National Rural Health Association

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment, etc.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS) proposed rule. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Calculation of the CY 2024 PFS Conversion Factor.

NRHA is extremely concerned about the more than 3% decrease in physician payments compared to CY 2023. 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. **NRHA urges 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.**

Despite the drastic payment cut, **NRHA is pleased to see that the estimated payment rates for certain provider types will increase** due changes in relative value units (RVUs) and the proposed implementation of the complexity add-on code and behavioral health payment adjustments. Family practice physicians are important providers in rural communities and thus we are supportive of the estimated 3% increase in their payment. We also support the 2% increase for essential non-physician practitioners (NPPs), nurse practitioners and physician assistants, in rural facilities. Last, a 2% payment increase for clinical social workers, clinical psychologists, and psychiatrists will be beneficial for these provider types serving rural communities.

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.

b. Requests To Add Services to the Medicare Telehealth Services List for CY 2024.

NRHA supports CMS' proposal to add administration of Social Determinants of Health (SDOH) Risk Assessment to the Medicare Telehealth Services List on a permanent basis. Rural Americans face some unique SDOH that often serve as a barrier to both accessing care and diagnosis or treatment for a condition. Rural populations are more likely to experience social factors that impact health such as poverty, lower educational attainment and literacy, lower health literacy, and unemployment.[1,2] Thus it is critical that rural beneficiaries can receive an SDOH risk assessment both in-person and via telehealth to begin addressing SDOH that affect health.

NRHA reiterates our comments from last year's PFS proposed rule on CMS' authority to permanently extend coverage for audio-only services.[3] We disagree with CMS' reading of § 1834(m)(2)(A) of the Social Security Act[4] and believe that it is an unduly narrow interpretation.[5] CMS interprets the provision to require that "telehealth services be so analogous to in-person care such that the telehealth service is essentially a substitute for a face-to-face encounter." This is an unnecessarily restrictive reading of the statute. The statute only provides that reimbursement for telehealth must be equal to the amount the provider would have been paid if the service were furnished in-person. The statute is silent on whether the services must be "so analogous" to in-person care so that it is "essentially a substitute" for an in-person visit.

In future rulemaking, NRHA urges CMS to adopt a broader reading of § 1834(m)(2)(A) such that audio-only services are authorized beyond CY 2024 and added to the Medicare Telehealth Services List on a permanent basis. NRHA suggests that CMS allow audio-only for telehealth visits for circumstances in which a beneficiary does not consent to audio/video technology or is not capable due to broadband or other connectivity resource issues. NRHA acknowledges that audio-only services are not appropriate for all visits and that audio/video or in-person may be better suited depending upon the nature of the visit. However, some evaluation and management (E/M) visits may be as effective using audio-only as using audio/video or face-to-face encounters. Per provider discretion, audio-only visits may serve as an appropriate substitute for audio/video technology or in-person care.

Further, 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. Audio-only telehealth is also extremely effective for reaching the older

[1] https://www.ruralhealthinfo.org/topics/social-determinants-of-health
[2] Sally C. Curtin & Merianne Rose Spencer, *Trends in Death Rates in Urban and Rural Areas: United States, 1999 – 2019*, NCHS Data Brief No. 417, Sept. 2021, https://stacks.cdc.gov/view/cdc/109049.
[3] https://www.ruralhealth.us/getattachment/Advocate/Executive-Branch/NRHA-PFS-comment-FINAL-9-6-22.pdf.aspx?lang=en-US.
[4] *See* 87 Fed. Reg. 45,891.
[5] "The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system."

beneficiaries, particularly those 80 years old and older.[6] Rural patients must not be forced to travel longer distances to care because they do not have the same access to broadband infrastructure as urban and suburban areas. Rural residents benefited greatly from expanded telehealth during and after the PHE and consequently will suffer when the flexibilities are removed.

e. Implementation of Provisions of the CAA, 2023.

