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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016
By electronic submission at http://www.regulations.gov

RE: 42 CFR Part 405, 410, 411, 414, 415, and 495: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to the proposed rules regarding the Medicare program and Physician Fee Schedule. Our comments are limited to rural-specific issues and are structured to parallel questions posed, or issues stated, by CMS (not technical comments regarding specific sections of the proposed rule).

Overall, the Panel supports efforts to improve the Physician Fee Schedule, the Medicare Shared Savings Program, and other issues highlighted in this proposed rule. Medicare represents a higher proportion of patients for most rural health care organizations and clinicians than in urban areas, so Medicare policies may have a disproportionate impact on rural providers, hospitals, and beneficiaries. Therefore, we hope our comments below serve as valuable input during the proposed rule finalization.

Telehealth Services

The Pane is supportive of CMS's proposal to expand access to home dialysis as appropriate sites for telehealth services as well as the use of telehealth for individuals with a stroke, since both conditions are prevalent among rural Medicare beneficiaries.

Bundles Episode of Care for Management treatment for Substance Use Disorders (SUDs)

Bundled payment is not a methodology that necessarily works in rural settings, since the full range of services and support most often necessary to successfully implement a "bundle" are not always available in

rural communities; and it is the Panel's hope that CMS consider additional rural relevant payment models to help address Substance Abuse Disorder. However, if a bundled payment methodology is developed, rural health systems should have the option for voluntary participation.

Evaluation & Management (E/M) Coding Structure and Payment

CMS proposes removing the requirement for medical necessity documentation for home visits. The Panel agrees that the CMS proposal will reduce documentation burden on rural providers whose patients may have fewer transportation options. CMS is proposing to create a single rate under the Physician Fee Schedule (PFS) for CPT codes for level 2 through 5 E/M visits. If rural patients have a greater number of chronic diseases treated during an office visit, and the proposal would collapse all five office visits codes into one code, it would limit a rural provider's opportunity to be paid additionally for more complex patients. Providers will be incented to see as many patients as possible in as little time as possible. Consequently, we caution CMS to consider the unintended consequences this particular proposed rule may cause.

The Panel agrees with the following proposals: expanding the policy that allows physicians to review previously documented information and focus their documentation on what has changed since the last visit, rather than re-documenting a defined list of required elements; allowing the practitioner to indicate they reviewed and verified the patients' medical record regarding the chief complaint and history that was entered by ancillary staff or the beneficiary; and CMS's proposal that states providers will not need to re-record parts of the elements as long as there is proof the practitioner reviewed and updated the previous information.

CMS' proposal to develop a single set of RVUs for E/M office-based and outpatient visit levels 2 through 5 for new patients and a different set for established patients will require much additional research. The Panel supports development for review only, but with broad stakeholder input. The same cautions should apply to emergency department E/M codes as to office-based and outpatient visit codes. Moreover, collapsing codes will encourage quick office visits for single medical issues. This may be particularly problematic for rural patients with multiple medical concerns.

If changes to the CPT coding system are implemented, the Panel encourages CMS to delay the implementation of their proposed E/M visit policies until January 1, 2020 because updating clinic (and hospital) processes and EHR systems will take considerable time and expense, proportionally more for rural practices and hospitals.

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

The Panel agrees with CMS's proposal, for providers billing under the PFS, to separate payment for certain communication technology-based services such as remote evaluation services conducted via pre-recorded "store and forward" video or image technology. Particularly in rural areas, "store and forward" lessens geographic restrictions. In addition, the Panel agrees with CMS's proposal to provide payment to practitioners that use remote evaluation services when at least five minutes are furnished by an RHC or FQHS provider to a patient that has been seen in the RHC or FQHC within the previous year. Furthermore, the Panel also supports CMS' proposal to create a new Virtual Communications G-code for use by RHCs and FQHCs only. Lastly, the Panel is in strong favor of CMS' proposal to waive the RHC and FQHC face-to-face requirements when these services are furnished to an RHC or FQHC patient. However, these proposed rules should be extended to all clinics, not just RHCs and FQHCs.

