[Add date of submission]

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

**RE: CMS-1807-P;** Medicare and Medicaid Programs: CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment, etc.

***Submitted electronically via regulations.gov.***

Dear Administrator Brooks-LaSure,

[Your organization] is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule. We appreciate CMS’ continued commitment to the needs of rural Americans, and we look forward to our continued collaboration to improve health care access in our rural community.

[Insert short description of your organization.]

**Calculation of the CY 2025 PFS Conversion Factor.**

**[Your organization] is extremely concerned about the more than 3% decrease in physician payments compared to CY 2024**. We acknowledge that the downward adjustments to payment are statutory, but we are nevertheless troubled given the inflationary environment and supply chain challenges that rural hospitals and health care providers are facing. **We urge CMS to explore its authority to increase the PFS conversion factor to ensure that rural providers are paid at a rate that reflects the current economic and operational reality.**

**II. Provisions of the Proposed Rule for the PFS.**

*D. Payment for Medicare Telehealth Services under Section 1834(m).*

1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act.

e. Audio-Only Communication Technology To Meet the Definition of “Telecommunications System.”

CMS proposes to modify its definition of “telecommunications system” to include audio-only technology for any telehealth service furnished to a beneficiary in their home when a practitioner is technically capable of using audio-video technology, but the beneficiary does not consent to or does not have the ability to use audio-video communications. **[Your organization] strongly supports this proposal as audio-only telehealth is a critical tool for increasing access to care for rural beneficiaries.** Absent a congressional extension of Medicare telehealth flexibilities, originating site restrictions will apply again. This means that only those providers eligible to provide telehealth services pre-Public Health Emergency will be able to furnish audio-only services.

Rural patients face unique challenges in accessing both in-person and audio-video services, creating inequities in care. Rural patients, on average, travel further to access health care than their non-rural counterparts. This disincentivizes rural residents from seeking care if they do not have the ability or resources for travel. Broadband infrastructure is lacking in rural areas and computer and smartphone ownership is also lower. These factors make some rural residents incapable of using audio-video technology.

[Add your experience with audio-only telehealth, including patient stories, to emphasize the importance of audio-only coverage.]

**[Your organization] urges CMS to finalize this policy and further expand its reading of § 1834(m)(2)(A) to permanently allow for audio-only telehealth for all services beyond any congressional extension.**

2. Other Non-Face-to-Face Services Involving Communications Technology Under the PFS.

a. Direct Supervision Via Use of Two-Way Audio/Video Communications Technology.

[Your organization] supports CMS’ proposal to temporarily continue to define direct supervision to allow the presence and immediate availability of the supervising practitioner through audio-video technology. We further support making this flexibility permanent for certain low-risk services. We urge CMS to finalize both proposals.

[Add your experience with this flexibility here. CMS is not permanently allowing audio-video supervision for all services because they are concerned about any patient safety issues that may arise. If you have any anecdotes to support that this has not caused any patient safety concerns, please include.]

## *E. Valuation of Specific Codes.*

4. Valuation of Specific Codes for CY 2025.

(40) Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation – Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136)).

[CMS is issuing a broad request for information on the newly implemented Community Health Integration (CHI) services, Principal Illness Navigation (PIN) services, and Social Determinants of Health (SDOH) risk assessment. **Discuss your experience with these services if you have utilized them and offer any areas for improvement.** For example, if you do not bill for these services, what are the barriers to doing so? CMS is specifically asking for auxiliary personnel, other than community health workers, that should be able to bill for these codes and barriers to auxiliary personnel training, certifications, and licensure barriers in rural communities. Offer any suggestions that you have.]

## *G. Enhanced Care Management.*

2. Advanced Primary Care Management (APCM) Services (HCPCS Codes GPCM1, GPCM2, and GPCM3).

[Your organization] thanks CMS for its work on improving primary care delivery. Coordinated, whole person primary care is essential for beneficiary health and wellbeing. However, we note that some practice-level capability requirements around performance measurement for participation may serve as a barrier to rural provider participation. Further, rural patients may be deterred from participating because of cost-sharing. [Insert your thoughts on the proposed APCM services and the feasibility of providing them in a rural setting. Find more details on APCM from our MPFS listening session [here](https://nrha-prod-eastus-be.azure.silvertech.net/NationalRuralHealth/media/Documents/Advocacy/2024/CY-2025-MPFS-listening-session-7-31-2024.pdf).]

**III. Other Provisions of the Proposed Rule.**

*B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).*

2. General Care Management Services in RHCs and FQHCs.

c. Proposed Payment Policy for General Care Management Services.

CMS proposes to unbundle the general care management code G0511 to allow RHCs and FQHCs to bill for individual codes. **[Your organization] applauds CMS for this proposal and asks that CMS finalize as proposed.** Over the years CMS has added several new codes to G0511, making billing for these services overly complex. Additionally, RHCs and FQHCs, as well as CMS, cannot track on which individual services are being used and billed. This proposal will simplify payment and allow for insight into what care management services RHCs and FQHCs are furnishing. **We also support the proposal to allow add-on codes for additional time spent** in order to meet beneficiary needs and make up for any potential decrease in reimbursement due to the change in billing.

