National Rural Health Association

September 14, 2026

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

RE CMS-1848-P: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Submitted electronically via regulations.gov.

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule. We appreciate CMS's 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.

I. Calculation of the CY 2027 PFS Conversion Factor

NRHA is concerned about the conversion factor decrease of 1.19% for qualifying alternative payment model (APM) participants and 1.68% for non-qualifying APM participants compared to CY 2026. 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 clinics 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.**

II. Provisions of the Rule for the PFS

B. Determination of Practice Expense (PE) Relative Value Units (RVU)
2. Practice Expense Methodology

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CMS proposes to update the methodology used to calculate practice expenses by: (1) allocating indirect PEs using the work RVU and clinical labor RVU for all services (except codes 010-090), and (2) removing the indirect practice cost index (IPCI) from the calculation of indirect PE RVUs. NRHA supports the proposed modification to the calculation of indirect PE RVUs. Rural physicians frequently practice in low-volume settings with significant clinic staffing demands and limited ability to distribute overhead expenses across large patient populations. We agree that using both work and clinical labor RVUs better value services that can be broken down into both parts and better align payment with realities of modern rural health care delivery.

NRHA also agrees with CMS that the 2007 survey data is dated and no longer accurately represents the value of certain services. As an alternative, NRHA would prefer for the Clinician Practice Information (CPI) or Physician Practice Information (PPI) to be used. If CMS is not willing to utilize these surveys over the 2007 data, then we support removing the IPCI altogether. NRHA also supports the 5% stabilization factor for the PE RVU methodology to mitigate large changes in the initial implementation of the IPCI removal. We would appreciate further explanation into the application of this cap. For instance, we assume that the 5% cap applies on an annual basis so that PE RVUs could increase over 5% over multiple years.

For the changes to PE methodology in this section and the following, **NRHA respectively requests that CMS continue to evaluate the effect of these changes on rural providers.** We appreciate CMS's dedication to simplifying and strengthening PE RVU distributions and request continuous monitoring of how these changes impact rural providers. Rural hospitals and clinics cannot subsidize decreases in physician payment via RVUs, which could put them in a position of financial jeopardy or difficulty in recruiting practitioners.

4. Changs to Direct PE Inputs for Specific Services

d. Updates to Practice Expense (PE) Methodology- Site of Service Payment

In the CY 2026 PFS, CMS decreased the PE RVUs for services furnished in a facility to 50% of the amount allocated for non-facility services. CMS proposes extending the site of service differential to indirect PE allocations for visits furnished during a Part A skilled nursing facility (SNF) stay. **NRHA agrees with CMS's assessment that the indirect costs associated with SNF services are not dependent on whether the stay is covered under Part A or Part B.**

NRHA requests more information from CMS on the process used to determine 50% as the rate at which to decrease PE payments for services in a facility setting. Physicians who provide a service in a facility may not be employed by a hospital, thus not benefitting from reduced overhead costs. Therefore, additional information such as a modifier, would be necessary to determine if this adjustment truly reflects the physicians' time and resources.

NRHA has remaining concerns regarding the facility vs. non facility setting payment differentials and asks CMS to closely monitor the impact on rural health care delivery systems. While CMS notes that physician employment patterns have shifted over time, the

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operational realities of rural health care differ significantly from those in urban and suburban markets. Rural hospitals increasingly employ physicians because independent practice arrangements are often not financially viable in low-volume communities. As a result, reductions in facility practice expense payments may not simply affect physician reimbursement but may instead shift additional financial pressure onto rural hospitals that already subsidize essential physician services in order to maintain local access to care.

Many rural hospitals operate with limited financial margins and rely on employed physician networks to sustain access to primary, specialty, surgical, and emergency care services. Hospitals are two and a half times more likely to acquire rural physician practices than other entities.[1] From 2018 to 2026, almost 12,000 rural physicians became hospital employees.[2] When physician reimbursement decreases, rural hospitals are frequently required to absorb those losses through physician compensation guarantees, practice support agreements, and other recruitment and retention investments necessary to maintain an adequate workforce. Because rural hospitals often serve as the primary source of health care within their communities, reductions in physician payment can create downstream effects that extend beyond individual practitioners and threaten the stability of local health care infrastructure.

These concerns are particularly acute for procedural specialties. Rural surgeons and other specialists frequently practice in low-volume environments while maintaining call coverage, staff readiness, equipment, and facility capacity that remain available regardless of patient volume. Although CMS assumes that physicians furnishing services in facility settings incur lower indirect practice expenses, rural providers often continue to bear substantial fixed costs associated with maintaining both office-based and facility-based operations. Furthermore, many rural hospitals must subsidize these specialties because procedure volumes alone are insufficient to support the workforce necessary to ensure community access to care. Payment reductions that disproportionately affect procedural specialties may therefore contribute to physician recruitment and retention challenges and increase the risk that rural patients will lose access to local surgical and specialty services.

