

Performance Measurement for Rural Low-Volume Providers

FINAL REPORT
by the NQF Rural Health Committee
SEPTEMBER 14, 2015



NATIONAL
QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0013.

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EXECUTIVE SUMMARY

Public and private healthcare purchasers and insurers increasingly use healthcare performance measures for various types of accountability applications, including accreditation, network inclusion/exclusion, public reporting, and payment incentive programs. Participating in performance measurement and improvement efforts, however, may be especially challenging for those who provide care in rural areas. Although rural hospitals and clinicians participate in a variety of private-sector, state, and federal quality measurement and improvement efforts, many quality initiatives run by the Centers for Medicare & Medicaid Services (CMS) exclude rural healthcare providers. In 2014, the Department of Health and Human Services (HHS) contracted with the National Quality Forum (NQF) to convene a multistakeholder Committee to identify challenges in healthcare performance measurement for rural providers and to make recommendations for meeting these challenges, particularly in the context of CMS pay-for-performance programs. The recommendations within this report are those of the multistakeholder Rural Health Committee convened by NQF.

Providers in rural areas face a number of challenges when delivering care and when engaging in performance measurement and quality improvement efforts. Many of these challenges stem from distance and from the diversity of rural areas. While many rural areas are relatively close to urban or suburban areas, many are not, and in fact, many are quite remote. Geographically isolated areas typically have fewer healthcare settings and providers than less isolated areas, and these very rural areas may experience difficulties due to transportation issues and lack of information technology capabilities. Multiple and disparate demands (e.g., direct patient care, business and operational responsibilities) compete for the time and attention of those who serve in small rural hospitals and clinician practices, and rural providers often have limited time, staff, and finances available for quality improvement activities. Many rural areas also have a disproportionate number of vulnerable residents (e.g., those with economic or other social

disadvantages, those in poor health, and those with poor health behaviors). This heterogeneity has particular implications for healthcare performance measurement, including limited applicability of measures that are appropriate for non-rural areas. Moreover, rural providers may not have enough patients to achieve reliable and valid performance measurement results. While urban areas may experience many of these same difficulties, in rural areas they likely pose greater challenges for, and have greater impact on, quality measurement and improvement activities.

Although rural hospitals and clinicians do participate in a variety of private-sector, state, and federal quality measurement and improvement efforts, many Centers for Medicare & Medicaid Services (CMS) quality initiatives systematically exclude some rural hospitals and clinicians from participation because they are paid differently than other providers or because of other measurement challenges. This exclusion

may impact their ability to identify and address opportunities for improvement in care and may deny rural residents access to information on provider performance. Moreover, exclusion of rural providers from the CMS quality programs prevents these rural providers from earning payment incentives that are open to non-rural providers.

Integrating rural providers into Medicare quality improvement programs now holds greater urgency in light of the recent legislative actions by Congress and regulatory and other efforts by HHS to accelerate the timeframe for achieving value-driven healthcare (i.e., paying providers based on quality and cost rather than on quantity).

In 2014, HHS tasked the National Quality Forum to convene a multistakeholder 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. The specific objectives of this project were to:

- Make recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians
- Make recommendations to help mitigate measurement challenges for rural providers, including the low case volume challenge
- Identify measurement gaps for rural hospitals and clinicians

Providers of interest for the project included Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Community Health Centers (CHCs), small rural non-CAH hospitals, other small rural clinical practices, and the clinicians who serve in any of these settings.

The 20-member **multistakeholder Committee** convened by NQF met via a series of webinars and a two-day, in-person meeting. The recommendations of the Committee are as follows:

Overarching Recommendation

The Committee agreed that non-participation in CMS quality improvement programs by rural providers deprives many rural residents of easily accessible information about provider performance, prevents many rural providers from earning payment incentives that are available to non-rural providers, possibly hinders implementation of comprehensive quality measurement efforts on behalf of rural residents, and potentially signals that rural providers cannot provide high-quality care.

Accordingly, the Committee's overarching recommendation was *to make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers but allow a phased approach for full participation across program types and address low case volume explicitly.*

Supporting Recommendations

The Committee also made several additional, stand-alone recommendations that will, if implemented, help to ease the transition to mandatory participation. These supporting recommendations are grouped into four topic areas, as follows.

Development of Rural-Relevant Measures

- Fund development of rural-relevant measures
- Develop and/or modify measures to address low case volume explicitly
- Consider rural-relevant sociodemographic factors in risk adjustment
- When creating and using composite measures, ensure that the component measures are appropriate for rural (particularly low-volume) providers

Alignment of Measurement Efforts

This recommendation encompasses alignment of measures, data collection efforts, and technical assistance and other informational resources.

Measure Selection

- Use guiding principles for selecting quality measures that are relevant for rural providers
- Use a core set of measures, along with a menu of optional measures for rural providers
- Consider measures that are used in patient-centered medical home models
- Create a Measure Applications Partnership (MAP) workgroup to advise CMS on the selection of rural-relevant measures

Pay-for-Performance Considerations

- For rural providers, create payment programs that include incentive payments, but not penalties
- Offer rewards for rural providers based on achievement or improvement
- Encourage voluntary groupings of rural providers for payment incentive purposes
- Fund additional work to consider how peer groups for rural providers should be defined and used for comparison purposes

The Committee made three additional recommendations specific to data collection and use that would benefit other quality measurement

and improvement efforts for both rural and non-rural providers.

In response to public and member comment, the Committee suggested a timeframe for the uptake of several of the Committee's recommendations by CMS. Specifically, the Committee recommended:

- immediate funding by CMS to develop rural-relevant measures and to consider how peer groups for rural providers should be defined and used for comparison purposes;
- creation of a rural health workgroup for MAP within one year (i.e., prior to the 2017 pre-rulemaking cycle);
- continuation of ongoing alignment efforts within the public sector and full private-sector alignment within three years;
- creation of incentive-only payment programs for rural providers within three years; and
- mandatory participation in CMS quality improvement programs within two to four years.

Taken together, the Committee's recommendations can help advance a thoughtful, practical, and relatively rapid integration of rural providers into CMS quality improvement efforts. Moreover, many of the Committee's recommendations, particularly those relating to alignment, are applicable not only to CMS quality improvement initiatives, but also to efforts of other public- and private-sector stakeholders.

BACKGROUND AND CONTEXT

The goal of healthcare performance measurement is to improve the quality of care delivered to patients and their families, and ultimately, to improve the health of individuals and communities. Performance measurement results are used for a variety of purposes, including internal quality improvement efforts by clinicians, hospitals, nursing facilities, etc.; public reporting to inform healthcare consumers and to aid in decisionmaking; and various types of payment incentive programs by both public and private payers.

CMS, the nation's largest healthcare insurer and purchaser, has instituted, per legislation, many setting- and provider-based programs aimed at driving healthcare improvement, increasing transparency, and influencing payment.¹ Earlier programs have run the gamut from encouraging voluntary participation in reporting performance results to CMS (often through financial incentives) to publicly reporting quality measurement results to applying negative payment adjustments (i.e., "penalties") if results are not reported. More recently, programs created under the Affordable Care Act (ACA) have instituted payment adjustments, including bonuses and sometimes penalties, based on results of both quality and cost measures (i.e., pay for performance).

However, some existing legislation has systematically excluded certain facilities and clinicians for programmatic, methodological, or other reasons. For example, most of the CMS hospital-based programs exclude facilities that are not paid through the Inpatient Prospective Payment System (IPPS). Similarly, the CMS clinician-based programs currently exclude providers who are not paid under the Medicare Physician Fee Schedule. Moreover, hospitals and clinicians that do not meet requirements for a minimum number of cases may not be able to

participate fully in the various CMS programs (for example, their results would not be publicly reported).

A large proportion of the hospitals, clinics, and clinicians that are excluded from these CMS quality programs operate in rural areas. Therefore, many care providers serving rural communities do not receive financial incentives and comparative performance data that are provided through the programs for the purpose of spurring improvement. Moreover, rural patients and their families may not have access to publicly reported performance results for many of their healthcare providers.

As Congress extends pay-for-performance (P4P) programs and CMS evolves its regulatory policies, more rural providers likely will be subject to CMS P4P programs. For example, although program expansion for non-prospective payment system (PPS) hospitals is not imminent, the ACA mandates a demonstration program to inform how facilities that are typically excluded can participate in the Hospital Value-Based Purchasing (HVBP) program. Also, under current rules, only physicians in practices with 100 or more eligible professionals are included in the Value-Based Payment Modifier (VBPM) program for 2015; however, this program will be extended to all fee-for-service Medicare clinicians (both physicians and non-physicians) by 2018.

In January of 2015, HHS unveiled its goals and a timeline for "rewarding value" rather than volume.² Specifically, HHS aims to have 30 percent of Medicare payments in alternative payment models (e.g., accountable care organizations (ACOs), primary care medical home (PCMH) models, bundled payment arrangements, etc.) by the end of 2016 (50 percent by the end of 2018). HHS also seeks to link 85 percent of Medicare

fee-for-service payments to quality by 2016 (90 percent by 2018) through programs such as the HVBP and the Hospital Readmissions Reduction Program.

In April of 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA),³ which repealed the Medicare Sustainable Growth Rate formula.⁴ Beginning in 2019, physicians and other eligible professionals will participate in one of two payment pathways:

- *Merit Based Incentive Payment System (MIPS)*, which will adjust fee-for-service payments with a bonus or penalty, depending performance on quality, resource use, clinical practice improvement activities, and meaningful use of electronic health record systems. This program will consolidate the current Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), and Meaningful Use programs
- *Alternative Payment Model (APM)*, which will provide bonus payments for clinicians who participate in a qualified APM in which providers will take on substantial financial risk

It is unclear how these two new policy changes will affect rural providers.

While many stakeholders desire the eventual participation of currently excluded rural providers in CMS quality improvement programs, including P4P programs, the very rurality of these providers may pose significant measurement and design challenges for the various programs. These rural providers are influenced by both the geography and

the culture of the areas and populations they serve.

Regardless of the methodology used to define the rural population of the U.S.,^{5,6} statistics indicate that those living in rural areas may be more disadvantaged overall than those in urban or suburban areas, particularly with respect to sociodemographic factors, health status and behaviors, and access to the healthcare delivery system.⁷ For example, people in rural areas are more likely than others to have lower incomes, lower educational attainment, higher unemployment rates, and higher rates of poverty.⁸ According to data from the *2014 Update of the Rural-Urban Chartbook*, those in rural areas are, in general, more likely to be older (i.e., age 65 and above).⁹

Rural residents also are more likely to engage in certain riskier health behaviors (e.g., smoking among adolescents and adults; leisure-time physical inactivity) and have higher overall mortality in all age categories (i.e., children and young adults, working-age adults, and those 65 and older), compared to those in other geographic areas. Healthcare provider shortages, as well as limited availability of other resources such as technological expertise and transportation networks in rural areas, also affect how care is delivered (e.g., the need to transfer high-acuity patients to other facilities for specialty care). Moreover, many rural providers face challenges in quality measurement and associated accountability efforts because of low patient volume, which can impact the reliability, validity, and utility of performance metrics.

PROJECT PURPOSE AND OBJECTIVES

In 2014, the Department of Health and Human Services (HHS) contracted with the National Quality Forum (NQF) to convene a multistakeholder 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.

This project had the following objectives:

- Make recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians
- Make recommendations to help mitigate measurement challenges for rural providers, including the low case volume challenge
- Identify measurement gaps for rural hospitals and clinicians

Rural providers of specific interest for the project included:

- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Community Health Centers (CHCs)
- Small rural non-CAH hospitals
- Other small rural clinical practices
- Clinicians who provide care in any of the above settings

The project's approach and timeline are included in [Appendix A](#). The multistakeholder Committee members, HHS representatives, and NQF staff involved in the project are listed in [Appendix B](#). A glossary of terms used throughout this report is included in [Appendix C](#). Vignettes that showcase the heterogeneity in rural healthcare and measurement challenges faced by rural providers are featured throughout the report.

