National Rural Health Association

September 12, 2025

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

RE: CMS-1832-P; Medicare and Medicaid Programs: CY 2026 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) 2025 Medicare Physician Fee Schedule (MPFS) 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 2026 MPFS Conversion Factor.

NRHA is pleased to see an increase to the MPFS conversion factor for the first time in five years. On top of almost annual payment reductions, MPFS is one of the only Medicare payment systems without a payment update that is tied to inflation, meaning that Medicare payment to clinicians is nowhere near the cost of providing care.[1] Recent cuts to physician payment, plus no mechanism to keep pace with inflation, threatens access to care for rural beneficiaries. Rural beneficiaries already face worse health outcomes than their urban peers, including higher risk of dying from the top five causes of death. Low MPFS reimbursement is also a leading cause of rural physician practices closing or being absorbed by large health systems.[2]

[1] American Medical Association, *Medicare physician payment continues to fall further behind practice cost inflation,* Jan. 2025, https://fixmedicarenow.org/sites/default/files/2025-01/Medicare%20Gap%20Chart_2025.pdf.
[2] Tanya Albert Henry, *Medicare pay cuts: What they mean for rural America*, American Medical Association, Mar. 13, 2025, https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-pay-cuts-what-they-mean-rural-america; *Preserving rural health care: The impact of site neutral payments*, National Rural Health Association, Nov. 2024, 1 https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/nrha-site-neutral-policy-brief-2024.pdf.

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II. Provisions of the Proposed Rule for the PFS.

B. Determination of PE RVUs.

5. Development of Strategies for Updates to Practice Expense Data Collection and Methodology.

c. Updates to Practice Expense (PE) Methodology—Site of Service Payment Differential.

CMS proposes revising the PE methodology for services furnished in the facility setting (e.g., hospital) compared to the non-facility setting (e.g., physician's office). CMS' proposal would create a payment differential between the two settings and effectively reduce payments for services in the facility setting. CMS notes that this is necessary because practice patterns have changed since the onset of the MPFS, which was built with the underlying assumption that most physicians would work in private practice. Now most physicians are employed by hospitals, and MPFS payment should reflect this change.

NRHA disagrees with CMS' position on a site of service payment differential. Although intended to control Medicare spending and reflect changes in healthcare delivery, this policy threatens rural beneficiaries' access to care.

Rural communities rely upon hospitals to provide essential care, particularly in remote areas. The more rural the county where a Medicare beneficiary resides, the more likely it is that they seek care in a hospital outpatient department rather than a physician's office.[3] In fact, rural hospitals' average share of revenue from outpatient services has increased from 66% in 2011 to almost 75% in 2021.[4] Further, as it becomes increasingly difficult for independent rural physician practices to remain open, hospitals acquire these practices in an effort to retain access points for rural patients. Hospitals are two and a half times more likely to acquire rural physician practices than other entities.[5] This policy would unfairly impact rural facilities as the operational realities in rural areas make private practice difficult to sustain. The payment differential threatens the operational viability of rural facilities, leading to reduced access to care for rural populations who already face significant barriers to care and health disparities. **NRHA urges the agency to consider the unique circumstances of rural health care providers and asks that CMS not finalize this proposal.**

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

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.

NRHA supports CMS' proposal to permanently define direct supervision to allow the presence and immediate availability of the supervising practitioner through audio-video technology, except for certain surgical procedures. This policy has been in place since the onset of the COVID-19 public health emergency (PHE) and has allowed flexibility and eased workflows for rural providers.

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[3] 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-are-criticalpreserving-access-care-rural-communities.

[4] Randall A. John, et al., *Revenue Source Trends in Rural Hospitals*, Department of Health Policy and Management, Gillings School of Public Health, University of North Carolina at Chapel Hill, 2021, 10, https://www.shepscenter.unc.edu/product/trends-in-revenue-sources-among-rural-hospitals/.

[5] American Hospital Association, *supra* note 3.

