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September 27, 2019

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW, Room 445-G  
Washington, DC 20201

**Re: Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations**

Dear Administrator Verma,

The National Rural Health Association (NRHA) is pleased to offer comments on the CMS proposed rule for the physician fee schedule for calendar year 2019. We appreciate your continued commitment to the needs of the 62 million Americans residing in rural and underserved areas and look forward to our continued collaboration to improve health care access and quality.

NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and patients. We work to improve rural America's health needs through government advocacy, communications, education and research.

We appreciate CMS' continued emphasis on narrowing the gap between rural patients and the providers. This letter outlines suggestions for which the NRHA believes this NPRM can be strengthened. We look forward to our continued collaboration in ensuring the one-quarter of Americans living in rural areas have access to critical health care services in their local communities and rural providers receive the equitable reimbursements they deserve.

**NRHA supports the proposal to establish a Medicare Ground Ambulance Services Data Collection System to ensure setting more accurate payment rates.** As rural hospitals continue to close, there is an increased strain being placed upon emergency services, and ambulatory transports in particular. Especially when it comes to Critical Access Hospitals, which have to transport a patient within a 96-hour time frame, transport services are heavily burdened. Many times, a rural ambulatory provider will face longer average trips due to terrain, low quality roads and other unique rural factors.

The proposed 50 percent increase being made permanent in standard mileage rate for ground ambulance transports that originate in rural areas will be crucial for emergency services in rural areas. As NRHA is supportive of this change made permanent.

**While NRHA is pleased low volume rural providers are not mandated to participate in a program designed for large practices, this exclusion hurts small rural practices that will receive a no positive payment updates while medical inflation reduces the value of those payment, resulting in a de facto reimbursement level cut.** NRHA understand and appreciates that the low volume exemption was intended to serve as a carve out for rural providers from a system that was not tailored to work for a variety of practice size and patient mix. However, the unintended, yet very harmful, effect of this is that the inability of practices to receive positive updates sufficient to maintain the value of current payments is a major concern. Rural providers serve a patient population that is older, sicker, and poorer than their urban counterparts. These providers are more reliant on Medicare payments as a result of this patient mix. These rural patients also tend to have a greater chronic diseases burden as well as a greater rate of acute illness such as cancer. These stealth payment cuts will threaten the financial viability of rural practice. This is particularly concerning since 77 percent of rural America is already a primary care health professional shortage area, a number not likely to improve with diminishing payments.

The majority of rural providers were initially pleased with the increased low volume threshold, which will exempt a majority of rural providers from the QPP program. Rural providers are providing excellent, high quality care to a vulnerable patient population. Due to the shortage of providers in rural America, these rural providers are focused on providing the direly needed care to their community without additional time to spend on creating a paper trail with the only purpose of providing to distant bureaucrat's documentation of the many valuable patient services they provide that are not compensated nor are they seeking to demonstrate just how sick their patient population is when they already know their patients and community. The resources required to document quality and value are instead spent by these clinicians providing quality and value in a way that best meets the needs of the community and patients they serve. Without positive payment updates, these exempt providers face a loss of 18 percent by 2026, a loss that will continue to grow thereafter.

**Small changes could allow the QPP program to work for more low volume providers including ensuring measures are appropriate for low volume and rural providers to encourage and expand rural participation and opportunity under the QPP program.** CMS should adhere to the recommendations outlined in "Performance measurement for rural low-volume provider: Final report by the NQF Rural Health Committee" dated September 14, 2015, which strongly recommends that rural providers are not exempt from this program. This report was created pursuant to HHS requesting the National Quality Forum to convene a multi-stakeholder Committee to identify challenges in healthcare performance measurement for rural providers and to make recommendations for mitigating these challenges, particularly in the context of CMS pay-for-performance programs. In August 2018, the NQF issued its set of rural relevant measures developed through a multi-disciplinary Measures Application Partnership (MAP) and sent them to CMS as a key recommendation in the 2015 report.

