September 11, 2023

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

RE: Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment, etc.

Submitted electronically via regulations.gov at https://www.regulations.gov/commenton/CMS-2023-0121-1282

Dear Administrator Brooks-LaSure,

On behalf of the Louisiana Rural Health Association (LRHA), thank you for the opportunity to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the calendar year (CY) 2024 Medicare Physician Fee Schedule.

LRHA is a membership association that is made up of Louisiana rural health care providers. This includes rural health clinics (RHCs); federally qualified health centers (FQHCs); and rural hospitals across the state. LRHA works to provide a unified voice that promotes and enhances the quality of rural health in Louisiana.

LRHA appreciates the opportunity to provide input on behalf the needs of rural patients and providers in Louisiana, and we look forward to our continued collaboration to improve health care access throughout rural America. In addition to reviewing our comments, we encourage you to review the comments submitted by our national partner, the National Rural Health Association (NRHA).

Calculation of the CY 2024 PFS Conversion Factor.

LRHA is extremely concerned about the more than 3% decrease in physician payments compared to CY 2023. We acknowledge that the downward adjustments to payment are required by statute, but we are nevertheless troubled given the inflationary environment and supply chain challenges that rural health care providers and hospitals are facing. **We urge 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).

LRHA thanks CMS for implementing the provisions of the Consolidated Appropriations Act (CAA) of 2023 that extend Medicare telehealth flexibilities through December 31, 2024. **We are also pleased that CMS proposes to pay the higher, non-facility PFS rate for telehealth visits provided in the patient's home**.

CMS is also proposing to continue defining direct supervision to allow the presence and immediate availability of a supervising practitioner through audio/video technology through December 31, 2024. We agree that this aligns with other telehealth flexibilities extended through the same time period and will give providers time to adjust back to pre-public health emergency (PHE) policies. Additionally, LRHA supports retaining this flexibility on a permanent basis beyond CY 2024.

Moving forward, **we ask that CMS extend audio-only coverage beyond December 31, 2024, by adding it to the Medicare Telehealth Services List on a permanent basis.** We disagree with CMS' narrow interpretation of § 1834(m)(2)(A) of the Social Security Act. CMS reads the statute to mean that telehealth services must be so analogous to in-person care that it is essentially a substitute for a face-to-face encounter. CMS must adopt a broader reading of the statute such that audio-only services are permanently authorized. We suggest that CMS allow audio-only telehealth visits for circumstances in which a beneficiary does not consent to audio/video technology or is not capable due to broadband or other connectivity resource issues.

We believe audio-only services are an important tool in increasing access to care for our vulnerable rural communities. Under the COVID-19 telehealth flexibilities, many of our providers were able to connect with patients via audio-only and have found it to be an extremely valuable tool to connect with patients who are unable to go to the office for an in-person visit and are unable or unwilling to connect via an audio-visual platform. Often, these patients have limited access to transportation, limited access to the broadband connection needed for audio-video visits, or have a discomfort with or lack of technical literacy needed to conduct and audio-video visit. In many cases, the flexibility to conduct an audio-only visit, allowed for a patient to receive much needed services that would have otherwise been neglected or delayed.

E. Valuation of Specific Codes.

LRHA supports CMS' proposals for community health integration (CHI) and principal illness navigation (PIN) services and the new social determinants of health (SDOH) standalone risk assessment. Payment and coding policies that accurately reflect the time, resources, and intensity of identifying and addressing SDOH are incredibly important for ensuring that providers can furnish these services to their beneficiaries. Historically, rural providers have had very limited capacity to screen for SDOH due to the lack of resources and payment to support the associated activities.

Rural beneficiaries face unique SDOH compared to their urban counterparts, including affordable and safe transportation and access to healthy foods. Unfortunately, rural residents are also more likely to live in poverty, have lower education and literacy (including health literacy) levels, and have little to no access to broadband. These factors make addressing SDOH a key goal for rural providers.

F. Evaluation and Management (E/M) Visits.

CMS proposes to further delay the implementation of its new split/shared visits policy that was finalized in CY 2022. This policy would assign billing to the practitioner that provides a "substantive portion" of an E/M visit. Until 2025, practitioners may continue to use the current history, exam, or medical decision-making policy to determine who bills for the visit. We thank CMS for delaying implementation of this policy.

LRHA urges CMS to withdraw the "substantive portion" policy and continue using its current history, exam, or medical decision-making policy. We do not believe that "over half" is an appropriate definition of "substantive portion" for the purpose of paying for split/shared services. This is troublesome for rural providers as NPPs often provide the majority of care for rural patients. Consequently, rural providers would receive less payment under the PFS for split/shared visits. CMS should not move forward with a "substantive portion" policy beginning in CY 2025 that disenfranchises rural beneficiaries and providers.

J. Advancing Access to Behavioral Health Services.

We were pleased to see that Congress allowed marriage and family therapists (MFT) and mental health counselors (MHC) to bill Medicare directly in the CAA, 2023 and thank CMS for implementing this change. Adding MFTs and MHCs as billable providers will increase access to behavioral health services in safety net facilities. **We commend CMS for going beyond Congress' mandate in the statute and allowing addiction counselors to enroll in Medicare as MHCs.** As opioid use and substance us disorder continue to grow in rural areas, rural beneficiaries need adequate access to treatment. We hope that access to addiction counselors will provide another source of treatment for rural beneficiaries facing opioid and substance use disorders.