NRHA thanks CMS for implementing provisions in the CAA, 2023 that extend Medicare telehealth flexibilities through December 31, 2024. This will ensure rural beneficiaries are able to access critical telehealth services as they have since the onset of the pandemic.

e. Place of Service for Medicare Telehealth Services.

NRHA is pleased to see that CMS proposes to pay the non-facility PFS rate for telehealth visits provided in the patient's home. Telehealth is an important tool for rural providers and resource for rural beneficiaries. The overhead costs for providing telehealth services are more of a burden on rural providers, therefore it is crucial that providers are paid adequately to ensure rural beneficiaries can use this vital service.

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.

CMS is proposing to continue defining direct supervision to allow the presence and immediate availability of a supervising practitioner through audio/video technology through December 31, 2024. We agree that this aligns with other telehealth flexibilities extended through the same time period and will give providers time to adjust back to pre-PHE policies.

NRHA also supports retaining this flexibility on a permanent basis beyond CY 2024. There has been no evidence that this type of direct supervision has caused patient safety or quality concerns. Virtual supervision makes workflows more efficient by freeing up practitioners' time, which is valuable in rural settings where they often wear many hats and have heavy caseloads.

E. Valuation of Specific Codes.

4. Valuation of Specific Codes for CY 2024.

b. Community Health Integration Services.

NRHA commends CMS for creating two new HCPCS codes for community health integration (CHI) services. Identifying and addressing SDOH are a key part of making informed medical decisions for many rural beneficiaries, yet rural providers have not had the tools to do so. New codes that will allow for community health workers (CHWs) to address SDOH and receive payment will encourage rural providers to screen and connect beneficiaries to the resources that they need to thrive. Rural residents experience barriers to access to transportation, food, housing, and clean water

[6] Harriet Komisar, *Telehealth and Medicare: The Use of Audio-Only Visits*, AARP, Aug. 3, 2023, https://blog.aarp.org/thinking-policy/telehealth-and-medicare-the-use-of-audio-only-visits.

that are safe, healthy, and affordable.[7] Poverty rates in rural areas are typically higher than urban areas, rural residents have lower education and literacy levels (including health literacy) and are more likely to be unemployed and uninsured.[8] Overall, rural people face lower life expectancies and generally worse health outcomes. Strategies to tackle SDOH and improve health are much needed for rural beneficiaries.

We suggest that CMS make CHI services even more accessible to rural populations by allowing payment for community paramedics as CHI personnel. Community paramedicine allows EMTs and paramedics to operate in expanded roles by providing public health, preventive services, and primary care to underserved populations.[9] Creating a pathway for Medicare reimbursement for this emerging type of care would greatly benefit the rural agencies furnishing these services and expand access to areas that cannot support them currently.

Community paramedicine programs furnish care for patients that are at home or in other non-urgent settings but are under the supervision of a physician or NPP.[10] NRHA believes that this supervisory framework aligns with what is proposed for other personnel performing CHI services, like CHWs, as community paramedics likely are operating under general supervision already. Community paramedics would also be able to meet the "incident to" regulations at 42 C.F.R. § 410.26.

Generally, community paramedics provide care coordination, community coordination, and primary care services by helping with transport, referrals, connecting patients to resources, post-discharge follow ups, chronic disease management. And more.[11] Community paramedics already furnish the kinds of services that correspond with the proposed CHI services. Accordingly, community paramedics would easily be able to meet the certification and training requirements for CHI personnel and perform the proposed services. Additionally, community paramedicine programs are typically funded and run through hospitals or EMS programs. This also aligns with the proposed CHI framework as CHI personnel can be either employed by a health care provider or external or under contract so long as "incident to" regulations are met.

We appreciate CMS' proposal to leave CHI personnel training and licensure up to the states rather than imposing a federal mandate. Requirements to become licensed as a CHW vary from state to state and should not be interrupted with federal regulations from CMS. Also, NRHA supports the ability to contract with CHW and other auxiliary personnel that are external to the practice or hospital. Many CHWs are employed by community-based organizations, not health care facilities, and this contract relationship will make it easier for providers to furnish CHI services.

