National Rural Health Association

October 29, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: Medicare Reimbursement for Community Health Worker Travel

Dear Administrator Oz,

The National Rural Health Association (NRHA) writes to propose two modifications to ensure that Community Health Workers (CHWs) can fully participate in the new Community Health Integration (CHI) and Chronic Care Management (CCM) benefits to be successfully and sustainably implemented in the rural communities that need it most.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

The need for the policy modifications discussed below is underscored by the unique demographic challenges of rural America. Rural communities are aging more rapidly than their urban counterparts and face a higher burden of chronic conditions and disparate health outcomes.[1] For rural Medicare beneficiaries, CHW services are essential for managing complex health needs, connecting them with community resources, and overcoming the social and environmental barriers that contribute to poorer health.

Chronic Care Management Benefit

CHWs are integral to providing chronic care management (CCM) services alongside rural physicians and other practitioners. Currently, CHW services can be billed under Medicare CCM time accrual codes 99490 or 99439 as a part of the care team. CHWs help provide rural clinicians with important support in extending their reach to rural isolated older adults but there exists no billing mechanism for CHWs or the billing practitioner to be reimbursed for travel time associated with home or community-based visits.

NRHA urges CMS to amend CCM codes 99490 and 99439 to include travel time as a billable activity. This can be done by adding similar language as described above: "Chronic care management services, at least 20 minutes of clinical staff time, *including round-trip travel from the practice location to the patient's home or community setting furnished in a rural area as defined in 42 C.F.R. § 413.231(b)(2)*, directed by a physician or other qualified health care professional, per calendar month […]." This simple amendment will help primary care teams better support beneficiaries with CCM needs by meeting them in their homes and communities.

Community Health Integration Benefit

[1] https://www.cdc.gov/rural-health/php/about/leading-causes-of-death.html

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Additionally, Medicare's new CHI benefit[2], effective January 1, 2024, reimburses services that address health related social needs which interfere with a patient's diagnosis or treatment, including services provided by CHWs. While the new CHI benefit is a laudable step toward addressing rural Medicare beneficiaries' unmet social needs, the time-based billing structure of these codes has no provision for CHW travel which is a significant and unavoidable cost in geographically dispersed communities. The codes reimburse only for the cumulative time spent performing a defined set of service activities, with no mechanism to account for the time CHWs spend traveling to a patient's home or other community setting. In rural areas, where travel is a substantial and unavoidable component of service delivery, this omission creates an additional financial burden.

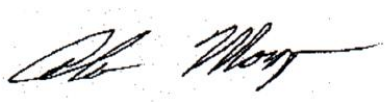
To effectuate accurate travel time reimbursement, NRHA suggests that **CMS change the language in the G0019 and G0022 codes to include travel time in the minutes billed for the month.** This approach would integrate travel directly into the existing service codes, offering a solution that works within the current billing framework rather than creating a new one. This could be achieved by amending current CPT code language to read: *"CHI services performed by certified or trained auxiliary personnel under general supervision, including round-trip travel from the practice location to the patient's home or community setting furnished in a rural area as defined in 42 C.F.R. § 413.231(b)(2); 60 minutes per calendar month"* and "*CHI services including round-trip travel from the practice location to the patient's home or community setting furnished in a rural area as defined in 42 C.F.R. § 413.231(b)(2), each additional 30 minutes per calendar month.*"

Alternatively, a clear and proven precedent for resolving this issue already exists within the Medicare program: the travel allowance for specimen collection. HCPCS codes P9603 and P9604 provide separate reimbursement for the "transportation and personnel expenses" incurred by a trained technician traveling to a homebound beneficiary's location. **CMS could create a similar code for CHW travel, modeled on P9603 and P9604, to provide direct reimbursement for mileage or travel time in rural areas.** This approach would leverage a successful and analogous precedent within Medicare, cleanly separating the payment for the service from the logistics of delivering it.

The rationale for these policy changes is clear: when a patient cannot get to a service, the cost of getting the service to the patient must be recognized. A Medicare beneficiary in a geographically isolated rural area faces a functionally identical access barrier. The need for a CHW to travel is an essential prerequisite to furnishing the covered CCM or CHI service. As such, it is critical that CMS target policy modifications toward making CCM and CHI services viable and accessible in the rural communities that need them the most. Addressing uncompensated travel is a necessary and critical correction to ensure that CHWs are accessible to all, no matter where they live.

NRHA thanks CMS for its attention to this issue and looks forward to continuing to work together to improve health care access for rural beneficiaries. If you would like to discuss further, please contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,



Alan Morgan

[2] The Medicaid CHI benefit is covered by HCPCS codes G0019 and G0022.

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