The scope of practice in a Community Health Center (CHC) in a frontier area is wide.

Such centers may care for those with mental illness, heart disease, diabetes, cancer, routine acute illnesses, and emergency situations, often in the same day. A provider might stabilize a man with chest pain who has driven 45 minutes to get to the clinic before transferring him to a larger center for additional care; administer an experimental medication because the nearest specialist was eight hours away; and manage patients with severe depression and schizophrenia because there is a 6-month wait to see a psychiatrist. Doctors at frontier CHCs also see patients who are hospitalized, reside in a nursing home, or are enrolled in hospice. These providers must wear many quality improvement “hats,” including that of data collector, IT specialist, metric analyzer, and improvement coordinator, yet despite the various challenges, many are committed to quality measurement and improvement.

KEY ISSUES REGARDING MEASUREMENT OF RURAL PROVIDERS

Throughout the project, the Committee identified several key issues and challenges that can negatively influence quality measurement and/or improvement activities for rural providers, most of which are interrelated to a greater or lesser extent. These include:

- **Geographic isolation.** Although not all rural areas are geographically isolated, many are. This isolation can result in limited availability of healthcare providers, including specialists and post-acute care providers, difficulties with transportation, and lack of broadband access that can severely limit information technology capabilities. Isolation can also diminish the amount of support available from referral, academic, or other leadership centers that might otherwise supply significant medical, educational, or other resources.
- **Small practice size.** Many rural hospitals and clinician practices tend to be small, and these often have 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 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.
- **Heterogeneity.** There is incredible heterogeneity across rural areas of the U.S. While many rural areas are relatively close to urban or suburban areas, many are not, and in fact, many are quite remote.¹⁰ Many rural areas, particularly frontier areas, must contend with seasonal hazards that impact care provision. In addition, many rural areas (although not all) have a disproportionate number of vulnerable residents (e.g., economic or other social disadvantages, those in poor health, those with poor health behaviors, etc.). This heterogeneity affects healthcare performance measurement and has implications for the applicability of measures or measure sets, adjustment of measures for patient characteristics, reliability of measures, and use of measures. This heterogeneity in setting and patient population also drives diversity among providers, which has implications when comparing providers for accountability purposes.
- **Low case volume.** Many (although not all) rural providers do not have enough patients to achieve reliable and valid measurement results. The low case volume challenge may be particularly relevant for certain condition-specific measures and/or for providers in more isolated rural areas. Relatedly, many rural providers may not offer a full suite of healthcare services (e.g., some small hospitals or CAHs may not do surgery, have ICUs, etc.), and thus some measures used in various quality improvement programs will not apply to all rural providers.

The Committee also noted several additional measurement challenges that arise due to the way CAHs, RHCs, and CHCs bill for and receive payment for services provided to Medicare beneficiaries.¹¹ The Committee acknowledged that urban and suburban areas experience some of the same challenges as rural areas, but members believe that these challenges are more likely to impede quality measurement and improvement in rural areas.

RECOMMENDATIONS

After discussion of many of the rural health and setting-specific challenges related to performance measurement of rural providers, the Committee agreed that their recommendations should, at minimum, address four key issues:

- Low case volume
- Need for measures that are most meaningful to rural providers and their patients and families
- Alignment of measurement efforts
- Mandatory versus voluntary participation in CMS quality improvement programs

The Committee offered their recommendations under two key assumptions. First, past experience of quality measurement and improvement efforts can inform future efforts for rural providers. Second, the design of current CMS quality programs (including how measures are developed, selected, and used and how payment adjustments are determined and allocated) should not constrain the Committee's recommendations for future measurement and improvement efforts for rural providers. Thus, the Committee's recommendations can be used to enhance existing CMS quality improvement programs, create completely new programs designed specifically for rural providers, or both.

Because many of the challenges of measurement for rural providers are interconnected, many of the recommendations to address these challenges also are interconnected. Importantly, many of the Committee's recommendations directly address the low case volume challenge, while several others address this challenge indirectly. Because the purpose of the project was to make recommendations for mitigating measurement challenges within the context of CMS quality improvement programs, the resulting recommendations are, of necessity, predominantly provider-centric.

Overarching Recommendation

Make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but allow a phased approach for full participation across program types and address low case volume explicitly.

As mentioned earlier, many rural healthcare providers are systematically excluded from participation in various CMS quality improvement programs due to both legislative guidance and the regulatory implementation process. Specifically, CAHs are not mandated to report quality measurement data for the Hospital Compare program, although they can *voluntarily* submit

One night an 88-year-old woman in northeastern Maine fell and fractured her hip.

Her fracture was diagnosed in the emergency department (ED) in a CAH, one of two hospitals in the county. Her pain was managed, but she had to be transferred to a tertiary care hospital 100 miles away for surgery because the orthopedic surgeon was out of town. This transfer required a long, painful ambulance ride to a setting unfamiliar and inconvenient for both the patient and her family. Her son, who lived with his wife and three children only a few miles from his mother, was tragically killed when his car slid on a snow-covered road as he travelled to visit his mother.

data for public reporting through this program. CAHs are, however, excluded from the Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), and Hospital VBP programs because they are not paid under the Medicare's hospital IPPS as stipulated by the enacting legislation for these programs. Likewise, clinicians who practice solely in RHCs and CHCs are not eligible to participate in the PQRS, Physician Compare, or VBPM programs.¹² Moreover, rural providers in these or other settings (i.e., small hospitals or small practices) may be unable to participate fully in these programs on a measure-by-measure basis due to low case volume.

Because these rural providers are excluded from these quality improvement programs, they may be less likely to implement comprehensive quality measurement efforts, thus lessening their ability to identify and address opportunities for improvement in care. Exclusion from such programs also may imply, inadvertently, that measurement and improvement efforts on behalf of rural residents are unimportant to the U.S. healthcare system as a whole. Exclusion from these programs also results in a lack of easily accessible information about provider performance for rural residents. Not only does this lack of data deny many rural residents the ability to choose providers based on performance (when there are multiple providers to choose among), it also may suggest, albeit inadvertently, that rural providers cannot provide high-quality care and may thus drive an outmigration of patients from rural hospitals and practices. In such cases, rural residents may seek care from non-rural providers, potentially increasing the burden of rural residents (e.g., having to drive further to obtain care) and harming the financial viability of rural providers. Finally, exclusion of rural providers from the CMS quality programs also prevents rural providers from earning payment incentives that are open to non-rural providers. Accordingly, the Committee recommended that CMS and Congress should not only allow participation in quality initiative programs for all rural providers, but **make such participation mandatory**.

However, the Committee recognized that requiring participation of all rural providers across all of the various CMS programs, including pay-for-performance programs, cannot and should not be implemented immediately because of various factors. These include relative inexperience of many rural providers in federal quality measurement efforts, constrained resources of many rural (particularly small) providers, and the low case volume challenges inherent in many measures included in current CMS programs. Accordingly, the Committee strongly supported the use of a **phased approach** for including CAHs, RHCs, and CHCs in CMS quality improvement programs.

One example of a phased approach would be to begin including these rural providers in pay-for-reporting programs and then gradually transition to public reporting and then, perhaps, to pay-for-performance programs. Such a phased approach, which would require the cooperation of Congress and CMS, would be consistent with past policy for providers in other settings.

For example, in the PPS hospital setting (which includes small rural hospitals), CMS implemented pay-for-reporting programs to incentivize providers to report quality data on a set of performance measures. At about the same time, CMS also began to report measure results publicly in order to provide information to consumers, payers, purchasers, and other stakeholders to help inform their decisionmaking regarding healthcare issues. Subsequently, CMS—per the ACA—implemented a value-based payment program whereby hospitals received incentives based on their performance on certain quality and cost measures. Over time, the incentive structure has changed so that negative payment adjustments (“penalties”) are applied if providers fail to report quality data, reach a performance threshold, or show improvements in their performance score (depending on the particular program). For PPS hospitals, this transition from pay-for-reporting to value-based purchasing with both positive and negative payment

adjustments has been underway for more than a decade. CMS has implemented a similar approach for clinicians (including rural providers who work in small clinician practices) who are paid through the Medicare Physician Fee Schedule (as well as for providers in other post-acute care/long-term care settings), although the timeframe has been shorter. As noted earlier, the evolution of value-based payment incentive programs for clinicians will continue with implementation of the MACRA.

Committee members recognized that many rural providers (e.g., those CAHs who have been voluntarily reporting performance scores for public reporting through Hospital Compare) may not need or want a formal, phased approach that transitions through types of programs. One solution would be to mandate participation in an overall quality improvement program, but to structure the rewards in a hierarchical manner (e.g., providers who simply report performance scores to CMS would earn a certain bonus amount, those who allow public reporting of their scores would earn an additional amount, and those whose performance meets a certain threshold for achievement and/or improvement would earn an even higher bonus).

Supporting Recommendations

As noted earlier, the Committee agreed that the likelihood of low case volume, particularly for many measures that are used in current CMS quality improvement programs, is a key measurement challenge facing rural providers, no matter the setting. Consequently, **low case volume must be addressed prior to mandatory participation** in CMS programs by CAHs, RHCs, and CHCs and must also be addressed for other rural providers including small hospitals and those who work in small clinician practices. The Committee further agreed that issues related to measure development, measure selection, alignment of measurement efforts, and pay for performance also must be addressed **prior to** mandatory (or continued) participation by rural providers.

Accordingly, the Committee made several recommendations that will, if implemented, help to ease the transition to mandatory participation. As such, the recommendations described below should be viewed as both stand-alone and interdependent recommendations, but should not be construed as a listing of most important to least important. Taken together, these supporting recommendations, along with the overall

It's a typical Monday morning in a small clinician practice in a remote rural area.

The doctor arrives early (after being on-call over the weekend) to catch up medication orders, phone calls, lab reviews, and charting; huddles with staff to discuss any follow-up needs from the previous weekend; troubleshoots the EHR; meets with a payer to negotiate fee schedules; and finally sees patients. The doctor may spend the evening doing other administrative and quality improvement activities. Small rural practices do not have the means to hire a financial officer, care coordinator, quality improvement coordinator, bookkeeper, compliance administrator, or technology expert. As more and more private and public payers use performance measurement results, the burden of data collection and reporting dramatically increases, particularly when measures used for different purposes are not aligned.

recommendation of mandatory participation, can help advance a thoughtful and practical integration of rural providers into CMS quality improvement efforts.

Development of Rural-Relevant Measures

The Committee's recommendations regarding measure development include funding the creation of rural-relevant measures, developing new measures or modify existing measures so as to address explicitly the challenge of low case volume, including rural-relevant sociodemographic factors in risk-adjustment approaches, and ensuring that composite measures are appropriate for rural (particularly low-volume) providers.

Fund development of rural-relevant measures.

The Committee recommended that CMS fund the development and/or modification of measures that are particularly relevant to, and appropriate for, rural providers (especially for low-volume providers). The Committee recognized that in some cases, de novo measure development is needed, but in other cases, modification of existing measures to make them appropriate for use by rural providers may be needed. The Committee identified the following rural-relevant topic areas for potential measure development or modification at this time.

- **Patient hand-offs and transitions.**¹³ The Committee acknowledged that there are already several quality measures that address hand-offs and transitions, but agreed that additional measures are needed for rural providers. The Committee specifically noted the need for measures that assess the appropriateness of transfers (i.e., that transfers are made for the right reasons). They also suggested a need for measures that assess whether transfers are made at the appropriate time. However, they also recognized the difficulties inherent in measures of transfer timeliness for rural providers (for example, if a facility does not have an ICU, a patient may be kept, appropriately, for a longer period in

the emergency department). The Committee also acknowledged that successful hand-offs and transfers require coordination between providers and that limitations in healthcare infrastructure often hinder rather than facilitate coordination.