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[7] RHIhub, Social Determinants of Health for Rural People, June 6, 2022, https://www.ruralhealthinfo.org/topics/social-determinants-of-health.
[8] *Id.*
[9] RHIhub, Community Paramedicine, Jan. 27, 2023, https://www.ruralhealthinfo.org/topics/community-paramedicine.
[10] Karen B. Pearson, John Gale, & George Shaler, *Community Paramedicine in Rural Areas: State and Local Findings and the role of the State Flex Program*, Flex Monitoring Team (Feb. 2014) https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/pb35.pdf.
[11] National Rural Health Resource Center, Implementing and Sustaining Rural Community Paramedicine, June 2021, https://www.ruralcenter.org/sites/default/files/Community%20Paramedicine%20Summit%20June%202021%20Final.pdf.

d. Social Determinants of Health (SDOH) – Proposal to Establish a Standalone G Code.

As noted, rural providers need extra resources to identify and address SDOH. NRHA members consistently have voiced that they do not provide such screenings due to the lack of payment and coding infrastructure. **Accordingly, NRHA supports CMS' proposed G code for SDOH risk assessments.** We appreciate that this code is proposed to be added to the Medicare Telehealth Services List as well.

e. Principal Illness Navigation (PIN) Services.

NRHA supports CMS' proposed PIN coding and payment policies. Much like the two proposals above, we believe that appropriate payment will foster greater rural use of these services. Given that rural residents are more likely to experience chronic illnesses like COPD, depression, substance use disorder, and diabetes, access to PIN services will be incredibly beneficial.[12]

F. Evaluation and Management (E/M) Visits.

2. Office/Outpatient (O/O) E/M Visit Complexity Add-On Implementation.

CMS proposes to implement HCPCS code G2211 as a separately payable add-on code for O/O E/M visits. G2211 is meant to account for care provided to highly complex patients. Rural beneficiaries are more likely to suffer from multiple chronic conditions, making them more complex patients.[13] Even if a rural beneficiary does not have multiple conditions, they are still more likely to have a chronic disease and face higher mortality rates for chronic diseases.[14] NRHA is optimistic that rural primary care physicians will benefit as well from using G2211 and in turn enhance access for rural beneficiaries.

3. Split (or Shared) Visits.

CMS proposes to further delay the implementation of its new split/shared visits policy that was finalized in CY 2022. This policy would assign billing to the practitioner that provides a "substantive portion" of an E/M visit. Until 2025, practitioners may continue to use the current history, exam, or medical decision-making policy to determine who bills for the visit.

In last year's PFS rulemaking, NRHA urged CMS to change the definition of "substantive portion" (more than half) or move forward with the substantive portion policy and carve out rural providers. Considering that CMS is again delaying the implementation, **NRHA urges CMS to withdraw its substantive portion policy.** We do not believe that "over half" is an appropriate definition of "substantive portion" for the purpose of paying for split services. This policy is particularly

[12] RHIhub, Chronic Disease in Rural America, May 20, 2022, https://www.ruralhealthinfo.org/topics/chronic-disease.
[13] National Center for Health Statistics, *Health, United States, 2017*, Table 39, (2017) https://www.cdc.gov/nchs/data/hus/2017/039.pdf.
[14]

troublesome for rural providers as NPPs often provide the majority of care for rural patients. Consequently, rural providers will receive less payment under PFS for split or shared visits.

NPPs play an incredibly important role in the rural health care system as rural communities face physician shortages and enduring recruitment and retainment challenges. The supply of NPPs is also projected to grow by double over the next fifteen years, signaling that an increasing number of NPPs will be providing patient care.[15] Rural practitioners will feel the brunt of the split or shared visit policy as NPPs are more likely to provide most of the care in rural areas. This creates a paradox wherein rural facilities rely upon NPPs to provide care but also need Medicare payments the most; however, under this policy rural facilities would receive 15% less because NPPs would more often provide the "substantive portion" of a visit. Rural facilities cannot take on a lesser payment amount for these services when they are already operating under thin margins.