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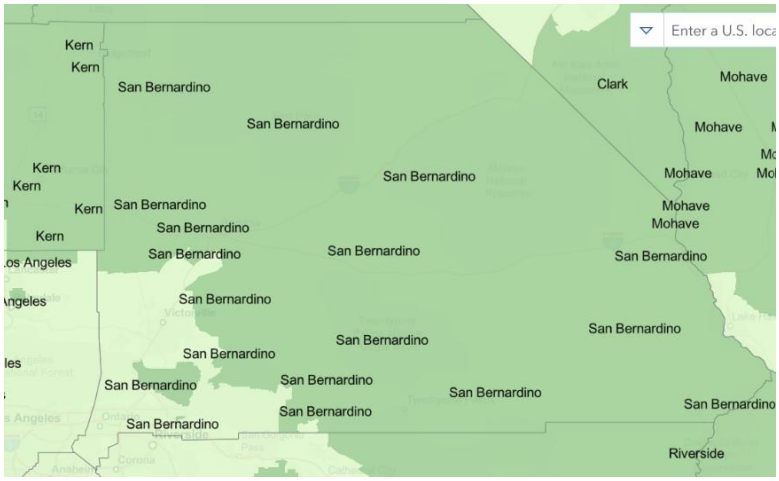
Similarly, NRHA supports applying the virtual direct supervision policy to cardiac, pulmonary, and intensive cardiac rehabilitation services under 42 C.F.R. § 410.32 in order to maintain access to specialty services for rural beneficiaries.

b. Proposed Changes to Teaching Physicians' Billing for Services Involving Residents With Virtual Presence.

Since the COVID-19 PHE CMS has allowed teaching physicians to "be present for the key portion of the service through real-time audio-video technology" for services where the resident and patient are together in person and for telehealth services in all residency training locations, including both in metropolitan statistical areas (MSAs) and non-MSAs. CMS proposes to end virtual supervision of residents providing telehealth service in MSAs.

NRHA asks CMS to permanently allow virtual supervision of residents for telehealth services in all residency locations. We appreciate that CMS proposes continuing virtual supervision in non-MSAs, which are generally considered rural areas, but we are concerned that this does not encompass all rural training locations that benefit from the current flexibility.

Using MSA and non-MSA to determine urban and rural areas excludes rural census tracts that are bordering large urban areas and thus are roped into an MSA. One example of this is a new rural psychiatry program that is located in San Bernadino County, pictured below. The county is large and contains an urban area; however, most of the county is considered rural (shaded in dark green) by another federal definition of rural.[6] Under CMS' proposal, if this rural psychiatry program is not able to utilize virtual supervision and faculty are not available in the area, residents will have to travel further away to sites where faculty are onsite. This is common for rotations where faculty are often more specialized and not located in rural areas, like child-adolescent psychiatry. In general, there are fewer psychiatrists[7] and other specialists[8] located in rural areas, so this flexibility is much needed.



[6] How We Define Rural, Health Resources and Services Administration, Feb. 2025, https://www.hrsa.gov/rural-health/about-us/what-is-rural (The Federal Office of Rural Health Policy (FORHP) definition of rural better captures rural areas by defining rural as: 1) Non-metropolitan counties; 2) Outlying metropolitan counties with no population from an urban area of 50,000 or more people; 3) Census tracts with RUCA codes 4-10 in metropolitan counties; 4) Census tracts of at least 400 square miles in area with population density of 35 or fewer people per square mile with RUCA codes 2-3 in metropolitan counties; and 5) Census tracts with RRS 5 and RUCA codes 2-3 that are at least 20 square miles in area in metropolitan counties).

[7] Dawn A. Morales, Crystal L. Barksdale, and Adrea C. Beckel-Mitchener, *A call to action to address rural mental health disparities*, 4 J. CLINICAL AND TRANSLATIONAL SCIENCE 463, 465 (2020) https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/pdf/S2059866120000424a.pdf.

[8] Melissa E. Cyr, et al., *Access to specialty healthcare in urban versus rural US populations: a systematic literature review*, BMC HEALTH SERVICES RESEARCH, Dec. 18, 2019, https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4815-5.