NRHA is particularly concerned that the cumulative impact of these changes could further accelerate consolidation and diminish service availability in rural communities. Rural patients are more likely to depend on hospital-based outpatient departments and other facility-based settings for access to care, particularly in geographically isolated areas where alternative providers may not exist. If payment reductions make it more difficult for rural hospitals to recruit and retain physicians, patients may face longer travel times, delayed treatment, and reduced access to specialty and procedural care close to home.

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[1] American Hospital Association. (2024). Analysis: Hospitals and health systems are critical to preserving access to care in rural communities. https://www.aha.org/2024-01-25-analysis-hospitals-and-health-systems-arecriticalpreserving-access-care-rural-communities

[2] *Physicians Advocacy Institute > PAI Research > PAI-Avalere Health Report on Physician Employment Trends and Practice Acquisitions: 2018-2026*. (2018). Physiciansadvocacyinstitute.Org. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Health-Report-on-Physician-Employment-Trends-and-Practice-Acquisitions-2018-2026

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NRHA respectively requests that CMS continue to evaluate the effect of these changes on rural providers, hospitals, and beneficary access to care. Specifically, CMS should assess how changes to facility practice expense payments affect physician recruitment, service line sustainability, hospital financial performance, and beneficiary access in rural and underserved communities before considering additional expansions of the site-of-service payment differential.

6. Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

b. Global Surgical Packages

NRHA supports pausing the MACRA-required data collection on global surgical packages to alleviate the burden of unnecessary reporting requirements on physicians. While it is important to maintain clinical oversight and ensure compliance with clinical standards and billing metrics, NRHA believes that adequate data collection on global surgical packages has been reached. Continued reporting requirements may impose unnecessary administrative burden on physicians and health care organizations, particularly in rural communities where providers often practice in smaller settings with limited administrative support.

C. Payment for Medicare Telehealth Services

1. Changes to the Medicare Telehealth Services List

b. CMS Proposal to Add New Codes to the List

NRHA supports the proposed additions to the telehealth services list, such as pediatric speech therapy and advance care planning. As 80% of rural areas are medically underserved,[3] telehealth continues to serve as a lifeline for rural communities that face limited access to care. Telehealth modalities such as video, audio-only, and remote patient monitoring continue to transform care in communities that would otherwise face long transportation times, lack of specialty care, and financial or logistical difficulties in making appointments.

Studies indicate that for rural patients in certain situations, telehealth can lead to even better outcomes when compared to in-person care.[4] Further, telehealth visits boast average savings of $19-$121, can help rural patients avoid costly emergency department visits, and keep chronic conditions manageable.[5] **NRHA urges CMS to continue prioritizing and investing in telehealth in rural regions.**

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[3] Arredondo, K., Touchett, H. N., Khan, S., Vincenti, M., & Watts, B. V. (2023). Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative Review. *Journal of General Internal Medicine*, *38*(S3), 916–922. https://doi.org/10.1007/s11606-023-08122-6

[4] Chu, C., Cram, P., Pang, A., Stamenova, V., Tadrous, M., & Bhatia, R. S. (2021). Rural Telemedicine Use Before and During the COVID-19 Pandemic: Repeated Cross-sectional Study. *Journal of Medical Internet Research*, *23*(4), e26960. https://doi.org/10.2196/26960

[5] Kichloo, A., Albosta, M., Dettloff, K., Wani, F., El-Amir, Z., Singh, J., Aljadah, M., Chakinala, R. C., Kanugula, A. K., Solanki, S., & Chugh, S. (2020, August). *Telemedicine, the current COVID-19 pandemic and the future: a*

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2. Telehealth Flexibilities and Modifiers

In accordance with the *Consolidated Appropriations Act, 2026*, NRHA supports CMS's proposed updated regulatory guidance. This includes:

- Waiving geographic site restrictions on Medicare telehealth services through December 31, 2027
- Expanding permissible originating sites through December 31, 2027
- Extending the waiver of the in-person visit requirement for RHC and FQHC mental health telehealth through December 31, 2027
- Extending their authority to bill for non-behavioral telehealth visits through December 31, 2027

NRHA supports CMS's efforts to maintain access to telehealth services for RHCs and FQHCs and urges CMS to ensure that the transition to individual CPT and HCPCS codes for distant-site telehealth services does not create additional administrative or financial burdens for rural providers.

NRHA strongly urges CMS to work with Congress to permanently allow coverage of audio-only telehealth services. 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, practitioners should have the option to use their clinical judgment to determine if audio-only is appropriate.** NRHA members have stressed the importance of permanently keeping audio-only as an option. Rural patients face unique challenges in accessing both in-person and audio-video services, creating inequities in care. Broadband infrastructure is lacking in rural areas and computer/smartphone ownership is also lower compared to urban areas.[6] Rural beneficiaries have more hesitancy around telehealth because of complicated technology with which they are not familiar. These factors make some rural residents incapable of using audio-video technology. Audio-only telehealth is also extremely effective for reaching the older beneficiaries, particularly those 80 years old and older.[7] Additionally, members noted that using audio-only telehealth has made appointments that do not require physical touch more efficient and thus they are better able to serve all of their patients, which helps to increase access and address rural workforce shortages.

4. Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

CMS proposes to modify the in-person requirement for residents to bill for certain services. **NRHA strongly supports the modification to the previous policy, which allows for**

narrative review and perspectives moving forward in the USA. Family Medicine and Community Health; PubMed. https://doi.org/10.1136/fmch-2020-000530

[6] Curtis, M. E., Clingan, S. E., Guo, H., Zhu, Y., Mooney, L. J., & Hser, Y. I. (2021). Disparities in digital access among American rural and urban households and implications for telemedicine-based services. *The Journal of Rural Health*, *38*(3), 512–518. https://doi.org/10.1111/jrh.12614

[7] 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.

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teaching physicians to be virtually present in care settings, to clarify that the teaching physician or resident may be in the same physical location as the patient. This clarification will reduce instances in which services cannot be billed because one party is virtual while the other is in the same facility as the beneficiary. NRHA appreciates CMS's attention to this issue and maintains that this modification will improve care across rural health facilities that are working to promote their residency programs and utilize telehealth services to care for beneficiaries.

NRHA further continues to encourage CMS to allow teaching physicians to be virtually present regardless of whether or not the resident is physically or virtually present. NRHA recognizes that virtual presence may not be appropriate for all services or clinical circumstances and should remain subject to the teaching physician's clinical judgment.

D. Valuation of Specific Codes
2. Methodology for Establishing Work RVUs
c. Valuation of Specific Codes for CY 2027
(27) Maternity Care Services[8]

CMS proposes to remove two level 2 and two level 4 established patient office E/M visits in alignment with the RUC's recommendation to revise the maternity care billing process. **NRHA strongly supports the reallocation of work RVUs from the four E/M visits to the new labor and delivery CPT codes. This projected 15% increase in work RVUs for each labor and delivery code would have a substantial impact on rural maternity care.** Over half of rural counties no longer have access to an obstetric (OB) services unit.[9] Improving payment adequacy for maternity care services could help support the financial sustainability of rural practices and strengthen their ability to recruit and retain clinicians who provide maternity care. More frequently, OB services are likely to be offered by a family practice physician,[10] with prenatal care five times more likely to be supplied by a family physician in rural settings compared to urban.[11]

Acknowledging that maternity care codes such as labor management, delivery, and postpartum care represent distinct services that may be provided by different physicians is crucial. Bundled maternal care codes make billing for physicians difficult, as transfers occurring towards a patient's delivery date can cause financial difficulties for rural providers. Further, rural providers who provide maternal care but do not ultimately oversee the delivery cause confusion in billing.

[8] CPT Codes 59320, 59325, 59412, 59871, 59XX1, 59XX2, 59XX3, 59XX4, 59030, 59051, 59XX5, 59XX6, 59414, 59300, 59XX7, 59XX8, 59XX9, 59X10, 59X11, 59X12, and 59160
[9] GAO. Maternal health: Availability of hospital-based obstetric care in rural areas. GAO.gov. October 19, 2022. Accessed January 11, 2024. https://www.gao.gov/products/gao-23-105515
[10] Brigance C, Lucas R, Jones E, et al. Nowhere to go: Maternity care deserts across the U.S. 2022 Report. March of Dimes. 2022. Accessed January 11, 2024. https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf
[11] Cohen, D., & Coco, A. (2009). Declining trends in the provision of prenatal care visits by family physicians. Annals of family medicine, 7(2), 128–133. https://doi.org/10.1370/afm.916

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(48) Remote Monitoring[12]

CMS proposes multiple changes to the implementation structure, and billing of remote patient monitoring (RPM) and remote therapy monitoring (RTM) services. This includes requiring an initiating patient visit for both RPM and RTM services, however this visit can be conducted virtually. CMS further proposes prohibiting third parties or services vendors from monitoring patients. Instead, direct clinical staff would be solely responsible for furnishing these services. Finally, CMS seeks comment on bundling all CPT codes into four HCPCS G-codes to bill for RPM and RTM services.

Remote monitoring services align with the Trump Administration's goal to move towards continuous and proactive care. These services allow rural clinicians to identify a patient's worsening condition before they end up in an emergency room and allow physicians and clinical staff to catch medication management issues earlier on. This foresight enables clinicians to respond to changes in patient conditions by adjusting treatment plans before a crisis occurs and are especially important for Medicare patients with multiple chronic conditions that are both highest risk and highest cost living in rural areas. RPM/RTM services decrease the cost to taxpayers by preventing expensive emergency room visits and enabling greater preventative/responsive care.