CMS should not move forward with the substantive portion policy in CY 2025 as it disenfranchises rural beneficiaries and providers. CMS should retain its current policy and withdraw the substantive portion policy finalized in CY 2022.

J. Advancing Access to Behavioral Health Services.

1. Implementation of Section 4121(a) of the Consolidated Appropriations Act, 2023.

The CAA, 2023 established Medicare payment for marriage and family therapists (MFT) and mental health counselors (MHC) services. NRHA long advocated for including these two practitioners as separate benefit categories under Medicare and is pleased to see that CMS is implementing this change. **We also applaud CMS for going beyond Congress' mandate in the statute by allowing addiction counselors to enroll in Medicare as MHCs** if all criteria are met. As opioid use and substance us disorder continue to grow in rural areas,[16] rural beneficiaries need adequate access to treatment. We hope that access to addiction counselors will provide another source of treatment for rural beneficiaries facing opioid and substance use disorders. Last, we support MFTs and MHCs expanded ability to bill for and furnish Health Behavior Assessment and Intervention (HBAI) services.

2. Implementation of Section 4123 of the CAA, 2023.

NRHA supports CMS' implementation of § 4123 of the CAA, 2023, which requires the agency to cover psychotherapy crisis services provided outside of the office setting and pay at 150% of the PFS non-facility rate. NRHA anticipates that this may make psychotherapy services more accessible for rural beneficiaries that would otherwise travel to a provider for crisis care.

5. Adjustments to Payment for Timed Behavioral Health Services.

[15] American Association of Medical Colleges, *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034* (June 2021), 47 https://www.aamc.org/media/54681/download?attachment.
[16] Grace Sparks, et al., *KFF Tracking Poll July 2023: Substance Use Crisis and Accessing Treatment*, KAISER FAMILY FOUNDATION, Aug, 15, 2023, https://www.kff.org/other/poll-finding/kff-tracking-poll-july-2023-substance-use-crisis-and-accessing-treatment/.

In last year's PFS rulemaking cycle, NRHA noted that behavioral health services are likely undervalued because Medicare payment rates are based upon complexity and the relative resources needed to perform particular services, which disadvantages nonprocedural services.[17] As a result, CMS is proposing to fix payment for timed behavioral health services by phasing in an adjustment to the work RVUs for psychotherapy codes over 4 years. **NRHA thanks CMS for this proposal and we support increased payment for important behavioral health services.** We applaud efforts to increase payment for behavioral health services to recruit and retain more professionals and thereby improve beneficiary access.

K. Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services.

1. Medicare Payment for Dental Services.

NRHA urges CMS to continue expanding coverage for dental services under Medicare. Seniors often lack access to oral health care and therefore are at the highest risk for poor oral health. This inequity is even more acute in rural areas where dental care is lacking for all age demographics. In 2018, just over half of rural residents indicated that they visited a dentist in the past year, whereas 67% of residents in metropolitan areas had.[18] Additionally, seniors in rural areas were less likely to have visited the dentist than their urban and suburban counterparts.[19] Travel, affordability, and lack of dental insurance may disincentivize rural residents, especially seniors, from seeking dental care. But dental workforce shortages in rural communities also contribute to accessibility given that 67% of dental HPSAs are in rural areas.[20] Over 4,000 dental practitioners are needed in rural areas to remove these designations.[21]

2. Proposed Additions to Current Policies Permitting Payment for Dental Services Inextricably Linked to Other Covered Services.

NRHA supports adding chemotherapy, CAR T-cell therapy, and antiresorptive therapy to § 411.15 to allow Medicare coverage for associated dental or oral exams and diagnostic and treatment services to eliminate an oral infection. This is another step in the right direction towards increased dental coverage for rural beneficiaries.