The need to create rural relevant measures does not suggest that there is a need to create separate measures for rural providers. Rural providers are often general practitioners that participate in a vast array of activities based on the need of their service population and on the resources available to their community. The selected core measures, however, must be applicable to these primary care practices and they must address the challenges of these practices. Specifically, to encourage participation by rural providers, these measures must:

- address low case volume;
- facilitate fair comparisons for rural providers;
- address actionable activities for rural providers;

- require feasibility for data collection by rural providers;
- exclude measures that have unintended consequences for rural patients;
- address areas of high risk for patients;
- support local access to care;
- be evidence-based;
- address areas where there is opportunity for improvement;
- be designed to be suitable for use in internal quality improvement efforts; and
- align with other programs.

The central aim of these core measures is to support the provision of better and affordable care, and to support healthier populations and healthy communities. Clearly, these requirements are not unique to rural practice settings. The challenges experience by rural providers, however, must be considered when selecting both core and optional measures.

Many rural hospitals and clinician practices are small, with limited time, staff, and finances available for quality improvement activities, including data collection, management, analysis, reporting and improvement. In many rural areas, few individuals have the specialized technological skills (e.g., ability to use EHRs or registries for measurement calculation/improvement) and/or quality improvement skills to use measurement results to drive improvements in care. Lack of financial resources also impacts their ability to invest in HIT infrastructure and in quality improvement initiatives. Finally, those who serve in small hospitals and practices often have multiple, disparate responsibilities (e.g., direct patient care, business and operational responsibilities, etc.) that compete with quality improvement activities. However, it is possible to develop measures that do not penalize rural providers for the realities of rural practice. We support changes that incentivize participation in this program by low volume, rural providers, as these practices benefit from participation in this program, despite the challenges of doing so.

**Additionally, NRHA urges performance comparisons between equivalent cohorts. This modest change would allow small and rural practices participating in the QPP program the opportunity to be compared with their peers.**

NRHA is pleased with the support expressed for small, independent practices. While NRHA is pleased with the bonus points for small practices, we are concerned this bonus will not be sufficient to overcome the disparities that current separate small rural providers from large urban providers. Our experience with smaller primary care practices shows they have fallen behind larger practices in terms of practice with data collection and analytics and quality reporting of the metrics included in the QPP. This is not to say these providers are not providing the necessary and appropriate care to their patients, but that they have not put in place the infrastructure to provide care based on the requirements of the QPP and ensuring they are maximizing their scores.

Large practices have long been involved in the type of population health management programs that small practices are just beginning to implement today. They are active participants in Medicare Advantage programs, which cover 1/3 of beneficiaries, and are accustomed to wellness visits, care coordination and comprehensive diagnosis coding of their patients to accurately reflect their chronic conditions. In contrast, most independent providers do not have those processes in place and still believe that it is morally wrong for them to record more than the “reason for visit” diagnosis on a claim, causing the HCC scores of their patients to be significantly below average. This problem was pointed out in MedPAC’s 2012 report on rural programs, and is proven again by our data. Although it is widely published in peer-reviewed research that rural patients are sicker and poorer than the rest of the country, of our 23 rural ACOs, six have HCC scores below 1.0.

**NRHA is supportive of the office/outpatient evaluation and management (E/M) Coding and CMS' efforts to reduce regulatory burden.** NRHA supports the adoption of the work relative value units (RVUs) recommended by the RVU Update Committee (RUC) for all the office/outpatient E/M codes, the new prolonged services add-on code, and CMS' proposal to maintain separate values for levels two through four visits rather than implement its plan for a blended payment rate for those services. Most rural providers are operating on slim margins, over 46% are operating at a loss according to the UNC Shep's Center, and the services they provide have undervalued for decades. We implore CMS to implement the changes in 2020, rather than 2021 as proposed in the rule.

