National Rural Health Association

September 9, 2024

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

RE: CMS-1807-P; Medicare and Medicaid Programs: CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment, etc.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 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 2025 PFS Conversion Factor.

NRHA is extremely concerned about the more than 3% decrease in physician payments compared to CY 2024. We acknowledge that the downward adjustments to payment are statutory, but we are nevertheless troubled given the inflationary environment and supply chain challenges that rural hospitals and health care providers are facing. **NRHA urges CMS to explore its authority to increase the PFS conversion factor to ensure that rural providers are paid at a rate that reflects the current economic and operational reality.**

II. Provisions of the Proposed Rule for the PFS.

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

1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act.
e. Audio-Only Communication Technology To Meet the Definition of "Telecommunications System."

CMS proposes to modify its definition of "telecommunications system" to include audio-only technology for any telehealth service furnished to a beneficiary in their home when a practitioner is technically capable of using audio-video technology, but the beneficiary does not consent to or does not have the ability to use audio-video communications. Absent a congressional extension of

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Medicare telehealth flexibilities, originating site restrictions will apply again. **NRHA strongly supports this proposal as audio-only telehealth is critical tool for increasing access to care for rural beneficiaries.** Absent a congressional extension of Medicare telehealth flexibilities, originating site restrictions will apply again. This means that only those providers eligible to provide telehealth services pre-Public Health Emergency will be able to furnish audio-only 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 providers may choose to offer a service in an audio-only format regardless out of necessity, but now they are able to be reimbursed for it, which is critical for struggling small safety-net rural providers. 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.

Rural patients face unique challenges in accessing both in-person and audio-video services, creating inequities in care. Rural patients, on average, travel further to access health care than their non-rural counterparts. This disincentivizes rural residents from seeking care if they do not have the ability or resources for travel. Broadband infrastructure is lacking in rural areas and computer and smartphone ownership is also lower. NRHA members have also noted that certain technology, like two-factor authentication, that is required for audio-video visits is challenging. 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.[1] Rural beneficiaries must not be forced to travel longer distances to care because they do not have the same access to technology as urban and suburban areas. Rural residents have benefited greatly from expanded telehealth during and after the PHE and consequently will suffer when the flexibilities are removed.

NRHA urges CMS to finalize the proposal to amend the definition of "telecommunications system" to include audio-only communication technology.

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 temporarily continue to define direct supervision to allow the presence and immediate availability of the supervising practitioner through audio-video technology. We further support making this flexibility permanent for certain low-risk services. We urge CMS to finalize both proposals.

E. Valuation of Specific Codes.

4. Valuation of Specific Codes for CY 2025.
(40) Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation – Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136)).

[1] 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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CMS is soliciting information on the newly implemented Community Health Integration (CHI) services, Principal Illness Navigation (PIN) services, and Social Determinants of Health (SDOH) risk assessment.

NRHA has heard limited feedback from members on their use of the new CHI and PIN codes, likely because many rural providers as still integrating the codes into their practice patterns. For Rural Health Clinics (RHCs) in particular, we believe usage is low in the first year of implementation but do not have data because the CHI and PIN codes are currently bundled into G0511. We look forward to future utilization information pending CMS finalizing its proposal to unbundle G0511. Some NRHA member hospitals have indicated that they use community health workers (CHWs) or work with community organizations to help with health-related social needs like food, transportation, and housing. However, they may not be billing these new codes because they are not aware. Other remote rural hospitals have indicated to NRHA that they cannot offer these services and bill the new codes because there are no community resources to which the auxiliary personnel can connect their patients when a need is identified.

NRHA asks that CMS consider making CHI services more accessible to rural populations by allowing payment for community paramedics as auxiliary personnel. Community paramedicine allows EMTs and paramedics to operate in expanded roles by providing public health, preventive services, and primary care to underserved populations.[2] 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.[3] 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.[4] 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.

Regarding the SDOH risk assessment, NRHA has heard that many rural providers have been reticent to use it. RHCs and Federally Qualified Health Centers (FQHCs) do not receive payment so they do not use this code. **NRHA urges CMS to allow RHCs and FQHCs to be paid for administering SDOH risk**

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[2] RHIhub, Community Paramedicine, Jan. 27, 2023, https://www.ruralhealthinfo.org/topics/community-paramedicine.
[3] 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.
[4] 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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assessments to create parity with other providers. Additional barriers to using the SDOH risk assessment code are rural providers' comfort level with asking about SDOH and limited time during an appointment to screen and help solve patients' problems related to SDOH. Rural providers also do not want to screen for SDOH when they know there may not adequate community resources or funding with which to connect the patient.