Additionally, rural patients often face long travel times to reach providers and may lack the transportation or resources to make frequent visits. RPM/RTM services extend a rural provider's scale of care by allowing them to check in with patients and monitor their vitals without costly trips to an office. These services have the potential to modernize care and improve rural health outcomes for patients.

NRHA strongly opposes the proposal to only allow RPM or RTM service payment when furnished directly by clinical staff. Many rural health facilities that utilize RPM and RTM services operate through clinically integrated models or are parts of larger health systems. Additionally, rural care centers often have limited staffing and outsource RPM/RTM management to vendors who have the capacity to ensure that these services are available to patients in a safe and standardized way. **CMS's proposal to prohibit third parties from assisting in monitoring vitals endangers program viability and would likely result in rural practices being unable to offer these services.** As an alternative, CMS could explore use of baseline requirements for clinician monitoring, such as a minimum check-in period or charting check, or introduce a modifier to signal if clinicians are using third party services.

NRHA supports CMS's proposal to require an initiating in-person or telehealth visit for remote monitoring services on the basis that this visit does not need to be solely dedicated to discussing remote care. As previously mentioned, requiring an entirely separate visit would be a significant burden on patients. NRHA believes clinicians should discuss these services with patients to ensure that patients are good candidates for remote monitoring and understand what is required of them to engage in these services.

[12] CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470

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Furthermore, health systems and independent physician practices may not have sufficient time to adopt these changes by the specified date of January 1, 2027. Specifically, small rural hospitals and critical access hospitals already face negative operating margins, low staffing, and little capital. NRHA is concerned that if these facilities face the expensive and time-consuming hurdle of restricting their remote monitoring programs, they will elect to drop these services altogether. This would impact not only future patients, but patients who currently use remote monitoring services.

Finally, **NRHA opposes bundling the 17 CPT codes into four HCPCS G-codes.** In 2025, rural health clinics (RHCs) began billing using individual CPT and HCPCS codes as opposed to the consolidated G-code structure. As RHCs have only recently begun using HCPCS codes, switching to another coding mechanism risks creating confusion and additive provider burden that could result in clinicians not offering RPM/RTM services. While NRHA appreciates CMS's intent to streamline and consolidate billing practices, **we ask that CMS delay the implementation timeline as January 1, 2027, does not provide hospitals and clinics adequate time to change their billing software and educate their clinicians.**

(50) Smoking and Tobacco use Cessation[13] and Screening, Brief Intervention, and Referral to Treatment (SBIRT)[14]

NRHA supports the proposal to increase the work RVU for smoking and tobacco use cessation services by 19.1%. We applaud CMS's attention to time-based, behavioral health-focused treatments. This increase is particularly important for rural communities, where tobacco use remains more prevalent and contributes significantly to chronic disease burden, cancer, cardiovascular disease, and respiratory illness. According to the Centers for Disease Control and Prevention, adults living in nonmetropolitan counties are substantially more likely to smoke cigarettes than those living in metropolitan areas.[15] Enhanced reimbursement for smoking and tobacco cessation counseling can help ensure that rural physicians and other practitioners have the resources necessary to provide evidence-based interventions that address longstanding rural health disparities.

(51) Psychiatric Collaborative Care Model (CoCM)[16] and APCM BHI add-on codes[17]

CMS proposes refining the work RVUs of certain CPT codes related to CoCMs to a blended level 3 and level 4 E/M rate. NRHA supports the CMS's recognition that the current valuation of CoCM codes could be refined to further strengthen integrated, evidence-based models of behavioral health care. However, we believe that the true valuation of these services reflects a level 4 and level 5 E/M service.

[13] CPT Codes 99406, 99407
[14] HCPCS Codes G2011, G0396, G0397
[15] CDC National Center for Health Statistics. Sohi I, Ng AE. *Cigarette and Electronic Cigarette Use Among Adults by Urbanization Level: United States, 2024.* NCHS Health E-Stats. Published March 26, 2026. Accessed September 14, 2026. Available at: https://www.cdc.gov/nchs/data/hestat/hestat115.htm
[16] CPT codes 99492, 99493, 99494, G2214
[17] HCPCS Codes G0568, G0569

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Patients enrolled in CoCM are selected based on higher levels of complexity. These patients often have multiple mental health and advanced chronic diseases or face housing instability or food insecurity. Most patients require multiple plan adjustments throughout their treatment which requires additional time spent reviewing their care plan, discussing options with the patient, and tracking symptoms. This level of sustained, multidisciplinary clinical care demonstrates significant time and effort by the physician. Therefore, **NRHA urges CMS to adopt a valuation that reflects at least a level 4 E/M service.**

(53) Evaluation and Management (E/M) Visit Complexity Add-on[18]

