RURAL POLICY RESEARCH INSTITUTE
RUPRI Health Panel
Keith J. Mueller, PhD, Chair
Alva O. Ferdinand, DrPH, JD
Alana D. Knudson, PhD
Jennifer P. Lundblad, PhD, MBA
A. Clinton MacKinney, MD, MS
Timothy D. McBride, PhD
Nancy E. Schoenberg, PhD
https://rupri.org/

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The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to this proposed rule, CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program. Our comments focus on five topics included in the proposed rule.

1. Telehealth services (FR pages 52286 – 52307)

We appreciate the decision to continue furnishing specific hospital and emergency department services with telehealth through CY 2024. We encourage CMS to consider permanent status at the end of that time, after assessing impacts on patients and access to services (FR page 52292). We offer the same comment concerning Health and Well-Being Coaching services (same page). In both instances we encourage collecting evidence of access to services in rural communities. For the same reason, we endorse CMS adding the HCPCS code GXXX5: administration of the evidence-based Social Determinants of Health Risk Assessment (FR page 52293). We agree with CMS implementation of the Consolidated Appropriations Act (CAA) delay of the requirement for an in-person visit with physician or practitioner prior to an initial telehealth visit, including visits furnished by FQHCs or RHCs, to January 1, 2025. We encourage further study during that time to test assess any need to reinstate the requirement (FR page 52298). We applaud the CMS decision to delay requiring in-person direct supervision of diagnostic tests, physicians' services, and some hospital outpatient services until December 31, 2024. We agree with the need to collect further data and address the need for in-person supervision beyond that date. Access to essential services may be improved in rural areas by allowing virtual supervision (FR page 52302). Similarly, we support continuing to allow teaching physicians to use telehealth when supervising residents in other training locations. This approach may be particularly helpful in supporting rural residency sites (FR pages 52302-3).

2. Services Addressing Health-Related Social Needs (FR pages 52325 – 52336)

We endorse new codes and subsequent payment for the three types of services provided by auxiliary personnel – community health integration (CHI), social determinants of health risk assessment, and principal illness navigation (PIN). As stated on FR page 52338, many Social Determinants of Health (SDOHs) interfere with, or present barriers to, receipt of appropriate health services. We recommend that that CHI services be allowed to occur in-person, audio-video, or two-way audio to accommodate the distance and travel barriers often faced by rural Medicare beneficiaries and the community-based organizations which provide services and support (FR page 42329). We appreciate flexibility in how persons are trained to be qualified to deliver CHI services (FR page 52328). As that requirement is fully implemented, we suggest

that there be accessible, affordable approaches for rural residents to receive necessary training. The same is true for training needed for personnel providing PIN services (FR page 52334). CMS requests comments (FR page 52331) on whether to require billing practitioners (for SDOH risk assessment) to have the ability to deliver services or partnerships with community-based organizations to address the needs. We encourage such a requirement to assure sustainability of necessary infrastructure, believing rural communities will accomplish this primarily through partnerships. We suggest one modification: that partnerships need not be with formal organizations, since in small communities the services may be provided without a formal structure.

3. Advancing Access to Behavioral Health Services

We endorse adding Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) to the lists of practitioners eligible to order diagnostic tests and to furnish Medicare telehealth services (FR page 52363).

4. Rural Health Clinics and Federally Qualified Health Centers (FR pages 52395 – 52410)

Given rural locations of RHCs and FQHC sites, we recommend CMS extend the definition of direct supervision to permit virtual presence beyond December 31, 2024 (FR page 52397). Doing so facilitates timely access to services that on-site personnel could effectively deliver. Creating codes for RHCs and FQHCs to use for the purpose of billing for services addressing health related social needs separate from the RHC All Inclusive Rate or FQHC Prospective Payment System payments is a welcome recommendation (FR pages 25402-3).

5. Medicare Shared Savings Program (FR pages 52416 – 52496)

We support modifying Section 425.20 to add an expanded window for assignment. Using the previous 24 months as the time during which a visit to a primary care physician (FR page 52444) provides a longer window for rural beneficiaries who receive most of their primary care in nearby RHCs from non-physician providers, seeing the physician less often. Changing the window and recognizing visits with PAs or NPs is consistent with rural realities and increases opportunities for rural healthcare organizations to participate in the program.

Respectfully submitted,

Keith J. Mueller, PhD
Chair, RUPRI Health Panel
University of Iowa
College of Public Health
145 N Riverside Drive
Iowa City, IA 52242
Keith-mueller@uiowa.edu
www.rupri.org