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NRHA asks that CMS continue to allow virtual supervision of residents for telehealth services in all residency training locations in order to maximize rural training. Alternatively, we ask that CMS consider allowing virtual supervision of residents for telehealth services in outlying metropolitan counties with no population from an urban area of 50,000 or more people and census tracts with RUCA codes 4-10 in metropolitan counties in addition to non-MSAs. This would more accurately capture rural areas that face barriers to recruiting faculty, especially those in specialties.

E. Valuation of Specific Codes.

2. Methodology for Establishing Work RVUs.

CMS raises concerns that the methodology for establishing work RVUs has not accounted for efficiencies gained in non-time-based services, like radiology and diagnostic tests. The agency believes that advancements in technology and operational improvements are not accurately reflected in work RVUs for these services. As such, CMS proposes a -2.5% adjustment to the intraservice portion of physician time and work RVUs for non-time-based codes to account for efficiencies gained by clinicians as they become more experienced with procedures over time. CMS would apply the adjustment every 3 years to reflect efficiency gains made during that time period.

NRHA is concerned by this proposal. The efficiency adjustment will reduce work RVUs permanently as it would be applied directly to the valuation of individual services, whereas efficiency adjustments in other payment systems (e.g., the Inpatient Prospective Payment System) are applied directly to the conversion factor and therefore are automatically annually adjusted for inflation. The work RVU efficiency adjustment will permanently bring down the value of work RVUs in the MPFS payment methodology.

Because the MPFS does not have an inflationary adjustment built into its methodology like hospital payment system, the proposed efficiency adjustment has the potential to further erode payment over time as it would be applied every 3 years. Medicare generally pays rural physicians 50% less for diagnostic and imaging tests compared to their urban counterparts, meaning that this efficiency adjustment will more adversely impact rural practices.[9] Further, until this proposed rule CMS has not increased physician pay in five years[10] and beginning in CY 2026, the statute only provides for modest increases.[11] Overall, this proposal will worsen Medicare physician pay for rural providers, which is already inadequate.

NRHA urges CMS against finalizing the proposed efficiency adjustment. The one-size-fits-all adjustment for non-time-based codes does not reflect the unique challenges associated with rural practice or other considerations.

G. Enhanced Care Management.

Created in the CY 2025 MPFS rule, Advanced Primary Care Management (APCM) is a new delivery model that includes three new G-codes to recognize the resource costs associated with furnishing APC services to beneficiaries. These codes would describe a set of care management services and include a broader range of services to simplify billing and documentation requirements. In this

[9] Michael Kitchell, *Medicare's physician payment policies hurt rural Americans*, Des Moines Register, Jan. 7, 2023, https://www.desmoinesregister.com/story/opinion/columnists/iowa-view/2023/01/07/medicare-physician-payment-policies-hurt-rural-americans/69782275007/.
[10] Henry, *supra* note 2.
[11] 42 U.S.C. § 1395w-4(d)(20) (for CY 2026 and beyond the qualifying APM conversion factor is 0.75% and nonqualifying APM conversion factor is 0.25%).

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proposed rule, CMS puts forth new add-on codes to allow providers furnished APCM services to also furnish behavioral health integration (BHI) and psychiatric collaborative care model (CoCM) services.

NRHA supports CMS' creating new add-on codes to account for behavioral health services. As discussed further below in Section III.b.2, we do not believe that many rural practices or providers are currently utilizing APCM codes. We ask that CMS consider how it may help educate and assist rural providers in advancing their primary care practice by furnishing APCM.

I. Policies To Improve Care for Chronic Illness and Behavioral Health Needs.

3. Community Health Integration and Principal Illness Navigation for Behavioral Health.

CMS is clarifying that marriage and family therapists (MFTs) and mental health counselors (MHCs) can bill Medicare directly for Community Health Integration (CHI) and Principal Illness Navigation (PIN) services related to the diagnosis or treatment of behavioral health conditions. NRHA supports this clarification.