**NRHA is concerned about proposed changes to MIPS cost measures.** NRHA is comprised of members in rural areas, providing essential care to their small communities. We remain concerned about the impact of outlier, high-cost cases on these practices and their performance on cost measures—and we offer recommendations to mitigate these potential impacts. We are also concerned about the potential for overlap between the total cost of care and episode-based measures as primary care physicians will be measured on total costs that also include episodes. This discrepancy would hold primary care physicians doubly accountable for costs, particularly on episodes where they are unable to control costs. Rural physicians provide a broader range of primary care services that would often be referred to specialists in urban areas. These primary care providers save Medicare money, while providing excellent care to beneficiaries without the need for burdensome travel.

**NRHA urges CMS to provide more Advanced APM options for rural providers to be able to move towards value-based care.** NRHA is cautiously optimistic about CMS' recent announcement of the Primary Care First (PCF) initiative and its potential to strengthen access to comprehensive and coordinated primary care. But the association is concerned over the delayed timeframe. However, we continue to believe more Advanced APM options must be available to primary care physicians to move the Medicare program towards value—especially for rural providers.

Smaller and rural providers lack resources or the expertise needed to transition to a value-based payment model could benefit from technical assistance from the government. Additional help to providers would be the opportunity to test out their alternative payment models on a small scale prior to full implementation. Most physicians have experience changing care delivery but have not been trained in the development of incentives, payment models or risk management. Large health systems may have the resources and expertise to develop and implement these models that address both the clinical and payment elements such as determination of payment amounts, risk sharing and risk adjustments. Small and rural practices are at greatest risk of not being able to afford the technical support to redesign care and payment or the infrastructure and human capital investments needed to successfully assume risk and participate in alternative payment models.

**NRHA is concerned about the impact the changes to the Geographic Practice Cost Indices (GPCIs) will have on rural providers.** With the loss of the 1.0 PW GPCI Floor in some areas and adjustments to the PW, PE, and Malpractice GPCIs, rural Iowa providers stand to lose approximately \$22.5 million in Medicare payments. NRHA realizes that CMS is required by statute to recalculate GPCIs every four year, but instead of the proposed changes to the GPCIs, NRHA supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in rural areas). A cursory examination of the proposed geographic adjustment factors (GAFs) shows that the GPCIs tend to favor urban and suburban localities over their rural counterparts, even though the latter tend to be underserved. Among the 20 lowest GAFs when the proposed GPCI's are fully implemented in 2021, all represent states or portions of states that are predominantly rural, while among the 20 highest GAFs, all but one (Alaska) represent urban or suburban localities. Thus, the GPCI structure works at cross purposes to the health professional shortage area (HPSA) bonus and other incentives intended to encourage and support rural physicians. We believe rural Medicare beneficiaries would be better served if GPCIs were eliminated from the MPFS, so the HPSA bonus and other incentives are not

undermined in their efforts to sustain the rural physician workforce needed to care for those beneficiaries. NRHA will continue efforts with Congress to

**NRHA is supportive of CMS' general care management services codes for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs).** The association is encouraged by CMS' intent to set the payment for code G0511 at the average of the national, non-facility payment rates for codes GCCC1, GCCC3, and 99484, if CMS otherwise finalizes its proposals related to GCCC1 and GCCC3.

### **Feedback on MVP proposal:**

**NRHA is appreciative of CMS' acknowledgement of the complexity within MIPS and their willingness to improve the program by providing ECs with more timely and meaningful performance feedback that can be used for continual quality improvement and care management.** We are supportive of the goals of the four guiding principles for MVPs. However, we note that while the MVP structure may reduce burden related to selection of measures, it does not necessarily reduce the overall burden of the program. As currently structured, MIPS ECs will still need to report each category separately. We believe CMS could further reduce reporting burden by incorporating multi-category credit into the MIPS and/or MVP structure. CMS' goal should be to reduce overall program burden—not only burden associated with selecting measures and activities. Additionally, NRHA believes MIPS complexity and the complexity of quality measure choice is not the biggest barrier to APM participation. One of the major barriers continues to be there are not enough APMs in which a physician can participate. In addition, many small practices are not equipped to handle the financial risk of an Advanced APM. However, a restructured MIPS program could better prepare these practices for the transition to an APM. We strongly urge CMS to carefully consider the impact of MVPs on rural providers.

