Centers for Medicare & Medicaid Services

Open Door Forum: Rural Health

Moderator: Jill Darling

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2:00 pm ET

Coordinator: ...and thank you for standing by. At this time, all participants are in a listen only mode until the question and answer session of today's conference. At that time, you may press star 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect. I will now turn today's call over to Jill Darling. Thank you. You may begin.

Jill Darling: Thank you, (Denise). Good morning. And good afternoon, everyone. I'm Jill Darling from the CMS Office of Communications. And welcome to today's Rural Health Open Door Forum. We appreciate your patience as always, as we try to get folks in, and wait for speakers to arrive over the phone. So thank you again for your patience. Before we get into the agenda, I have one brief announcement. This Open Door Forum is open to everyone, but if you are a member of the press you may listen in, but please refrain from asking questions during the Q and A portion of the call.

If you have any inquiries, please contact CMS at Press@cms.hhs.gov. And I will hand the call off to our co-chair John Hammarlund.

John Hammarlund: Thanks very much, Jill. Well thank you all very much for joining today's Rural Health Open Door Forum call. And let me be the first to say Happy National Rural Health Day to you all. We certainly appreciate the dedication, the hard work, the toiling that you do to bring quality care to the residents of your communities. And we want to honor the work that you do today, and every day. So we are going to make sure that we cover really important topics today, on our Open Door Forum call. You know that we strive on these Open Door Forum calls, to try to get the right information into your hands.

We know that CMS produces an awful lot of information, and I've been told by a lot of rural providers, that it's like drinking from a fire hose. But what we try to do on these calls is to make sure that we distill that information down to the bite size chunks that we think you really should be hearing from, and also we want to be listening to you today. So we have a really rich agenda. I want to thank all of the speakers who joined our call today, to talk about these important topics. And then we look forward to hearing your questions.

At the end of today's call we will also give you the Web site, I mean, excuse me, the email address to use, because we really truly want you to help build the agendas for these calls moving forward. So we want to get your thoughts on what we should be talking about six weeks from now. So we'll look forward to getting your input. Again, thank you for joining this call. Happy National Rural Health Day. And with that, I'll turn it back to Jill to take us to the first agenda.

Jill Darling: Great. Thanks, John. First off, we have Darci Graves who will talk about the CMS Framework for Advancing Healthcare in Rural, Tribal, and Geographically Isolated Communities.

Darci Graves: Thank you, Jill. Good morning and good afternoon, everyone. My name is Darci Graves and I'm a Technical Advisor with the CMS Office of Minority Health. I also serve as one of the co-chairs for the CMS Rural Health Council. I'm here to share that earlier this week, CMS launched its new framework for advancing healthcare in rural, tribal, and geographically isolated communities. One of the key advancements of this framework is the expansion of its geographic footprint to be more inclusive, and allow CMS to expand its health equity reach to rural, tribal, frontier communities, as well as the US territories.

To ensure that CMS's approach is responsive to the unique needs of rural, tribal, and geographically isolated communities, we engaged with individuals from across the nation with lived experience receiving, supporting, or providing health and healthcare services in these communities, to help shape this framework. The framework focuses on six priorities over the next five years. The new framework builds upon the CMS Rural Health Strategy, which was released in 2018, to reflect changes in the healthcare landscape since its development.

In alignment with the CMS framework for health equity, this framework also supports CMS's overall efforts to advance health equity, expand access to quality affordable health coverage, and improve health outcomes to all those we serve. CMS's approach to operationalizing this framework over the next five years will be informed by ongoing public engagement and continued

monitoring of trends in health and healthcare that uniquely impact rural, tribal, and geographically isolated areas.

Through the adoption and implementation of this framework, CMS will continue to work to promote policies and programs that help make high quality healthcare in these communities available and affordable. Earlier this year, building on what we learned from the original strategy, the CMS Rural Health Council held a series of listening sessions to inform a framework that continues to reflect the current needs and priorities of rural, tribal, and geographically isolated communities, and is responsive to changes in the healthcare landscape, such as those resulting from the COVID-19 pandemic.

Through these listening sessions, as well as discussions with federal partners, the CMS Rural Health Council received feedback from individuals across the nation, and this feedback was used to help identify the key priorities, which make up the CMS framework for advancing healthcare in rural, tribal, and geographically isolated communities. The first priority is to apply a community informed geographic lens to CMS programs and policies. CMS recognizes the importance of engaging with individuals that have experiences receiving or supporting the delivery of healthcare services in rural areas.

The second priority is to increase collection and use of standardized data to improve healthcare for those communities that we're discussing. We recognize that so many providers may lack the resources in infrastructure, necessary for data collection and reporting, and therefore we are striving to increase available standardized data across settings of programs, which will enable CMS and its partners, to address changes in populations over time, and

leverage information to connect individuals living in rural, tribal, and geographically isolated communities, to the appropriate and needed healthcare services.