III. Other Provisions of the Proposed Rule.

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

2. Implementation of the Consolidated Appropriations Act (CAA), 2023.

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[17] Maura Calsyn and Madeline Twomey, *Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services*, CENTER FOR AMERICAN PROGRESS (Jul. 13, 2018) https://www.americanprogress.org/article/rethinking-the-ruc/.
[18] Rural Health Information Hub, *Oral Health in Rural Communities*, https://www.ruralhealthinfo.org/topics/oral-health.
[19] America's Health Rankings, United Health Foundation, *Senior Report 2018*, (May 2018), 44 https://assets.americashealthrankings.org/app/uploads/ahrsenior18-finalv1.pdf.
[20] BUREAU OF HEALTH WORKFORCE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, *Designated Health Professional Shortage Areas Statistics: Third Quarter of Fiscal Year 2023*, 3 (June 30, 2023) https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.
[21] *Id.*

b. Direct Supervision via Use of Two-Way Audio/Video Communications Technology.

As in Section II.D.2, **NRHA supports CMS' proposal to continue allowing direct supervision via audio/video technology at RHCs and FQHCs.** Without this extension RHCs and FQHCs would need practitioners' physical presence to meet direct supervision requirements beginning January 1, 2024. NRHA agrees that this abrupt transition from public health emergency (PHE) flexibilities to pre-PHE standards may not be feasible for many rural providers. **CMS should retain this flexibility on a permanent basis beyond CY 2024 for RHCs and FQHCs if it decides to do so for other providers.**

c. Section 4121 of the CAA, 2023.

NRHA thanks CMS for implementing § 4121 of the CAA to allow marriage and family therapists and mental health counselors to bill Medicare directly. The addition of these two new billable provider types has the potential to increase needed behavioral health services in some RHCs and FQHCs.

3. Updates to Supervision Requirements for Behavioral Health Services Furnished at RHCs and FQHCs.

In the CY 2023 final rule, **CMS finalized a policy to allow behavioral health services to be furnished under general rather than direct supervision. We are happy to see that CMS proposes to extend this policy to RHCs and FQHCs.** Easing of supervision requirements for rural providers will maximize physician and NPPs time, make workflows more efficient, and in turn increase the availability of behavioral health services for rural beneficiaries.

4. General Care Management Services in RHCs and FQHCs.

b. Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Services Furnished in RHCs and FQHCs.

In the CY 2018 rule, CMS established HCPCS code G0511, a General Care Management (GCM) code, for RHCs and FQHCs to bill when at least 20 minutes of chronic care management or general behavioral health integration (BHI) services are furnished to a patient in a calendar month. Last year, CMS also finalized a policy to include chronic pain management in G0511.

Now, CMS proposes to include both RPM and RTM services in G0511. **Continuing to include new suites of services under the GCM code is an unsustainable policy.** First, adding new services will continue to change the payment amount for G0511, which is also proposed in this rule. Second, CMS' policy for G0511 is that an RHC can only bill G0511 one per calendar month per patient, meaning that the patient may only receive one type of service (i.e., only RPM or only BHI) each month regardless of their need for multiple services.[22] As CMS adds more services that are not standalone billable RHC visits to G0511, the more patients are limited, and the more payment may change. **NRHA asks that CMS does not RPM and RTM under G0511 and instead create separate codes so that RHCs may bill outside of the AIR and allow patients to receive CCM and RPM or RTM in one month.**

c. Services Addressing Health-Related Social Needs.

[22] CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Frequently Asked Questions* (Dec. 2019), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf.

NRHA recognizes the increased time and resources that are necessary to address SDOH and agrees that payment outside of RHC's traditional AIR is appropriate to account for such expenditures. However, the same issue presents itself with adding CHI and PIN to G0511 as for RPM and RTM services. **We ask that CMS reconsider its proposal to add CHI and PIN services under the general care management code G0511 because it disadvantages rural patients and RHCs.** CMS should create separate HCPCS codes for these services in RHCs and FQHCs so that they are paid outside of the AIR and beneficiaries are not limited to one suite of GCM services under G0511.