[Add any additional information about your experience with G0511 and the need to unbundle codes. How will this change make your work easier?]

d. New Codes for Advanced Primary Care Management (APCM) Services.

[Your organization] thanks CMS for allowing RHCs and FQHCs to furnish APCM services. We are pleased that they are being included in new services and have the opportunity to provide APCM services to their beneficiaries. We ask that CMS monitor and evaluate the use of APCM services at RHCs and FQHCs to help reveal any potential barriers to uptake. We note that practice-level capability requirements around performance measurement for participation may serve as a barrier to participation for certain RHCs. Further, patients may be deterred from participating because of cost-sharing. We would appreciate CMS’ diligence in monitoring RHCs’ usage in order to inform whether future tweaks to APCM services would make them more accessible in rural settings.

[Add any thoughts you have on the APCM proposal. Would this be feasible in your RHC/FQHC? Find more details on APCM from our MPFS listening session [here](https://nrha-prod-eastus-be.azure.silvertech.net/NationalRuralHealth/media/Documents/Advocacy/2024/CY-2025-MPFS-listening-session-7-31-2024.pdf).]

3. Telecommunication Services.

c. Telecommunications Technology.

CMS proposes to continue to pay RHCs and FQHCs for telehealth visits whether or not Congress extends telehealth flexibilities. **[Your organization] supports continuing to pay for RHC and FQHC telehealth visits to ensure rural beneficiaries retain access to care.** CMS proposes to continue to allow RHCs and FQHCs to bill for telehealth visits using G2025 and be paid the current rate based upon the average amount for all MPFS telehealth services. CMS also outlines an alternate proposal wherein RHCs and FQHCs would receive payment under their specific methodology at the per visit payment rate by amending the definition of a “visit” to include audio-video telehealth. **We strongly support the alternate proposal and urge CMS to finalize payment parity for telehealth visits at RHCs and FQHCs** by amending the definition of a “visit” to include telehealth.

[Discuss the importance of telehealth to your RHC/FQHC patients. Include details about how payment parity would benefit your clinic and any other relevant information.]

d. In-Person Visit Requirements for Remote Mental Health Service Furnished by RHCs and FQHCs.

CMS is proposing an additional extension of the in-person visit requirement for remote mental health services. This extension would apply to visits furnished before January 1, 2026. Beneficiaries may experience a lapse in care if the in-person requirement went into effect on January 1, 2025. As such, [your organization] supports this additional extension so that beneficiaries and providers have a longer glidepath to implementing the in-person visit requirement after subsequent delays in implementation.

4. Intensive Outpatient Program Services (IOP).

**We support CMS’ proposal to allow RHCs and FQHCs to bill for 4-service days in the IOP.** We are hopeful that allowing RHCs and FQHCs to bill for 4-service days will encourage more rural uptake.

[Are your providing IOP services? If so, explain how adding a 4-service day will help. If not, please expand upon why you are not able to provide these services, including any barriers.]

5. Payment for Preventive Vaccine Costs in RHCs and FQHCs.

CMS proposes to pay RHCs and FQHCs for Part B preventive vaccines at the time of service. [Your organization] supports this policy and encourages CMS to finalize as proposed in order to alleviate cash flow issues for rural providers. Allowing these providers to bill at the time of service will effectively give them an interim payment as opposed to the current policy.

[Include any relevant information on how this policy will impact your RHC/FQHC.]

6. Productivity Standards.

**[Your organization] supports CMS’ proposal to remove productivity standards for RHCs** and agrees that it is duplicative given the payment limits established in the Consolidated Appropriations Act of 2021.

[Include any relevant information on how this policy will impact your RHC.]

7. Proposed Rebasing of the FQHC Market Basket.

CMS is rebasing the FQHC market basket based on 2022 cost reports, which are the most current available. We support this rebasing to ensure the FQHC PPS reflects the true cost of providing care in a health center setting.

[Include any relevant information on how this policy will impact your FQHC.]

8. Clarification for Dental Services Furnished in FQHCs.

a. Payment for Dental Services Furnished in FQHCs.

[Your organization] appreciates CMS’ clarification that when RHCs and FQHCs furnish covered dental services they would be considered a qualifying visit.

[Include any relevant information on how this policy will impact your RHC/FQHC.]

b. Medical and Dental Visits Furnished on the Same Day.

**[Your organization] asks that CMS allow medical and dental visits furnished on the same day to be paid separately rather than be payable as one visit.** Allowing separate payment will make providing dental services in RHCs and FQHCs more sustainable.

[RHCs – do you provide any dental services? If not, please explain any barriers to doing so and discuss why paying for dental visits separately could encourage your RHC/other RHCs to furnish dental care.]

*C. Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Conditions for Certification and Conditions for Coverage (CfCs).*

2. Proposed Changes to the RHC and FQHC Conditions for Certification and Conditions for Coverage (CfCs).

a. Provision of Services (42 C.F.R. 491.9).