The third priority is to strengthen and support healthcare professionals in these dedicated communities. Strengthening the healthcare workforce in rural areas remains imperative with rural providers and listening session participants, in detailing the importance of improving recruitment and retention of healthcare providers and allied health professionals, strengthening provider capabilities and reducing administrative and financial burdens for workers.

The fourth priority is to optimize medical and communication technology for rural, tribal, and geographically isolated communities as reliance on technology, including telehealth, patient portals, and other medical and communication tools continues to grow. CMS acknowledges that rural providers and community organizations in underserved and technology under-resourced areas, must not be left behind. Building on lessons learned from the COVID-19 pandemic, CMS will collaborate with rural organizations and government agencies to optimize medical and communication technology for people living in rural, tribal, and geographically isolated communities.

Our fifth priority is to expand access to comprehensive healthcare coverage, benefits and services, and supports for individuals in rural, tribal, and geographically isolated communities. CMS recognizes the potential connection between a lack of healthcare coverage and health outcomes contributing to disparities. As such, we will continue to work to ensure that individuals in rural areas can access necessary support and services.

And our sixth and final priority, is to drive innovation and value based care in rural, tribal, and geographically isolated communities. CMS will continue to explore opportunities to advance innovations in care that support healthcare providers to participate in innovative models, address the unique needs of tribal and geographically isolated communities, and respond to public health emergencies and disasters with agility. You can find the framework and a few other new publications on our Web site at Go.CMS.gov/RuralHealth. I will now turn things over to my colleague, Kianna Banks. Kianna?

Kianna Banks: Thank you, Darci. I'm Kianna Banks, and I'm a Technical Advisor in the Clinical Standards group of the Center for Clinical Standards and Quality. And our group is responsible for developing and maintaining the health and safety standards for Medicare and Medicaid participating providers and suppliers. Those providers and suppliers include hospitals, critical access hospitals, long-term care facilities, ambulatory surgical centers, and a host of others, which now includes rural emergency hospitals.

So rural emergency hospitals were established by Congress in the Consolidated Appropriations Act of 2021. They're an outpatient-only provider that may only convert from either a critical access hospital or a rural hospital with not more than 50 beds. They are required by the statute, to provide emergency care, observation services, and they may provide additional outpatient services as well. There are some additional specific statutory requirements for REHs, or Rural Emergency Hospitals. For instance, rural emergency hospitals must have an average annual per patient length of stay that does not exceed 24-hours.

They must have an agreement with a Level 1 or Level 2 trauma center. And they must meet the critical access hospital emergency services requirements. So we proposed in a separate standalone rule of a comprehensive set of conditions of participation for rural emergency hospitals based on the statutory requirements, and also based on comments that we received on a request for information that was published last year, which we used to help inform our policymaking.

On the proposed rule, we received over 4,000 comments, which were generally supportive of our proposals. And we finalized the majority of the provisions of proposed with only some slight modifications. So we mirrored the rural emergency hospital standards after the critical access hospital standards where appropriate. Of course, keeping in mind that rural emergency hospitals are an outpatient-only provider and critical access hospitals must provide inpatient services. And we also mirrored some of the standards after the hospital and ambulatory surgical center requirements, which is another outpatient-only provider.

I'd just like to highlight the staffing requirements, as the statute requires that the emergency department of the rural emergency hospital be staffed at all times. We highlighted that rural emergency hospitals have the flexibility to determine who is best to fulfill the 24/7 onsite staffing requirement based on the scope of services provided by the facility and the population served. We also added skills. We also noted that this individual is expected to have skills that include effective communication, and the ability to recognize life-

threatening emergencies and provide cardiopulmonary resuscitation to patients presenting to the emergency department if necessary.

And also, regarding the emergency services requirement, as I stated earlier the statute requires that rural emergency hospitals meet the critical access hospital requirements for emergency services. So they must have a practitioner on call at all times. And the practitioner must be onsite within 30 or 60 minutes, depending on if the facility is located in an area that is considered frontier. And again, that is also a critical access hospital existing requirement.

I'd also like to mention the CRNA or Certified Registered Nurse Anesthetist oversight requirement. We did propose and finalize the requirement that CRNAs be supervised by a physician. Of the 4,000 comments that we received on the proposal, about 3,000 were from CRNAs who suggested the removal of the physician oversight requirement. We did finalize the provision as proposed. This is an existing requirement in hospitals and critical access hospitals and ambulatory surgical centers as well. And now it's a consistent requirement for rural emergency hospitals also.

The rural emergency hospital conditions of participation also include standards for governing bodies, medical staff, nursing services, QAPI, infection control, patient's rights, and emergency preparedness, to name a few. And in this final rule we also finalized updates to the critical access hospital conditions of participation. For starters, for the location and distance requirement, we included a definition of primary roads in the regulatory text.