NRHA asks that CMS consider making CHI services more accessible to rural populations by allowing payment for community paramedics as auxiliary personnel. The role of community paramedics in rural health care delivery aligns closely with the goals of the Administration's Make America Healthy Again (MAHA) agenda by focusing on prevention and chronic disease management while meeting beneficiaries where they are. Community paramedicine allows EMTs and paramedics to operate in expanded roles by providing public health, preventive services, and primary care to underserved populations.[12] 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 non-physician practitioner.[13] Community paramedics would be able to meet the "incident to" regulations at 42 C.F.R. § 410.26 as they likely are operating under general supervision already. 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.

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 related services.[14] Community paramedics already furnish the kinds of services that correspond with CHI services. Accordingly, community paramedics would easily be able to meet the certification and training requirements for CHI personnel and perform CHI services. Additionally, community paramedicine programs are typically funded and run through hospitals or EMS programs, which aligns with the CHI framework as CHI personnel can be either employed by a health care provider or external under contract so long as "incident to" regulations are met.

4. Technical Refinements To Revise Terminology for Services Related to Upstream Drivers of Health.

a. Policies To Improve Care for Chronic Illness and Behavioral Health Needs.

(1) Social Determinants of Health Risk Assessment (HCPCS Code G0136)

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[12] Community Paramedicine, RHIhub, https://www.ruralhealthinfo.org/topics/community-paramedicine.

[13] 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.

[14] 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.

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NRHA does not support CMS' proposal to delete the social determinants of health risk assessment HCPCS code. CMS claims that the resource costs described by the code are already accounted for in existing codes, such as evaluation and management visits. We disagree with this as we have heard from NRHA members that they do not typically screen for upstream drivers of health because before the advent of HCPCS code G0136 they could not bill for this service. Rural clinicians are often stretched thin due to workforce shortages and have less flexibility to extend appointments or furnish services for which they will not be reimbursed. Retaining G0136 would allow rural clinicians to continue to be paid for these crucial screening services.

Identifying and addressing upstream drivers of health are a key part of making informed medical decisions for many rural beneficiaries, yet rural providers historically have not had the tools to do so. Rural provider utilization of G0136 may have remained low in the last two years since its implementation because they lacked education on the new code and because RHCs and FQHCs cannot bill for this code. NRHA does not believe that it is appropriate to pull this code before it has reached its potential to help rural beneficiaries' address their upstream drivers of health. We urge CMS against removing G0136. Similar to its proposed revisions to CHI services, CMS could consider renaming G0136 to "upstream drivers of health risk assessment" to bring into line with the agency's objectives.

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

1. Medicare Payment for Dental Services.

NRHA is disappointed to see that CMS is not proposing new dental services that are eligible for Medicare payment. **NRHA urges CMS to continue expanding coverage for dental services under Medicare** in future MPFS rulemaking cycles**,** particularly when connected to common chronic diseases**.** Over the last few years CMS has expanded the clinical scenarios under which it will provide coverage for dental services. Certain dental services delineated by the agency are covered by Medicare so long as they are "inextricably linked to" the clinical success of another covered medical service.

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.[15] Further, seniors in rural areas were less likely to have visited the dentist than their urban and suburban counterparts.[16] 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.[17] Over 4,000 dental practitioners are needed in rural areas to remove

[15] Oral Health in Rural Communities, RHIhub, https://www.ruralhealthinfo.org/topics/oral-health.
[16] America's Health Rankings, United Health Foundation, *Senior Report 2018*, (May 2018), 44 https://assets.americashealthrankings.org/app/uploads/ahrsenior18-finalv1.pdf.
[17] 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.

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these designations.[18] NRHA believe further coverage of dental services under Medicare will help increase access to this critical care in rural areas.

Research increasingly suggests that oral health affects overall health[19] and poor oral health is connected to heart disease, diabetes, strokes, kidney disease, and high blood pressure. This makes the lack of access to dental care more troubling for rural beneficiaries as these types of chronic diseases are more prevalent in rural communities.[20] Increasing Medicare coverage for dental services connected to chronic diseases aligns with the Administration's MAHA agenda and would improve rural health outcomes.

