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August 25, 2015
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
P.O. Box 8012
Baltimore, MD 21244-8016
By electronic submission at http://www.regulations.gov

RE: 42 CFR Parts 405, 410, 411, 414, 425, 495: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

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 offer comments in response to questions posed by CMS in the Proposed Rule regarding Payment Policies in the Physician Fee Schedule and Other Revisions. Our comments are limited to rural-specific issues and are structured to parallel the general questions posed by CMS (not technical comments regarding specific sections of the proposed rule).

Improved payment for care management services (p 41708-10)
We applaud the commitment to supporting primary care and recognizing care management as a critical component of primary care and the importance of integrating behavioral health care. We support establishing additional codes to reflect time in excess of the typical encounter. Specific payment for care coordination should serve as a transition to a payment system based on risk-adjusted capitation and clinical quality, not based on fee-for-service.

Reducing the administrative burden for CCM and TCM services (p 41711)
The administrative burden of compliance is proportionately higher for small rural practices. Therefore, calculations of administrative costs need to consider ability to absorb the burden, even if it is thought to be a small percentage of total payment.

Payment for CCM services delivered by FQHCs and RHCs (p 41794-7; §405.2462)

We have commented previously on the need to develop a CCM payment policy that incorporates FQHCs and RHCs and therefore strongly support this rule.

Requiring RHCs to file HCPCS (p 41797-8)
We support requiring this reporting.

Additional quality measures (p 41815)
We encourage CMS to follow the recommendations of National Quality Forum report, "Performance Measurement for Rural Low-Volume Providers."

Hospital, FQHC, and RHC support for recruitment and retention (pp 41910-13)
We support allowing the new exception by hospitals and FQHCs to physicians employing nonphysician practitioners. We urge CMS to consider expanding the definition of services beyond "primary care services" to include behavioral health providers, for whom there is acute need in shortage areas. We concur with the proposed approach to define service areas for FQHCs and RHCs (p. 41913) with one clarification: the geographic area served by the FQHC or RHC may include one or more zip codes from which it draws no patients, provided that such zip codes are entirely surrounded by zip codes in the geographic area from which it draws at least 90 percent of its patients. We support using patients rather than encounters to determine service area. However, we are concerned that the methodology does not take into consideration potential patients. A primary reason for a provider entity to contract for services may be to add patients or expand in a given rural or frontier area. The methodology should take into consideration efforts to improve access for patients rather than looking solely at existing market penetration.

Advance Care Planning (p 41773)
We support activating the advance care planning codes for physicians, and making those services option (and paid) as part of the annual wellness visit. For many patients, care at end of life can involve treatment which is not aligned with patient preferences. For rural residents, honoring end-of-life care preferences is even more important. In addition to the demographics of rural Medicare beneficiaries (who are generally older and more frail), rural health care often involves travel and overcoming access issues to tertiary care and specialists which increase cost and burden for patients, families, and the health care system. Rural providers and their patients are well served to do advance care planning, and should be paid for the time and effort to carry out these often difficult planning and preference conversations.

Sincerely,

The Rural Policy Research Institute Health Panel

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