CMS proposes replacing the HCPCS code G2211 with a modifier (MOD1) to establish visit complexity. The agency also proposes a second modifier to identify a visit complexity add on for accountable care organizations (ACOs). While NRHA appreciates that CMS continues to recognize the importance of complexity when treating patients, **we do not support eliminating HCPCS code G2211 and/or transitioning to MOD1 and MOD2.** The G2211 code was finalized in the CY 2021 PFS and was effectively implemented in CY 2024. At that time, less than 15% of eligible G2211 visits were billed using this code- significantly less than was expected.[19]

Rural physicians frequently serve as the primary source of comprehensive, longitudinal care within their communities and often manage a broader scope of patient needs due to specialist shortages and limited access to behavioral health services. As a result, rural clinicians routinely furnish the type of relationship-based, complex care that HCPCS code G2211 was intended to recognize. Transitioning from an established HCPCS code to a modifier-based structure may increase administrative burden, create coding uncertainty, and result in underutilization of these payments during implementation. These challenges may be especially pronounced for small rural practices, Rural Health Clinics, and Critical Access Hospital provider-based clinics that operate with limited billing and compliance resources.

Billing education takes significant time- it often takes years for physicians to become familiar with coding changes. Changing the code to a modifier would likely mean that few eligible visits would use this modifier in CY 2027, leading to significant underbilling of services. Furthermore, for physicians who have productivity elements that are written in their employment contracts, RVUs are generally the vehicle in which productivity is measured. Replacing the G-code with a modifier could potentially devalue their services, and for rural physicians who are unable to participate in ACOs, they could be unfairly ineligible to utilize MOD2. Finally, many EHR systems only allow four modifiers to be applied per line item, meaning that clinicians may not be able to apply MOD1 or MOD2 at all for certain services.

[18] HCPCS Code G2211

[19] Ganguli, I., Daley, N. E., Hicks, A. L., McWilliams, J. M., & Rosenthal, M. B. (2026). Billing of Medicare's G2211 Longitudinal Care Code Among Traditional Medicare Beneficiaries. JAMA, 335(11), 1003. https://doi.org/10.1001/jama.2026.0424

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(54) Shared Medical Appointments (SMAs)

CMS proposes creating a new HCPCS G-code for SMAs. This code would allow for physicians to bill for group medical services, including multiple patients receiving behavioral care in a group setting. This service can be provided in person or virtually. **NRHA strongly supports the creation of a code for SMAs.** SMAs allow clinicians to efficiently deliver education, counseling, and individualized care to multiple patients while maximizing the reach of a limited health care workforce. NRHA is increasingly concerned about the aging rural population, as over twenty percent of individuals 65 and older reside in a rural area.[20] Transportation challenges and geographic isolation lead to an increased likelihood of loneliness and social isolation in rural areas. SMAs are one vehicle in which older adult loneliness can be combatted.[21] Group-based visits may allow rural clinicians to efficiently deliver education, counseling, and individualized clinical care while also providing opportunities for peer support.

(58) Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

CMS proposes to decrease payment for subsequent O/O E/M visits that occur on the same day for the same physician. This proposal would pay 100% for the most expensive E/M visit and pay all others 50%.

NRHA strongly opposes this proposed reduction for E/M and/or global services furnished on the same day. Rural patients must often travel long distances for surgical services. In rural communities, specialty care is limited, and independent practices that offer these services are even more limited. For rural patients, consolidating care into a single visit is often essential to maintaining access to specialty and surgical services. Rural residents frequently travel significant distances to receive specialty care and may face transportation barriers, caregiving responsibilities, missed work, and other challenges that make multiple visits difficult or impossible. Policies that reduce reimbursement for same-day services may create financial disincentives for providers to coordinate care in ways that minimize patient travel burden.

During the RUC review process, downward adjustments are made when payment overlap is identified. CMS acknowledges this process and states concern that these adjustments are often small. **NRHA believes these adjustments are representative of the time, effort, and resources clinicians and staff spend on patients that have multiple services in one day.** Rural facilities operate with limited staff, equipment, and specialty capacity. Furnishing multiple clinically appropriate services during a single encounter does not necessarily result in a proportional reduction in physician work, clinical staff time, care coordination,

[20] U.S. Census Bureau. U.S. older population grew from 2010 to 2020 at fastest rate since 1880 to 1890. Published May 25, 2023. https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-populationgrew.html

[21] L'Heureux T, Parmar J, Dobbs B, et al. Rural Family Caregiving: A closer look at the impacts of health, care work, financial distress, and social loneliness on anxiety. Healthcare. 2022;10(7):1155. https://www.mdpi.com/2227- 9032/10/7/1155

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documentation, scheduling, or facility resources. In many cases, same-day care delivery represents a more efficient use of scarce rural health care resources.

While we agree with CMS that it would be incredibly problematic for physicians to intentionally schedule these services on different days in order to avoid the payment reduction, we cannot ignore that it is a possibility that would **significantly impair rural patients from accessing these services and potentially create medical risk.**

Providers who schedule patients for multiple services in one day align with the Administration's goal of increasing coordination and reducing inefficiencies in care. When a patient receives multiple services from the same physician and clinical staff on the same day or is able to receive an evaluation and treatment in the same day, they have a greater ability to discuss their care with the clinical team, coordinate post-operative recovery, and are likely to have fewer post-operative visits. NRHA is concerned that reducing payment for same-day E/M and procedural services may undermine incentives for care coordination and efforts to reduce unnecessary travel burden for rural patients.