Regardless of MVP, practices that attest to PCMH recognition or accreditation should receive full credit in the improvement activities. We believe a specialty medical home designation alone, in the absence of a primary care medical home, is not sufficient to earn automatic improvement activities credit. Specialty practices support and complement a primary care medical home, but do not replicate all aspects of the medical home, and do not replace the need for a primary care medical home. **Small and rural practices should also receive the same flexibilities in the improvement activities category provided to them in the current MIPS structure.**

### **Request for Information on Potential Opioid Overuse Measure:**

**Would you select this measure to support your quality measure initiatives?** NRHA is not supportive of this performance measure. We oppose measures that address specific milliequivalents among patients currently on opioids. There is a lack of agreement and evidence in the scientific community on measures that cite specific dosages. There are unintended consequences (i.e., patients being stopped abruptly, refusal to accept patients with an opioid use disorder [OUD], refusal to prescribe opioids completely even in situations in which benefits might outweigh risks). Considering recent feedback from the CDC, AMA, and speakers at the CMS Quality Conference, experts have suggested that use of morphine milligram equivalents (MME) in quality measures is too prescriptive, difficult to locate in the EHR, and inadvisable for use in performance measures. A >90 MME/d cut off must be applied cautiously to a provider of pain services in the context of a rural setting without ready access to adjunctive therapies and pain consultants to help treat those patients. A small, but certain number of chronic pain patients are receiving >90 MME/d of opioids and are in the process of tapering to the lowest effective dosage needed to control pain according to protocol. There are other “legacy” patients who have been through multiple procedures and are stable on a high dose—these are not the ones who seek medications unless forced to because of a forced taper. We do not believe we are yet ready for dosage-based opioid measures to be used for accountability without additional

evidence and testing, and without availability of complete prescription information to the physician at the time of prescribing. It would be more impactful to push real-time, complete prescribing data to providers using all-payer claims and prescription/pharmacy databases at point of care so physicians can accurately identify unsafe levels and can use this information to make patient-centered decisions, and thereby prevent unintentional over-prescribing in the first place. A primary care physician (or other clinician) might be careful in opioid prescribing practices but have limited control over patients getting large quantities of opioids from other clinicians. The physician may not know about other prescriptions and should not be held accountable for that. Aggregation of such data would allow identification of outliers but should not be used to assess provider performance without confirmation that the outlier status is unjustified. **There are a limited number of rural physicians that provide pain management therapy whose numbers may be high due to referral patterns.**

**Would you implement this measure in its current state? We do not recommend** implementation of this measure in its current state. Lack of insurance and availability is a real concern in rural areas, and alternative pain management therapies is a problem. As previously stated, some legacy patients that are stable must be excepted. We would prefer a measure that looks at compliance with the use of adjunctive treatments and/or compliance with pain management and opioid prescribing protocols Administrator Verma Page 40 of 61 September 18, 2019 (reinforced by National Academy of Medicine [NAM] tapering paper and the recent New England Journal of Medicine [NEJM] editorial from the authors of the 2016 CDC guideline on the misapplication of the 90 MME recommendation). We also agree with authors of the NEJM editorial that efforts should focus on “starting fewer patients on opioid treatment and not escalating to high dosages in the first place to reduce the numbers of patients prescribed high dosages in the long term particularly for new patients.”

**How can we improve the usability of this measure?** NRHA does not recommend implementation of this measure in its current state.