Stage 3 Meaningful Use Measures for Medicaid Eligible Professionals (EP)

CMS is proposing to change objective 6 (Coordination of Care Through Patient Engagement) and acknowledges the challenges that many rural practices have with the "view, download, transmit" measure. The Panel supports keeping the thresholds at five percent, rather than increasing to 10 percent and 25 percent as scheduled. At the same time, technical assistance should be made available for rural clinicians to continue to advance their use of EHRs and patient portals, and efforts should be made in the EHR vendor certification process to assure that certification requirements are designed and implemented in such a way to support that EHR options are available which are relevant to and useable by rural practices at the appropriate scale, price, and technical support levels to continue to increase adoption and effective use for quality improvement and patient engagement.

Updates to the Quality Payment Program

Regarding CMS's proposal to remove 34 quality measures and add 10 new MIPS quality measures, the Panel urges CMS not to remove measures that are topped out for some, but not others. In addition, CMS is proposing a tiered scoring system for quality measures where measures would be awarded points based on their value. The Panel believes that adding additional complexity to the scoring system may make it less workable, especially for under-resourced rural practices.

The Panel thinks that the use of claims data, where CMS is proposing to allow small practices to continue using the Medicare Part B claims collection type, should reduce rural practice burden if those claim data accurately reflect quality of care delivered. Additionally, the Panel agrees with CMS that small practices should continue to choose to participate in MIPS as a virtual group. Nonetheless, the Panel would like to bring up anecdotal observations they have made for CMS to consider, which seems to show a focus on small practices but not necessarily rural or underserved. The primary criteria are less than or equal to 15 clinicians and many CAHs do not meet this threshold. At least in Minnesota, much of the small underserved rural (SURs) support has been with small specialty clinics (because the criteria is all about size).

Eligibility Threshold for the MIPS Program

The Panel appreciates the attempt to increase flexibility and reduce the burden on MIPS eligible clinicians in small and solo practices (many of which are in rural areas) by attempting to modify the definition of the low-volume threshold. Rural providers face unique challenges because of the lack of infrastructure, flexibility, and resources to quickly adapt to the Quality Payment Program (QPP) requirements. Therefore, providers ineligible for MIPS lose an opportunity to learn and implement value-based care delivery and cannot realize potential MIPS bonuses. The Panel recommends that CMS consider further research and analysis regarding the unintended effects of changing the definition of low-volume threshold. The Panel is in favor of an opt-in option even for practices that fall below the low-volume threshold so that they can still participate. Finally, we encourage CMS to focus on continuing to find ways to support rural providers and offer resources requisite to meet MIPS reporting criteria and other requirements.

The Panel recognizes that QPP objectives include improved health outcomes, smarter spending, reduced burden of participation, and program fairness and transparency. Furthermore, the Panel recognizes that current proposals are designed to increase flexibility and allow clinicians to choose QPP participation in a way that is best for them, their practice, and their patients. As CMS continues implementing provisions of the QPP, the Panel recommends that CMS consider unique rural provider situations while furthering QPP goals. As fewer rural clinicians (and all clinicians) participate, it becomes less likely that the QPP objectives of increased reporting, transparency, and quality improvement will be broadly achieved.

MIPS Performance Category Measures and Activities

The opioid crisis has disproportionately affected rural communities. Therefore, CMS' proposal to further clarify the types of outcome measures that are considered high priority and to include quality measures that relate to opioids is commendable and imperative. However, the Panel believes that outcome measure use is hindered by fewer outcomes (than process completions) during a measurement period. This is particularly true in low-volume rural areas. Thus, "outcomes" must be sufficiently prevalent in low-volume practices to be statistically reliable and actionable by the MIPS clinician.

Promoting Interoperability Performance Category Measure

The Panel supports aligning the Medicaid quality measure requirement (formerly known as Medicaid Meaningful Use) with the Medicare MIPS quality measure reporting requirements. For 2019, CMS is proposing that Medicaid Eligible Professionals (EP) would report on any six eCQMs that are relevant to the EPs scope of practice, regardless of whether they report via attestation or electronically. From a rural perspective, we support the continued ability for EPs to report via attestation, since many rural clinics are not able to submit electronically.

The Panel commends CMS' continued work on these critical issues and we thank you for the opportunity to submit comments prior to the finalization of this proposed rule.

Sincerely,

The Rural Policy Research Institute Health Panel

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