced by safety-net providers and their patients using telehealth in the event Congress does not pass a telehealth extension by December 31, 2024.

However, as opposed to continuing the G2025 policy through December 31, 2025, **NARHC strongly encourages CMS to implement the alternative proposal they considered in this year's proposed rule and change the RHC medical definition of a visit to include visits done via telecommunications technology.**

Congress has recognized, since the RHC program was created in 1977, that it costs more to deliver health care in rural, medically underserved areas. Therefore, RHCs receive higher traditional Medicare and Medicaid reimbursement than their fee-for-service counterparts. However, RHCs receive

significantly less money for a medical telehealth visit than an in-person encounter. This payment differential, coupled with other challenges of utilizing telehealth in a rural area - for example, access to quality broadband - has limited RHCs' ability to invest in telehealth technologies and truly incorporate them as part of their care delivery options. Additionally, the G2025 billing system obscures claims data, preventing policymakers from understanding what RHC services are being provided via telehealth.

In the CY22 MPFS, CMS changed the mental health definition of a visit to include those done via telecommunications technology, therefore reimbursing these services through normal payment mechanisms and paying parity for in-person and telehealth visits.

We recognize that the "special payment rule" initiating this payment differential between in-person and medical telehealth visits was created by Congress, however, when this payment structure expires on December 31, 2024, we implore CMS to utilize its authority to fix a significant barrier in RHC provision of telehealth services moving forward by changing the definition of a medical visit.

CMS stated that they "determined that it [this alternative proposal] would have unintended consequences, especially in cases where the RHC AIR or FQHC PPS per-visit rates would be significantly higher than the PFS rate that would apply if other entities furnished the same service to the same beneficiary in the same location." NARHC respectfully asks CMS to elaborate on what they believe these unintended consequences may be. Again, the benefit of the RHC designation is enhanced traditional Medicare and Medicaid reimbursement. To NARHC's understanding, there has been no widespread fraud, abuse, or other unintended consequences resulting from the changed definition of a mental health visit, so there is no logical reasoning on which to base the belief that changing the definition of a medical visit would have those negative results, either.

CMS also stated that "continuing to pay temporarily for RHC and FQHC services furnished via telecommunication technologies in the same manner as we have done over the past several years preserves the flexibility for RHCs and FQHCs to continue access to care, mitigates administrative burden, and mitigates potential program integrity concerns." We again disagree. Simply offering lower reimbursement to safety net providers through a crude special payment rule because it is just a continuation of current policy is not reducing administrative burden. Instead, it continues to limit safety net providers' ability to invest in these important technologies. If there are program integrity concerns, CMS has the ability to monitor utilization of telehealth through a simple modifier code, and address issues **if** they arise. However, simply continuing the disparate policy is not an appropriate guardrail and continues to have the potential to limit access to care.

We appreciate CMS evaluating their authority here and urge them to further consider the alternative proposal to change the definition of an RHC visit. This option would protect the integrity of the program without disadvantaging the country's safety net providers.

Telehealth Outside of RHC Hours of Operation Clarification

In the 2024 MPFS Proposed Rule, NARHC requested clarification from CMS as to whether distant site telehealth services may be provided outside the RHC's hours of operations. NARHC believes that RHCs should **not** be limited to only offering telehealth during the hours of operation of the physical RHC as such a policy would only limit access to care for safety-net patients. Further, other providers are not

limited to only providing telehealth services during posted hours and we believe this flexibility should extend to RHCs.

In the 2024 final rule, CMS stated the following: “Currently, RHCs and FQHCs are required to furnish services during their hours of operation and if services are furnished at times other than the RHC’s or FQHC’s posted hours of operation, they may not be billed to Medicare Part B if the practitioner’s compensation for these services is included in the RHC/FQHC cost report. This policy is discussed in Pub. 100-02 Medicare Benefit Policy Manual, Chapter 13, section 40.2 “Hours of Operation.”” This has not fully clarified CMS policy here for the RHC community. Section 40.2 also states “Qualified services provided to an RHC or FQHC patient other than during the posted hours of operation are considered RHC or FQHC services when the practitioner is compensated by the RHC or FQHC for the services provided, and when the cost of the service is included in the RHC’s cost Report."