**NRHA is encouraged that CMS recognizes the need to revise the total per capita cost measure but has concerns before implementation.** While the revised measure addresses some of our previous concerns, we are still concerned with the appropriateness of this measure rural providers. Small and rural providers may have less influence on total costs for their patients. Small referral networks exacerbate this issue, particularly for rural practices, as physicians may not have the option of referring to a lower-cost specialist. CMS should provide additional protections for small and rural practices to mitigate the impact of outliers. CMS should also explore the appropriateness of comparing all physicians to all physicians for this measure. While CMS does make geographic adjustments when calculating the measure, it is unclear whether these are adequate. NRHA notes that these adjustments are based, in part, on GPCIs. We oppose the use of GPCIs as they tend to favor urban and suburban localities over their rural counterparts. We encourage CMS to minorize costs for small and rural practices at the 95th percentile, as opposed to the 99th percentile, to better protect against the random variation that will occur with smaller numbers of attributed beneficiaries. Smaller referral networks and the increased impact of outliers will always be concerns for small and rural practices and need to be accounted for in the measure design and implementation. The association is also concerned with the potential for measure overlap as it pertains to total cost of care and episode-based measures. Some MIPS ECs may only be measured on episode-based cost measures, while primary care physicians will be measured on total costs that include these episodes. This discrepancy holds primary care physicians doubly accountable for costs, particularly on episodes where they did not and could not control costs. NRHA strongly urges CMS and its measure development team to address this disparity before any implementation.

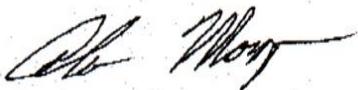
**NRHA urges CMS to extend protections for rural providers when considering the Medicare spending per beneficiary clinician measure.** CMS continues to believe the existing measure is appropriate to use in MIPS. CMS is proposing to change the attribution methodology to distinguish between medical episodes and surgical episodes. A medical episode is first attributed to the TIN

billing at least 30% of the inpatient E/M services on Part B claims during the inpatient stay. The episode is then attributed to any clinician in the TIN who billed at least one inpatient E/M services that was used to determine the episode's attribution to the TIN. A surgical episode is attributed to the surgeon(s) who performed any related surgical procedure during the inpatient stay, as determined by clinical input, as well as to the TIN under which the surgeon(s) billed for the procedure. CMS is proposing to add service exclusions to remove costs that are unlikely to be influenced by the clinician's care decisions. CMS is proposing to exclude unrelated services specific to groups of Medicare severity-diagnosis related groups (MS-DRGs) aggregated by major diagnostic categories (MDCs). CMS is proposing to include the revised Medicare spending per beneficiary (MSPB) clinician measure beginning with the CY 2020 performance period. As we are recommending for the total per capita cost measure, we ask CMS to extend protections for rural providers.

CMS has wisely focused on providing technical support for small and rural practices, which will hopefully narrow the gap between small and large practices. However, when these small and rural practices are exempt from the program and the potential bonus, especially in the light of stagnant reimbursements, they are absorbing the costs of reporting without the resources to change their clinical practice. In order to avoid punishing providers that are making the effort to adopt the new models of care, we propose that practices with 15 or fewer providers, and those with 16 or more providers, be divided into two distinct comparison groups. For future years, this cohort distinction could be modified based upon a statistical analysis to ensure practices are being compared with a peer group defined by their statistical ability to perform equally well under MIPS. CMS could then compare similar-sized provider groups to one another and calculate Hierarchical Condition Category scores and MIPS percentiles within each of the 2 distinct cohorts. This approach will promote a more rational comparison and may avoid levying penalties on providers simply by virtue of their small practice size. This will account for the differences in resources and care management development of the two groups, incentivize both groups to improve, and still identify those who are not making a reasonable effort.

Thank you for the chance to offer comments on this proposed rule, and for your consideration on our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care. If you would like additional information, please contact Max Isaacoff at [misaacoff@nrharural.org](mailto:misaacoff@nrharural.org), or 202-639-0550.

Sincerely,



Alan Morgan  
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National Rural Health Association

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