III. Other Provisions of the Proposed Rule.

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

NRHA offers several provisions for CMS to consider in future MPFS rulemaking cycles to lessen administrative burden on RHCs.

Behavioral health.

In the CY 2025 MPFS proposed rule, CMS considered, but did not move forward with, defining "facility for the care and treatment of mental diseases" as it pertains to the services that RHCs can provide. NRHA urges CMS to define "facility for the care and treatment of mental diseases" in the CY 2026 rulemaking. This approach would simplify the RHC survey process and provide clear guidance for RHCs. CMS should define "a facility primarily for the care and treatment of mental diseases" as clinic types that provide behavioral health care only, including certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. There is precedent for this approach as RHCs also cannot be "rehabilitation agencies" which is a term that CMS defines elsewhere.[21] This straightforward approach would make the survey process around meeting this requirement easy to implement and cite. So long as the RHC provides primary care services there should be no citation for providing any level of behavioral health care because any RHC providing primary care could not qualify as one of the facilities listed above. **CMS should include this language in subsequent interpretive guidance and in 42 C.F.R. § 491.2** as follows:

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

Annual Wellness Visits at RHCs

Rural beneficiaries need better access to preventative care. While CMS has made strides to include more preventative care services under Medicare, like Annual Wellness Visits (AWV), rural beneficiaries still lag behind in receiving this care. AWVs can be important tools to increase awareness

[18] *Id.*

[19] CareQuest Institute for Oral Health, *Mouths Matter More Than You Know – Oral Health's Connection to Overall Health*, Dec. 2020, https://www.carequest.org/system/files/CareQuest-Institute-Mouths-Matter-More-Than-You-May-Know-Brief.pdf.

[20] Chronic Disease in Rural America, RHIhub, https://www.ruralhealthinfo.org/topics/chronic-disease.

[21] Outpatient Rehabilitation Providers, CMS.gov, Centers for Medicare and Medicaid Services, https://www.cms.gov/medicare/health-safety-standards/certification-compliance/outpatient-rehabilitation-providers#:~:text=Rehabilitation%20Agency%20%2D%20An%20agency%20that,a%20team%2C%20specialized%20rehabilitation%20personnel.

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and use of preventative care like cancer screenings and vaccinations that historically underserved populations, like rural, have not had access to.[22]

Overall, rural providers are less likely to provide AWV to any patients compared to metropolitan practices.[23] One explanation for lower rural uptake is that providers are not offering these visits to beneficiaries[24] 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 to 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.[25]

A third potential reason for lower uptake is due to the billing practices of unique rural provider types. **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 All Inclusive Rate (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 burden on beneficiaries by allowing them to receive both services in one day rather than making multiple trips and making RHC visits more efficient for clinicians.

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

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[22] 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

[23] 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.

[24] *Id.*

[25] 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/.

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(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.

2. Payment for Care Coordination Services.

b. Integrating Behavioral Health Into Advanced Primary Care Management.

As described in Section II.G., CMS proposes new add-on codes to allow providers furnishing Advanced Primary Care Management (APCM) services to also furnish Behavioral Health Integration (BHI) and psychiatric Collaborative Care Management (CoCM) services. CMS proposes to allow RHCs and FQHCs to bill for these optional add-on codes as well. In order to effectuate this change, CMS also proposes to unbundle HCPCS code G0512 and require that RHCs and FQHCs bill for individual CPT codes under G0512.

NRHA supports this proposal but highlights concerns regarding RHC uptake of these new codes. First, we believe 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, 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. Further, rural patients may be deterred from participating because of cost-sharing.