G. Enhanced Care Management.

2. Advanced Primary Care Management (APCM) Services (HCPCS Codes GPCM1, GPCM2, and GPCM3).

NRHA thanks CMS for its work on improving primary care delivery. Coordinated, whole person primary care is essential for beneficiary health and wellbeing. However, we note that some APCM practice-level capability requirements around performance measurement for participation may 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 will likely be a useful flexibility for many providers. But given lower participation in value-based care among rural practitioners, there is little 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. **NRHA asks that CMS monitor rural use of APCM services to address any potential barriers to uptake in future rulemaking.**

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 urges CMS to continue expanding coverage for dental services under Medicare. Seniors often lack access to oral health care and therefore are at the highest risk for poor oral health. This inequity is even more acute in rural areas where dental care is lacking for all age demographics. In 2018, just over half of rural residents indicated that they visited a dentist in the past year, whereas 67% of residents in metropolitan areas had.[5] Further, seniors in rural areas were less likely to have visited the dentist than their urban and suburban counterparts.[6] 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.[7] Over 4,000 dental practitioners are needed in rural areas to remove these designations.[8] NRHA believe further coverage of dental services under Medicare will help increase access to this critical care in rural areas.

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

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[5] Rural Health Information Hub, *Oral Health in Rural Communities*, https://www.ruralhealthinfo.org/topics/oral-health.

[6] America's Health Rankings, United Health Foundation, *Senior Report 2018*, (May 2018), 44 https://assets.americashealthrankings.org/app/uploads/ahrsenior18-finalv1.pdf.

[7] 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.

[8] *Id.*

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CMS only covers dental services that are inextricably linked to the clinical success of other covered Medicare services. In this proposed rule, CMS proposes to add coverage for dental exams prior to or contemporaneously with dialysis services and medically necessary diagnostic and treatment services to eliminate a dental infection prior to or contemporaneously with dialysis for beneficiaries with end-stage renal disease. **NRHA supports this addition and urges CMS to finalize as proposed.**

III. Other Provisions of the Proposed Rule.

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

2. General Care Management Services in RHCs and FQHCs.
c. Proposed Payment Policy for General Care Management Services.

CMS proposes to unbundle the general care management code G0511 to allow RHCs and FQHCs to bill for individual codes. **NRHA applauds CMS for this proposal and asks that CMS finalize as proposed.** Over the years CMS has added several new codes to G0511, making billing for these services overly complex. NRHA members voiced confusion over whether they were able to bill G0511 more than once per month per beneficiary and reported concerns over Medicare Administrative Contractors reimbursing incorrectly when these services were furnished more than once per month per beneficiary. Additionally, RHCs and FQHCs, as well as CMS, cannot track on which individual services are being used and billed. This proposal will simplify payment and allow for insight into what care management services RHCs and FQHCs are furnishing. NRHA also supports the proposal to allow add-on codes for additional time spent in order to meet beneficiary needs and make up for any potential decrease in reimbursement due to the change in billing. In addition, NRHA asks CMS to clarify whether cost-sharing for beneficiaries for the unbundled care management services would be at 20% of individual CPT code reimbursement.

d. New Codes for Advanced Primary Care Management (APCM) Services.

NRHA thanks CMS for allowing RHCs to furnish APCM services. We are pleased that RHCs are being included in new services and have the opportunity to provide APCM services to their beneficiaries. NRHA asks that CMS monitor and evaluate the use of APCM services at RHCs and FQHCs to help reveal any potential barriers to uptake. We note that some requirements around performance management for participation may serve as a barrier for certain RHCs as mentioned above in Section II.G.2. NRHA would appreciate CMS' diligence in monitoring RHCs' and FQHCs' usage in order to inform whether future tweaks to APCM services would make them more accessible in rural settings.

3. Telecommunication Services.
c. 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

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rate by amending the definition of a "visit" to include audio-video telehealth. **NRHA strongly supports the alternate proposal.**

NRHA urges CMS to finalize payment parity for telehealth visits at RHCs and FQHCs by amending the definition of a "visit" to include telehealth. Since Medicare telehealth flexibilities have been implemented, rural beneficiaries' usage has been lower than urban beneficiaries.[9] 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 Public Health Emergency (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.[10] 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 continue telehealth services long-term.[11] 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 expand access to care.**

d. In-Person Visit Requirements for Remote Mental Health Service Furnished by RHCs and FQHCs.