And based on comments in the proposal, we modified the definition of primary roads to require numbered federal highways that have two or more lanes each way, to be considered a primary road. We believe that this change is responsive to comments, provides a clear description of primary roads of travel, and allows for flexibility for providers. We also included a standard for patient's rights in the critical access hospital conditions of participation, which is consistent for which we finalized for rural emergency hospitals. And it's also consistent with the existing hospital conditions of participation as well.

So now each of those providers, critical access hospitals, hospitals, and rural emergency hospitals, have consistent patient's rights requirements, as a separate condition of participation.

And lastly, for critical access hospitals, we provided flexibility for critical access hospitals that are part of a larger health system, by allowing them to have a unified and integrated governing body, medical staff, infection control program, and QAPI program. This is also consistent with the hospital conditions of participation, and now the rural emergency hospital conditions of participation as well.

And now I'll turn it over for the discussion of the updates that remain to the OPPS and ASC payment rates.

Josh McFeeters: Actually, we're going to talk about the payments for REHs. This is Josh McFeeters from the Division of Outpatient Care. And our division handles our payment policy for rural emergency hospitals. Rural emergency hospitals will receive payment from two sources. The first source is a payment for

individual services performed at REHs that we pay at the OPPS payment rate for a service plus an additional 5% payment.

This additional 5% payment will be excluded from beneficiary cost sharing. In order not to limit the types of services that REHs can provide, CMS will also allow REHs to provide certain outpatient services beyond those paid under the OPPS, which will be payable at the applicable fee schedule amount without the additional 5% payment. The second payment source is a monthly facility payment. For calendar year 2023, the REH monthly facility payment will be $272,866, which translates into an annual facility payment of $3.27 million for calendar year 2023.

This payment amount will be the same for all REHs. In subsequent years the payment amount will be updated by the hospital market basket percentage. The REH statute allows an entity that is owned and operated by a REH that provides ambulance services, to receive payment under the ambulance fee schedule. We are also updating ambulance regulations to ensure that ambulances can service REHs. The REH statute also allows REHs to include a unit that is a distinct part of the facility licensed as a skilled nursing facility, to furnish post-hospital extended care services.

Payment for services provided by a REH in such a unit, we made a skilled nursing facility prospective payment system. Regarding Section 603, we finalized our policy in the final rule for both non-accepted off campus provider based departments that existed prior to an interview conversion to a REH, and any new off campus PBDs that are created post-conversion, that Section 603 payment reductions will not apply.

We also clarify that provider-based rural health clinics or RHCs, may maintain their accepted status under Section 1861, subsection kkk, subsection 6, subsection B of the Act, when their associated hospital converts to a REH. Next, my colleague, David Rice, will discuss updates to the OPPS and ASC payment rates.

David Rice: Thanks, Josh. This is David Rice. I'm the Director of the Division of Outpatient Care. And I'm going to cover the OPPS and ASC payment updates, as well as a couple of other policies that might be of interest to rural providers in the OPPS final rule. In accordance with Medicare law, EMS is updating the OPPS payment rates for hospitals that meet the applicable quality reporting requirements by 3.8%. This update is based on the projected hospital market basket percentage increase of 4.1%, reduced by a 0.3 percentage point for the productivity adjustment.

For calendar year 2023, CMS is also finalizing its proposal to consider behavioral health services furnished remotely by clinical staff of hospital outpatient departments, including staff of critical access hospitals, through the use of telecommunications technology to beneficiaries in their homes, as covered outpatient services for which the payment is made under the OPPS. Currently, this flexibility is available through the public health emergency specific policy referred to as Hospitals Without Walls.

But the emergency waivers that enable this flexibility, will expire when the public health emergency for COVID-19 ends. So CMS is also finalizing its proposal to require that payment for behavioral health services furnished

remotely to beneficiaries in their homes, may only be made if the beneficiary receives an in person service within six months prior to the first time hospital clinical staff provide the behavioral health service remotely, and that there must be an in person service without the use of communications technology, within 12-months of each behavioral health service furnished remotely by hospital clinical staff.

CMS is also clarifying in the final rule, that in instances where there is an ongoing clinical relationship between the practitioner and the beneficiary at the time the public health emergency ends, the in person requirement for ongoing treatment will apply. CMS is also finalizing its proposal that audio-only interactive telecommunications systems may be used to furnish these services in instances when the beneficiary is unable to use, does not wish to use, or does not have access to two-way audio/video technology.

I'll also mention that in this final rule we finalize a policy to exempt rural (unintelligible) community hospitals from the clinic visit payment policy. CMS currently pays the physician fee schedule equivalent payment rate for the clinic visit service when provided at an accepted off campus provider based department, paid under the OPPS. The PFS equivalent payment rate is approximately 40% of the OPPS payment rate. And the clinic visit is the most frequently billed service under the OPPS.

In order to maintain access to care in rural areas, CMS is finalizing its proposal to exempt rural sole community hospitals from this policy, and pay for clinic visits furnished and accepted off campus provider-based departments of these hospitals, at the full OPPS rate. CMS believes that

implementing this exemption will help to maintain access to care in rural areas, by ensuring rural providers are paid for clinic visit services provided at off campus provider-based departments, at rates comparable to those paid by on campus departments.

