NOSORH

National Organization of
State Offices of Rural Health

September 2, 2016

Centers for Medicare & Medicaid Services

SUBJECT: CMS Physician Fee Schedule NPRM 1654-P

To Whom it May Concern:

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health. Our mission is to work with the fifty State Offices of Rural Health to improve health in rural America. State Offices of Rural Health are anchors of information and neutral observers and conveners for rural health. They support collaboration, information dissemination and technical assistance to rural communities and health care providers across the nation including critical access hospitals, certified rural health clinics, oral health and other providers.

NOSORH submits these comments to ensure the unique needs of these rural providers and their important role in improving care for millions of rural Americans is understood.

Thank you for the opportunity to comment. If we can provide additional information on the impact of proposed regulations for rural and underserved communities and the providers who serve them please feel free to email teryle@nosorh.org or call for assistance.

Sincerely,

Teryl Eisinger

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National Organization of State Offices of Rural Health

Draft NOSORH Comments on the Proposed Rule Affecting the Medicare Physician Fee Schedule

Introduction

The Notice of Proposed Rulemaking (NPRM) CMS–1654–P published by the Centers for Medicare and Medicaid Services (CMS) on July 16, 2015 proposes new and revised provisions related to the Medicare Physician Fee Schedule and other issues. Several of these provisions will have impact on health service providers in rural communities. In this communication the National Organization of State Offices of Rural Health (NOSORH) makes specific comment on how the proposals in the NPRM would affect these rural providers and submits recommendations on how the requirements can be implemented in a way which does not create unanticipated problems for the nation's rural health system.

General Comments: **NOSORH strongly supports reimbursement changes which accurately reflect the real costs of providing health care in rural communities**. Appropriate reimbursement levels are essential to sustaining an adequate rural health system. Without an adequate health system residents of rural communities would need to travel to secure basic health services. This would impose significant additional time/cost burdens on these residents, likely reducing their timely use of health care. The ultimate result of reduced access would be delayed use health services, which can result in a sicker population – costing both the individual and the overall health economy.

To the degree that any proposed physician fee schedule changes reduce reimbursement for rural providers below the actual costs of providing basic care, they could be damaging to rural community residents. It is difficult to estimate the actual impact of readjustments to the physician fee schedule on all rural providers. **NOSORH recommends that CMS closely monitor the results of the proposed changes on the rural health system, conducting study of the impact on rural providers and consulting with representatives of the rural sector including the National Advisory Committee on Rural Health and Human Services.**

Specific Comments and Recommendations: NOSORH sees many positive changes in the provisions of the proposed rule which should help the rural health system. NOSORH's comments and recommendations on specific NPRM sections follow:

- **Chronic Care Management (CCM), Transition Care Management (TCM) and Evaluation and Management (E/M)**: CMS is proposing modifications to the reimbursement of these types of outpatient care coordination that de-emphasize the need for after-hours access to electronic health records. The change is apparently a response from rural practitioners who felt that the requirement for 24/7 access to care plans through EHR was burdensome and possibly inappropriate for rural communities. The new proposed rule allows alternative means of communicating the care coordination plan after-hours, including fax. This should be helpful for rural practices.

  In addition, CMS proposes adding and re-valuing codes for these services, including services for those patients with behavioral issues or cognitive impairments. This should be a net improvement for rural practices conducting primary care medical home activities. **NOSORH supports all these proposed changes.**

- **Telehealth**: The NPRM proposes several additions to the list of Medicare approved telehealth procedure codes. Many of these affect outpatient monitoring of discharged patients. Overall the additions to the list are a net positive for rural practices. In its proposed rule CMS also clarifies the coding for telehealth originating sites vs. remote sites.

It should help the process of telehealth billing. **NOSORH supports these proposed improvements.**

- **Geographic Practice Cost Indexes (GPCIs)**: CMS is updating its geographic cost adjusters for payment. It proposes continuing the same basis of analysis for most costs, and includes a 'floor' for adjustments for five frontier states - Wyoming, Montana, Nevada, North Dakota and South Dakota. This will provide a measure of payment stability for these states similar to that provided to Alaska under other statutory authority. While these changes do not significantly change the ongoing question of regional payment equity, it should be a net positive for many rural providers. **NOSORH supports the proposed changes and recommends that CMS monitor how the GPCI calculation changes affect the sustainability of health services in rural communities.**

- **Required Data Collection**: CMS proposes to require all practitioners who furnish a 10- or 90-day global service to submit a claim(s) providing information on all services furnished within the relevant global service period. In addition, CMS proposes to require participation by practitioners selected for the broad-based survey through which we are proposing to gather additional data needed to value surgical services, such as the clinical labor and equipment involved that cannot be efficiently collected on claim. This will increase burden on all a subset of all provider practices, including rural ones. It is difficult to say if the additional reporting requirement will be particularly burdensome to rural practices. NOSORH recognizes the importance of having accurate cost data. **NOSORH recommends that CMS consult with representatives of rural providers to assure that the proposed reporting requirement is not unduly burdensome for the rural health system.**

- **TCM and CCM in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**: CMS clarifies the requirements, including supervision, associated with the reimbursement of FQHCs and RHCs for TCM and CCM. The proposed rule appears to be fairly straightforward, providing clarity in what is expected related to these services. On the face of it there does not appear to be any particular negative impact on these types of rural provider. The clarification about CCM being delivered under the general supervision of an RHC provider is particularly helpful.

  While the handling of patients with newly developed care management plans is outlined in the NPRM, it is less clear how claims for patients in FQHCs and RHCs with pre-existing care management plans should be handled. **NOSORH suggests that CMS insert additional language in the NPRM permitting claims for services these patients.**
- **Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT)**: Diabetes is a major issue for residents of rural communities. The proposed provisions in the NPRM for extending the DPP and DSMT efforts should be a significant benefit for rural patients with diabetes. NOSORH has consulted with the National Association of Rural Health Clinics (NARHC) and learned that there are potential barriers which can impact the extension of the DPP and DSMT programs in RHC settings. **NOSORH recommends that CMS examine the analysis of these issues to be provided by NARHC in its comments on the NPRM and modify the rule's provisions to permit the extension of these programs in all rural practices, including RHCs.**