As many rural communities struggle to recruit and retain behavioral health professionals, LRHA applauds CMS for increasing payment for psychotherapy services. We support the proposal to increase the work relative value units (RVUs) for psychotherapy codes over the next four years.

III. Other Provisions of the Proposed Rule.

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

LRHA supports CMS' proposal to continue allowing direct supervision via audio/video technology at RHCs and FQHCs. This aligns with CMS' proposal above for other providers. Again, we support adopting this policy on a permanent basis for RHCs and FQHCs.

We also thank CMS for implementing § 4121 of the CAA, 2023 to allow marriage and family therapists and mental health counselors to bill Medicare directly in RHCs and FQHCs. The addition of these two new billable provider types has the potential to increase needed behavioral health services in rural areas through RHCs and FQHCs.

CMS proposes to include remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services in the general care management code (GCM), G0511. Last year, CMS finalized a policy to include chronic pain management (CPM) in G0511 as well. **LRHA believes that continuing to include new suites of services under the GCM code is an unsustainable policy.** CMS' policy for G0511 is that an RHC can

only bill G0511 once per calendar month per patient, meaning that the patient may only receive one type of service (i.e., only RPM or only CPM) each month regardless of their need for multiple services.

CMS further proposes to include CHI and PIN services to G0511. We recognize the increased time and resources necessary to address SDOH and agree that payment outside of the all-inclusive rate is appropriate to account for such expenditures. However, as with RPM and RTM services, this policy disadvantages rural beneficiaries of RHCs because they cannot access multiple services under G0511 in one month.

As CMS adds more services that are not standalone billable RHC visits to G0511, the more beneficiaries are limited, and the more payment may change. Patients who are in need of these services are chronically ill and in need of numerous and frequent healthcare and health management services. We believe patients should be able to receive all medically necessary services in a timely manner and services should not be limited simply due to coding and billing rules.

We ask that CMS does not place RPM and RTM under G0511 and instead create separate codes so that RHCs may bill outside of the AIR and allow patients to receive CCM and RPM or RTM in one month when medically necessary. The proposed approach is unsustainable and inequitable for rural beneficiaries and RHCs.

S. A Social Determinants of Health Risk Assessment in the Annual Wellness Visit.

LRHA applauds CMS' proposal to include an optional SDOH risk assessment with separate payment to annual wellness visits (AWVs). Rural providers have found addressing SDOH difficult without additional resources and therefore have not had the tools to properly handle beneficiaries' SDOH that impact the diagnosis or treatment of conditions.

AWV underutilization in rural areas is a likely contributer to rural health inequities. Because AWVs are an important tool for increasing awareness and use of preventive care, such as cancer screenings and vaccinations, lack of AWVs in rural clinics leads to lack of access to these services in rural populations.[1]

One way to expand access to AWVs for rural beneficiaries is allowing RHCs to bill for the visit in conjunction with a medical visit provided on the same day. RHCs are currently able to conduct same day billing (two visits billed on the same day that are separately reimbursed) for initial preventive physical exam visits, but not AWVs. Currently, RHCs receive their AIR for AWVs because these services are not eligible for same day billing. As a result, RHCs are not incentivized, and often do not have capacity, to furnish AWVs due to inadequate reimbursement. Due to known rural barriers to accessing care, such as limited transportation, it is in the best interest of the patient to have the ability to receive an AWV at the same time they are already receiving medical services in an RHC, rather than having to schedule an additional appointment. **LRHA urges CMS to fix this inequity by including AWVs in § 405.2463:**

> "(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."

[1] https://www.ruralhealth.us/blogs/ruralhealthvoices/june-2023/how-rural-providers-can-act-big-and-stay-small-wit

Payment for Inextricably Linked Dental Services

LRHA strongly supports CMS's proposal to pay for certain dental services inextricably linked to certain cancer treatments. We appreciate CMS's work with the Agency for Research and Healthcare Quality (ARHQ) to highlight the evidence linking dental care to successful cancer treatment.

However, we are concerned that patients may not have the ability to fully benefit from this proposal given the extremely low number of dentists enrolled in Medicare. We encourage CMS to partner with experts to educate dentists how to enroll in Medicare and directly bill for these services or to furnish these services incident to a physician or practitioners' professional services.

Finally, while we support this proposal, we urge the agency to do whatever is permitted by law to expand Medicare beneficiaries' access to dental care. The concept of inextricably linked medical and dental services is limiting and perpetuates notion that oral health is independent of overall health. We encourage the agency to broadly interpret all exceptions to the statutory Medicare dental exclusion and to leverage its authority to strengthen oral health care access. Seniors in rural areas are less likely to have dental visits and more likely to require teeth extractions than their urban counterparts.[2] We believe that increasing coverage of dental services under Medicare and increasing dental provider enrollment in Medicare can help to reduce these disparities and improve oral health outcomes for all seniors.

Conclusion

LRHA is thankful for the opportunity to provide input on this proposed rule. If you would like additional information, please contact Denaé Hebert at dhebert@lrha.org or 337.366.5915.

Sincerely,

Denaé M. Hebert
Executive Director
Louisiana Rural Health Association

[2] America's Health Rankings Senior Report 2018 edition, https://assets.americashealthrankings.org/app/uploads/ahrsenior18-finalv1.pdf