The exemption for rural sole community hospitals is in keeping with prior CMS policies to provide rural sole community hospitals a 7.1% add-on payment for OPPS services, to account for their higher costs compared to other hospitals. And finally, I'll note that for the ambulatory surgical center update, CMS is likewise with the OPPS update using the hospital market basket update and finalizing an update of 3.8% for ASC rates for calendar year 2023. And at this point, I will pass it over to Susan Bauhaus to discuss the home health payment policies.

Susan Bauhaus: Thank you, David. And good afternoon, everyone. On October 31st CMS issued a final rule updating the Medicare home health prospective payment system rates and wage index for calendar year 2023. CMS estimates that payments to home health agencies will increase in aggregate by 0.7% or $125 million compared to calendar year 2022.

This increase reflects the effects of the 4% home health payment update percentage or $725 million increase, and estimated 3.5% decrease that reflects the effects of the prospective permanent behavioral assumption adjustment of negative 3.925%, or a $635 million decrease that's being phased in, and an estimated 0.2% increase that reflects the effects of an update to the fixed dollar loss ratio used in determining outlier payments, or a $35 million increase.

The calendar year 2023 final rule finalized a repricing methodology to determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures, beginning with calendar year 2020, and ending with calendar year 2026. This methodology predicts what the Medicare program would have spent under the pre-PDGM payment methodology, using actual calendar year 2020 and 2021 data, accounting for actual behavior changes as a result of the PDGM.

Using this methodology and updated claims data for the final rule, CMS determined that Medicare paid more under the new system than it would have under the old system, and would have to make a negative 7.85% permanent adjustment to the 30-day payment rate in calendar year 2023, as compared to negative 7.69% in the proposed rule. However, to mitigate such a large decrease in home health payments in a single year, we finalized phasing in the permanent adjustment by reducing it by half for calendar year 2023.

This results in a negative 3.925% permanent adjustment to the 30-day payment rate in calendar year 2023, to ensure that aggregated expenditures under the PDGM would be equal to what they would have been under the old payment system. The remaining permanent adjustment, along with any other potential adjustments needed to the base payment rate to account for behavior change based on data analysis, will be proposed in future rulemaking.

This rule also discusses the comments received on the best approach to implement the statutorily required temporary payment adjustment for calendar years 2020 and 2021, and those comments will be considered for future

rulemaking. The rule also finalizes the recalibration of the PDGM case mix weights and updates the low utilization payment adjustment thresholds, functional impairment levels, comorbidity adjustment subgroups for calendar year 2023, and the FDL used for outlier payments.

This rule also finalizes the reassignment of certain diagnosis codes under the PDGM case mix groups, and aligns with the fiscal year 2023 inpatient perspective payment system final rule and other rules, by finalizing a permanent budget-neutral 5% cap on negative wage index changes for home health agencies, in order to smooth year to year changes in the pre-floor, pre-reclassified hospital wage index.

This rule also includes a discussion of the comments received on the collection of data, regarding the use of telecommunications technology during a 30-day home health period of care on home health claims. We will begin collecting data voluntarily, beginning January 1, 2023 using three new G codes. This data collection will be mandatory beginning July 1, 2023. Lastly, this rule will update the home infusion therapy services payment rates for calendar year 2023, as required by the 21st Century CURES Act.

The Act specifies that annual updates be equal to the percent increase in the consumer price index for all urban consumers, or the CPI-U, for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment for calendar year 2023. The CPI-U for June 2022 is 9.1%. And the corresponding productivity adjustment is a reduction of 0.4%, making the final home infusion therapy payment rate update for calendar year 2023, 8.7%.

The single payment amounts are also adjusted in a budget-neutral manner using a geographic adjustment factor, or GAF. The final GAF, national home infusion therapy payment rates, and locality adjusted home infusion therapy payment rates, are now posted on CMS's home infusion therapy services web page. Next Gift Tee will give an update on the calendar year 2023 physician fee schedule final rule.

Gift Tee: Oh, thank you, Susan. Good morning, good afternoon, everyone. I will be covering our finalized policies under the physician fee schedule. To John's point, there's a lot that's packed into this rule, and we're only going to cover a little bit of it. So I encourage you to hop into the rule and read the sections that are of interest to you, but there's a lot of good information there. So I will quickly touch on the conversion factor under the PFS for 2023.

As you all might be aware, and certainly as discussing the rule, the rule lays out a series of standard technical changes involving our practice expense, including the implementation of the second year of the clinical labor pricing update that we finalized last year, and our standard rate setting refinements to a recommendation - valuation recommendations that we received from the AMA (unintelligible) and other interested parties.

Considering those refinements and other statutory requirements that contributed to the convergence factor for CY 2022, specifically the protecting Medicare and American farmers from Sequester Cuts Act of 2022, which provided a temporary 3% increase, which I know is due to expire for CY 2023. And also our budget neutrality requirements to adjust or account for

changes in RVUs that are reflecting the policy that we're implementing and finalizing this year.