We request CMS to confirm in writing what “billing to part B” means. We believe that based on the above guidance that after-hours telehealth is only not billable to Part B (as in physician fee schedule reimbursement on the 1500) and therefore IS allowable as an RHC service billed to Part A (if costs are accounted for). If this interpretation is CMS intent, we ask for that to be more explicitly stated in the final rule.

Audio-Only Communication Technology
We appreciate CMS proposing to permanently cover audio-only communication technology. This flexibility is imperative for rural providers and patients' abilities to utilize these emerging technologies in areas where adequate broadband access has not yet been achieved, or in situations where patients do not otherwise have access to video technology.

Intensive Outpatient Program (IOP) Services

NARHC appreciates Congress establishing Medicare coverage for Intensive Outpatient Program (IOP) Services in RHCs beginning January 1, 2024, and thanks CMS for promulgating and updating regulations on these services as RHCs consider expanding their behavioral health services to include this program.

In our 2024 comments, NARHC expressed support for the codified changes to the RHC IOP scope of benefits and services, certification, plan of care requirements, and special payment rule methodology. However, currently RHCs are limited to just billing for the 3-service days, even if they provide more services to patients. We urged CMS to grant RHCs the same opportunities as hospital-based IOPs to bill, and be adequately reimbursed for, the furnishing of 4-service days as well as 3-service days, depending on the number of services appropriate for their patients.

Therefore, we support the 2025 proposal to provide a payment rate for 4 or more-services per day in the RHC setting, aligned with the 4 or more-services per day for hospital outpatient departments. This parity, and access to equal opportunities to engage in the services, is critical for supporting safety-net utilization of these new programs.

Payment for Preventive Vaccine Costs in RHCs

RHC statute requires that flu, COVID-19, and pneumococcal vaccines and their administration to Medicare patients must be reimbursed at 100% of reasonable costs, instead of the 80% limit that applies to other services. The hepatitis B vaccine has been reimbursed as part of the RHC All-Inclusive Rate, however no insurance or deductible applies given that it is a preventive service.

NARHC appreciates CMS hearing RHC concerns about the Medicare vaccine reimbursement process and the cash flow challenges that result from the wait time between purchasing and administering vaccines and the cost report settlement. **We support the proposal to allow RHCs to bill for the administration of pneumococcal, flu, COVID-19, and hepatitis B vaccines at the time of service beginning on July 1, 2025 in order to address these cash flow challenges.**

However, this proposed change will **not** fix the underlying issue of the cost report mechanism used in the settlement. More specifically, the high-dose vaccines often needed for Medicare patients are more expensive, and not appropriately accounted for when averaged with other, non-Medicare lower-cost vaccines. This may lead to RHCs being required to pay Medicare back at the time of settlement.

In addition to clarifying billing details of this change in their issuance of cost reporting instructions and sub-regulatory guidance prior to July 1, 2025 - such as whether RHCs will bill vaccines to Part B on a CMS-1500, or on a UB-04 like traditional RHC claims - we encourage CMS to consider the underlying settlement methodology.

Finally, **we support CMS aligning RHCs with PFS providers in allowing RHCs to bill HCPCS code M0201** when one of these four preventive vaccines are administered in a patient's home.

Productivity Standards

Currently, RHC productivity standards are established as 4,200 visits per full-time equivalent (FTE) physician and 2,100 visits per FTE nurse practitioner, PA, and certified nurse midwife. Other RHC practitioners are not subject to productivity standards, nor are FQHCs or other similar facilities.

Since all RHCs are now subject to some sort of upper payment limit (either the clinic specific cap for grandfathered RHCs or the national statutory cap for new and independent RHCs), the productivity standards have less impact as a cost control measure. Additionally, as patient care evolves from traditional, quick face-to-face encounters to more comprehensive, various modality care, meeting these standards, particularly for physicians, is becoming more challenging.