Second, **we seek clarification from CMS on how the BHI and CoCM services will be categorized for RHCs.** Currently, RHCs are surveyed based on the total number of hours spent providing primary care versus behavioral health care and can be cited if their hours spent providing the latter exceed 50%. This is extremely limiting and NRHA members have continued to ask for more flexibility in this space given the need for behavioral health care access in rural areas. Counting BHI and CoCM services as behavioral health care would discourage RHCs from providing these services. NRHA asks that CMS count BHI and CoCM as primary care, given that they are add-on codes for APCM, and that the agency swiftly provide sub-regulatory guidance to that effect.

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c. Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation Services – HCPCS Code G0071.

Similar to the proposal above, CMS proposes to unbundle G0071 to better effectuate payment policy for APCM at RHCs and FQHCs. **NRHA is supportive of the concept of unbundling codes and creating alignment between RHCs, FQHCs, and fee-for-service providers.** However, we note that CMS' policy to unbundle G0511, finalized in last year's MPFS rulemaking cycle, has yet to be implemented. CMS extended the deadline for RHCs and FQHCs to report individual CPT and HCPCS codes for care coordination services until July 1, 2025, and later extended it again September 30, 2025.[26] **NRHA asks that CMS provide more support to work out the kinks in the current unbundling process and apply lessons learned to the proposed G0071 and G0512 unbundling if finalized.** Again, NRHA appreciates and supports CMS' intent behind the policy to unbundle codes but urges the agency to streamline the process to ensure RHCs and FQHCs can be paid properly for the affected services.

3. Services Using Telecommunications Technology.

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

As stated above, NRHA supports CMS' proposal to permanently define direct supervision to allow the presence and immediate availability of the supervising practitioner through audio-video technology. **We also support applying this policy to the RHC and FQHC settings.**

c. Payment for Medical Visits Furnished via Telecommunications Technology.

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

Additionally, while CMS will continue to pay for telehealth services provided through RHCs and FQHCs, NRHA notes that if Congress does not extend originating site flexibilities, rural beneficiary access may still decline. Without a congressional extension, beneficiaries will no longer be able to receive non-behavioral health telehealth services in their homes. Even rural beneficiaries will be forced to travel to a qualifying originating site to receive telehealth services. This will diminish the benefit of an RHC or FQHC serving as a distant site telehealth provider as beneficiaries would be forced to resume traveling to a provider to receive telehealth services. The two different expiration dates for payment and originating sites also add to confusion for providers and beneficiaries. While RHCs and FQHCs would technically retain the option to furnish telehealth services and receive payment from Medicare if this proposal is finalized, beneficiaries may not understand that they can no longer receive these services from their home. **We ask that the agency work closely with its**

[26] RHC & FQHC Care Coordination Services: HCPCS Code G0511 Deadline Extended to September 30, MLN Connect, CMS.gov, Centers for Medicare and Medicaid Services (June 5, 2025) https://www.cms.gov/training-education/medicare-learning-network/newsletter/2025-06-05-mlnc#_Toc199925700.

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partners in Congress to ensure a long-term extension of all Medicare telehealth flexibilities before their expiration.

(1) Alternative Proposal Considered for Payment of Medical Visits Furnished via Telecommunication Technology.

CMS considered amending the definition of an RHC encounter and FQHC encounter to include visits conducted via telehealth. This change would effectuate payment parity for these critical rural providers. Currently, unlike any other Medicare fee-for-service providers, RHCs and FQHCs do not receive the same amount for providing care via telehealth compared to in-person.

NRHA urges CMS to finalize the alternative proposal for RHC and FQHC telehealth visits. Amending the definition of a visit for RHCs and FQHCs would be administratively simpler and more straightforward. Adding telehealth services to the definition of a visit would make billing for such services less burdensome on these providers. We ask that CMS seriously consider the alternative proposal as it aligns with the provider burden reduction goals of the administration.

Since Medicare telehealth flexibilities have been implemented, rural beneficiaries' usage has been lower than urban beneficiaries.[27] One element of this disparity may be that some rural providers, like RHCs, have not been able to support telehealth services because of the added costs associated with furnishing them. Prior to the PHE and the subsequent extensions of telehealth flexibilities, many RHCs and FQHCs did not provide telehealth services because they could not serve as distant site providers and billing for the originating site facility fee was challenging and an administrative burden compared to the payout.[28] Therefore, many RHCs and FQHCs have only began to integrate telehealth into their clinic since the PHE increased telehealth opportunities.