In combination, the conversion factor for CY 2023 is $33.06, which is a decrease of a $1.55 to the CY 2022 PFS conversion factor of $31.61. Again, I just want to emphasize that that 3% payment increase was really only for CY 2022 and required in the statute.

I will now cover our updates to geographic practice cost indices and malpractice data. Medicare statute requires us to update the data we use to reflect resource cost differences in different service areas at least every three years. So, this year we updated the work practice expense and malpractice GPCs, which measure resource cost differences among localities compared to the national average. In addition to the requirements update the data at least every three years, the statute also requires that data updates be phased in over two years. Therefore, the CY 2023 GPCs are a 50/50 blend of the previous year's GPC value and the updated (SPS) value for each locality. The GPC update will be fully implemented in CY 2024, when the phase-in is complete.

As statute requires, we have also updated the data inputs used to calculate the malpractice RVUs that fold into physician payment. Our update includes technical refinements intended to improve stability in the system, by expanding the use of available specialty-specific premium data drawing on our experience, engagement, and interested parties who asked us to continue to improve our malpractice RVU calculation methodologies, and to use as much comprehensive data as possible.

This year we also finalized rebasing and revision of the 2017-based Medicare economic index with some technical revisions to the proposed method based on public comments. In the proposal we had discussed rebasing and revising the MEI for this year, and solicited comments regarding the future use of the 2017 based MEI weights and PFS rate-setting, and then how we calculated the GPCs. The proposed method for determining the 2017 MEI relies on estimating base year expenses from publicly available data from the US Census Bureau NIAC 6211 Office of Physicians.

The proposed methodology also allows for the use of data that are more reflective of current market conditions of physician ownership practices rather than only reflecting costs for self-employed physicians. And would also allow the MEI to be updated on a more regular basis since the proposed data sources are updated and published on a regular basis. I want to emphasize that finalizing the use of the 2017-based MEI cost rates that set PFS rates, would not change overall spending on PFS services, but would result in significant distributional changes to payments among PFS services across specialties and geographies.

However, in consideration of our ongoing efforts to update the PFS payment rates with more predictability and transparency, and in the interest of ensuring payment stability, we propose not to use the updated MEI cost share rates to set PFS payment rates for CY 2023. However, we solicited comment on the potential use of the proposed updated MEI cost share rates to calibrate payment rates and update the GPCs under the PFS in the future.

So the final CY 2023 MEI update is 3.8% based on the most recent historical data available as noted above, were based and revised MEI rates were not used in CY 2023 PFS rate-setting. However, they are used in other payment systems that rely on the MEI for updates.

Now, I'll quickly hop into our changes to evaluation management services in the non-office outpatient settings. Just as a reminder recap for CY 2021, we finalized several policies that took into account the changes to E&M visit codes, as explained in the AMA CPT code book, which took effect January 1, 2021.

We finalized valuation of the following code sets that include, rely upon, or are analogous to office outpatient E&M visits, can measure it with the increases in the values we've finalized for the office outpatient E&M, specifically end stage renal disease, monthly capitation payment services, transitional care management services, maternity services, cognitive impairment assessment, and care planning service, the initial preventive physical examination, and initial subsequent annual wellness visits, emergency department visits, therapy evaluations, and psychiatric diagnostic evaluations and psychotherapy services.

This year as part of that ongoing review of the E&M code set broadly, the AMA CPT editorial panel approved revised coding and updated guidelines for other E&M visits effective for January 1, 2023. Similar to the approach we finalized in the CY 2021 PFS final rule for office outpatient E&M visit coding and documentation, we finalized and adopted most of these AMA CPT changes in coding and documentation, for the other non-office outpatient

E&M visits, which include hospital inpatient, hospital observation, emergency department, nursing facility, home, or resident services, and also the cognitive impairment assessments.

This revised coding and documentation framework includes CPT code changes, revisions to the other E&M code descriptors, including new descriptive times where relevant, revised interpretive guidelines for levels of medical decision making, choice of medical decision making, or time to select code level, except for a few families like emergency department visits and cognitive impairment assessment, which are not time services. And also eliminated the use of history and exam to determine code level.

In addition to the changes to the base set of other E&M services, AMA CPT also considered changes to prolonged services, which function like add-on code, providing additional payment for extended visits per additional time increments. The CPT editorial board restructured the prolonged service codes that applied to other E&M visits for 2023. We expressed concern in the proposed rule that the revised CPT prolonged service framework would allow for duplicative or unwarranted billing, and pose barriers to oversight, and also increase administrative complexity compared to the predecessor codes.

Therefore, we finalized the creation of Medicare-specific coding for payment of other ENM prolonged services, similar to what CMS adopted in CY 2021 for payment of the office outpatient prolonged services. These services would be reported with three separate Medicare-specific G codes. We also finalized the yearlong delay of the split or shared visits policy, we had established in rulemaking for 2022. As a reminder, this policy determines which

professional should bill for a shared visit, by defining the substantive portion of the service as more than half of the total time.

