National Organization of
State Offices of Rural Health

August 24, 2018

TO: Centers for Medicare & Medicaid Services

SUBJECT: Proposed Rule for Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) CMS 1693-P

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health (SORH). 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. SORH are dedicated to addressing the issues that impact access to care and ensuring the vitality of hospitals, clinics and providers who serve nearly sixty million rural Americans. SORH support collaboration, nformation 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 are to ensure issues that the unique issues which impact practices throughout rural America are 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,

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Executive Director
National Organization of State Offices of Rural Health

NOSORH Comments on CMS Revisions to

Payment Policies Under the Physician Fee Schedule

Overview

On July 27, 2018 the Centers for Medicare and Medicaid Services (CMS) published proposed rules identifying Revisions to Payment Policies Under the Physician Fee Schedule for the Medicare Program (CMS–1693–P). In this communication, the National Organization of State Offices of Rural Health (NOSORH) makes specific comment and recommendation related to these proposed rules.

NOSORH's comments are specific to the sections of the proposed rules which propose changes to Medicare payments for Communication Technology-Based Services and Remote Evaluations. NOSORH's comments will address implications of these payments for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The comments will explore how the new categories of service integrate with other FQHC and RHC services billed under an All Inclusive Rate (AIR).

General Comments

Benefit to Rural Patients: NOSORH is strongly supportive of the proposed additions to billable FQHC and RHC services. Any approach which can lead to elimination of unnecessary clinical visits is of particular importance to residents of rural communities. Rural residents generally face higher travel costs in making clinical visits than do urban residents – both in terms of the costs of conveyance as well as costs of travel time needed to get to a clinical site.
Many rural communities lack adequate public transportation, and rural residents rely more heavily on automobiles. If a rural family has only one vehicle and that vehicle is normally used by a household member to get to work, the need to get to a distant health care provider can create significant logistical and financial issues. Rural families may need to forego a day of work to get the sick patient to health care, or secure a ride from someone else – either on a voluntary basis or for pay. This is challenging, particularly for rural families with limited means. The addition of services which can reduce unnecessary clinic visits is of major financial benefit for rural residents.

Benefit to FQHCs and RHCs: NOSORH recognizes the potential financial benefit for FQHCs and RHCs. Both FQHCs and RHCs are important mainstays of the rural health care delivery system. Any reimbursement modifications which help them are important to rural communities. The proposed changes will permit these health care providers to bill Medicare for services which previously went uncompensated. This additional revenue is a benefit to these health care providers who often face challenges to their financial sustainability.
More importantly, services which help eliminate unnecessary visits will help FQHCs and RHCs improve their ability to serve rural communities. Many FQHCs and RHCs are in federally-designated health care underserved areas where the local supply of health care services cannot meet the demand for these services. To the degree that communications technology based services and remote evaluation can prevent unnecessary visits, they will free up capacity in FQHCs and RHCs that can be used to better address unmet needs.

Specific Comments

Potential Administrative Burden: The proposed rules establish look-back and look-forward restrictions on the eligibility of these billable services. A service is billable only if it is not related to a clinical visit in the last 7 days, and additionally, if it is not related to a clinical visit in the subsequent 24 hours. These restrictions will create additional administrative burdens for FQHCs and RHCs. Rather than billing immediately for services, FQHCs will need to review prior patient clinical activity, assess the diagnostic category of any recent activity and then delay for 24 hours to

ascertain whether the service is followed by a clinical visit. Most computer billing systems are not set up for this type of review and a supplemental billing process will need to be appended to existing systems. Given the relatively low rate of reimbursement for communications technology-based services and remote evaluation, the cost of this supplemental billing process is significant.

NOSORH recommends that the extent of the increased administrative burden associated with the proposed changes be examined in greater depth by CMS. NOSORH further recommends that the look-back and look-forward restrictions be modified, as discussed below.

<u>Look Back and Look Forward Restrictions</u>: NOSORH believes that the restrictions proposed on billing of these services should be thoroughly examined.
The 7 day look-back period proposed is problematic. A calendar-based limit on related follow-up contacts to a clinical visit is somewhat arbitrary, and may not reflect the clinical reality. Furthermore, there is a contradiction inherent in making a communications-based technology or remote evaluation services ineligible for 7 days after a clinical visit. A patient can return to a FQHC or RHC the day after a clinical visit for the same reason and that visit will be reimbursed at the full AIR. There is no 7-day limitation on related face-to-face follow-up visits. In contrast, a related communications-based technology or remote evaluation service delivered during this period would not be eligible for reimbursement – even if it prevented a more expensive face-to-face visit. Placing a 7-day limitation on communications technology or remote evaluation services restricts their potential usefulness.

NOSORH believes that if a follow-up face-to-face FQHC or RHC visit during a 7 day window is not considered, for billing purposes, as part of the previous visit under the AIR, a communications based technology or remote evaluation service should be considered similarly.

To the degree that the communications technology based or remote evaluation service appropriately prevents an unnecessary visit, it leads to a savings – both for Medicare and for the patient.

NOSORH recommends that the 7 day look-back restriction be eliminated.
NOSORH believes that the 24-hour look-forward restriction is more appropriate, given the all-inclusive rate of payment for RHCs and FQHC. A communications-based technology or remote evaluation service that is followed by a face-to-face visit within a day could be considered as connected to that visit and included within the AIR. From an administrative point of view, this would create limited problems – a relatively small one day delay in billing.

<u>Frequency Limitations</u>: NOSORH does not believe that there is a need to impose any frequency limitations on the number of billable communications technology-based and remote evaluation services. These services are distinct from those billed under the FQHC and RHC AIR, and are reimbursed at a significantly lower level. There is little financial incentive for overuse of these services.

NOSORH recommends that the proposed reimbursement be implemented without any frequency limitations. CMS can monitor the implementation to assure that there is no inappropriate use of the new reimbursement.

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