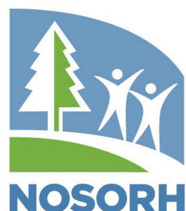

National Organization of
State Offices of Rural Health

September 8, 2023

NOSORH Comments on CMS CY 2024 Payment Policies under the Physician Fee Schedule - Notice of Proposed Rulemaking (NPRM)

Introduction

On August 7, 2023, the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (DHHS) published a Notice of Proposed Rulemaking (NPRM) entitled *CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes*. This NPRM proposes an omnibus set of payment policies, many of which have significant implications for the rural health care system. In this communication, the National Organization of State Offices of Rural Health (NOSORH) provides input in response to that NPRM. NOSORH's comments highlight key provisions that will help sustain the nation's rural health care system.

NOSORH was established in 1995 to assist State Offices of Rural Health (SORHs) in improving access to and the quality of healthcare for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. NOSORH and its members work closely with rural health care providers nationwide, including Rural Health Clinics, Federally Qualified Health Centers, and rural hospitals. NOSORH brings its knowledge of rural essential community providers to its analysis of the provisions of this NPRM.

NOSORH is encouraged by many of the flexibilities and waivers included within the NPRM. Most policies were implemented successfully during the COVID-19 Public Health Emergency (PHE). Their temporary extension, as detailed in the NPRM, will allow rural health care providers to meet the needs of rural residents more effectively. NOSORH looks forward to the time when the provisions will be made permanent.

Comments

NOSORH's specific comments on the NPRM follow.

Provision: Reimbursement of Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)

Discussion: Rural communities in the nation have significant, unmet behavioral health needs. A June 30, 2023, report from the DHHS Health Resources and Services Administration (HRSA) indicates that there are 3,940 rural mental health Health Professional Shortage Areas (HPSAs) nationwide, representing over 60% of all mental

health HPSAs. In addition, 492 mental health HPSAs are identified as *partially* rural, representing another 7.5% of all mental health HPSAs. This documented shortage of behavioral health providers can be addressed by improving reimbursement of a broad range of providers.

As proposed in the NPRM, adding MFT and MHC reimbursement within appropriately supervised Rural Health Clinic (RHC) operations would be a welcome improvement. The advantageous all-inclusive rate within RHCs will help sustain the availability of these services.

NOSORH notes that the category of MHC, typically licensed under state regulations, may have different names in different places. For example, for its programs, the National Health Service Corps (NHSC) refers to this behavioral health professional category as Licensed Professional Counselor (LPC). In the definition of MHC, it will be important to ensure that all equivalent types of providers, no matter how they are titled, are reimbursed for their work within RHCs.

Recommendation: NOSORH strongly supports the proposed provision allowing RHCs to bill for the services of Marriage/Family Therapists and Mental Health Counselors. NOSORH suggests that CMS use a definition of MHC that would include all appropriately trained and qualified health professionals currently licensed by states or recognized by the NHSC. Defining this category by education, clinical training, and licensure will ensure that appropriately qualified providers can be reimbursed.

Provision: Reimbursement of Addiction Counselors

Discussion: Substance abuse in rural areas has increased dramatically for more than a decade. A 2015 study from the CDC indicated that the overdose death rate in rural areas exceeded that in urban areas. This reflected a four-fold increase in these deaths from a decade earlier. Since that study, the challenge of rural substance abuse has grown. The increase in cheap and widely available fentanyl has compounded the problem. Fentanyl has been mixed with other illegal drugs, causing an alarming surge in inadvertent overdoses and deaths. The rural shortage of providers able to tackle the problem makes any response a major challenge. This shortage parallels the overall shortage of behavioral health care providers in rural areas.

The NPRM provision permitting reimbursement of Addiction Counselor services within RHCs would be a helpful response to this issue. Addiction Counselors could be reimbursed like MHCs, subject to similar supervision requirements as proposed. This will help sustain the availability of these essential services in rural communities.

NOSORH notes that the category of Addiction Counselor may have different names in different states. The NHSC, for its programs, refers to these providers as Substance Use

Disorder Counselors. In the definition of Addiction Counselor, it will be important to ensure that all equivalent types of providers, no matter how they are titled, are reimbursed for their work within RHCs.

Recommendation: NOSORH strongly supports the proposed provision allowing RHCs to bill for the services of Addiction Counselors.
NOSORH suggests that CMS use a definition of Addiction Counselor that would include all appropriately trained and qualified health professionals currently licensed by states or recognized by the NHSC. Defining this category by education, clinical training, and licensure will ensure that appropriately qualified providers can be reimbursed.

Provision: Direct Supervision Requirements in RHCs

Discussion: During the COVID-19 Public Health Emergency (PHE), CMS permitted an expanded definition of '*direct supervision*' for physician oversight of RHC physician assistants and other staff. During the PHE, direct supervision was expanded to permit the "*presence and immediate availability*" of the supervising practitioner through real-time audio and visual interactive telecommunications. The NPRM proposes continuing this direct supervision definition through December 31, 2024. This will allow additional assessment of the effectiveness of audio and visual telecommunications for supervisory purposes.

NOSORH believes that using audio-visual technology for supervision during the COVID-19 PHE did not create significant clinical safety problems. NOSORH believes that subsequent formal assessments will confirm the safety of such arrangements. The extension of these arrangements through December 31, 2024, will permit the provision of RHC services under these arrangements to continue until they can be permanently authorized.

Recommendation: NOSORH strongly supports the proposed continuation of an expanded definition of direct supervision for RHCs.

Provision: Extension of Telehealth Flexibilities and Payment Methodologies

Discussion: The NPRM proposes several measures which will be of benefit to the rural health care system:

- A provision continuing reimbursement of telehealth services on the Medicare Telehealth Services List will assure continuity of operations consistent with those of the PHE through December 31, 2024.

- A provision delaying the requirement for an in-person visit with a physician or practitioner within six months before initiating behavioral health telehealth services is particularly important in rural areas. This provision and the addition of new practitioner types to RHCs will improve the accessibility of behavioral health services in rural areas.

- A provision extending current opioid treatment program flexibilities through December 31, 2023, will improve the accessibility of these critical services. The flexibility permitting periodic assessments to be furnished via audio-only telecommunications is particularly important for rural health care.

- Finally, a provision that defines a *telehealth originating site* as any site in the nation where the beneficiary is located is important for rural health care. The continued use of this expanded definition permits coverage of any location, including an individual's home. This is extremely valuable for rural patients unable to travel to a provider site.

NOSORH notes that these provisions are extensions of flexibilities provided during the PHE. The flexibilities have helped improve the effectiveness and accessibility of telehealth services in rural areas with no significant patient safety impacts.

Recommendation: NOSORH strongly supports the proposed extensions of telehealth flexibilities.

We appreciated the opportunity to submit comments on these important conditions of participation and hope you find value in the outlined recommendations.

Let me know if you have questions, would like discussion, or if I may be of assistance.
Thanks so much.

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