However, for CY 2023, as in CY 2022, we're allowing that the substantive portion of a visit could be comprised of any of the following elements - a relevant history, performing a relevant physical exam, making a medical decision through use of MDM, or spending time, more than half of the total time spent by a practitioner who bills for the visit. As finalized, clinicians who bill for the split or shared visits, will continue to have a choice of all the elements that I just mentioned, instead of using total time to determine the substantive portion, until CY 2024.

In our telehealth space and other services involving communication technology, we finalized several policies related to the Medicare telehealth services list, making several services that are temporarily available as telehealth services for the PHE, available through 2023, to allow additional time for the collection of data that can support their eventual conclusion as permanent additions to the Medicare telehealth services list.

We also finalized our proposal to allow physicians and practitioners to continue to bill with a place of service indicator that would have been reported, had the service been furnished in person. These claims will still require the modifier 95 to identify them as services furnished as telehealth services. And claims can continued to be billed with the place of service code that would be used if the telehealth service had been first in person through the later of the end of CY 2023, or the end of the year in which the PHE ends.

I'll quickly touch on virtual supervision and remote therapeutic monitoring for the duration of the PHE, to limit infection exposure. We revised the definition of direct supervision to allow or include virtual availability of the supervising physician or practitioner, using interactive audio/video real time communications technology. We will continue this policy through the end of the year in which the PHE ends, but a reminder that in CY 2022 and in this year's rule, we did solicit comment on whether this revised definition should continue following the PHE, and if so, in what circumstances.

In our remote therapeutic monitoring space, we proposed payment for RTM using four new HCPC C codes instead of the CPT codes that had been previously established. This policy was intended to address coding billing concerns rates by interested parties. As part of that proposal, we also discussed our interest in the types of data collected, how the data collected may be used to solve specific health conditions, and what those health conditions are, and also the costs associated with the RTM devices that are available, to collect RTM data.

In consideration of the public comments we received, we finalized the policy instead, to use existing CPT codes that were created for CY 2022, while we consider the broader RTM landscape and future RTM-related coding. This year we also test on dental and oral health services. Under Medicare, payment for dental services is generally precluded by statute. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition.

Effective for CY 2023, we finalized our proposal to clarify and codify certain aspects of the current Medicare fee for service payment policy for dental services. Again, when that service is an integral part of a specific treatment of a beneficiary's primary medical condition. We also discussed clinical scenarios under which Medicare Part A and Part B payments can be made for dental services, such as dental exams and necessary treatments prior to or with organ transplants, cardiac valve replacements, and valve plasty procedures.

We also finalized payment for dental exams and necessary treatments prior to the treatment for head and neck cancer, starting in CY 2024, and finalize a process beginning in CY 2023, to review and consider public recommendations for Medicare payment for dental services and other potentially analogous clinical scenarios. I'm going to quickly touch on some of the work that we did in our behavioral health space.

In 2022 CMS set a goal to improve access to and quality of mental healthcare services. In light of current needs among Medicare beneficiaries for improved access to these services, we considered regulatory revisions that may help to reduce existing barriers and make ready use of services of behavioral health professionals such as licensed professional counselors, licensed marriage and family service.

We finalized our proposals to add an exception to direct supervision requirements under residency regulations, to allow behavioral health services provided under the general supervision of a physician or non-physician practitioner, rather than under direct supervision, when these services or supplies are provided by auxiliary personnel incident to the services of a

physician or NPP. We believe that this change will facilitate utilization and extend the reach of behavioral health services.

We also finalized a proposal to create a new general behavioral health integration code describing a service personally performed by clinical psychologists or clinical social workers to account for monthly care integration where the mental health service furnished by a CT or CSW, are serving where those clinicians are serving, as a focal point of care integration. Further, we finalized our proposal to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.

Lastly, I'll touch on a policy that we finalized in this year's rule, to allow direct access to audiologists without an order from a physician or a non-physician practitioner. The policy, as we finalized, will allow the use of a new modifier instead of what we had proposed the HCPCS C code, because we were persuaded by a commenter, that a modifier would allow for better accuracy of reporting and reduce burden for audiologists.

The services that can be billed using the code that audiologists already use, can now be billed with this new modifier, to indicate those instances when a beneficiary is receiving direct access to an audiologist without an order from a physician. This direct policy will allow beneficiaries to receive care for specifically nonacute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations, for the purpose of prescribing, fitting, or changing hearing aids.

The modification and our finalized policy, necessitates multiple changes to our claims processing systems, which will take some time before we operationalize. Audiologists may use Modifier AB along with the finalized list of CPT codes, for dates of service on or after January 1, 2023. I want to highlight here that the policy as finalized, permits audiologist to bill for this direct access, without a physician or practitioner order, once every 12-months per beneficiary.