If CMS is not willing to delay implementation of this proposal, we encourage the reduction to be set at 25%, as opposed to 50%. When CMS proposed this policy in 2019, many physicians and associations asked for further rationale on 50% as the percentage for reduction. We respectfully reiterate this request and ask for more information on how CMS decided that 50% is the appropriate number for reduction.

(59) Revisions to Teaching Physician Policy Related to the Primary Care Exception

CMS proposes expanding the primary care exception for residents. Currently, residents can only bill for E/M visits without the presence of a teaching physician for level 1-3 visits. CMS proposes allowing them to bill for level 4 and 5 visits in primary care centers. **NRHA fully supports expanding the primary care teaching exception for GME residents for level 4 and 5 E/M services.** Including these services will give residents further opportunity to learn, and deferring clinical judgment to the GME program ensures residents are prepared to furnish these services. Rural training programs often have limited faculty resources and would benefit from fully utilizing residents to an appropriate extent. This would then allow the teaching physicians to focus their time on residents who require greater guidance or are treating patients with complex needs.

Residents who spend training time in a rural area are 5 times more likely to practice in a rural area.[22] The rural workforce shortage, coupled with the primary care shortage, makes it difficult for rural primary care practices to recruit and retain clinicians. Only 10% of physicians practice in a rural community,[23] despite these areas containing 20% of the U.S.

[22] American Medical Association. (2022, September 27). *Recipe for more rural physicians: More exposure in residency training*. American Medical Association. https://www.ama-assn.org/education/improve-gme/recipe-more-rural-physicians-more-exposure-residency-training

[23] Association of American Medical Colleges. 2023 State Physician Workforce Data Report. AAMC; 2023. Accessed November 22, 2024. https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report

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population.[24] Over 66% of primary care health professional shortage areas (HPSAs) are in a rural area.[25] Allowing for greater independency in residency could bolster the attractiveness of primary care residencies and help recruit much-needed physician to these practices. NRHA further encourages to allow residency training programs autonomy to determine which services are appropriate for residents to furnish independently, such as certain behavioral health related visits.

E. Request for Information: Redesigning Primary Care to Make America Healthy Again

2. Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

CMS proposes restructuring O/O E/M visits into three categories, rather than using the generic codes (99202–99215). The three categories include longitudinal care visits, acute care visits, and consultative care visits. Additionally, they are considering establishing a Prospective Primary Care Payment (PPCP) within the Medicare Shared Savings Program (MSSP). Further, CMS is seeking information on whether care management services such as chronic care management should be bundled or unbundled.

Primary care is an important tool in rural communities as rural patients strongly value local, long-term connections with practitioners and have less access to specialty care physicians. NRHA appreciate that CMS is exploring how to best value primary care as rural clinicians face unique demands when proving primary care services.

NRHA does not believe that the longitudinal, acute, and consultative care categorization is the best method to bill for primary care services. Rural primary care physicians frequently deliver comprehensive care that spans longitudinal management, acute treatment, preventive services, behavioral health support, and specialty care coordination within a single encounter. Because specialist access is limited in many rural communities, primary care providers often address concerns that might otherwise be managed by multiple clinicians. As a result, creating separate billing categories for longitudinal, acute, and consultative care may not accurately reflect how care is delivered in rural communities. Many rural visits involve elements of all three categories, making it difficult to identify a single visit purpose without introducing additional coding complexity and administrative burden.

3. Care Management Code "Family"

CMS notes a lack of uptake in the advanced primary care management (APCM) model. NRHA believes that the vast majority of RHCs have not furnished APCM services since they began this year. RHCs are small providers with limited resources and capacity to provide new,

[24] U.S. Census Bureau. New Census Data Show Differences Between Urban and Rural Populations. December 2022. Accessed November 22, 2024. https://www.census.gov/newsroom/press-releases/2022/population-changes.html

[25] Health Resources and Services Administration. Health Professional Shortage Areas Dashboard. Updated September 2023. Accessed November 22, 2024. https://data.hrsa.gov/topics/health-workforce/shortage-areas

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innovative services. Without adequate guidance and support from CMS, it is unlikely that RHCs will begin furnishing APCM services. RHCs generally need substantial education and training on new billing codes and as it stands there is little available for them. We appreciate that new opportunities like APCM are available to RHCs but note that CMS needs to make additional support available to RHCs to effectuate meaningful use of such new services.