- **Alcohol/drug treatment.** Because substance abuse is highly prevalent in many rural areas, measures that focus on alcohol and drug screening and treatment are highly relevant for rural providers. The Committee agreed that measures of alcohol and drug screening are already available but noted that substance abuse measures focusing on effective interventions at the primary care level should be developed, as the options for substance abuse treatment often are limited in rural areas.
- **Telehealth/telemedicine.** Currently, no measures focused on telehealth or telemedicine are endorsed by NQF. Because telehealth and telemedicine are tools that allow greater access to care, they are of particular importance to rural residents. However, the Committee generally agreed that it may be too early to develop quality measures that focus on telehealth/telemedicine. Members noted that simple structural measures of telehealth or telemedicine likely would not be helpful, in part because implementing this type of care delivery requires cooperation between providers (e.g., a primary care provider in a rural area and a specialist outside that particular area), leading to potential difficulties with attribution, and because current, state-specific requirements may make consistent measurement difficult. The Committee also agreed that condition-specific telehealth/telemedicine measures are not needed (e.g., assessing blood glucose control for diabetes patients who participate in telehealth/telemedicine). However, members did agree that current measures (including disease-specific measures) should be specified so that care delivered via telehealth/telemedicine

is “counted” in the measures. Finally, the Committee agreed that use of telehealth/telemedicine should be incorporated into measures of access to care.

- **Access to care and timeliness of care.**

Although a few quality measures endorsed by NQF can be considered access-to-care measures (e.g., those assessing follow-up care), the Committee agreed that additional measures of access to care are needed. While access-to-care measures may not always be considered “quality measures” per se, they provide a needed complement to other measures of care quality. However, while agreeing with the importance of access to care, the Committee did express concern that use of access-to-care measures may be problematic for rural providers, particularly if used in payment programs (e.g., potential for a payment penalty if obstetric services are not provided). The Committee considered timeliness of care as another way of assessing access to care. While there are several NQF-endorsed timeliness measures, members noted that many of these are condition-specific and thus subject to low case volume. They also noted that timeliness-of-care measures could be used to assess productivity, which may not always equate to quality, particularly in rural areas.

- **Cost.** The Committee was somewhat conflicted about the need for additional cost measures for rural providers. On one hand, members recognized the need for cost information in the context of pay-for-performance programs, and noted that because many rural providers are paid by CMS through cost-based reimbursement schemas rather than through Medicare prospective payment structures, the current cost measures cannot be applied to those providers. They also noted that costs generated by primary care providers in rural areas may not be comparable to costs generated by primary care providers in non-rural areas because rural primary care providers typically provide more services themselves rather than referring to specialists. They further noted that comparing the costs of low-volume rural providers to high-volume urban providers is inappropriate given diseconomies of scale in rural areas that result from providing local access to care. On the other hand, they expressed concern that a focus on cost measures might detract from promoting development of needed quality measures. The Committee also discussed patient out-of-pocket costs. Members agreed that while these can be a barrier to access and therefore a potential factor to consider in risk-adjustment approaches, development of out-of-pocket cost measures is not needed.

Two years ago, the smallest and most rural of the 12 clinics in a Nebraskan ACO added a care coordinator position. The care coordinator helps patients with post-discharge follow-up after hospital admissions and ED visits, and as a result, has helped to correct many medication errors. The clinic even added a second care coordinator position because the results were so good. To spread learning, care coordinators from all 12 clinics share success stories and discuss common problems and solutions via an online discussion board. These care coordinators have proven that small, rural primary care clinics can implement the quality infrastructure needed to drive improvement.

- **Population health at the geographic level.**

As noted earlier, the Committee agreed that population health measures are important and, moreover, could potentially resolve the low case volume issues that are associated with disease-specific measures. Members acknowledged several potential difficulties inherent in such measures, including cultural influences that impact healthcare decisions, availability of community resources, feasibility of data collection, and appropriate use of such measures. In general, the Committee recognized the need for shared accountability across multiple stakeholders (e.g., individuals, communities, healthcare providers, etc.) in order to improve population health, but did not support the use of population health measures in pay-for-performance programs for individual hospitals and clinicians (at least not until attribution issues are properly addressed). Instead, they supported a stepwise approach to the use of population health measures. For example, members for the most part supported the use of such measures at higher levels of analyses (e.g., the ACO level). They also recommended development of measures that assess provider engagement in population health efforts, as such measures that could be used to incentivize participation in wellness activities and programs.

- **Advance directives/end of life.** The Committee agreed on the need to promote engagement in shared decisionmaking regarding end-of-life care planning and suggested that measures regarding advance directives or physician orders for life-sustaining treatment (POLST) measures be developed. The Committee noted that advance care planning is needed for all adults, not just older adults, and not just for those nearing end of life. The Committee also noted that the impact of limited access to hospice or other care alternatives in many rural areas should be considered when developing measures that assess end-of-life care.

The Committee did emphasize, however, that development of new measures should not lead

to an increased measurement burden for rural providers. The Committee also cautioned that any measures developed to address the above topic areas may not be appropriate for all types of programs at all times. For example, some may be appropriate for immediate inclusion in pay-for-performance programs, while others may never be appropriate for such programs, and others may become appropriate for such programs only after providers gain experience with them in other ways. Finally, the Committee noted that while particularly relevant for rural providers, the measurement concepts listed above would be appropriate for non-rural providers as well.

Develop and/or modify measures so as to address low case volume explicitly.

The Committee also made several recommendations related to measure development and/or modification that specifically address the challenge of low case volume, as follows:

- **Consider measures that are broadly applicable across rural providers.** The Committee identified several topic areas (e.g., vaccinations, screening, blood pressure control, diabetes control, medication reconciliation) that would apply to a large proportion of patients served by rural providers. Such measures should be considered for use in core and optional measure sets available to rural providers (a recommendation described later in this report).
- **Consider measures that reflect the wellness of the community.** Because many factors affect community wellness, population-based measures do not assess performance of individual providers, although they may sometimes be used for individual clinician-level or facility-level accountability. Although these types of measures address one of the triple aims of the National Quality Strategy (i.e., increasing the health of the population), the Committee did not support use of such measures in pay-for-performance initiatives for rural providers. However, members did recognize the usefulness of population health

measures for internal quality improvement at the provider level. Because the denominator for these kinds of measures is a particular subpopulation (e.g., community, region, age-based group, etc.) there typically would be no difficulty in terms of case volume.

- Reconsider exclusions for existing measures.** Many measures exclude large numbers of patients for valid reasons. For example, the HCAHPS measures exclude patients who reside in nursing facilities or who receive hospice care due to the difficulty in collecting data from these patients and the concern that they may conflate their hospital experiences with those of the nursing facility or hospice. However, for rural providers with very small patient panels, excluding these patients exacerbates the low case volume challenge, as potentially many otherwise eligible patients are not surveyed. Measure developers should consider the impact of low case volume for certain providers when developing and revising measures.
- Consider measures constructed using continuous variables.** Measuring an aspect of care using a continuous variable rather than a binary variable may require a smaller sample size to detect meaningful differences between providers. Examples would be assessing the time until a medication is given rather than just whether or not a medication was given or measuring the number of preventive services received rather than whether or not preventive services were received. Note, however, that care should be taken when considering such measures for rural providers (particularly timing measures), as such measures would be sensitive to outliers and because the environmental context could potentially invalidate comparisons between providers.
- Consider ratio measures.** Ratio measures are measures where the numerator is not necessarily a part of the denominator. For example, in a measure of bloodstream infections, the numerator is the number of

bloodstream infections but the denominator may be the number of days during which the patient has a central line. These kinds of measures could circumvent the low case volume problem because each patient could contribute many “units” to the denominator. Like measures using continuous variables, however, both the strengths and weaknesses of such measures should be well understood prior to use in accountability programs.

The above recommendations will not eliminate the low case volume challenge for all rural providers, but these options that may lessen the problem for some providers.

Consider rural-relevant sociodemographic factors in risk adjustment.

In response to recommendations by a multistakeholder panel of experts in healthcare performance measurement and disparities, NQF recently lifted, for a two-year trial period, a previous prohibition against including sociodemographic (SDS) factors (e.g., age, race, ethnicity, income, educational attainment, primary language, etc.) in risk adjustment (also known as case mix adjustment) of healthcare performance measures.

Because many patients served by rural providers are socially and/or financially disadvantaged, the Committee applauded this change in policy, seeing it as a way to facilitate more valid comparisons among rural providers. In addition to many of the factors already identified by NQF’s SDS Expert Panel (income, education level, insurance status), the Committee also recommended that the following rural-relevant SDS factors be considered in potential risk-adjustment methodologies:

- Distance to referral hospital
- Time of travel to referral hospital or physician office
- Availability of other healthcare resources in the area (e.g., primary care provider density, availability of home health, nursing facilities, or hospice)

- Shortage area designations defined by HRSA (i.e., Health Professional Shortage Area, Medically Under-Served Areas, Medically Under-Served Populations)
- Frontier area designations
- Housing security
- Food security

Some members of the Committee also noted that the size of the medical staff reflects the availability of resources and therefore might merit consideration in risk-adjustment methodologies. However, the size of the medical staff is not a patient-related factor and therefore may not be appropriate for case-mix adjustment of healthcare performance measures. Similarly, it is unclear whether other factors such as seasonality (which is important in rural areas where weather can severely restrict travel) are appropriate for case-mix adjustment. The Committee noted that NQF's ongoing SDS Trial Period may help inform decisions regarding appropriate risk adjustment for patients in rural areas, particularly around community-level factors such as housing or food security.

The Committee also recommended that at least one rural health expert be empanelled on the yet-to-be-formed NQF Disparities Standing Committee, the formation of which was recommended by NQF's SDS Expert Panel. The NQF Disparities Standing Committee will monitor implementation of the revised policy, monitor for unintended consequences (particularly for disadvantaged patients and safety net providers), assess trends in disparities, review and provide guidance related to methodologies for adjustment and stratification (e.g., use of community factors, collection of standard sociodemographic data), and help ensure that social and demographic disparities in care do not get overlooked, but rather remain an integral part of quality measurement. This Committee will have the expertise needed to determine if the above-listed factors would be suitable for case-mix

adjustment. Inclusion of at least one rural health expert on this panel will ensure that disparities among rural residents are considered and that non-rural experts can benefit from knowledge and practices used in rural healthcare delivery.¹⁴ This Committee—particularly with the inclusion of at least one rural health expert—will be able to consider and provide specific guidance about how the challenge of low case volume can be balanced, or possibly mitigated, by appropriate risk adjustment for rural providers.

Ensure that the component measures are appropriate for rural (particularly low-volume) providers when creating and using composite measures.

Committee members noted that creating a composite performance score from disparate individual measures, as some CMS programs currently do, may be particularly problematic for rural providers, either because they do not offer services assessed by the individual measures or have very few patients who “qualify” for some of the individual measures. For example, in some programs, such as the Hospital Acquired Condition (HAC) Reduction program, if a provider cannot report on one or more of the measures in a domain, then the score for that provider depends more heavily on the other measures in that domain (or in other domains). The Committee therefore recommended that if CMS uses a composite measure approach to assess provider performance, such composite measures should comprise individual measures that are applicable to rural (particularly low-volume) providers. Preferably, all providers would be assessed on the same measures within the composite; at minimum, providers should be assessed on the same number of measures in the composite (so that no one measure is more heavily weighted for one provider than another). Individual measures used in such composites ideally would come from the core and optional measure sets that are specifically selected for rural providers as recommended by the Committee (see recommendation regarding core and option measure sets, discussed below).

Alignment of Measurement Efforts

Lack of alignment in quality measurement efforts was another of the key challenges for rural providers identified by the Committee. Accordingly, the Committee strongly recommended continued efforts to align measures, data collection efforts, and improvement and informational resources.