However, even with the onset of the PHE and associated telehealth expansion, RHCs note that payment is not sufficient to start up or maintain telehealth services long-term.[29] Further, some RHCs have been hesitant to make investment in telehealth infrastructure and technology given the uncertainty of their distant site status. NRHA members have found that costs to provide telehealth visits are similar to or the same as in-person, including staffing costs, a system or platform for the telehealth visits, space for the provider to meet virtually with the patient, and all overhead costs associated with the brick-and-mortar clinic. As such, **payment parity is paramount to help RHCs and FQHCs make the necessary investments in telehealth to maintain and expand access to care.**

C. Ambulatory Specialty Model.

2. Provisions of Proposed Ambulatory Specialty Model.

CMS proposes to institute the Ambulatory Specialty Model (ASM), a new, mandatory alternative payment model designed to improve prevention and disease management for beneficiaries with

[27] GOVERNMENT ACCOUNTABILITY OFFICE, *Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks* 13 (2022) https://www.gao.gov/assets/d22104454.pdf.
[28] OFFICE OF MINORITY HEALTH, CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Examining Rural Telehealth During the Public Health Emergency* 32 (2023) https://www.cms.gov/files/document/examining-rural-telehealth-jan-2023.pdf.
[29] *Id.* at 33.

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heart failure and lower back pain. Eligible clinicians in selected geographic areas would be required to participate in the model.

c. Proposed ASM Participants.

CMS notes that selected geographic areas may include rural areas, which includes ZIP codes designated as rural by the Federal Office of Rural Health Policy (FORHP). This means that clinicians in the identified specialties that practice in a rural area may be required to participate if they fall into one of the chosen geographic areas**.**

NRHA generally supports integrating rural providers into value-based care models; however, we do not support mandating rural provider participation. 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, even with support. 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.

NRHA acknowledges the low-volume exception built into the proposed model. However, NRHA believes that many rural providers that exceed the low-volume exception are nonetheless ill-equipped to begin participating in this model. As such, NRHA urges CMS to finalize a voluntary participation option for any providers in a chosen FORHP-designated rural area. **To be clear, NRHA supports rural inclusion in ASM and hopes that any rural providers chosen are able to participate; however, the option to abstain from the model must be available to these clinicians.**

E. Medicare Diabetes Prevention Program (MDPP)

CMS launched MDPP in 2018 as an additional preventive service covered by Medicare to prevent or delay the onset of type 2 diabetes. 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) compared to urban areas (21).[31] Accordingly, **NRHA supports proposals that increase access to diabetes prevention and management.**

1. Changes to § 410.79(b).

NRHA supports the proposed changes to § 410.79(b) that would give the opportunity for suppliers to expand virtual learning in MDPP. First, CMS proposes to continue the "extended flexibilities period" through 2029 so that suppliers may furnish MDPP services through virtual, synchronous sessions. NRHA agrees with CMS' assessment that beneficiaries in areas with limited or no MDPP suppliers could still take advantage of this covered preventive service.

CMS proposes a new online delivery modality for MDPP sessions. This would include asynchronous sessions as opposed to the "extended flexibilities period" which only includes synchronous distance learning sessions. To the extent that rural beneficiaries have access to adequate broadband and

[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/.

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internet, **NRHA supports testing the new online-only modality through December 31, 2029, to expand rural beneficiaries' access to MDPP.**

NRHA would like to note that due to the way that RHCs are paid and how MDPP services are reimbursed, RHCs cannot bill for MDPP services. Therefore, RHCs rarely serve as MDPP suppliers. RHCs are an important point of outpatient care and serve around 60% of all rural Americans. We ask that CMS consider how to incentivize RHCs to furnish MDPP services as suppliers. We believe that RHCs could fill in gaps where MDPP suppliers are not accessible for rural beneficiaries.