Again, NRHA stresses that including several services and associated CPT codes under G0511 is not only an unsustainable approach but also inequitable for rural beneficiaries. CMS does not allow RHCs to bill more than one care management service per month for the same beneficiary.[23] Fee-for-service providers are able to bill for all of these services for one beneficiary during the same month, yet RHCs can only provide one of these suites of services and bill G0511 once per month per beneficiary. **This is hindering access to services that address SDOH for rural beneficiaries.** It is likely that beneficiaries who would benefit from CCM services would also benefit from CHI or PIN services, but unnecessary CMS rules do not allow these beneficiaries to receive the full scope of needed services.

F. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs).

2. Additional Flexibilities for Periodic Assessments Furnished via Audio-Only Telecommunications.

NRHA supports CMS' decision to continue audio-only coverage of periodic assessments at OTPs through CY 2024. This aligns with other federal telehealth extensions passed by Congress and included in this proposed rule. We are happy to see that coverage for audio-only is being extended for OUD services. Additionally, **NRHA encourages CMS to consider making this policy permanent beyond CY 2024** to the extent it remains authorized by SAMHSA and the Drug Enforcement Administration. As CMS itself notes, individuals living in rural areas are more likely to be offered and use audio-only telehealth services because of broadband or technology limitations. Retaining audio-only coverage beyond 2024 will also minimize any disruptions in treatment as ending this policy abruptly may discourage OTP patients from continuing their course of treatment. This is especially important for OTPs as these are the only settings where patients can receive methadone. At this time, it is critical to maintain as much access to OUD treatment as possible, including audio-only services, as OUD continues to devastate rural communities.[24]

G. Medicare Shared Savings Program.

2. Quality Performance Standard and Other Reporting Requirements.

[23] *Id.*

[24] Opioid Use Disorders in Rural Communities, Need for Substance Use Disorder Programs in Rural Communities, RHIhub (Nov. 23, 2020) https://www.ruralhealthinfo.org/toolkits/substance-abuse/1/need#:~:text=Opioid%20Use%20Disorders%20in%20Rural%20Communities&text=Emergency%20department%20visits%20related%20to,the%20last%20quarter%20of%202017.

CMS proposes to establish Medicare CQMs for Accountable Care Organizations (ACOs) as a new collection type. Medicare CQMs would be a transition collection type to help ACOs build the infrastructure and capacity needed to report all payer and all patient MIPS CQMs and eCQMs. NRHA applauds this effort to support ACOs in the transition to digital quality measure reporting.

3. Determining Beneficiary Assignment Under the Shared Savings Program.

CMS proposes to add a new definition for "expanded window for assignment" to mean a 24-month period used to assign beneficiaries to an ACO or identify assignable beneficiaries. This 24-month period includes the 12-month assignment window plus the 12 months preceding that assignment window. **NRHA supports CMS' proposal to use an expanded window for beneficiary assignment. Specifically, NRHA appreciates the expanded window as it will better account for beneficiaries that mostly receive primary care from NPPs** during the assignment window but saw a physician in the 12-month preceding window. NPPs are critical components of rural health care delivery and play important roles on beneficiary care teams.

I. Medicare Diabetes Prevention Program (MDPP).

CMS launched MDPP in 2018 as an additional preventive service covered by Medicare. CMS had expected over 100,000 beneficiaries to enroll and therefore reduce Medicare costs through prevention. However, as of 2021, MDPP had less than 5,000 beneficiaries participating[25] even though a projected 16.4 million would be eligible and 305[26] out of 1,500 eligible organizations are participating.[27] NRHA performed a cursory review of organizations eligible to participate in MDPP and found that just under 250 of the 1,500 are located in rural ZIP codes. Of those that are eligible, we suspect that many are not participating.