Alignment of Measures

The Committee emphasized the need for a uniform set of measures that can be used across HHS programs (particularly CMS and Health Resources and Service Administration [HRSA] programs) and, to the extent possible, across other federal programs (e.g., the Indian Health Service) and those used by private payers, credentialing and accrediting bodies, etc. This recommendation is consistent with the April 2015 recommendation of the Institute of Medicine (IOM) for a streamlined set of measures to provide benchmarks for health progress across the nation. As noted earlier, members also noted a need for measures that can be used across multiple healthcare settings across the continuum of care (e.g., in both ambulatory and hospital settings), even if the measures are

not completely identical because of differences in data availability by setting. For example, measures such as medication reconciliation would apply to both hospital and ambulatory settings and would incentivize improved communications and patient safety. Measures that are applicable across settings may be particularly helpful for CAHs because they often provide services (e.g., physical therapy, occupational therapy, imaging) that are typically provided in an outpatient setting in non-rural areas.

Alignment of Data Collection Efforts

The Committee also recognized that data collection can be particularly burdensome for rural providers, either because small rural providers may not have the staff needed to collect data (e.g., for measures that require laborious abstraction from medical records) or because they may not have the resources (financial, staff expertise, etc.) to invest in or maximize use of sophisticated HIT systems that would facilitate calculating and reporting of quality measures. Committee members therefore recommended that HHS work to develop standardized processes so that data that are used for various purposes

A certified nurse midwife (CNM) planned to talk to a patient with a BMI of 27+ (categorized as overweight) about the need for weight loss, increased physical activity, and other preventive health issues during a well woman visit at a rural health clinic in central Mississippi. But the patient quickly asked for medication to stimulate her appetite, saying that she felt “too skinny and needed to thicken up.” This clinic serves a sociodemographically vulnerable population in a designated Health Professional Shortage Area, and CNMs play an important role by providing maternity care as well as other primary care services. The nurse midwife engaged the patient in a discussion of the health risks of overweight and obesity, yet the patient reiterated her desire to gain weight. As the discussion progressed, the patient revealed various cultural reasons for wanting to gain weight. Cultural norms and beliefs can be strong determinants of health, and providers like this nurse midwife need to educate their patients and invest major effort in preventive care.

(e.g., Hospital Compare, HRSA's Medicare Beneficiary Quality Improvement Project, The Joint Commission accreditation) would have to be reported by providers only once. Note that this recommendation can be operationalized only if there is alignment of the measure sets for the various purposes. The Committee also recommended that HHS provide additional financial or other resources to assist rural providers in their data collection and reporting activities.

Alignment of Technical Assistance and Other Informational Resources

The Committee reiterated that many rural providers will continue to require technical assistance in order to facilitate their participation in federal programs (e.g., advice on data collection/reporting, improvement science, etc.). While members acknowledged that CMS and other federal offices already provide this kind of assistance (e.g., through the Quality Improvement Organization program under CMS, the Flex program under HRSA, etc.), they recommended that such resources be aligned across HHS to support rural providers more efficiently and effectively.¹⁵ Such assistance will be particularly critical for those that are (or will be) new to quality measure reporting and/or to small providers who do not have sufficient staff expertise for measurement and improvement activities. The Committee also noted that when performance measures are used by those offering technical assistance services, those measures should be aligned to the extent possible.

Finally, the Committee recommended that HHS align its informational resources on programs, policies, and initiatives related to quality measurement and create opportunities for rural health stakeholders and staff from HHS agencies (e.g., CMS, HRSA, etc.) to interact. In addition to providing an informational "one-stop shop" for rural providers, such alignment of informational resources across HHS could foster more compatible policies to benefit all providers.

Selection of Measures

The Committee recognized a need to use a rural-relevant lens when selecting measures for CMS programs that include rural providers. The Committee's recommendations regarding measure selection include identifying guiding principles, using both core and optional measure sets, considering measures used in patient-centered medical home models of care, and creating a Measure Applications Partnership (MAP) workgroup specifically focusing on rural measurement.

Use guiding principles for selecting quality measures that are relevant for rural providers.

The Committee did not view creating lists of measures for use in CMS accountability programs as within its purview during this project, in part because the specific measures may vary based on provider (hospital versus clinician) and use (e.g., pay-for-reporting versus pay-for-performance) and because measures may transition from one use to another over time as experience builds. Instead, Committee members identified several principles that CMS or other stakeholders should use when selecting measures for quality improvement programs that are appropriate for rural healthcare providers. Many of the principles are consistent with the criteria used by NQF to evaluate individual candidate performance measures for potential endorsement. The NQF measure evaluation criteria reflect desirable characteristics of performance measures and are used to determine the suitability of measures for use in both internal quality improvement efforts and in accountability applications, including pay for performance. Several of the principles also are consistent with the measure selection criteria used by MAP, an NQF-convened multistakeholder group that is charged with providing recommendations to HHS on the selection of quality performance measures for at least 20 federal quality improvement programs. The MAP criteria are intended to help MAP identify characteristics that are associated with ideal measure sets for public reporting and payment programs.

The following table lists the Committee’s suggested principles for selecting measures to assess performance of rural providers. The table indicates whether the principle is currently included as part of NQF’s endorsement criteria, MAP’s measure selection criteria, both, or neither.

Although many of the principles overlap with NQF endorsement or MAP criteria or are applicable across multiple settings and providers (not just rural providers), there often is a rural perspective to consider during the measure selection process.

TABLE 1. PRINCIPLES FOR SELECTING MEASURES TO ASSESS PERFORMANCE OF RURAL PROVIDERS

Principles	NQF Endorsement Criteria	MAP Measure Selection Criteria
<p>Address the low case volume challenge. Because many rural areas will have small sample sizes that will impact measure reliability, measures used for rural providers should be broadly applicable for most rural providers.</p>		
<p>Facilitate fair comparisons for rural providers. Because of the heterogeneity of rural providers as well as challenges (e.g., distance) that are particularly relevant to rural (as opposed to urban or suburban) providers, selected measures must allow for fair comparisons between providers. This can be accomplished either through the construction of the measure itself (e.g., through appropriate case-mix adjustment) or through program policy such as establishing appropriate peer groups for comparison, or both.</p>		
<p>Address areas of high risk for patients. The Committee noted that some care processes should “just happen” regardless of provider or size of patient panel and these should be prioritized for selection into quality improvement programs (e.g., medication reconciliation).</p>		
<p>Support local access to care. To the extent possible, the Committee favors use of measures that promote provision of care at the local level. The Committee recognized that such measures may not yet exist (e.g., telehealth measures). They also noted that such measures may not necessarily be appropriate for individual providers, but instead be better suited for “higher” levels of analysis such as health plans, ACOs, or even geographic populations.</p>		
<p>Address actionable activities for rural providers. It is important to realize that not all medical conditions or procedures are addressed by all rural providers and therefore many measures may not be appropriate for use with rural providers. Additionally, some activities (such as triage and transfer) may be more common among rural providers. Some Committee members suggested that measures selected for use for providers who are new to quality measure reporting should be completely within the control of the provider (e.g., process measures versus outcome measures). However, the Committee did not reach consensus on this aspect of selection, as many outcome measures certainly can be influenced, if not directly controlled, by providers. Moreover, improvement activities initiated as a consequence of outcome measures necessarily require local solutions.</p>		

Principles	NQF Endorsement Criteria	MAP Measure Selection Criteria
Be evidence-based. Measures should be supported by empirical evidence demonstrating clinical effectiveness and a link to desired health outcomes.	✓	
Address areas where there is opportunity for improvement. In some cases, measures that are “topped out” in some areas of the country may still offer opportunity for improvement in rural areas, and these should thus be considered for selection into programs for rural providers.	✓	
Be suitable for use in internal quality improvement efforts. Because the primary goal of measurement is to improve the quality of care received by patients and their families, rural providers should be able to use measures selected for various external programs in their own internal quality improvement efforts.	✓	
Require feasibility for data collection by rural providers. Because of resource constraints, the data collection process can be overly burdensome for many rural providers. Thus, measures selected for use in CMS programs should rely on data that are readily available or are feasible to collect (e.g., in structured data fields in EHRs). In addition to reducing the burden of reporting, ease of data collection can also facilitate internal quality improvement efforts because often the same staff members who collect the data also implement improvement activities.	✓	✓
Exclude measures that have unintended consequences for rural patients. Measures that could potentially hinder access to healthcare in rural communities should not be selected for use in quality improvement programs.	✓	✓
Be suitable for use in particular programs. All measures have strengths and weaknesses, but there is general consensus that only the “strongest measures” (in terms of evidence, reliability, validity, etc.) should be used in pay-for-performance programs. Relatedly, measures selected for particular programs ideally should be diverse in type and in terms of burden required of rural providers. Moreover, they should be useful for the programs for which they are selected (for example, measures used for public reporting should be meaningful for consumers and purchasers who use the results for decisionmaking).		✓
Select measures that align with other programs. Alignment with other programs will help reduce measurement burden for rural providers; this will be particularly relevant for rural providers with severe financial or staff constraints.		✓
Support the triple aim. Measures chosen for use in CMS programs should support each of the aims for the National Quality Strategy (NQS): better care, healthy people/healthy communities, and affordable care. Because many rural communities have a high percentage of socially, economically, or medically disadvantaged residents, measures that support the aim of creating and maintaining healthy communities may be particularly salient.		✓

Use a core set of measures, along with a menu of optional measures, for rural providers.

As noted earlier in this report, there is tremendous heterogeneity in the services that are delivered by rural providers as well as in the patients they serve. For example, some providers may serve a substantial number of patients with diabetes, while others may serve very few. Similarly, some CAHs provide surgical care while others do not. Only 76 percent of rural hospitals with 25 or fewer beds perform inpatient surgery, compared to 93 percent of rural hospitals with 26-50 beds; also, less than 20 percent of the smallest hospitals have Intensive Care Units (ICUs), while more than 90 percent of hospitals with more than 50 beds offer this care.¹⁶

To address this heterogeneity, Committee members recommended use of a core set of measures in CMS programs for rural providers (ideally, no more than 10-20) and that this core set be supplemented by a menu of optional measures that can be used as applicable. These core and optional sets would not necessarily be identical across settings (i.e., for both inpatient and ambulatory settings), although the core set in particular could be aligned—or be aligned to some extent—across topic areas (e.g., transitions of care, patient safety, etc.). Measures in the core set should be cross-cutting rather than disease-specific, unless the latter are limited to activities such as screening for a specific condition. In contrast, measures in the optional set should allow the flexibility needed to tailor measurement based on the types of patients served and the types of services offered. Moreover, the number of measures available in the optional set must be large enough—and the number of measures to be reported on must be small enough—that providers with even the smallest case volumes should be able to find applicable measures. A key advantage of use of a core set of measures is that users of measures would be able to compare all rural providers in a particular setting across a small set of measures. It should be noted that use of core

and optional measure sets for rural providers does not necessarily imply that all measures in the set should be used *exclusively* for rural providers, as many measures likely would be appropriate for both rural and non-rural providers.

The Committee noted that a variety of measure types (including structural, process, outcome, patient experience, and composite measures) should be available in these core and optional sets. While members agreed that outcome measures are particularly desirable, they noted that low case volume may be a particular challenge for some providers, depending on the measure. However, they also recognized that patient experience measures (one type of patient-reported outcome measure) might be particularly relevant for rural providers and would likely not suffer as much from low case volume challenges, as they are typically not condition- or service-specific. However, the Committee recognized the potential data collection burden and cost implications for these kinds of measures.

Finally, the Committee also recommended that measures used in the core and optional sets use a variety of data collection strategies and data sources, so that the burden of data collection is minimized. The Committee specifically cautioned against including measures in the core and optional sets that rely on the efforts of few individuals. This recommendation is particularly relevant for very small practices that have limited staff (e.g., nurses who have the expertise to abstract data for measurement but who must also provide direct patient care).

