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September 27, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA—PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Dear Administrator Verma,

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) 2021. We appreciate your continued commitment to the needs of the 60 million Americans living in rural and underserved areas and look forward to our continued collaboration to improve health care access and quality.

NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership encompasses 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 health in rural America through government advocacy, communications, education, and research.

We appreciate CMS's continued emphasis on narrowing the gap between rural patients and providers. This letter outlines NRHA's suggestions to strengthen this notice of proposed rulemaking (NPRM). We look forward to our continued collaboration to ensure that the nearly one-quarter of Americans living in rural areas have access to critical health care services in their local communities and rural providers receive the equitable reimbursements they deserve.

NRHA applauds CMS's proposals related to telehealth and other remote services. The advancement of telehealth during the public health emergency (PHE) has been a silver lining for many rural providers. By making permanent some of the telehealth flexibilities established during the PHE, CMS will drastically increase service opportunities for rural providers and patients. NRHA supports the work CMS and the Trump Administration has done to advance telehealth services, especially in rural America. NRHA was pleased with CMS's decision to add services to the list of Medicare telehealth services for the duration of the PHE. Allowing some of these services, like group psychotherapy, care planning for a patient with cognitive impairment, and others, to be permanently retained moving forward will help providers and patients alike. The telehealth provisions during the PHE from the Administration, coupled with the work Congress did within the Coronavirus Aid, Relief, and Economic Security (CARES) Act, has produced historic telehealth advancements. NRHA believes these historic strides in telehealth advancement should not be curtailed at the end of the pandemic.

As coronavirus began to spread across the country, it became increasingly evident that Medicare's 60 million beneficiaries—an older and sicker population—were among the highest risk populations for COVID-19. With so much uncertainty, mundane tasks such as hospital or doctor's office visits could pose a dangerous choice for beneficiaries. Allowing for Medicare payment for telehealth services have allowed beneficiaries to receive a continuation of care during the pandemic. In fact, Definitive Healthcare, a data analytics firm, found a 4,000 percent increase in telehealth claims when comparing January through April 2019, compared with the same period in 2020. Further, the week ending April 18, 2020, saw nearly 1.3 million beneficiaries utilizing telehealth services compared to just 11,000 in the week ending March 7, 2020: an increase of more than 11,718 percent in just a month and a half for Medicare claims alone. The greater flexibility and looser regulations have allowed Medicare patients to continue receiving care they otherwise may not be able to receive during the pandemic.

While there is evidence that in recent months telehealth utilization among Medicare beneficiaries has flattened as states continue to reopen business and doctors resume in-office operations, there is still demand for virtual services. NRHA understands that there are simply some services and procedures that cannot go digital. However, we believe CMS and the Trump Administration have allowed a new method to provide every day, low-acuity care, like disease management, behavioral and mental health care, and evaluation visits. Allowing for the continuation of these services to be provided via telehealth would particularly increase quality of care in rural areas. In some rural communities, Medicare beneficiaries must travel long distances to receive mundane, everyday care. This includes disease management for diseases such as diabetes, asthma, and hypertension, as well as for behavioral and mental health care. In particular, the Medicare population in rural America has had a disproportionate level of access to mental health care services due to the lack of qualified mental health professionals practicing in rural America. Allowing Medicare beneficiaries to continue receiving mental health care via telehealth would help narrow the gap between rural and urban access to mental health care.

In addition to the services provided, we believe it is critical to maintain the ability to utilize audio-only services past the PHE. In some rural communities, there is still insufficient access to broadband services. While we appreciate recent actions by the Trump Administration to create a

taskforce between the United States Department of Agriculture (USDA), Federal Communications Commission (FCC), and Department of Health and Human Services (HHS) to advance rural broadband specifically to improve the deployment of telehealth services. We applaud this effort and hope that the Administration continues to advance rural broadband initiatives that allow Medicare beneficiaries to receive reliable, sustainable broadband in the comfort of their home. Unfortunately, however, we know that the deployment of broadband to every rural Medicare beneficiary will take a significant amount of time, if possible, at all. In the meantime, it is critical to allow Medicare beneficiaries to continue to receive the care they need via audio-only services. Further, even as broadband becomes accessible across rural America, the elderly population Medicare serves sometimes has difficulties utilizing technology past a telephone. The audio-only aspect is critical for this population to continue receiving high-quality access to care.

NRHA hopes that CMS allows the flexibility to continue providing excellent care to this population. With that in mind, NRHA is supportive of changes to direct supervision requirements within the PFS. At the beginning of the PHE, among all the 1135 waivers adopted, CMS revised the definition of direct supervision to include virtual presence of the supervising physician or practitioner using telehealth technologies. Within the PFS itself, CMS proposes to extend this revised definition until the end of the calendar year in which the PHE ends, or December 31, 2021, whichever is later. This is a fantastic development. The extension of this flexibility allows more time for providers, patients, and policy makers to observe and examine the added benefits of telehealth services. As mentioned above, there are some services that simply will not be able to be provided via telehealth but added flexibility in some circumstances could increase the quality of care in rural America. NRHA believes that after CMS collects data on the services and circumstances where direct supervision flexibility is utilized, they should look to allow permanent flexibility for these services.

