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.***

Dear Administrator Brooks-LaSure,

[YOUR ORGANIZATION] is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the calendar year (CY) 2024 Medicare Physician Fee Schedule. We appreciate CMS’ continued commitment to the needs of rural patients and providers, and we look forward to our continued collaboration to improve health care access throughout rural America.

[Add a brief paragraph describing your organization.]

**Calculation of the CY 2024 PFS Conversion Factor.**

**[YOUR ORGANIZATION] is extremely concerned about the over 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.**

[Discuss the impacts of low Medicare payment to your organization. Be as specific as possible.]

**II. Provisions of the Proposed Rule for the PFS.**

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

[YOUR ORGANIZATION] 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**. [Explain why the higher payment rate for telehealth services is important to your organization. How will it help sustain patient access to care?]

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, [YOUR ORGANIZATION] supports retaining this flexibility on a permanent basis beyond CY 2024. [If possible, describe how the direct supervision flexibility has benefited your organization and practitioners.]

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.

[Explain how audio-only visits are important to your patient population. Give specific examples if possible.]

*E. Valuation of Specific Codes.*

**[YOUR ORGANIZATION] 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 we can furnish these services to our beneficiaries. Historically, rural providers have not screened for SDOH because of the lack of resources and payment to support the associated activities. [Add any information on how addressing SDOH is difficult for your providers and any specific SDOH that your patient population experiences. How will these new codes help?]

Rural beneficiaries face unique SDOH compared to their urban counterparts, including affordable and safe transportation and access to healthy foods. Unfortunately, rural residents are 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.

[YOUR ORGANIZATION] 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, we will 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. [If relevant, add anecdotes or information about opioid/substance use and access to treatment in your community.]

As many rural communities struggle to recruit and retain behavioral health professionals, [YOUR ORGANIZATION] 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 4 years. [Expand on the behavioral health workforce shortage and how it impacts your facility and/or community.]

**III. Other Provisions of the Proposed Rule.**

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

**[YOUR ORGANIZATION] 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 in 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. **[YOUR ORGANIZATION] 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 one 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. **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. 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.*

[YOUR ORGANIZATION] 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.

AWVs have traditionally had less uptake with rural providers. [Do you provide AWVs? If not, explain why. If you do, describe any challenges that you face furnishing them.] This is a health equity concern because AWVs are an important tool for increasing awareness and use of preventive care like cancer screenings and vaccinations that historically underserved populations, like rural, have had less access to.

**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 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. **[YOUR ORGANIZATION] 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.”

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. If you would like additional information, please contact [YOUR NAME OR OTHER REPRESENTATIVE] at [EMAIL] and/or [PHONE NUMBER].

Sincerely,

[E-SIGNATURE]

Name

Title

Organization