Measures included in such a core set should apply to a majority of patients in rural settings, and measures chosen by providers from the optional set should be those for which they have a large enough patient pool. Examples of measures that would be appropriate for the core measure set would include screening, immunization, or medication reconciliation measures, as well as

measures that address the rural-relevant topic areas discussed earlier. While this would not necessarily solve the low case volume problem for all rural low-volume providers, it would greatly reduce the number of providers who have too few patients for reliable and valid measurement.

Echoing the Committee's recommendation, an April 2015 report from the Institute of Medicine also advocated use of a core set of measures. This report, *Vital Signs: Core Metrics for Health and Health Care Progress*,¹⁷ recommended a set of 15 "core measures" that will provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas. Additional "related priority measures" also were identified for each of the core measures. The core measures included, among others, well-being, addictive behavior, care access, preventive services, and patient safety (these also were identified by the Committee as priority areas for rural-relevant measurement.)

Consider measures that are used in patient-centered medical home models.

Because much rural healthcare involves the delivery of primary care, and because many public and private efforts currently are directed towards the establishment of PCMHs, the Committee recommended particular consideration of measures used in PCMH models. Many such measures exist, conform to the principles cited above, and are already in use by many rural providers (thus reducing the burden of data collection). Examples of such measures include those focused on breast, cervical, and colorectal cancer screening, poor control of HbA1c, blood pressure control, and pneumonia vaccination.

Create a MAP workgroup to advise CMS on the selection of rural-relevant measures.

Given that many rural providers (e.g., those in small hospitals or small clinical practices) are already included in CMS quality improvement programs and given the Committee's recommendation that

participation of CAHs, RHCs, and CHCs become mandatory, the Committee strongly recommended that experts in rural health be given a role in the selection of measures to be used in such programs. Specifically, the Committee recommended that a rural health workgroup be added to MAP. MAP uses a two-tiered organizational structure whereby setting- or population-specific workgroups review and provide recommendations on measures for relevant programs and/or provide input on measurement gaps and areas for measure refinement and development. Current workgroups exist to provide input on the selection and coordination of measures for hospitals, clinicians, and post-acute and long-term care providers, as well as input on measures and issues related to the quality of care for Medicare/Medicaid dual eligible beneficiaries. Recommendations from the individual workgroups are then reviewed and approved by the MAP Coordinating Committee prior to submission of the recommendations to HHS.

A rural workgroup would function much like the MAP Dual Eligible Beneficiaries Workgroup, which is tasked with providing recommendations on issues related to the quality of care for beneficiaries who are dually eligible for both Medicare and Medicaid. Activities of this workgroup include identifying a set of the best available measures to address the needs of this unique population, identifying persistent measure gaps, and addressing measurement topics relevant to vulnerable individuals, including quality of life, person- and family-centered care, shared decisionmaking, and functional outcomes. Ideally, a MAP rural workgroup would reflect the various types of rural providers, including those from CAHs, RHCs, CHCs, and small PPS hospitals and clinician practices, and reflect the diversity of the rural population in the U.S. (e.g., rural-adjacent areas, frontier areas, heavily minority areas, etc.). This MAP workgroup also would use the measure-selection principles cited above when making its recommendations to HHS.

A single mother brought her 18-month old daughter to a walk-in clinic in a small, remote community. Based on the mother’s information, the presentation symptoms, and the baby’s age, the local provider diagnosed “nursemaid’s elbow,” a common upper-extremity injury in small children. However, the treatment provided was unsuccessful. The provider then ordered x-rays—which required a long drive to the nearest facility with radiology services—and based on the results, referred the baby to an orthopedic surgeon more than 100 miles away. The surgeon recognized the injury as consistent with abuse fracture. Fortunately, the fractures healed uneventfully, and the abusive situation was corrected.

Small rural hospitals and CAHs often lack specialty care, particularly for general surgery, obstetrics, and orthopedic surgery. Ideally, however, local providers will work closely with these specialists to deliver high-quality care. As an example, one hospital implemented monthly meetings where they use a case-study approach to educate local primary care physicians to recognize and treat many common musculoskeletal conditions. In one of these meetings, the above story prompted a rich discussion of the proper evaluation of upper-extremity injuries in young children, appropriate work-up of nursemaid’s elbow, and recognition of abuse injuries. As a group, participants agreed on a “low-threshold” policy for orthopedic referral when non-accidental trauma is suspected and on ordering x-rays before attempting treatment unless the history and clinical presentation of a nursemaid’s elbow is obvious.

Pay-for-Performance Considerations

The Committee also made several recommendations regarding both the design and implementation of payment programs for rural providers.

For rural providers, create payment programs that include incentive payments, but not penalties.

Many rural providers operate on a relatively thin financial margin, with little room to absorb payment reductions (or “penalties”) without concomitant reductions in staff and/or services. Additionally, RHCs and CHCs, as well as many CAHs and small rural hospitals and clinician practices, operate in federally- or state-defined shortage areas (e.g., Health Professional Shortage Areas or Medically Underserved Areas) and may be considered part of the nation’s healthcare safety net. Thus, the Committee agreed that quality programs for rural providers should not apply penalties, as these may compromise that safety net. Accordingly, Committee members recommended that, for the foreseeable future, CMS payment incentive programs for rural providers should be designed to provide “bonus” payments only, not penalties.¹⁸ Such a policy would incentivize reporting and improvement but would preserve the rural providers’ safety net role in the communities they serve. Members noted that such a policy would make the Committee’s recommendation of mandatory participation in CMS quality programs more palatable to those rural providers who have been excluded from CMS programs to date. They also noted that because per capita healthcare expenditures for rural residents generally are lower than for those in other areas,¹⁹ “bonus” payments for rural providers should be feasible. Finally, members noted the CMS precedent for not applying penalties in quality improvement programs; for example, for several years, the PQRS program offered only positive incentives, and currently the VBPM program does not apply penalties to physicians in very small practices.

Offer rewards for rural providers based on achievement or improvement.

Pay-for-performance programs often are designed to reward providers based on achievement of some threshold value (e.g., a national benchmark value) or on demonstration of a certain amount of improvement since a baseline period, even if they have not attained a particular measurement threshold. However, characteristics of patients in rural areas (e.g., health behaviors, cultural norms, sociodemographic factors, distance from providers) may constrain the ability of rural providers to achieve threshold values for certain quality measures. Similarly, rural providers may be unable to attain a certain level of improvement for some measures, either because they already have a very high performance (therefore making incremental improvement difficult) or because of low case volume (in which case, achieving a statistically significant improvement may be difficult, if not impossible). Accordingly, the Committee recommended that pay-for-performance programs for rural providers should incorporate both an achievement component and an improvement component. The Committee noted that CMS’s design of the HVBP offers a precedent for this type of arrangement.²⁰ Members cautioned that because low case volume is a particular challenge for many rural providers, any requirement for statistically significant improvement would have to be carefully considered.

Encourage voluntary groupings of rural providers for payment incentive purposes.

While the Committee agreed that detailed CMS feedback regarding performance scores should be provided at the clinician level (as is done currently in the Medicare FFS Physician Feedback Program), members were much more critical of holding individual clinicians accountable in pay-for-performance programs, particularly for rural and/or small volume providers who often have significant resource constraints and challenges with low case volume. Instead, the Committee recommended that CMS should encourage rural

providers to establish collaborative groups, as desired, for payment incentive purposes. Entry into such groups should be completely voluntary. Moreover, the groups should not be limited to clinicians only, but should be open to CAHs, RHCs, and CHCs, as well as to small rural hospitals and clinician practices. Establishment of such groups could accelerate quality measurement and improvement efforts and could help address the low case volume challenge. Because programmatic safeguards would have to be put in place to ensure that gaming is minimized during the formation of these provider groups, Committee members suggested that HHS support this effort through establishment of a grant or pilot project.

Fund additional work to consider how peer groups for rural providers should be defined and used for comparison purposes.

Another key concern of the Committee, particularly in the context of pay-for-performance programs, is how to ensure fair comparisons for rural providers. While the issue of fair comparisons is relevant to non-rural providers, the Committee emphasized the difficulties in identifying appropriate comparison groups for rural providers due to the heterogeneity of the patients, service offerings, and overall circumstances surrounding care delivery in rural areas. In general, the Committee favored use of peer groups to assure “like-to-like” comparisons. Suggestions for defining peer groups included comparing providers with similar service lines or capabilities (e.g., those providing surgical services or those with ICU capacity), those with similar geographic isolation profiles, and/or those with similar patient characteristics.²¹ There was less enthusiasm for comparison within provider type (e.g., CAH to CAH) because of heterogeneity within provider types and often a lack thereof between provider types (e.g., a 5-bed CAH may be much different than a 25-bed CAH, but there may be relatively few real differences in care provided by RHCs, CHCs, or small clinical practices). There was also resistance to comparing providers solely on a regional basis. The Committee also recognized

that for some measures (typically outcome and cost/resource use measures), appropriate statistical case-mix adjustment could potentially reduce the need for peer group comparisons, but noted that more study is needed to better understand this complex issue. Finally, after a considerable amount of discussion around this issue, the Committee acknowledged the need for additional consideration of this topic and recommended that CMS fund efforts to define and use appropriate comparison groups for rural providers.

Additional Recommendations

During their deliberations, the Committee also provided three additional recommendations that would benefit other quality measurement and improvement efforts for both rural and non-rural providers. These recommendations, which are specific to data collection and use, are as follows:

- **Relax requirements for use of vendors in administering CAHPS surveys and/or offer alternative data collection mechanisms** (e.g., similar to CART tool for hospitals). CAHPS surveys obtain patient-reported feedback on their experiences with care; these data are used to compute performance results regarding access to care, patient-provider communication, and shared decisionmaking, among others. Currently, collection of CAHPS data requires use of approved data collection vendors, which can be prohibitively expensive for many rural providers. The Committee noted that many hospitals use the CMS Abstraction and Reporting Tool (CART), a free tool for submitting process measure data to CMS. Thus, Committee members recommended that a similar tool/process be developed to allow reporting of CAHPS data to CMS.
- **Facilitate quicker and broader access to performance scores and to Medicare data for quality improvement purposes.** Committee members applauded “feedback reports”

provided as part of the Physician Feedback of Quality Resource and Use Reports (QRURs)/ Value-Based Payment Modifier program (for clinicians) and the Medicare Shared Savings Program (for ACOs), noting that these data allow for the identification of patients in a service area, as well as the types, locations, sources, and, sometimes, costs of care provided to patients. The Committee recommended that this kind of data be provided to all providers as quickly as possible in order to improve the care coordination for patients, reduce the overall cost to Medicare, and drive overall improvement efforts. The Committee also recommended that CMS facilitate faster cycle time between actual performance and use of performance data in programs. Currently performance results used in CMS improvement programs may be 2 years or more out of date (e.g., data used in 2015 programs reflect care provided in 2013 or earlier). Such long look-back periods hinder receipt of rewards for more recent improvements in care.

- **Facilitate inclusion of CMS data into all-payer databases.** The Committee agreed that the growth of large multipayer databases is likely to increase and that the inclusion of Medicare data (and allowing use of such data by multiple stakeholders) would help to mitigate the low case volume challenge and may help to facilitate alignment of measurement efforts across payers.

Timeframe for Uptake of Recommendations

In response to public and member comment on the draft version of the report, the Committee agreed that suggestions regarding the timeframe for uptake of the Committee's recommendations would be a valuable addition to the report. Accordingly, the Committee agreed on the following through a series of e-mails that were exchanged after its last formal meeting.