Medically reasonable and necessary tests ordered by a physician or other practitioner, and personally provided by audiologists, will not be affected by a direct access policy, including the modifier and frequency limitation. Finally, and I promise I'm done after this, for CY 2023, we finalized updates to expand Medicare coverage policies for colorectal cancer screening, in order to align with recent United States preventive service taskforce and professional society recommendations to specifically expanding Medicare coverage for certain colorectal cancer screening tests, by reducing the minimum age payment and coverage limitation from 50 to 45 years.

And also expanding the regulatory definition of colorectal cancer screening tests to include a complete colorectal cancer screening, where follow on screening colonoscopy after Medicare covered non-invasive stool-based colorectal cancer screening test, returns a positive result. A functional outcome of the policy for complete colorectal cancer screening will be that for most beneficiaries cost sharing will not apply for either the initial stool-based test or the follow on colonoscopy. And with all of that, I will turn it to my colleague - turn it over to my colleague, Michele Franklin, to cover some of her policies.

Michele Franklin: Thank you, Gift Tee. Good morning, and good afternoon, everyone. I will be going over the issues impacting RHCs under the physician fee schedule CY 2023 final rule, which are chronic pain management, behavioral health integration services, and specified provider-based RHC payment limits per visit. For the chronic pain management and behavioral health services, CMS finalized the addition of chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code G0511, which aligns with changes made under the PFS for CY 2023.

Since the requirements for the chronic pain management and behavioral health integration services are similar to the requirements for the general care management services furnished by RHCs and FQHCs, which are the current services for which RHCs and FQHCs can use HCPCS code G0511, the payment rates for HCPCS code G0511 will continue to be the average of the national non-facility PFS payment rates for the RHC and FQHC care management and general behavioral health codes, CPT codes 99484, 99487, 998490, and 99491. And as well as the PCM codes, CPT codes 99424 and 99425.

Payment will be updated annually based on the PFS amounts for these codes, which is how these codes are currently updated. For the specified provider-based RHC payment limit per visit, CMS finalized the clarification that a 12 consecutive month cost report should be used to establish a specified provider-based RHC payment limit per visit. We believe 12 consecutive months of cost report data accurately reflects the cost of providing RHC

services and will establish a more accurate base from which the payment limits will be updated going forward.

Those are all of the issues that are impacting RHCs for the 2023 final rule, CY 2023 final rule. Thank you. And now I'll turn it over to John Hammarlund to discuss the importance of rule providers providing comments during the NPRM process. John?

John Hammarlund: Thanks a lot, Michele. Well I hope we made good on our promise today, everybody, to give you really important information that we believe you need to know. Certainly we appreciate your feedback. So we're going to close the call with this thought. You heard I think from Kianna that we had over 4000 comments on the rural emergency hospital provisions to the OPPS rule, and I - and you heard from Gift a number of times, based on the comments we received, we have taken these following actions in the final rule, for the physician fee schedule.

And I think it's just - it really makes a point that if there is any way you can take the time to provide us with your feedback, when we put out notice of proposed rules, we really encourage you to do it. I know it's a big request. You are busy providing care to your communities, you're resource-strapped, it takes a lot of time to read proposed rules, and sometimes the print's really small. But we really do encourage you and ask you to provide your comments, because you can help see the way to a final decision.

We read every single comment that comes in. And those comments inform our thinking. And the most helpful comments that you can provide are the

ones that tell your story, your community's story, how the policy will affect for better, for worse, your ability to provide quality care to your patients; how it will affect your bottom line and your operations; how it will affect patient access. And the fourth thing we want to hear from you about, is - when you comment, is, you know, give us suggestions about how we could meet our goal differently.

In other words, what alternative approach would you suggest that gets the same goal that we're trying to achieve, but might be better for your practice, or your clinic or your hospital, or your patients? So it's really important if you can, to take the time to tell your story to help inform our final decisions. We take all of your comments seriously. We try our very best to make sure that we are understanding the impact in your communities, and it's very valuable.

So thank you, to all of you who have provided comments in the past to our proposed rules. And thank you for taking up this opportunity in the future, when we propose rules. I can't tell you, there's just nothing more valuable than getting your individual feedback. So with that, I'll hand it back over to Jill Darling, to close out the call, or get us into the Q&A. Thanks.

Jill Darling: Yes. Thank you, John. And thank you to all of our speakers today. (Denise), please open the line for Q&A.

Coordinator: Thank you. At this time, if you would like to ask a question, please press star 1 on your touchtone phone. Once again, it is stars 1 for any questions. I do have one question. One moment, please. I have a question from (John Sutcliffe). Your line is open.

(John Sutcliffe): Thanks very much, everyone. And thanks for a great call. Per usual, of course you've got 4000 comments on rural emergency hospitals. Now it's 4001. This is a question. Can a rural emergency hospital participate in Hospital at Home?

(Danielle Adams): Hello. This is (Danielle Adams). And the provision for Hospital at Home is only for inpatient IPPS hospitals. So a rural emergency hospital would not be able to participate.