**[Your organization] supports CMS’ proposal to amend the provision of services conditions for certification and coverage to include new language stating that RHCs and FQHCs must provide primary care services.** Additionally, we support the proposal to include language from the RHC statute stating that RHCs are not rehabilitation agencies or facilities primarily for the treatment of mental diseases. We believe that if implemented correctly, this will allow RHCs to expand their provision of both specialty care and behavioral health care to meet the needs of their community. Currently, RHCs are surveyed based on the total number of hours spent providing primary care versus specialty and behavioral health care and can be cited if their hours spent providing the latter exceed 50%. This is extremely limiting and RHCs need more flexibility to meet beneficiary need, particularly around behavioral health services. It is critical to allow RHCs and FQHCs to provide more outpatient specialty care, particularly as other access points like community hospitals continue to close.[[1]](#footnote-1)

[Add information and anecdotes about what specialty services you are currently offering and how this change will help you expand those to meet the needs of your patient population.]

Rural areas continue to face barriers to accessing behavioral health care. RHCs can serve as an important access point for the behavioral health needs of rural residents as RHCs serve over half of the rural population.[[2]](#footnote-2) As such, **it is critical that CMS implement the regulatory changes and survey procedures in a way that allows RHCs to furnish more behavioral health care.**

**[Your organization] urges CMS to define “facility primarily for the care and treatment of mental diseases.”** This approach would simplify the RHC survey process and provide clear guidance for RHCs. CMS should define “a facility primarily for the care and treatment of mental diseases” as clinic types that provide behavioral health care only, including certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. There is precedent for this approach as RHCs also cannot be “rehabilitation agencies” which is a term that CMS defines elsewhere.[[3]](#footnote-3) This straightforward approach would make the survey process around meeting this requirement easy to implement and cite. So long as the RHC provides primary care services there should be no citation for providing any level of behavioral health care because any RHC providing primary care could not qualify as one of the facilities listed above. **CMS should include this language in subsequent interpretive guidance and in 42 C.F.R. § 491.2** as follows:

*Facility for the treatment of mental diseases* means a certified community behavioral health clinic, community mental health center as defined in 42 C.F.R. § 410.2, standalone opioid treatment program as defined in 42 C.F.R. § 8.2 and certified under § 8.11, or a facility that only provides intensive outpatient services as defined in 42 C.F.R. § 410.44.

[Discuss how this change will help you provide more behavioral health care.]

CMS is posing the following questions for RHCs. Our answers are below:

**What types of behavioral health services are currently offered by RHCs (that is, therapy, counseling, medication management, substance use disorder treatment, etc.), and how often are these services provided?**

[Add your response here.]

**For those RHCs that are currently providing behavioral health services, who provides those services (that is, physician, psychologist, social worker, marriage and family therapist, or mental health counselor)? What is the clinic’s capacity to accept new behavioral health patients? What potential impacts do you anticipate for RHCs and the community if they were able to provide more behavioral health services? How would these impacts be addressed?**

[Add your response here.]

**Are there specific behavioral health conditions that your clinic is better equipped to treat than others, and if so, what are those behavioral health conditions?**

[Add your response here.]

**For those RHCs that are not currently providing behavioral health services, what barriers or challenges does the RHC face that limit the ability to furnish behavioral health services (that is, geographic location, transportation issues, service area size, staffing issues, stigma, regulatory or survey concerns)?**

[Add your response here.]

**What standards or criteria should surveyors use to evaluate whether an RHC is operating as a ‘‘facility which is primarily for the care and treatment of mental diseases’’?**

Surveyors should evaluate whether an RHC is operating as a “facility which is primarily for the care and treatment of mental diseases’’ by determining that the RHC is *not* a certified community behavioral health clinic, community mental health center as defined in 42 C.F.R. § 410.2, standalone opioid treatment program as defined in 42 C.F.R. § 8.2 and certified under § 8.11, or a facility that only provides intensive outpatient services as defined in 42 C.F.R. § 410.44.

[Add any additional information here.]

b. Laboratory Requirements (42 C.F.R. 491.9).

**[Your organization] is supportive of CMS’ proposal to remove hemoglobin and hematocrit (H&H) tests from the list of diagnostic laboratory tests that RHCs must provide directly.** We also support the proposed changes to the culturing requirement at § 491.9(c)(2)(iv). As CMS notes, the H&H test is typically performed as part of a comprehensive blood count, which RHCs typically refer to the nearest hospital. Providing this regulatory relief to RHCs is critical.

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact [name] at [email].

Sincerely,

[Insert e-signature]

Name

Title

Organization

1. *See generally* RuralHospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> [↑](#footnote-ref-1)
2. <https://www.narhc.org/News/30432/Survey-Emphasizes-Scale-and-Significance-of-the-RHC-Program> [↑](#footnote-ref-2)
3. <https://www.cms.gov/medicare/health-safety-standards/certification-compliance/outpatient-rehabilitation-providers#:~:text=Rehabilitation%20Agency%20%2D%20An%20agency%20that,a%20team%2C%20specialized%20rehabilitation%20personnel>. [↑](#footnote-ref-3)