Recommendation (abbreviated)	Timeframe
Mandatory participation	2-4 years (2 years for initial participation, up to 4 years for some pay-for-performance programs)
Fund development of rural relevant measures	Immediate
Alignment	Continue ongoing efforts in the public sector; 3 years for private sector
MAP rural workgroup	<1 year
Payment programs that include incentive payments but not penalties	3 years
Fund additional work on peer group development	Immediate

ENDNOTES

- 1 Goodrich K, Garcia E, Conway PH. A history of and a vision for CMS quality measurement programs. *Jt Comm J Qual Patient Saf.* 2012;38(10):465-470.
- 2 Department of Health and Human Services (HHS). Better, smarter, healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value [press release]. Washington, DC:HHS; January 26, 2015. Available at <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>. Last accessed May 2015.
- 3 Medicare Access and CHIP Reauthorization Act of 2015, H.R. 2, 114th Cong, 1st Sess (2015), P.L. 114-10. Available at <https://www.congress.gov/bill/114th-congress/house-bill/2/text>. Last accessed May 2015.
- 4 Medicare's Sustainable Growth Rate formula was originally created to contain the growth of Medicare spending on physician services.
- 5 Depending on the definition, as few as 10 percent, or as many as 28 percent, of Americans live in rural areas. See: Hart LG, Larson EH Lishner DM. Rural definitions for health policy and research. *Am J Public Health.* 2005; 95(7), 1149-1155. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449333/pdf/0951149.pdf>; Last accessed January 2015.
- 6 Crosby RA, Wendel ML, Vanderpool RC, et al. *Rural Populations and Health: Determinants, Disparities, and Solutions.* San Francisco, CA:John Wiley & Sons; 2012.
- 7 However, it should be noted that rural areas are heterogeneous, and there may be substantial variation from one area to the next.
- 8 U.S. Department of Agriculture State Fact Sheets website. Available at <http://www.ers.usda.gov/data-products/state-fact-sheets/state-data.aspx?StateFIPS=00>. Last accessed January 2015.
- 9 There is some indication, however, that relatively fewer of the "oldest old" (i.e., those 85 and older) live in rural areas. See MedPAC. Serving rural Medicare beneficiaries. In: *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC:MedPac;2012:115-137.
- 10 The Federal government distinguishes between various "levels" of rurality. "Frontier" areas are the most remote and sparsely populated rural areas. Depending on the definition used, between 5.6 and 9.9 million Americans live in frontier areas.
- 11 Although CAHs bill Medicare Part A for their services like other hospitals, their payments are based on the cost of the care provided during the stay (i.e., cost-based) rather than on the stay's diagnosis-related group (DRG), a classification that is based in part on the diagnoses and procedures that are included on the claims. However, there is anecdotal evidence that the diagnostic and procedural coding for CAHs may not be as complete or as precise as that done in hospitals that are paid based on DRGs (since payment is unconnected to the coding). Hence, there is concern that patients seen in CAHs may have relatively higher acuity than what is indicated through the codes that are documented. However, if coding is incomplete or imprecise, comparisons of provider performance may not be accurate when claims-based measures are used. This may be exacerbated for outcome measures that are risk-adjusted using diagnostic and/or procedural data.

RHCs also are paid on a cost-basis through the Medicare Part B trust fund, although they actually submit Medicare Part A claims and consequently use a different coding system than that used by most other clinicians (who typically they submit Part B claims). However, most claims-based, clinician-level performance measures do not include this different coding system and therefore may not be applicable to clinicians in RHCs. Also, clinicians working in RHCs occasionally provide services that fall outside those covered by RHCs (e.g., more extensive diagnostic services) but these services are billed to Medicare Part B. Thus, while these clinicians may provide some services that could be reported to CMS programs such as Physician Quality Reporting System (PQRS), the bulk of the services they supply are not captured in PQRS. As with RHCs, CHCs bill Medicare Part A primarily (although some services are billed through Part B); thus, it is unclear the extent to which current claims-based measures can be used for the providers who work in either of these settings.
- 12 These clinicians can participate in these programs when they provide services outside of the RHC and CHC settings. Similarly, clinicians providing outpatient services in CAHs can participate in PQRS going forward, even if he/she has reassigned billing rights to the CAH.
- 13 The Committee agreed that grouping hand-offs and transitions as a single topic area is appropriate, although they clarified that hand-off measures assess provider-to-provider communication whereas transition measures assess the movement of patients from one setting of care to another.

14 As an example, race and ethnicity data are routinely collected by HRSA through its Uniform Data System.

15 A quality provision in the MACRA legislation notably includes support for technical assistance to help practices with 15 or fewer clinicians implement the MIPS or transition to APMs.

16 The 21st Century Rural Hospital. A Chart Book. March 2015. Available at <http://www.shepscenter.unc.edu/wp-content/uploads/2015/02/21stCenturyRuralHospitalsChartBook.pdf>. Last accessed September 2015.

17 Institute of Medicine. *Vital Signs: Core Metrics for Health and Health Care Program*. Washington, DC: The National Academies Press; 2015. Available at <http://www.iom.edu/Reports/2015/Vital-Signs-Core-Metrics.aspx>. Last accessed May 2015.

18 This method is currently used in the Value-Based Payment Modifier program for small physician practices.

19 iVantage Health Analytics. *Vulnerability to Value. Rural Relevance under Healthcare Reform 2015*. Portland, ME: 2015. Available at <http://www.ivantageindex.com/rural-healthcare-in-america-2015/>. Last accessed April 2015.

20 For each of the various measures included in the program, hospitals receive a score based on achievement or improvement, whichever is higher. The total performance score for each hospital is calculated as a weighted sum of measure scores for four domains (clinical process of care, patient experience of care, outcome, and efficiency).

21 A recently-developed taxonomy of population and health-resource characteristics for rural areas may also inform efforts to define peer groups for rural providers. This taxonomy uses variables such as hospital and nursing facility bed counts, the number of primary care and specialist physicians and other clinicians, demographic data including race, poverty level, and insurance status, and age to classify 10 different Primary Care Service Areas. See <http://cph.uiowa.edu/rupri/Place/taxonomy.html>.

APPENDIX A: Project Approach and Timeline

The goals of this project were 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. The approach used by NQF for this project is described below.

Multistakeholder Committee

NQF convened a 20-member multistakeholder Committee to accomplish the purpose and objectives of the project. Committee members were appointed based on their expertise and experience in statistical methodology, delivery of healthcare in rural areas, and/or implementation of quality performance measurement programs. The Committee included representatives from various stakeholder groups including private insurers, purchasers, payers, employers, consumers, and Medicaid program staff, as well as providers from CAHs, RHCs, CHCs, and small rural hospitals and clinician practices (see [Appendix B](#)).

Environmental Scan of Measures and Measurement Efforts

To help inform the Committee's deliberations regarding salient measurement issues that are associated with providing healthcare in rural areas, NQF conducted an [environmental scan](#) 1) to identify performance measures and measurement efforts that are being used by both public and private entities to assess and influence rural providers and 2) to identify and describe how these measures and programs are being used and validated to accurately reflect quality, cost, and/or resource use. To inform this environmental scan, NQF reviewed relevant peer-reviewed and grey

literature and publicly available repositories of measures (including NQF's portfolio of measures). NQF also sought input from the NQF members and key informants. Key results from the scan included a catalogue of more than 1,000 hospital- and clinician-level performance measures, which were tagged according to selected condition or topic areas, rural relevancy, and use in various federal quality improvement programs. Measures were tagged as relevant for rural providers based on both published and ongoing efforts to identify measures useful and meaningful for CAHs and RHCs.

Committee Deliberations and Recommendations

The multistakeholder Committee convened for a two-day, in-person meeting on February 5-6, 2015 to discuss the measurement challenges for rural health providers, prioritize topic areas for consideration, and make recommendations. NQF staff drafted a report of the recommendations, and the Committee further discussed and refined these during a follow-up, web-based meeting on March 19, 2015. NQF staff revised the draft report, and, after feedback from HHS, posted it for public comment from June 1 to June 30, 2015. Committee members met a final time via webinar on July 29, 2015, to discuss the public comments and discuss further refinements to the draft report. All public comments received as well as responses from the Committee are included in [Appendix D](#).

Project Timeline and Deliverables

The timeline and deliverables for the project are shown on the next page.

Sept 2014	Call for Committee nominations Began an environmental scan to systematically identify measurement opportunities for rural low- volume facilities and small-practice providers
Jan 2015	Web meeting to orient The Rural Health Committee to the project and share the results of the environmental scan Deliverable #1: Written environmental scan and analysis report
Feb 2015	2-day in-person meeting to identify measures and measurement gap areas that are applicable to rural low-volume providers and to recommend strategies for mitigating the identified challenges in implementing and using performance measures for value-based purchase/payment
March 2015	Committee web meeting to provide input on the draft report
April 2015	Deliverable #2: Draft report containing committee recommendations on priorities for rural health measurement
June 2015	Public comment period to obtain additional multistakeholder input on draft committee recommendations
July 2015	Committee web meeting to respond to public comments on the draft report
Sept 2015	Deliverable #3: Final report

APPENDIX B: Committee Roster, HHS Representatives, and NQF Staff

Committee Members

REPRESENTATIVE	ORGANIZATIONAL MEMBER
Kelly Court, CPHQ, MBA - <i>co-chair</i>	Wisconsin Hospital Association
Ira Moscovice, PhD - <i>co-chair</i>	University of Minnesota School of Public Health
Ann Abdella	Chautauqua County Health Network
Michael Baer, MD	AmeriHealth Caritas Pennsylvania
Tonya Bartholomew, OTR	Platte Valley Medical Clinic
John Gale, MS	University of Southern Maine
Aaron Garman, MD	Coal Country Community Health Center
Gregory Irvine, MD	St. Luke's McCall Orthopedics Clinic
Jason Kessler, MD	Iowa Medicaid Enterprise
Jason Landers, MBA	Highmark West Virginia
Bruce Landon, MD, MBA, MSc	Harvard Medical School
Jonathan Merrell, RN, BSN, MBA, IA	Indian Health Service
Guy Nuki, MD	BlueWater Emergency Partners
Kimberly Rask, MD, PhD	Alliant Health Solutions
Robert Rauner, MD, MPH	SERPA-ACO
Sheila Roman, MD, MPH	Independent consultant
Susan Saunders, MSN, CNM, WHNP-BC	American College of Nurse-Midwives
Stephen Schmaltz, MS, MPH, PhD	The Joint Commission
Tim Size, BSE, MBA, Doctorate Humanities (Honorary)	Rural Wisconsin Health Cooperative
Brock Slabach, MPH, FACHE	National Rural Health Association

Department of Health and Human Services Representatives

REPRESENTATIVE	FEDERAL GOVERNMENT MEMBER
Girma Alemu, MD, MPH	Health Resources and Services Administration
Kristin Martinsen, MPM	Health Resources and Services Administration
Megan Meacham, MPH	Health Resources and Services Administration
Curt Mueller, PhD	Health Resources and Services Administration
Martin Rice, MS, RN-BC, CPHIMS	Centers for Medicare & Medicaid Services

National Quality Forum Staff

STAFF MEMBER	TITLE
Helen Burstin, MD, MPH	Chief Scientific Officer
Severa Chavez	Project Analyst
Mitra Ghazinour, MPP	Project Manager
Karen Johnson, MS	Senior Director
Marcia Wilson, PhD, MBA	Senior Vice President

APPENDIX C: Glossary of Terms

Critical Access Hospital (CAH) – CAH is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute-care hospital CoP. Some of the requirements for CAH certification include having no more than 25 inpatient beds; maintaining an annual average length of stay of no more than 96 hours for acute inpatient care; offering 24-hour, 7-day-a-week emergency care; and being located in a rural area, usually, although not always, at least 35 miles away from any other hospital or CAH.¹

Community Health Center (CHC) – CHCs serve communities with limited access to healthcare. Health center program fundamentals include the following: located in or serve a high need community; governed by a community board; provide comprehensive primary healthcare; provide services available to all; and meet other performance and accountability requirements. There are three types of health centers, including grant-supported federally qualified health centers, non-grant-supported health centers, and outpatient health programs/facilities operated by tribal organizations.²