NARHC greatly appreciates CMS acknowledging these perspectives by proposing to eliminate productivity standards and are in full support of this proposal.

Payment for Dental Services Furnished in RHCs

While Medicare is precluded from paying for most dental services, including routine cleanings and treatment, exceptions are made for certain outpatient services if the dental service is "inextricably linked to, and substantially related and integral to the clinical success of, other covered services," including

certain conditions treated in RHCs. If the service meets the "inextricably linked" standard and is provided by a dentist in the RHC, it will qualify as an encounter and be paid the RHC's All-Inclusive Rate.

Reliable, quality dental care is greatly needed in rural communities. NARHC appreciates CMS using their authority to provide Medicare coverage of these inextricably linked dental services. **We support the expansion of that list to include dialysis services for beneficiaries with End-Stage Renal Disease (ESRD).**

Medical and Dental Visits Furnished on the Same Day
Currently, if a patient is seen in the RHC for a medical visit and receives qualifying dental services on the same day, as well, the RHC would only be eligible for one All-Inclusive Rate reimbursement.

However, while the dental services are inextricably linked to a health condition the patient has, the services are distinct, done by a different clinical provider, and require additional equipment, supplies, and time. **Therefore, NARHC supports an exception to the same day visit limitations in the RHC and encourages CMS to allow these services to be paid as a separate billable encounter.** We believe this exception aligns with the rationale used for other same-day billing policies, i.e. separate medical and mental health visits on the same day.

Conditions for Certification Revisions

Provision of Services – Primary Care (42 CFR 491.9(a)(2)(i))
NARHC is very pleased that CMS has acknowledged the discrepancy between the RHC statute, regulation, and guidance that NARHC and other associations have raised over the past several years.

RHC statute and associated regulations stipulates that RHCs must be primarily engaged in "providing outpatient services." However, CMS State Operations Manual Appendix G explains that "RHCs may not be primarily engaged in specialized services." This has resulted in RHCs being surveyed to the requirement that more than 50% of their operating hours must be the provision of primary care services.

This has become a greater issue as more RHCs offer a host of specialty services within their facility, services that clearly meet the statutory and regulatory outpatient requirement but may tip total hours in the direction of specialty versus primary care services.

NARHC also appreciates CMS recognition that RHCs provide <u>comprehensive</u> healthcare services in underserved areas, including primary, specialty, and behavioral health services. **We support the proposed changes to the regulation at 491.9(2), intended to clarify the existing discrepancy while aligning with the RHC statute's intent.**

> (i) The clinic or center must provide primary care services.
> (ii) The clinic is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

If implemented as proposed, this would result in RHCs continuing to be required to provide primary care services, as they always have, but no longer be surveyed to a requirement that they provide more

than 50% of operating hours as primary care services, granting additional flexibility for each individual RHC's provision of services.

CMS states "This proposal would allow RHCs to provide more outpatient-specialty services within the practitioner's scope of practice to meet the needs of the patient population—for example, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, dermatology, cardiology, neurology, endocrinology, and ear, nose and throat." While there is not an exact definition of primary care in the Medicare program, 42 CFR provides a definition of how to count primary care practitioners, and includes general or family practice, internal medicine, pediatrics, and obstetrics and gynecology. In ensuring that RHCs have utmost flexibility in offering a range of services to their patients, it is important that CMS does not consider internal medicine, pediatrics, and OB/GYN services to be considered "outpatient-specialty services," and NARHC would appreciate this clarification being made in the final rule.

Provision of Services – Behavioral Health Care (42 CFR 491.9(a)(2)(ii)) / Mental Diseases Definition
RHC statute reads that a Rural Health Clinic is "only a facility which... (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases."