There are also APCM practice-level capability requirements around performance measurement for participation serve as a barrier to rural provider participation. For example, meeting the performance measurement requirements can be met through participation in certain ACO programs and value-based care models focused on primary care. This is likely a useful flexibility for many providers. But given lower participation in value-based care among rural practitioners, there is less benefit to this flexibility, and they will be required to register for and report on the "Value in Primary Care" MIPS Value Pathway.

6. Developing Prospective Payment in the Shared Savings Program

CMS is proposing to replace the current structure for awarding Advance Investment Payments (AIPs) with a per-beneficiary quarterly payment based on beneficiary risk factors. Their aim is to incentivize treatment of patients who are low-income, dually eligible, or in rural areas. CMS also proposes establishing prospective primary care payment (PPCP) option within the MSSP.

NRHA supports the quarterly payment as opposed to the current risk-factor methodology and believes that rural providers who treat patient populations that are at a socioeconomic disadvantage, geographically isolated, and/or unable to regularly access care. By recognizing rurality as a measure independent from economic status, CMS acknowledges the deeper challenges surrounding rural health access. This simpler methodology will allow rural providers participating in ACOs with greater predictability when planning staffing and care coordination. By explicitly recognizing rural residence in the AIP calculations, rural ACO participants will have greater capacity to succeed in the value-based care model.

NRHA supports the creation of the PCCP option within the MSSP on the basis that it is optional for providers. While NRHA supports integrating rural providers into value-based care models, we have significant concerns with rural provider readiness and bandwidth to participate in mandatory models. NRHA supports the movement to value-based care models over volume-based models but believes that rural providers must be thoughtfully included. Unfortunately, there are numerous rural providers that are not equipped to participate in value-based care yet. As such, mandatory models are not appropriate for all rural providers at this point and CMS must allow rural providers to opt out if needed.

III. Other Provisions of the Proposed Rule

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

CMS proposes new codes for advance care planning (ACP) services supplied by clinical staff and to recognize Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy

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(MNT) services as preventive services covered under the RHC benefit. **NRHA supports the proposal to create new ACP codes for DSMT and MNT services for RHCs.** Advance care planning is a comprehensive, patient-centered approach that can strengthen services rendered in RHCs and FQHCs. Diabetes prevalence is 9%-17% higher in rural areas compared to urban areas.[26] With additional codes, RHCs can effectively bill for diabetes and nutrition management and education among their communities. Additionally, NRHA supports the proposal to permit qualified practitioners, such as dietitians, to furnish these services.

The agency further proposes to increase the FQHC Prospective Payment System (PPS) base rate by an estimated 2.5% based on the FQHC market basket. **NRHA further supports the 2.5% increase for the FQHC PPS base rate.** Updating the base rate for FQHCs will help clinics operate despite workforce shortages, lower patient volumes, and substantial geographic barriers. Aligning payment policies in these settings will help ensure that patients are able to access nutrition services regardless of where they seek care.

D. Proposed Changes to the Ambulatory Specialty Model (ASM)

CMS proposes that physicians with a "cardiology" specialty designation be required to participate in the ASM model that is mandatory beginning January 1, 2027. Cardiologists with highly specialized practice areas such as interventional cardiology and intensive cardiac rehabilitation will be exempt. CMS also proposes adding 5 points to the scores of all physicians participating in the ASM who practice in a rural area. **While NRHA appreciates the 5 points rural adjustment, we ask that CMS not mandate participation for rural providers.** We remain significantly concerned with rural providers' bandwidth and readiness to participate in value-based care. NRHA hopes that rural providers choose to participate, but we encourage CMS to allow rural providers who are not ready to adopt this model of care to abstain from participation.

F. Medicare Prescription Drug Inflation Rebate Program

CMS proposes that all 340B covered entities be required to submit reporting data on a quarterly basis beginning January 1, 2027, including date of service, fill number, National Provider Identifier (NPI), and 340 identification information. **NRHA urges CMS to reconsider this proposal.** A new, parallel quarterly reporting structure risks duplicating information CMS and HRSA can already access, without demonstrating that existing tools are insufficient for the stated purpose. HRSA's 340B audit process currently evaluates savings usage at the covered entity level. FQHCs already report detailed utilization data through the Uniform Data System (UDS). NRHA also is concerned that a January 1, 2027, effective date leaves limited runway for rural covered entities to stand up new reporting systems, particularly if final rule text is not available until late 2026.

[26] Khavjou, O., Tayebali, Z., Cho, P., Myers, K., & Zhang, P. (2025). Rural–Urban Disparities in State-Level Diabetes Prevalence Among US Adults, 2021. Preventing Chronic Disease, 22. https://doi.org/10.5888/pcd22.240199

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Claim-level reporting proposed creates a disproportionate burden for rural and small covered entities. Many rural covered entities rely on contract pharmacy arrangements and virtual or replenishment inventory models rather than a dedicated 340B claims infrastructure. Producing fill-level and NPI-level data on a quarterly cadence would likely require new software, additional staff time, or third-party administrative support that smaller rural hospitals, critical access hospitals, and rural health clinics cannot readily absorb. New reporting requirements proposed augment the burden that rural covered entities are especially poorly positioned to bear given the reporting demands already anticipated under the forthcoming 340B rebate model.