CMS is proposing an additional extension to waive the in-person visit requirement for remote mental health services. This extension would apply to visits furnished before January 1, 2026. Beneficiaries may experience a lapse in care if the in-person requirement went into effect on January 1, 2025. As such, NRHA supports this additional extension so that beneficiaries and providers have a longer glidepath to implementing the in-person visit requirement after subsequent delays in implementation.

4. Intensive Outpatient Program Services (IOP).

NRHA supports CMS' proposal to allow RHCs and FQHCs to bill for 4-service days in the IOP. One grandfathered provider-based RHC in Texas noted that the payment for IOP services in CY 2024 was only about $70 more than its all-inclusive rate (AIR), therefore it made more sense to provide two AIR visits in one hour instead of providing IOP services. Other NRHA members have signaled the interest in IOP services but agreed that payment and recruiting staff are barriers. IOP rates are based

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[9] 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.

[10] 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.

[11] *Id.* at 33.

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on OPPS rates, the payment is not adequate for RHCs associated with a critical access hospital. **NRHA hopes that allowing RHCs and rural FQHCs to bill for 4-service days will encourage more uptake.**

5. Payment for Preventive Vaccine Costs in RHCs and FQHCs.

CMS proposes to pay RHCs and FQHCs for Part B preventive vaccines at the time of service. NRHA supports this policy and encourages CMS to finalize as proposed in order to alleviate cash flow issues for rural providers. Allowing these providers to bill at the time of service will effectively give them an interim payment as opposed to the current policy.

6. Productivity Standards.

NRHA supports CMS' proposal to remove productivity standards for RHCs and agrees that it is duplicative given the payment limits established in the Consolidated Appropriations Act of 2021. Given that this change will require a cost report and calculation change, NRHA suggests that this change be effective for cost reporting periods ending after December 31, 2024. Further, for RHCs that do not meet the guidelines for cost reporting periods that have not been final settled (i.e., without a Notice of Program Reimbursement) as of the publication date of the final rule, MACs should be instructed to apply a waiver during final settlement that would eliminate any application of the guidelines.

7. Proposed Rebasing of the FQHC Market Basket.

CMS proposes to update the FQHC market basket to a 2022 base year. NRHA supports this rebasing to ensure the FQHC PPS reflects the true cost of providing care in a health center setting.

8. Clarification for Dental Services Furnished in FQHCs.
a. Payment for Dental Services Furnished in FQHCs.

NRHA appreciates CMS' clarification that when RHCs and FQHCs furnish covered dental services they would be considered a qualifying visit.

b. Medical and Dental Visits Furnished on the Same Day.

NRHA asks that CMS allow medical and dental visits furnished on the same day to be paid separately rather than be payable as one visit. Allowing separate payment will make providing dental services in RHCs and FQHCs more sustainable.

The Public Health Service Act requires that FQHCs provide preventive dental care and 82% of FQHCs are able to provide such services on site.[12] However, few RHCs are able to and the cost of starting up and sustaining these services may be a barrier to doing so. Medicare only reimburses for dental care

[12] 42 U.S.C. § 254b(b)(1)(A)(III) (2022); National Association of Community Health Centers, *Snapshot: FQHCs and Oral Health* (June 2020) https://opus-nc-public.digitellcdn.com/uploads/nachc/redactor/cba0c4cce9fcbc031688ef195aad812716c8a4660a637a97811785dbe2e4350c.pdf.

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in specific circumstances and the procedures considered to be "inextricably linked" to another Medicare covered service are likely not commonly performed at RHCs. For those RHCs that are currently or are looking to provide dental care, better Medicare reimbursement is key. Further, in states where Medicaid covers adult dental care, it is likely the largest payer for these services provided in RHCs, yet it is generally inadequate to cover costs, meaning that other payers are important for making up losses. **CMS must consider allowing separate payment for dental services in RHCs and FQHCs.**

C. Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Conditions for Certification and Conditions for Coverage (CfCs).

2. Proposed Changes to the RHC and FQHC Conditions for Certification and Conditions for Coverage (CfCs).

a. Provision of Services (42 C.F.R. 491.9).

NRHA supports CMS' proposal to amend the provision of services conditions for certification and coverage to include new language stating that RHCs and FQHCs must provide primary care services. Additionally, we support the proposal to include language from the RHC statute stating that RHCs are not rehabilitation agencies or facilities primarily for the treatment of mental diseases. NRHA believes that if implemented correctly, this will allow RHCs to expand their provision of both specialty care and behavioral health care to meet the needs of their community. Currently, RHCs are surveyed based on the total number of hours spent providing primary care versus specialty and 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, particularly around behavioral health services.