F. Medicare Shared Savings Program (MSSP).

1. Executive Summary and Background.

c. Summary of Shared Savings Program Proposals.

NRHA does not support the proposal to limit ACOs inexperienced with performance-based risk to a single five-year agreement period in the BASIC Track and requiring inexperienced ACOs to transition to two-sided risk in their second agreement period. Rural ACOs are more likely to be inexperienced with performance-based risk and need flexibilities within MSSP to support their participation. Removing the ability to remain in the BASIC Track for more than one agreement period will likely disincentivize primarily rural ACOs from forming or participating in MSSP.

NRHA supports CMS' change regarding beneficiary assignment. Generally, an ACO needs 5,000 Traditional Medicare beneficiaries to enroll in MSSP. CMS proposes to allow ACOs to have fewer than 5,000 assigned beneficiaries in benchmark years one and two. If by benchmark year 3 the ACO does not have 5,000 beneficiaries, it must enter its next agreement period in the BASIC track. Also, CMS would cap shared savings and shared losses to a lower amount if an ACO has fewer than 5,000 assigned beneficiaries. One major challenge for rural ACOs is meeting the minimum assigned beneficiaries given more sparse populations and lower patient volumes in rural areas. This change will give rural ACOs the opportunity to remain in MSSP.

NRHA would like to note the loss of traditional Medicare beneficiaries to enrollment in Medicare Advantage (MA), and how that could impact rural participation in MSSP. Almost half of rural beneficiaries (48.1%) are enrolled in an MA plan, and over half of all metropolitan beneficiaries nationwide are in an MA plan (56.1%).[32] MA beneficiaries are not eligible to be enrolled in an ACO and therefore, as MA continues to grow, the number of rural beneficiaries participating in an accountable care relationship may not reach required numbers for covered lives. **NRHA advises CMS to consider the implications of growing MA enrollment in its approach to both MSSP and MA.**

I. Medicare Prescription Drug Inflation Rebate Program.

3. Medicare Part D Drug Rebates for Certain Drugs and Biologicals With Prices That Increase Faster Than the Rate of Inflation.

c. Exclusion of 340B Acquired Units From Part D Rebatable Drug Requirements.

[32] Fred Ullrich & Keith Mueller, *Medicare Advantage Enrollment Update 2024*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA, January 2025, 1, https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf?utm_medium=email&utm_content=Image%3A+right+arrow&utm_source=d.pubhealth.rupri&utm_campaign=RUPRI+Center+Announcements&utm_id=1186247592.1388688166.

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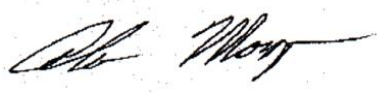
CMS proposes two different approaches to allow claim-level identification of Part D claims for 340B drugs. First, CMS would use existing data sources to associate prescriber National Provider Identifier (NPI) with 340B covered entities and 340B contract pharmacies. In addition to that proposal CMS proposes implementing an initially voluntary process for 340B covered entities to submit claim-level data to CMS to identify 340B claims billed to Part D (data repository).

NRHA supports the first approach that would require CMS to match prescribers to 340B entities to identify 340B claims. This removes the burden from covered entities and allows CMS to use data that it already has for determining rebates. NRHA wholly opposes the data repository approach as it shifts the burden onto rural covered entities. Rural covered entities already face increasing complexity in the program generally, including the forthcoming rebate models that will require extensive reporting.[33] We understand that this process would initially be voluntary in 2026 but CMS indicates that it is strongly considering making the repository mandatory following this testing period. We urge CMS to use the matching process to identify 340B Part D claims and abandon the repository approach, particularly a future mandatory data repository.

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 Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[33] 90 Fed. Reg. 38165 (Aug. 7, 2025) https://www.federalregister.gov/documents/2025/08/07/2025-14998/340b-program-notice-application-process-for-the-340b-rebate-model-pilot-program-correction.

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