If CMS proceeds with a new reporting requirement, NRHA recommends the following modifications:

1) build the reporting structure on existing systems, such as UDS and HRSA's 340B audit data infrastructure, rather than creating a new parallel data submission process;

2) provide a phased implementation timeline with a transition period and HRSA-supported technical assistance for rural and small covered entities;

3) clarify data security and proprietary-information protections for claim-level 340B identification data, particularly where contract pharmacy relationships are involved; and

4) commit to a defined evaluation period and criteria for how this data will be used to determine whether 340B participants are excluded from Part D definition rebate calculations, so that covered entities understand what the new burden is intended to accomplish.

H. Changes to Regulations Associated with the Ambulance Fee Schedule

NRHA appreciates CMS's proposals that align with the *Consolidated Appropriations Act of 2026*, including **support of the add-on increase of 3% for ground ambulance transports originating in a rural area and a 22.6% increase for "super rural" areas. NRHA also supports updating to the 2020 census and the July 2025 RUCA codes.** These updates are critical, as EMS reimbursement remains low due to coverage restrictions, further straining rural access to emergency services. For example, rural communities wait over twice as long for EMS services compared to urban zip codes.[27]

NRHA urges CMS to reconsider HRSA's recommendation to classify certain RUCA 2 and 3 codes as rural. RUCA 2 and 3 codes which have census tracts of 400 square miles in an area with a population density of 35 or fewer people per square mile. This definition is consistent with that used by HRSA and is a combination of input and data from the Census Bureau, Office of Management and Budget (OMB), and Department of Agriculture Economic

[27] Bryant, M. (2017, July 21). *Rural wait times for EMS more than twice that for urban, suburban areas*. Healthcare Dive. https://www.healthcaredive.com/news/rural-wait-times-for-ems-more-than-twice-that-for-urban-suburban-areas/447586/

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Research Service (ERS).[28] Some metropolitan counties contain large, unpopulated areas that are difficult for ground ambulance to reach to due road or mountainous terrain limitations.

IV. Updates to the Quality Payment Program Reporting and Data Submission

A. CY 2027 Modifications to the Quality Payment Program Reporting and Data Submission
3. Transforming the Merit-based Incentive Payment System (MIPS): MIPS Value Pathway (MVP) Strategy

CMS is proposing to fully transition from traditional MIPS to MIPS Value Pathways (MVPs). For CY 2027, CMS proposes three new MVPS: diabetes, hospitalists, and hypertension. NRHA continues to support CMS's goal to incentive patient-centered care and promote quality measures. **While NRHA does not necessarily oppose MVPs, we have concern with mandating participation in MVPs beginning in CY 2029.** MVPS are still new to rural physicians and have not seen widespread adoptions. Because we have not seen wide uptake in this program, we encourage CMS to explore operational burden, reporting requirements, and practice validity more fully in rural settings. We appreciate CMS's efforts in achieving an estimated 98% physician coverage through MVPs, however, **we urge CMS to delay mandatory implementation of MVPs until the feasibility of rural physician transitions have been thoroughly assessed and appropriate readiness benchmarks identified.** Finally, we ask that CMS conduct pilot studies with small rural practices to ensure minimal disruption if MVPs are completely adopted.

B. MIPS Final Score Methodology

To reduce administrative burden, CMS proposes to exempt small practices from reporting the MIPS Core Measure, submitting self-attestations, or incurring scoring penalties from failure to submit this reports. **NRHA supports this exclusion and applauds CMS attention to the unique challenges rural providers face**, including limited operational and administrative staff and aging IT systems.

Other Policy Proposals for Consideration

Rural communities are aging more rapidly than their urban counterparts and face a higher burden of chronic conditions and disparate health outcomes.[29] For rural Medicare beneficiaries, Community Health Workers (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

[28] *How We Define Rural | HRSA*. (2026, June 30). Hrsa.Gov. https://www.hrsa.gov/rural-health/about-us/what-is-rural
[29] Centers for Disease Control and Prevention. *Leading Causes of Death in Rural America*. CDC Rural Health. Updated August 27, 2024. Accessed September 14, 2026. https://www.cdc.gov/rural-health/php/about/leading-causes-of-death.html.

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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

Additionally, Medicare's new CHI benefit, 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.[30] 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**

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

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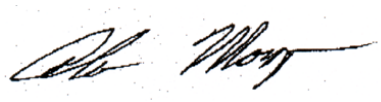
reimbursement for mileage or travel time in rural areas. This approach would leverage a successful and analogous precedent within Medicare, cleanly separating the payment for the service from the logistics of delivering it.

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 NRHA's Chief Policy Officer, Carrie Cochran-McClain, at ccochran@ruralhealth.us.

Sincerely,



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