NRHA believes it is critical to allow RHCs and FQHCs to provide more outpatient specialty care to meet local beneficiary needs, particularly as other access points like community hospitals continue to close.[13] NRHA has heard from its members that pediatricians, geriatricians, allergists, rheumatologists, and endocrinologists are in high demand and low supply in rural communities. Dermatologists are particularly needed in farm communities but again are often not practicing in these communities. Removing barriers to furnishing specialty care in RHCs may help increase the availability of these practitioners in rural areas.

Rural areas continue to face barriers to accessing behavioral health care. RHCs can serve as an important access point for the behavioral health needs of rural residents as RHCs serve over half of the rural population.[14] As such, **it is critical that CMS implement the regulatory changes and survey procedures in a way that allows RHCs to furnish more behavioral health care.**

NRHA urges CMS to define "facility for the care and treatment of mental diseases." 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

[13] *See generally* Rural Hospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

[14] https://www.narhc.org/News/30432/Survey-Emphasizes-Scale-and-Significance-of-the-RHC-Program

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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.[15] 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.

b. Laboratory Requirements (42 C.F.R. 491.9).

NRHA is supportive of CMS' proposal to remove hemoglobin and hematocrit (H&H) tests from the list of diagnostic laboratory tests that RHCs must provide directly. We also support the proposed changes to the culturing requirement at § 491.9(c)(2)(iv). As CMS notes, the H&H test is typically performed as part of a comprehensive blood count, which RHCs typically refer to the nearest hospital. Providing this regulatory relief to RHCs is critical.

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

2. Telecommunication Flexibilities for Periodic Assessments and Initiation of Treatment with Methadone.

a. Proposal To Allow Periodic Assessments To Be Furnished Via Audio-Only Telecommunications on a Permanent Basis.

In line with recent expansions of access to medications for opioid use disorder (MOUD) at OTPs,[16] CMS proposes to cover periodic assessments at OTPs furnished via audio-only technology permanently. **NRHA advocated for this policy in our CY 2024 MPFS comments and strongly supports this proposal as it has the potential to increase access to OUD treatment for rural beneficiaries.** Audio-only is an important option that must be available to rural beneficiaries due to lack of broadband access and difficulties utilizing audio-video telehealth technology among rural older adults and NRHA appreciates that CMS recognizes this fact. From 2020 – 2021 13% of adults over 65 filled at least one opioid prescription and 4.4% filled four or more opioid prescriptions.[17] In addition, adults over 65 living in rural areas were more likely than those in urban areas to fill an

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[15] 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.

[16] Cite SAMHSA rule

[17] Asako Moriya & Zhengyi Fang, *Statistical Brief #551: Any Use and "Frequent Use" of Opioids among Adults Aged 65 and Older in 2021-2021, by Socioeconomic Characteristics*, Agency for Healthcare Research and Quality (2023) https://www.ncbi.nlm.nih.gov/books/NBK601170/#stat551.s6.

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opioid prescription.[18] In comparison, 6.4% of adults under 65 fill one opioid prescription and less than 2% fill five or more opioid prescriptions in a year.[19] This makes rural Medicare beneficiaries more susceptible to OUD.

b. Proposal To Allow OTPs To Use Audio-Visual Telecommunications for Initiation of Treatment With Methadone.

CMS proposes to further align its Medicare OTP benefit with recent SAMHSA rulemaking by allowing use of audio-video telehealth to initiate OUD treatment with methadone. NRHA supported this policy by SAMHSA and encourages CMS to adopt it as proposed. Allowing audio-video coverage for initiation of methadone treatment for beneficiaries is needed because OTPs are the only settings where beneficiaries can receive this medication. At this time, it is critical to maintain as much access to OUD treatment as possible, including audio-only services, as OUD continues to devastate rural communities.[20]

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 Government Affairs and Policy Director Alexa McKinley Abel at amckinley@ruralhealth.us

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

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[18] *Id.*

[19] Asako Moriya & Zhengyi Fang, *Statistical Brief #552: Any Use and "Frequent Use" of Opioids among Adults Aged 18-64 in 2021-2021, by Socioeconomic Characteristics*, Agency for Healthcare Research and Quality (2023) https://www.ncbi.nlm.nih.gov/books/NBK601172/.

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

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