Frontier Areas – In general, frontier areas are sparsely populated rural areas that are isolated from population centers and services. Definitions of frontier for specific state and federal programs vary, depending on the purpose of the project being researched or funded. Some of the issues that may be considered in classifying an area as frontier include population density, distance from a population center or specific service, travel time to reach a population center or service, functional association with other places, availability of paved roads, and seasonal changes in access to services.³

Health Professional Shortage Areas (HPSAs) – Health professional shortage area means any of the following which the Secretary of HHS determines has a shortage of health professionals: (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.⁴

Hospital Acquired Condition (HAC) Reduction program – The HAC Reduction program is a pay-for-performance and public reporting program that supports the broader public health imperative to raise awareness and reduce the incidences of preventable HACs by applying evidence-based clinical guidelines. HACs are high-cost and/or high-volume conditions that occur during a hospital stay, result in higher costs of care, and can reasonably be prevented if evidence-based care is provided. Pressure ulcers, various surgical site infections, and injuries sustained in falls or other traumatic events are examples of HACs that are included in this program. Hospital performance under the HAC Reduction Program is determined based on a hospital's Total HAC Score, which can range from 1 to 10. The higher a hospital's Total HAC Score, the worse the hospital's performance under this program.⁵

Hospital Compare –Hospital Compare provides information on how well hospitals provide recommended care to their patients to help consumers make more informed healthcare decisions about where to receive healthcare. Hospital Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery, and other conditions.⁶

Hospital Inpatient Quality Reporting (IQR)

program – IQR is a pay-for-reporting and public reporting program that authorizes CMS to pay hospitals a higher annual update to their payment rates if they successfully report designated quality measures. This program was authorized by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.⁷

Hospital Outpatient Quality Reporting (OQR)

program – OQR is a pay-for-reporting program with performance information reported on the Hospital Compare website. The goals of the program are to establish a system for collecting and reporting on quality performance of hospitals that offer outpatient services such as clinical visits, emergency department visits, and critical care services.⁸

Hospital Value-Based Purchasing (HVBP)

program – HVBP is a pay-for-performance program that aims to improve healthcare quality by providing incentive payments to hospitals that meet or exceed performance standards. Hospitals are scored based on their performance on each measure within the program relative to other hospitals, or on how their performance on each measure has improved over time. Four domain-level scores (clinical process of care, patient experience of care, outcome, and efficiency) are calculated from scores of measures that make up the domains. Scores from each domain are weighted and summed to determine the total performance score. Measures selected for the HVBP program must be included in IQR and reported on the Hospital Compare website for at least one year prior to use in the HVBP program.⁹

Medically Underserved Area – Medically underserved areas/populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty, or a large elderly population.¹⁰

Medicare and Medicaid EHR Incentive

(“Meaningful Use”) program – MU provides incentives to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. The goal of this program is to promote the widespread adoption of certified EHR technology by providers and to incentivize the “meaningful use” of EHRs to improve quality, safety, efficiency, and reduce health disparities, engage patients and their families, improve care coordination, and maintain privacy and security of patient health information.¹¹

Medicare Shared Savings Program (Shared Savings Program)

– This program aims to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). The Shared Savings Program will reward ACOs that lower their growth in Medicare spending while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.¹²

Physician Compare – A federal website that reports information on physicians and other clinicians. The purpose of the website is public reporting of information and quality measures that are meaningful to patients.¹³

Physician Quality Reporting System (PQRS)

– PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. All PQRS measures will be used for public reporting on Physician Compare and for the quality component of the Value-Based Payment Modifier.¹⁴

Rural – This term has been defined in many ways, most often in terms of non-urban status. The Federal Office of Rural Health Policy (FORHP) defines rural as located outside a Metropolitan Statistical Area (MSA), or located in a rural census tract of an MSA as determined under the Goldsmith Modification or the Rural Urban Commuting Areas.¹⁵

Rural Health Clinic (RHC) – RHC is a federally qualified health clinic certified to receive special Medicare and Medicaid reimbursement. RHCs are required to be staffed by a team that includes one mid-level provider, such as a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM), who must be on-site to see patients at least 50 percent of the time the clinic is open, and a physician (MD or DO) to supervise the mid-level practitioner in a manner consistent with state and federal law. RHCs are only required to provide outpatient primary care services and basic laboratory services and must be located within non-urban rural areas that have healthcare shortage designations.¹⁶

Small Hospital – For the purposes of this report, a small hospital is defined as 49 available beds or fewer, as reported on the hospital's most recently filed Medicare Cost Report.¹⁷

Small Clinician Practice – For the purposes of this report, small clinician practices are defined as those with <10 eligible professionals.

Telehealth – The use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health, and health administration is called telehealth. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.¹⁸

Telemedicine – For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.¹⁹

Value-Based Payment Modifier Program – The VBPM program (also known as the Value Modifier) is a pay-for-performance program that provides differential payment to physicians or physician groups who are paid under the Medicare Physician Fee Schedule (PFS). The payment adjustments are calculated based upon the quality of care furnished compared to the cost of care during a performance period. High-quality and/or low-cost groups can qualify for upward adjustments in payments, while low-quality and/or high-cost groups or groups that fail to satisfactorily report measures to PQRS are subject to downward adjustments in payment. This program will be implemented in several phases. In 2015, the Value Modifier will be applied to physicians in practices of 100 or more eligible professionals (EPs), based on their 2013 performance. In 2016, the Value Modifier will be applied to physicians in practices of 10 or more EPs, based on their 2014 performance. Beginning in 2017, the Value Modifier will be applied to all physicians, regardless of group size (although groups with <10 EPs will not be subject to negative payment adjustments). In 2018, the Value Modifier also will be applied to non-physician EPs.²⁰

ENDNOTES

- 1 Health Resources and Services Administration (HRSA) website. Available at <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/critical.html>. Last accessed September 2015.
- 2 HRSA website. About Health Centers. Available at <http://bphc.hrsa.gov/about/>. Last accessed September 2015.
- 3 Rural Assistance Center website. Available at <http://www.raconline.org/topics/frontier#definition>. Last accessed September 2015.
- 4 HPSA Designation Criteria website. Available at <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html>. Last accessed September 2015.
- 5 CMS.gov. Hospital-acquired conditions website. Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html>. Last accessed September 2015.
- 6 CMS.gov. Hospital Compare website. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html>. Last accessed September 2015.
- 7 Centers for Medicare & Medicaid (CMS) website. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html>. Last accessed September 2015.
- 8 CMS.gov. Hospital outpatient quality reporting program website. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html>. Last accessed September 2015.
- 9 The FY 2015 IPPS/LTCH Final Rule. *Fed Registr* 2014;79:49853-50449. Available at <https://federalregister.gov/a/2014-18545>. Last accessed September 2015.
- 10 HRSA website. Available at <http://muafind.hrsa.gov/>. Last accessed September 2015.
- 11 CMS.gov. Eligible hospital information website. Available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligible_Hospital_Information.html. Last accessed January 2015.
- 12 CMS.gov. Shared savings program website. Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>. Last accessed September 2015.
- 13 CY 2015 Revisions to payment politics under the Physician Fee Schedule and other revisions to Medicare Part B (CMS-1612-P). *Fed Registr*. 2014;79:67547-68010. Available at <https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory>. Last accessed September 2015.
- 14 CMS.gov. Physician quality reporting system website. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/>. Last accessed September 2015.
- 15 HRSA website. How is rural defined? Available at <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/defined.html>. Last accessed September 2015.
- 16 HRSA website. Available at <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/rural-clinics.html>. Last accessed September 2015.
- 17 HRSA website. Small Rural Hospital Improvement Program (SHIP) Available at <http://www.hrsa.gov/rural-health/about/hospitalstate/smallimprovement.html>. Last accessed September 2015.
- 18 HRSA website. Telehealth. Available at <http://www.hrsa.gov/ruralhealth/about/telehealth/>. Last accessed September 2015.
- 19 Medicaid.gov. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>. Last accessed September 2015.
- 20 CMS. Value-Based Payment Modifier website. Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>. Last accessed September 2015.

APPENDIX D:

Public Comments Received on Draft Report and Committee Responses

Alabama Office of Primary Care and Rural Health

Carolyn Bern

Our providers felt that swing beds should be included in the measures.

>Committee Response

Thank you for your comment. The Committee recommended that exclusions for existing measures be reconsidered, as appropriate, in order to help address the low case volume challenge. This recommendation would potentially apply to the swing bed issue.

American Academy of Family Physicians

Heidy Robertson-Cooper

Overall, the AAFP is supportive the recommendations and agrees that rural providers face numerous challenges to when engaging in performance measurement activities. The AAFP supports the recommendation of pursuing alignment of quality measures across payers and programs. The AAFP has long held this position, and continues to advocate for this strongly. In conjunction, AAFP is supportive of a core set of measures used for PCMH activities that includes measures that are rural-relevant. As outlined in the “rural scan of hospital and provider measures” spreadsheet, many measures that are applicable to the PCMH are considered “rural relevant.” For those that are not, the AAFP supports that measurement benchmarks should be adjusted to account various factors that rural family physicians face such as low-case volume due to geographic location. The AAFP supports risk-adjustment for rural-relevant demographic factors. The consideration of risk-adjustment for rural-relevant sociodemographic factors is very important to help achieve “like-to-like” comparisons so those providers who provide care in rural areas are not negatively impacted in pay-for-performance programs.

>Committee Response

Thank you for your comment and your support of the Committee’s recommendations. While the Committee

does not support different benchmarks for rural providers, it does support the potential inclusion of rural-relevant sociodemographic factors in risk-adjustment approaches so as to better enable fair comparisons of providers as well as a consideration of both performance and improvement when designing accountability programs.

American Academy of Pediatrics (AAP)

Lisa Krams

In general, rural providers experience a number of significant roadblocks to implementing quality measurement. A task for CMS will be to find ways to accomplish this without creating onerous barriers to provision of care for these very busy (and often overworked) providers and physicians.

The draft report seems to assume that all rural providers are employed physicians in a CAH, FQHC, or RHC. Many rural physicians are not employed by these entities, and even fewer specialists are, since FQHCs and RHCs are, by definition, primary care facilities.

The report also assumes that rural practices are low volume across the board. This greatly depends on what metric is being considered for “low volume.” For example, a primary care pediatrician in a rural community may not see/treat many cases of Kawasaki’s disease, but they probably treat a comparable number of children with ADHD as their counterparts in urban settings. With rural health care provider shortages, there may actually be more volume per provider for common conditions such as colds, UTIs, ADHD, etc.

Telehealth continues to transform the practice and provision of health care, both for pediatrics and the field in general. The AAP strongly encourages NQF to consider issues related to telehealth in all initiatives.

The AAP appreciates that the report explicitly connects the poverty endemic in rural areas to the overall health of patients in those communities. Patients in rural communities often have more health

problems, and the physicians treating them have fewer resources at their disposal for treatment.

“Make participation in CMS quality improvement programs mandatory for all rural providers but allow a phased approach for full participation across program types”

- The AAP has some concerns about the concept of mandating participation in CMS quality improvement programs. In some cases, mandating more reporting and provider participation can have a negative impact on patient access to services.

“Use guiding principles for selecting quality measures that are relevant for rural providers”

- The AAP appreciates the idea of addressing actionable activities as one of the guiding principles. Any measurement requirements should be grounded in things that are within a rural provider’s control.

“Use a core set of measures, along with a menu of optional measures, for rural providers”

- The AAP would advocate for a core set of measures and optional measures that can be applied to pediatric populations and providers.
- We support the concept of a selection of optional measures, so that physicians put their energy into implementing measures that are relevant and meaningful in their own practices.
- Who will abstract the collected data? Personnel for non-clinical/administrative work may be in short supply in rural practices, and shifting nurses from patient care to non-clinical work poses a serious dilemma. In many pediatric practices, data collection already has a bad name. Providers need to be able to abstract data from their EHRs with a few key strokes to move it into registries, populate reports, and get rapid feedback.