NRHA is concerned about continued proposals to change MIPS cost measures. NRHA is comprised of members in rural areas, providing essential care to their small communities. We are still concerned about the impact of outlier, high-cost cases on these practices and their performance on cost measurers—and in the past, we have provided recommendations to mitigate these potential impacts. We continue to be concerned about the potential for overlap between the total cost of care and episode-based measurers as primary care physicians will be measured on total costs that also include episodes. This discrepancy would hold primary care physicians doubly accountable for costs, particularly on episodes where they are unable to control costs. Rural physicians provide a broader range of primary care services that would often be referred to specialists in urban areas. These primary care providers save Medicare money, while providing excellent care to beneficiaries without the need for burdensome travel.

NRHA supports the proposed policy changes for the Medicare Diabetes Prevention Program Expanded Model (MDPP) within the PFS. Many of the 1135 waivers released by CMS at the beginning of the COVID-19 PHE made providing care, and access to care, for rural providers and patients easier. CMS's MDPP proposal to allow suppliers to either deliver services virtually or suspend in-person services and resume later gives providers the ability to provide care more efficiently to vulnerable, at-risk population for the remainder of the COVID-19 PHE and future 1135 waiver events.

According to 2018 study conducted by the Southwest Rural Health Research Center (SRHRC) at Texas A&M titled 'The Burden of Diabetes in Rural America,' diabetes prevalence is approximately 17 percent higher in rural areas than urban areas. Additionally, earlier studies have showed rural adults were more likely to report a diagnosis of diabetes than urban adults. Overall, diabetes affects more than 25 percent of Americans aged 65 or older and is continuing to become more prevalent within this population. In 2016, it was estimated that Medicare spent \$42 billion on beneficiaries with diabetes than it would have spent if those beneficiaries did not have diabetes. Per beneficiary, that means more money is spent on Part D prescription drugs, more money is spent on hospital and facility services, and more money is spent on physician and other clinical services. The goal of the MDPP, to have a structure behavioral change aimed at preventing type 2 diabetes among this population, is critical in rural America, where the prevalence is more likely. Allowing greater flexibility of the MDPP during COVID-19 and other 1135 waiver events will allow Medicare beneficiaries partaking in this program to continue receiving the prevention and disease management care needed to curb the growing prevalence of diabetes in rural America.

NRHA supports the extension of medical record documentation flexibility within the CY 2020 PFS final rule to therapists for CY 2021. Within the 2020 final rule, CMS allowed any person authorized under Medicare to provide and bill for their services may review and verify the medical records rather than having to document notes in the medical record made by other professionals. This year, CMS clarified that this policy should also apply to therapists. Thus, as a result, therapists will be able to spend more time providing therapy services to their patients, rather than documenting care in medical records. In rural America, therapy and mental health professionals are often few and far between. Provider shortages lead to rural patients already being put on long waitlists. There simply are not enough mental health professionals to take care of the needs in rural America as it is. Paperwork and documentation take time away from patients who need help. While it is imperative to get more mental health and therapy professionals to rural America, allowing those who are currently providing care there now to do so at the highest level of efficiency is critical. Removing unnecessary, burdensome regulations is critical for therapists and mental health professionals as it is for other medical professionals.

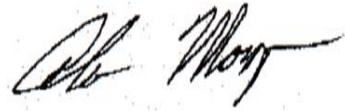
NRHA is supportive of efforts within the PFS to update the Opioid Use Disorder (OUD) related provisions. Within the 2020 final rule, CMS implemented several definitions, requirements, payment methodologies, and other programmatic aspects of a new Medicare Part B benefit for opioid treatment programs (OTP) as mandated by the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018. In this rule, CMS proposes to add to the list of reimbursable services, offers new flexibility for enrollment and clarifies activities that may be reimbursed under a specific add-on code. The proposed rule seeks to extend the definition of OUD treatment services to include naloxone and other opioid medications approved by the Food and Drug Administration (FDA) for the emergency use of an opioid overdose. Allowing for naloxone, an opioid antagonist for emergency treatment of known or suspected overdose able to be administered by individuals without medical training, could help patients in rural areas where medical professionals are not always readily available.

CMS is specifically seeking comments on how the agency might be able to further refine the addition of naloxone dispensing to the Part B benefit. Specifically:

- Whether the definition of OUD treatment services should be further expanded to include overdose education, and whether the weekly bundled payments for episodes of care should include payment for providing this education to the beneficiary and/or the beneficiary's family or whether CMS should establish a separate add-on payment to cover overdose education?
- NRHA would be supportive of efforts to expand overdose education to OUD treatment services. Education to the beneficiary and the beneficiary's family could help curb the opioid epidemic across the country, as well as in rural areas. Allowing for more education is key to prevention and having CMS provide add-on payments would make it more accessible.

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 or 202-639-0550.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Alan Morgan
Chief Executive Officer
National Rural Health Association