NRHA posits that there are several structural barriers in MDPP that make it difficult to operate in rural communities:

- Participating organizations must be CDC Diabetes Prevention Recognition Program certified or have preliminary MDPP recognition.[28]
- Participating organizations must enroll in Medicare as MDPP suppliers, even if they are already enrolled in Medicare.
- Payment for MDPP services is too low.[29]
- Complex payment structure resulting in payment lag.
- Initially not including telehealth or virtual services until the onset of the COVID-19 public health emergency.

[25] 86 Fed. Reg. 65,318.
[26] Centers for Medicare and Medicaid Services, Medicare Diabetes Prevention Program (MDPP) Expanded Model: Evaluation of Performance April 2018 – December 2021, https://innovation.cms.gov/data-and-reports/2022/mdpp-2ndannevalrpt-fg.
[27] 86 Fed. Reg. 65,318.
[28] 42 C.F.R. § 424.205(b).
[29] Harris Meyer, *Medicare Diabetes Prevention: Enrollment Short of Projections*, 40 HEALTH AFFAIRS 1682, 1685 (2021) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01292

For these reasons, NRHA believes that rural participation in MDPP by both beneficiaries and eligible organizations is low despite the need in rural communities.

CMS proposes to extend PHE flexibilities until December 31, 2027. These flexibilities let beneficiaries perform virtual weigh-ins and waive the maximum number of virtual services allowed. Thus, until 2028, beneficiaries in MDPP may receive MDPP services in-person, through distance learning, or a combination of the two. **NRHA applauds this 4-year extension with hopes that rural beneficiaries may be more incentivized to participate**, potentially with an MDPP supplier that is not local. Attending classes regularly may be more accessible for rural participants that have transportation challenges or no nearby MDPP provider. CMS should use this 4-year extension to monitor the uptake of the program and make an evidence-based decision on permanently extending virtual services.

CMS is proposing to also change the payment structure for MDPP. Thus far, MDPP has used a performance-based payment structure. CMS recognizes that this has been largely unsuccessful and led to beneficiary retention issues. As a result, CMS proposes to move to fee-for-service payment when beneficiaries attend sessions and retain performance-based payments for beneficiary weight loss and maintenance. **NRHA supports this change because it will now allow providers to receive payment in a timelier manner. However, the maximum amount that MDPP providers can receive per beneficiary is $768 for the entire year-long program and we caution CMS that this amount is not adequate to incentivize rural providers to enroll and provide MDPP services.**

L. Expand Diabetes Screening and Diabetes Definitions.

Diabetes is one of the leading chronic conditions among the rural population and it is up to 17% more prevalent in rural communities compared to urban.[30] Nationally, rural areas experience a higher diabetes mortality rate per 100,000 people (26) than urban areas (21).[31] Accordingly, NRHA supports proposals that will increase access to diabetes testing and treatment as this may address health equity concerns for groups that are disproportionately impacted by diabetes, like rural, Native, and Black populations.

4. Proposed Revisions.

NRHA supports the following proposals:

- Expanding and simplifying diabetes screening coverage so beneficiaries may receive up to two screenings per 12-month period.
- Modifying the regulatory definition of "diabetes" to increase flexibility for practitioners.
- Adding HbA1c tests to the types of diabetes screenings covered by Medicare.

S. A Social Determinants of Health Risk Assessment in the Annual Wellness Visit.

[30] Alva O. Ferdinand, et al., *Diabetes-Related Hospital Mortality in Rural America: A Significant Cause for Concern*, Southwest Rural Health Research Center, Texas A&M University (Mar. 2018), https://srhrc.tamu.edu/publications/srhrc-pb3-ferdinand-diabetes.pdf.
[31] Randy Randolph, et al., *Rural Population Health in the United States: A Chartbook*, North Carolina Rural Health Research Program, University of North Carolina at Chapel Hill (Feb. 2023) https://www.shepscenter.unc.edu/product/rural-population-health-in-the-united-states-a-chartbook/.

