

September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G Washington, D.C. 20201

RE: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Physician Fee Schedule (PFS) for calendar year (CY) 2022. We appreciate your continued commitment to the needs of the more than 60 million Americans residing in rural areas and look forward to our continued collaboration to improve health care access, outcomes, and quality.

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 infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

We appreciate CMS' continued emphasis on ensure care for rural beneficiaries through support of rural providers. The following are suggestions for how NRHA believes this proposed rule can be strengthened. We look forward to our continued collaboration in ensuring Americans living in rural areas have access to critical health services in their local communities and rural providers receive the equitable reimbursements they deserve.

III. Other Provisions of the Proposed Rule

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

NRHA has significant concerns with implementation of the rural health clinic (RHC) provisions from the CAA, 2021. Within this year's PFS, CMS was tasked with implementation of modernizing provisions imposed on both provider-based (PB) and independent RHCs within the CAA, 2021. In December, with passage of the CAA, 2021, all independent RHCs and PB RHCs created after December 31, 2019, became subject to a new upper-payment limit, or cap, which increases to \$190 by CY 2028. In April, Congress amended the date that PB RHCs are subject to the cap from December 31, 2019, to December 31, 2020.

NRHA strongly supports the increased upper-payment limit for independent RHCs. For years, our independent RHC members have communicated that the upper-payment limit was far too low and not reflective of the true cost of care. Thus, the law and proposed rule from CMS will be a



significant improvement for our independent RHC members. **However, NRHA believes implementing the rule for PB RHCs will have devastating consequences for the future of the PB RHC program and rural health more broadly.**

NRHA urges CMS to monitor impacts of the PB RHCs upper-payment limit changes on access for rural beneficiaries. We have heard from members who operate PB RHCs that they do not believe the new upper-payment limit accurately reflects costs associated with providing care in these communities and therefore question if they can continue to offer the service. While CMS is forced to implement the statute set forward by Congress in the CAA, 2021, NRHA encourages CMS to implement the statute in a manner that limits the impact on current and future PB RHC facilities.

Particularly concerning are the differing interpretations on the updated statute by regional Medicare Administrative Contractors (MAC). As you know, the April legislation moved the grandfather-date for PB RHCs from December 31, 2019, to December 31, 2020, but it also included a provision allowing those entities who had submitted their 855A applications by that date to be eligible for grandfather status. NRHA has heard from several members concerns that they will not be grandfathered into the previously uncapped rates due to varying MAC interpretation. **NRHA urges CMS to implement the statute in a manner allowing all PB RHCs who had submitted an 855A application by December 31, 2020, to be eligible for grandfathered rates. Further, NRHA urges CMS to not punish any PB RHC who may make updates to their facilities by removing their grandfathered status.** NRHA has heard concerns that a PB RHC who may want to update their facility or move facilities would lose their grandfather status. It is imperative that CMS utilize the PFS to ensure all providers established by December 31, 2020, be grandfathered in and are able to maintain that grandfather status.

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

NRHA is extremely supportive of CMS' actions to ensure rural providers are adequately represented in providing mental health services via telehealth. By allowing RHCs and federal qualified health centers (FQHC) to also be able to furnish mental health services via telehealth to beneficiaries there will be an increased access to care and services in our most rural, vulnerable communities. NRHA encourages CMS and Congress to allow RHCs and FQHCs to be allowed to continue all telehealth services beyond the end of the PHE.

II. Provisions of the Proposed Rule for the PFS

C. Changes in Relative Value Unit (RVU) Impacts

NRHA is concerned about the CY 2022 conversion factor (CF) being significantly reduced this year. Through passage of the Consolidated Appropriations Act (CAA), 2021, Congress provided a 3.75 percent increase in payment amounts for services furnished in CY 2021. This increase was a welcome benefit for providers struggling throughout the COVID-19 pandemic. Unfortunately, the expiration of this added benefit has resulted in CMS calculating the CY 2022 CF as though the 3.75 percent increase for CY 2021 had never been implied. Because of this, CMS estimates the CY 2022 PFS CF to be \$33.58, a decrease from \$34.89. This reflects the budget neutrality adjustment, the 0.00 percent update adjustment factor, and the expiration of the 3.75 percent increase for CY 2021 provided within the CAA.

NRHA believes the proposed decrease in CF calculation will have severe consequences for the provider community. Without Congressional action extending the moratorium on Medicare sequestration, the 3.75 percent CF decrease will coincide with the reinstatement of Medicare sequestration at the beginning of CY 2022. All told, physicians are facing a historic 9.75 percent payment cut beginning on January 1, 2022. **NRHA urges CMS to reconsider the methodology used to calculate the CF for CY 2022.** With the COVID-19 Delta variant hitting rural providers particularly hard, any proposed decrease in reimbursement could result in additional rural facilities closing their doors. Rural providers need sustainable, stable payment methodologies, not fluctuating reimbursements jeopardizing their financial stability.