This has been interpreted to mean that RHCs can only provide up to 49% of their services as behavioral health services, without clear regulatory or sub-regulatory guidance as to how these services should be counted, which ultimately unnecessarily reduces patient care access to these essential services. Therefore, NARHC appreciates CMS adding language to 491.9(a)(2)(ii) and recognizing the need for additional guidance on the outdated and arbitrary language.

We agree with CMS that "mental diseases" is outdated and may have additional negative impacts on stigma and help-seeking behavior. We appreciate CMS consideration as to how they may be able to use their authority to support provision of behavioral health services within the limits of the 1977 RHC statutory language.

NARHC appreciates the questions posed on the types of behavioral health services, providers, opportunities and challenges in RHCs. Rural Health Clinics offer a variety of behavioral health services including medication assisted management, individual therapy/counseling, and substance use disorder treatment. These services are provided by psychologists, LCSWs, Psychiatric Nurse Practitioners, MFTs, and MHCs, but behavioral health services are also often provided by primary care providers as well. Integrated primary/behavioral health services have shown to be a very successful model, particularly in rural, medically underserved areas, however RHCs face the unique barrier of being limited in the amount of behavioral health services they can provide due to the interpretation of "facility which is primarily for the care and treatment of mental diseases."

We believe that CMS is risking additional unintended consequences by seeking to define such an outdated term. Instead, **NARHC strongly urges CMS to define "a facility which is primarily for the care and treatment of mental diseases."** CMS should define these facility types as Certified Community Behavioral Health Clinics (CCBHCs), Community Mental Health Centers (CMHCs), standalone Opioid Treatment Programs (OTPs), or facilities that only provide intensive outpatient services.

In the immediately prior clause, CMS follows the intent of the statute "is not a rehabilitation agency" by defining a rehabilitation *agency.* Therefore, it is appropriate, and in line with statutory authority, to define a *facility* which is primarily for the care and treatment of mental diseases, instead of the outdated term "mental diseases" itself.

If a facility is **not** a rehabilitation *agency*, nor a *facility* which is primarily for the care and treatment of mental diseases, and it provides primary care, the facility should meet RHC provisions of care eligibility. As CMS did in clarifying provision of primary care services in this year's proposed rule, they could similarly do in this section, ensuring alignment with statutory intent, without surveying to arbitrary thresholds.

Again, we believe that simply defining mental diseases, and not basing it on the facility type, has significant potential to limit access to behavioral health services provided in Rural Health Clinics, and encourage CMS to consider this alternative.

Laboratory Services
RHC statute directs the HHS Secretary to ensure that RHCs provide routine diagnostic services. CMS has historically implemented this by requiring that RHCs have the equipment and supplies within the square footage of their RHCs to offer six specific lab services: chemical examinations of urine by stick or tablet method or both (including urine ketones); hemoglobin or hematocrit; blood glucose; examination of stool specimens for occult blood; pregnancy tests; and primary culturing for transmittal to a certified laboratory.

For several years, we have been hearing from RHCs and conveying to CMS that providers rarely order the hemoglobin/hematocrit test individually, and much more frequently they are ordered as part of a full panel. When this occurs, particularly for provider-based facilities who may be in close physical proximity to their parent hospital, many send patients to the full-service lab, making the equipment within the RHC duplicative, expensive, and wasteful.

While the RHC statute requires the provision of routine diagnostic services, we greatly appreciate CMS utilizing their authority here to modify the specific list of required lab services. **We support the proposals to remove hemoglobin and hematocrit (H&H) from the listed lab services that RHCs must have the equipment and supplies to perform directly as well as updating "primary culturing for transmittal to a certified laboratory" to "collection of patient specimens for transmittal to a certified laboratory for culturing" to reflect more current clinical laboratory standards.**

As CMS clarifies, if RHCs still choose to maintain the equipment and supplies to do on-site hemoglobin and hematocrit testing to meet the needs of their patients, there is nothing precluding them from doing so, therefore the RHC community has no concerns as to how this may impact access. It will however, in many cases, save RHCs square footage and money in no longer having unused equipment within their facilities.