NRHA applauds CMS' proposal to include an optional SDOH risk assessment to annual wellness visits (AWVs). Addressing SDOH may be necessary before performing an AWV or treating a condition, yet rural providers, until this proposed rule, have largely not had the tools to properly address SDOH. Including a SDOH risk assessment in an AWV may be one step towards making the service more feasible and rural-friendly for both patients and providers.

However, rural beneficiaries need better access to preventative care. While CMS has made strides to include more preventative care services under Medicare, like AWVs, rural beneficiaries still lag behind in receiving this care. AWVs can be important tools to increase awareness and use of preventative care like cancer screenings and vaccinations that historically underserved populations, like rural, have not had access to.[32]

Overall, rural providers are less likely to provide AWV to any patients compared to metropolitan practices.[33] One explanation for lower rural uptake is that providers are not offering these visits to any beneficiaries[34] because of capacity and resource constraints that make providing optional services more difficult. Another is that rural patients are often older and sicker, meaning that they are more complex and likely have multiple chronic conditions and health-related social needs. The current AWV is a one-size-fits-all tool that does not take into account the diverse needs of older adults, which disadvantages rural beneficiaries.[35]

One way to expand access to AWVs for rural beneficiaries is allowing RHCs to bill for the visit in conjunction with medical visit provided on the same day. RHCs can do this for initial preventive physical exam visits, but not AWVs. Currently, RHCs receive their AIR for AWVs because these services are not eligible for same day billing, or two visits billed on the same day that are separately reimbursed. As a result, RHCs are not incentivized to furnish AWVs because they either provide the service without adequate reimbursement or ask a beneficiary to return for an AWV on another day.

NRHA asks that CMS consider amending 42 C.F.R. § 405.2463(c)(1)(iii) to include annual wellness visits:

"(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."

This would exempt a separate medical or mental health visit plus an AWV from being considered a "single visit" and instead allow the RHC to bill for a visit and an AWV separately on the same day. This amendment would reduce the beneficiary burden by allowing them to receive both services in one day rather than making multiple trips and make RHC visits more efficient for providers.

Additionally, RHCs may only bill for AWVs if the patient is seen by an RHC practitioner.[36] In other settings, registered nurses (RNs) are allowed to perform and bill for AWVs. This policy again creates

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[32] Fabian Camacho, Nengliang Yao, & Roger Anderson, *The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening*, 8 J. PRIMARY CARE & COMMUNITY HEALTH 247, 254 (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932741/pdf/10.1177_2150131917736613.pdf

[33] Ishani Ganguli, et al., *Practices Caring For The Underserved Are Less Likely To Adopt Medicare's Annual Wellness Visit,* 37 HEALTH AFFAIRS 283, 289 (2018) https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2017.1130.

[34] *Id.*

[35] Patrick Coll, et al., *Medicare's annual wellness visit: 10 years of opportunities gained and lost*, 70 J. Am. Geriatric Soc. 2786, 2786 (2022) https://pubmed.ncbi.nlm.nih.gov/35978538/.

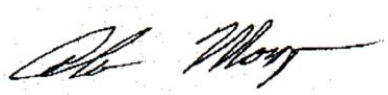
[36]

disparities between rural and other providers and disadvantages rural beneficiaries seeking preventive care services. NRHA suggests the following change to the regulatory text at § 405.2463(a)(1) to allow RNs to perform AWVs:

(a) ***Visit—General.***
(1) For RHCs, a visit is either of the following:
(i) Face-to-face encounter (or, for mental health disorders only, an encounter that meets the requirements under paragraph (b)(3) of this section) between an 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.

Thank you again for the opportunity to respond to this proposed rule and for consideration of our comment. We look forward to continuing our work together to ensure access to quality care for rural beneficiaries. If you have any questions, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,



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