D. Telehealth and Other Services Involving Communications Technology, and Interim Final Rule with Comment Period for Coding and Payment of Virtual Check-in Services--Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

d. Implementation of Provisions of the Consolidated Appropriations Act, 2021

NRHA is supportive of the telehealth benefit extensions provided within this year's proposed PFS. NRHA supports the CMS proposal to continue paying for services placed temporarily on the telehealth list through the end of CY 2023. By continuing these services through the end of CY 2023, NRHA believes CMS will collect significant data showing utilization of these services during the COVID-19 pandemic and beyond. This will provide CMS with a full scope of utilization, both during the public health emergency (PHE) and after, fully capturing the added benefit. NRHA looks forward to working with CMS in future PFS proposed rules to see telehealth services permanently added to the PFS.

In the CAA, 2021, Congress permanently extended Medicare telehealth coverage of mental health services beyond the duration of the PHE. **NRHA is supportive of this extension and applauds CMS for the implementation of removing geographic restrictions permitting the home as an originating site for mental telehealth services,** so long as the practitioner has provided these services to the patient within the last six months. Allowing for at home telehealth utilization, particularly in our most rural communities, is critical to increasing mental health care access for vulnerable populations.

The new Medicare provider type, the rural emergency hospital (REH), was established during the CAA, 2021. While CMS is primarily utilizing this year's Outpatient Prospective Payment System (OPPS) regulation to implement the provider type, CMS does amend current regulations to include REHs as telehealth originating sites beginning in CY 2023 through this year's PFS. **NRHA is supportive of the provisions allowing REHs to partake in telehealth flexibilities in 2023 upon their establishment.** Full comments on the REH request for information (RFI) will be included in our OPPS comments.

While NRHA is supportive of the capabilities being extended to RHCs and FQHCs, it is imperative that all rural providers are able to provide mental health services via telehealth, particularly critical access hospitals (CAH). Allowing mental health services to be provided via telehealth services is incredibly important in our rural communities. Mental health services are incredibly important for an elderly population that represents just 13 percent of the population, but 20 percent of suicide deaths. Since rural America has a higher elderly population than their urban counterpart, allowing all rural providers to be eligible to provide these services is critical to ensuring the mental health care of the population. NRHA is extremely supportive of the COVID-19 flexibilities that have allowed CAHs to provide outpatient services via telehealth during the PHE, and we believe that these flexibilities should be continued beyond the PHE for mental health

services as well as all others. Given the toll the ongoing COVID-19 pandemic is placing on Americans mental health needs, NRHA believes it is critical that CMS ensures all rural providers, including CAHs, are able to fully provide these services via telehealth.

e. Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology

NRHA is pleased to see the proposed rule to allow RHCs and FQHCs to furnish audio-only telehealth services, if audio-video is not an option. During the PHE, audio-only services have been a vital linkage to care for many patients. This is incredibly important in rural communities where there is limited broadband connectivity, both physically and financially. For many rural seniors, affordability of broadband services is a big issue thus making audio-only visit essential for those who may not have the resources for audio-video telehealth capabilities. NRHA urges CMS to implement this policy change in a simplified manner that doesn't overburden already stretched providers.

J. Vaccine Administration Services: Comment Solicitation: Medicare Payments for Administering Preventive Vaccines

NRHA encourages CMS to reevaluate reimbursement methodology for vaccine administration. NRHA appreciates CMS reevaluating the payment methodology for vaccine administering as we have heard from providers that the current methodology is increasingly insufficient. NRHA strongly feels that for rural communities a geographical impact add-on should be incorporated for the reimbursement methodologies. As with anything in rural health care delivery, geographical constraints add to the difficulty in providing services, even vaccine administration. NRHA encourages CMS to take into consideration the barriers geography plays in rural vaccine distribution and adjust reimbursement methodology accordingly. For rural providers to be able to truly provide for the needs of their communities, CMS must craft policies that are advantageous for beneficiaries in those communities.

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

NRHA is supportive of permanently allowing physicians to provide Opioid Use Disorder treatment and counseling services using audio-only technology. Over the past few years, CMS has taken decisive action to enhance providers ability to combat the growing opioid epidemic. Because of COVID-19, the opioid epidemic, much like the behavioral health epidemic, has continued to grow in public shadows. Allowing providers, especially those in rural America, all the tools possible to address this growing issue is critical to the overall wellness of our communities. NRHA supports CMS' continued focus to give providers flexibilities to combat opioid use disorder.

IV. Summary of the Quality Payment Program Proposed Provisions

A. CY 2022 Updates to the Quality Payment Program

Newly designed Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) requirements need to further reduce burdens. When CMS proposed the MVP approach in CY 2020, NRHA applauded CMS' acknowledgement of the complexity within MIPS and their willingness to improve the program by providing more timely and meaningful performance feedback. However, NRHA reiterates that while the MVP structure may reduce burden related to selection of measures,



it does not necessarily reduce the overall burden of the program. As currently structured, MIPS eligible clinician's (EC) will still need to report each category separately. NRHA urges CMS to further reduce reporting burdens by incorporating multi-category credit into the MIPS and MVP structure.

However, NRHA is supportive of CMS' proposal to grant hardship exemptions due to COVID-19 for 2021. We appreciate the flexibility the agency is providing ECs, making it possible for a clinician or group to be exempted from all MIPS performance categories in 2021. Given the toll COVID-19 has placed on health care providers across the country, NRHA appreciates the allowance of hardship waivers.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray circular watermark that contains the text "National Rural Health Association".

Alan Morgan
Chief Executive Officer
National Rural Health Association