(John Sutcliffe): Great. Thanks.

Coordinator: Thank you. And I do have another question. One moment. The next question comes from (Brenda Kwiring). Your line is open.

(Brenda Kwiring): Good afternoon. Thank you for today's call. I have two questions in regard to rural emergency hospitals. One, do we have a date open yet for the application process? And second question - in the proposed COP I was unable to clearly define whether or not REHs would be required to do patient satisfaction as far as like, you know, sending out emails and, to get their feedback. Is that kind of a requirement like it is for regular hospitals?

Kianna Banks: Hi. This is Kianna Banks. Regarding your first question for the date of application, I think that would be appropriate for the enrollment group. And I'm not sure if we have anyone from enrollment on the call. And regarding your second question regarding the patient side satisfaction requirements, there - that isn't a requirement at this time for rural emergency hospitals. That may change in the future, but at this time it's not a requirement.

(Brenda Kwiring): Thank you.

Kianna Banks: And we can - we will take your question regarding the date of application back to our team, and get you an answer to that if you want to send us an email.

(Brenda Kwiring): Sounds good. Thank you.

Coordinator: Thank you. And there is another question from Dr. (Jesse A. Cole). Your line is open.

Dr. (Jesse A. Cole): Thank you. I'm new to this, so if I'm out of line, please don't hesitate to step in and tell me. I don't really have time to follow all the rules, regulations, and requests. I wish I did, but I'm a full time practicing radiologist in Butte, Montana, at an independent diagnostic testing center, which is essentially an outpatient radiology clinic owned by myself and several other people. And we have provided outpatient good healthcare to the residents of southwest Montana which is a population in this whole area, of about 75,000. And I am currently the only full time interventional radiologist.

Recently I've been informed that Medicare will no longer allow me to perform many procedures or bill for many procedures on Medicare beneficiaries in my outpatient radiology clinic. But ironically, I guess I could do them if I had my own separate office. Some of those procedures don't even involve invasive procedures like diagnostic testing by ultrasound for bladder function. I won't go through the whole list of them, but for example, you know, what we do is

imaging. We do imaging to drain people's lungs from fluid, or drain fluid from around people's lungs.

I can - we haven't been able to do that for years, because we can't get reimbursed for the $500 or $600 wholesale cost, or retail to me cost of the kits. But now we're being told that we can't even do the procedure if we want to because we won't get reimbursed for anything. And it includes other things like breast biopsies and a whole host of other outpatient procedures, even abscess drainages or replacing patient feeding tubes. And this is a real inconvenience because if I see somebody in my clinic on an afternoon, I sometimes have to send them to a hospital a day later and they have to drive 20 miles to get these things done.

And I guess my question is I don't understand why these rule changes have been made to specifically exclude us if there is such a thing as a rural designation for an independent diagnostic testing center. And if there's any way that I can talk to somebody or we can work with this to try to get some of these policies rescinded I guess, or a waiver. Thank you. Hello? Are you kidding?

John Hammarlund: Do we have any...

Dr. (Jesse A. Cole): Oh, there you are. I thought I lost you.

John Hammarlund: Yes, no. No, just I'm checking to see if we have anybody in Baltimore who can address this question. If not, what we'll do is we'll make sure - we may ask you to submit it in writing and then one of the things I can do is try to

connect you up with a rural health coordinator that we have in the Denver regional office, that covers Region 8, and we can begin the dialog that way.

Dr. (Jesse A. Cole): That would be great. I know that Meridian does something in North Dakota, and I've kind of reached out to them. But to be honest, I really don't understand all the bureaucracy, but this is really important to us and our patients.

John Hammarlund: No, I understand. Anybody in Baltimore? So let me do this.

Man: Hey, John.

((Crosstalk))

John Hammarlund: I'm going to spell very slowly, the name of the Rural Health Coordinator in our Denver Regional Office. I'd like to ask that you reach out to her. And then we'll see what we can do to begin the dialog.

Dr. (Jesse A. Cole): Okay.

John Hammarlund: Okay. Her name is Jeannie Wilkerson. So, her email address is J-E-A-N-N-I-E, that's the Jeannie part, dot W-I-L-K-E-R-S-O-N, Jeannie.Wilkerson@CMS.HHS.gov. She's one of the Rural Health Coordinators. We have one in every one of the ten regional offices. And her job among other things, is to help have a dialog with folks like you, to see if we can get some answers to your questions.

Dr. (Jesse A. Cole): Okay. Thank you very much.

John Hammarlund: You're very welcome.

Coordinator: At this time we have no further questions in queue.

Jill Darling: All right. Well, thank you, everyone, for joining us today. We appreciate our speakers on our topics, and our callers as well for listening in. If you do have any future topics you'd like for us to potentially discuss, please send them into RuralHealthODF@CMS.HHS.gov. Have a wonderful day, everyone. And have a great Thanksgiving next week.

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