Finally, CMS solicited comments on evidence related to laboratory services in RHCs. In a recent webinar on the 2025 Proposed Rules, 82% of RHC respondents indicated that the necessity for RHCs to meet laboratory requirement (3) "examination of stool specimens for occult blood" was also no longer the best clinical practice. Most practices use the test that you send home with the patient which does not

qualify for the stringent requirement. Additionally, hundreds of RHCs are pediatric-only facilities. These practices would not do this lab test, however, to meet the requirement, must purchase supplies that are entirely wasteful. **Therefore, we encourage CMS to consider removing (3) "examination of stool specimens for occult blood" from the list as well.**

Drugs Covered as Additional Preventive Services (DCAPS)

NARHC appreciates CMS extending the drugs covered as additional preventive services (DCAPS) policy and reimbursement amounts to RHCs as they apply to fee-for-service providers and **supports this new proposal**. We ask CMS to clarify in the final rule whether these claims should be submitted on a UB-04 or a 1500. We also ask CMS to clarify if DCAPS would generate additional reimbursement if performed on the same day as another qualifying RHC encounter.

Other Provisions Not Addressed

NARHC thanks CMS for the significant amount of RHC related provisions in this year's proposed rule and looks forward to further engaging on the concerns outlined above in order to ensure that RHCs can fully utilize these expanded flexibilities. We were hopeful that CMS would use this rulemaking opportunity to address three additional topics of interest and concern to the RHC community which are discussed below.

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 only 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 policy creates a disincentive for RHCs to provide Annual Wellness Visits.

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.

In past years, NARHC has encouraged CMS to amend the definition of an RHC medical visit, section (c) Visit-Multiple to allow a medical visit and an Annual Wellness Visit to be paid at two separate All-Inclusive Rate payments when done for the same patient on the same day (shown below).

> ***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,** and a separate medical or mental health visit on the same day.

If this is not feasible, however, we would encourage CMS to consider, at minimum, an add-on payment when an Annual Wellness Visit is performed on the same day as a medical visit. FQHCs receive a 34.16 percent adjustment to their PPS rate when a patient is new to the FQHC, or when an IPPE or AWV is

furnished. CMS has previously stated that their "goal for the FQHC PPS is to implement a system in accordance with the statute whereby FQHCs are fairly paid for the services they furnish to Medicare patients in the least burdensome manner possible." They have stated that the 34.16 percent increase accounts for the greater intensity and resource use associated with these services. **We strongly encourage CMS to have a similar goal for RHC reimbursement and ensure fair and equitable payment for preventive services performed.**

Registered Nurses Performing Annual Wellness Visits

RHCs are only able to bill for Annual Wellness Visits (AWVs) if the patient is seen by an RHC practitioner. However, in traditional office settings, Registered Nurses (RNs) are permitted to complete all aspects of AWVs. This current policy creates a disparity between the two outpatient settings and makes it more difficult for AWVs to be performed in the RHC setting. As highlighted in various aspects of the past several year's proposed rules, CMS continues to make preventive and higher quality care a priority. **NARHC encourages CMS to amend the definition of an RHC visit, section (a) Visit-Medical to the following:**

(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.

(iii) Annual Wellness Visit.

RHC Urbanized Area Issue Finalized Policy

In March 2023, CMS released interim guidance on the process it will be utilizing to determine RHC rural location eligibility "while considering the most effective options for modifying its processes to align with the Census Bureau changes." NARHC is working with Congress to amend the statutory language and provide long-term clarity. We thank CMS for issuing this interim guidance and its use of both 2010 and 2020 maps to determine eligibility. We were pleased to see that this policy mostly preserves the historical location eligibility (areas of less than 50,000 people) for the RHC program, as we requested in our advocacy. Until Congress clarifies the issue in statute, we believe it would be beneficial to the RHC community if **CMS were to propose a more permanent policy on this issue**.

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) 543-0348.

Sincerely,

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