“Consider measures that are used in Patient-Centered Medical Home models”

- With any measures that are selected, AAP would encourage CMS to demonstrate that sufficient value has been demonstrated to warrant the cost.

“Consider rural-relevant sociodemographic factors in risk adjustment”

- “Availability of other healthcare resources in the area” is a tremendously important factor. Timely referral to specialist care, especially for pediatric

populations, is not always available, because specialists are often busy with their own urban populations.

- Consider adding the following SD factors: housing security (substandard housing, plumbing or lack of plumbing, handicapped access) and food security to the list of factors for consideration.

“For rural providers, create payment programs that include incentive payments, but not penalties”

- The AAP agrees with and supports the recommendation that any CMS-mandated quality improvement program should not include penalties.

“Offer rewards for rural providers based on achievement or improvement”

- Positive incentives are the most likely to produce success in the areas desired, but often the larger problem is a lack of time. When you are a clinic doctor, neonatologist, hospitalist, psychologist, and practice manager all rolled into one, time is your greatest ally and enemy.

“Create a MAP workgroup to advise CMS on the selection of rural-relevant measures”

- The AAP supports the establishment of a MAP workgroup specific to rural-relevant measures. We recommend that at least one pediatrician be a part of this group. The AAP, through our Council on Community Pediatrics, has a Rural Health Special Interest Group, and we would welcome an opportunity to work with NQF to identify pediatricians to join a Rural Health MAP Workgroup.

>Committee Response

Thank you for your comment. The Committee understands that all rural providers are not employed in CAHs, RHCs, or CHC and that all rural providers face the low case volume challenge. It has modified the report to make this more clear. To address concerns about mandating rural providers to participate in CMS quality programs, the Committee re-ordered its recommendations so as to better emphasize that mandatory participation is contingent the uptake and implementation of other its recommendations, including those that address the low case volume issue. The Committee also added housing and food security to the list of potential rural-relevant sociodemographic factors that might be considered in risk-adjustment approaches.

American Hospital Association

Akinluwa Demehin

The AHA believes that the real value in public reporting and pay for performance programs for any provider is achieved only when there are a focused set of measures that assess progress on critically important aspects of care provided by the organizations and providers being assessed. In other words, measuring the right things in the right way is the critical step in creating a program that is worth the investment of personnel and resources that will be required to achieve it. It is essential that low volume rural hospitals and other providers invest their efforts in measuring aspects of care that are truly important for the patients they serve and the care they provide. Small hospitals and other providers have scant resources, and diverting nursing or physician time from the direct provision of care in these — or frankly, in any health care delivery organization — should only be done when there is a reasonable expectation that the task to which their attention is diverted will lead to better care, better decision-making, and therefore, better patient outcomes. Thus, the first question to be answered should not be whether these organizations should be required to collect and report data, but rather, can a small set of critical measures be identified that will facilitate both quality improvement efforts and public reporting in rural low volume providers? For all of the reasons articulated so well in this report, it will be challenging to create such a list.

If the right measures are identified, there would be value to the future participation of CAHs and other rural providers in in appropriately designed public reporting programs. Given the thin margins and limited resources of rural providers, the Committee has recommended an incentive-only approach, and we agree that would be the most appropriate. However, we are skeptical that an incentive only approach would be politically viable in today's environment and keenly aware that unless the right set of measures and a fair methodology to account for low volumes can be developed and used, a program that intends to pay for performance may seem much more like a game of chance than well-designed public policy. We caution that a mandate to participate in such programs would be premature until we can be sure that the many

technical challenges of measuring the quality of rural low-volume providers accurately are addressed. For this reason, we suggest the expert panel consider articulating a more explicit “roadmap” that highlights the recommendations that are the highest priority to address, a sequence for implementing them, and instructions about what must be accomplished at each step before the next step is begun.

The development of a roadmap is especially important because a mandate for rural low-volume providers to participate in most CMS public accountability programs would require authorization from Congress. Any future statutory requirements must take into account the technical challenges of measurement, and use an appropriate pace of implementation. The expert panel has developed a commendable compendium of the challenges and potential solutions for measuring the quality of low volume rural providers, and we believe its recommendations will be the most actionable if they are prioritized and sequenced.

Require rural providers to report on a “required core set” of measures, with a menu of optional measures. The AHA strongly agrees that national quality reporting efforts should be focused on a limited number of important issues so that each part of the health care system is contributing toward common goals. However, we do not necessarily think focus is best achieved by asking all providers to report on the exact same measures. As the draft report correctly notes, “there is tremendous heterogeneity in the services that are delivered by rural providers and the patients they serve.” Thus, requiring all rural providers — CAHs, federally-qualified health centers (FQHCs), and physicians — to report on the same “core set” could lead to providers being asked to report measures that are irrelevant to the care they deliver or the patients they serve.

Instead, we suggest this recommendation be reframed so that it focuses on ensuring that rural low-volume provider quality measurement efforts are focused on consistent goals and objectives for improvement. These goals and objectives also should be aligned with broader national priorities for quality improvement. The actual measures used for any group of providers would then assess the critical processes of care or outcomes that should be achieved by that provider to support the common

goals and objectives. In this way, the wide variety of rural providers can be assessed on the measures that best help them achieve the common goals. Indeed, this type of approach was recently articulated by the Institute of Medicine in its Vital Signs report.

Create a MAP workgroup to advise CMS on the selection of rural-relevant measures. The AHA supports this recommendation in concept. However, we suggest this recommendation be made contingent on the emergence of Congressionally-mandated quality measurement programs for rural providers.

>Committee Response

Thank you for your comment. The Committee has re-ordered its recommendations so as to better emphasize that mandatory participation is contingent upon the uptake and implementation of other its recommendations, including those that address the low case volume issue. It has also added a proposed timeframe for implementing several of the recommendations. The Committee agrees that reporting on identical measures across settings is not always feasible, and has modified the report to reflect a need for at least some alignment of measure concepts across settings of care. Finally, the Committee agrees that a MAP workgroup specifically focused on rural providers is needed prior to mandated inclusion of CAHs, RHCs, and CHCs into CMS quality programs, as many other rural providers are already affected by these programs.

America's Health Insurance Plans

Carmella Bocchino

As part of a framework for measuring performance of rural providers, we would like to include strategies for increasing the amount of high-level providers into rural areas. It is believed that measurement alone of current rural providers will not incentivize enough improvement or access to the highest quality of care for rural populations.

It is preferred that a separate set of measures not be developed for rural health but rather identify measurement targets adjusted for small numbers and geographic occurrence rates.

In keeping with the philosophy of aligning and streamlining measurement, rural providers could

have a different or stratified measurement target for demonstrating improvement with existing metrics.

As for identifying measures that are relevant to rural providers, geographical population management might be better suited by using the approved core measures appropriate for disease specific management using those identified for higher occurrence within the rural area rather than creating a new or additional set of measures.

>Committee Response

Thank you for your comment. The Committee agrees that care alternative delivery options such as telehealth/telemedicine can help to increase access to specialty care for rural patients and therefore made recommendations regarding development of performance measures for telehealth/telemedicine specifically and access-to-care measures more generally. However, because the focus of this project is performance measurement, recommendations regarding workforce are out of scope. Although the Committee made recommendations regarding use of a core measure set and development of rural-relevant measures, it did not intend to imply that a separate set of measures be used for rural providers and the report has been modified to make this more clear. The Committee also modified the report to give examples of measure concepts that would be appropriate for the core set (e.g., screening, immunization, medication reconciliation, etc.). While the Committee does not support different benchmarks for rural providers, it does support the potential inclusion of rural-relevant sociodemographic factors in risk-adjustment approaches so as to better enable fair comparisons of providers, as well as a consideration of both performance and improvement when designing accountability programs.

Arkansas Dept of Health

Kimberly Armstrong

ORHPC agrees with the NQF project in that the issues and challenges facing Rural Healthcare facilities performance measures and the recommendations to address these issues of low case volume, heterogeneity, geographic isolations and small practice size are major factors and that most consideration should be placed on these areas to

standardize 1 performance measure for all. With that said, there should also be a phased in time depending of the different types of healthcare delivery facilities. Also, low case-volume and small practice size should be taken into context with less burden placed on these facilities for reporting purposes.

Comments regarding Performance Measurement for Rural-Low Volume Provider specific to critical access hospitals.

In agreement to make participation in CMS quality improvement programs mandatory for all rural providers in a phased in approach. Measures should be meaningful and reflective of the highest volumes in relation to types of service provided, such as Outpatient Acute MI measures for CAHs. There is a critical need for more timely care for AMI patients seen in rural settings that are transferred for acute coronary intervention or administered fibrinolysis. These measures reflect direct patient outcomes.

In agreement to use quality measures for rural providers that explicitly address low case-volume that are endorsed by the NQF.

CAH staff are many times overwhelmed in the many different professional roles they are fulfilling in these facilities. The quality measure reporting process should not be a huge overburden. Rural health professional and CAHs are directly involved in mandatory PQRS reporting now because many of them use type II billing method for Medicare Part B. This is new and very time intensive to the CAH quality office in tracking and submission of the PQRS quality measures for their providers that have professional fees billed under the hospital's Tax ID number for Medicare Part B. They will also now be included in the Value Modifier quality tiering and subsequent payment adjustments associated with these two programs.

It is crucial to keep any quality reporting or value based payment program that will be implemented in the future for low volume providers meaningful and prevent them from becoming too complicated or expansive so that true improvement in quality of care and patient outcomes can be obtained.

>Committee Response

Thank you for your comment and your support of the Committee's recommendations. The Committee agrees that the data collection and reporting is a challenge for rural providers in small hospitals or practices and therefore recommended alignment of measurement efforts, including alignment of measures and data collection efforts.

California Hospital Association

Alyssa Keefe

The California Hospital Association (CHA) applauds the committee in clearly articulating a number of key issues for consideration by HHS in measuring performance of small rural providers including critical access hospitals (CAHs) and rural health clinics (RHCs). CHA supports quality reporting for all providers and believes that data must be reliable and valid in order to support consumer choice and internal quality improvement efforts.

In reviewing the report recommendations, we understand that the premise by which all other recommendations are based is that there was consensus reached by the committee that CMS should augment existing pay for reporting and performance programs and mandate rural provider participation in those programs rather than stepping back and designing an appropriate program for small rural and critical access providers. CHA would not agree with this premise and asks the committee for clarification as it's somewhat unclear through the entire report. CHA urges the committee to make clear their intent as these recommendations have significant implications for implementation. For example, Congress created many of the existing programs for IPPS hospitals and purposely excluded critical access hospitals. Asking CMS to augment these programs for inclusion of these providers as the report suggests is not within their authority without congressional action. Rather, in the ACA, Congress mandated the development of a CAH demonstration program that has yet to move forward. While many of the challenges discussed impact small rural hospitals paid under IPPS, the majority of providers would benefit from a program that is designed address their

unique challenges. A demonstration or other CMMI initiative, such as the one called for in the ACA, would test measure reliability and validity and determine if a payment model similar to a value based purchasing program is sustainable using such measures while accounting for other circumstances (e.g. geographic isolation, lack of access to certain specialty services) before being scaled. CHA urges the committee to consider a very clear recommendation to Congress and HHS to first develop measures appropriate for the setting and, as a second step, test payment and performance models using the specific measures rather than suggest CMS augment existing programs. The committee further suggests that these payment models only be incentive based rather than penalty based. We agree that small rural and CAH providers should first proceed in pay for reporting before any pay for performance methodology is mandatory and believe that the recommendations should be clearer in that regard.

We believe strongly that CMS should continue to allow voluntary reporting on measures that are appropriate and to display them on Hospital Compare while it aggressively moves toward implementation of new programs designed to meet the needs of rural providers. We urge the committee to make strong statements regarding the importance of incentivizing voluntary reporting where measures are applicable to the provider.

Further, we believe that alternative payment models like ACOs and primary medical homes, while not prevalent in rural communities at this time may be at a later date. The very nature of the delivery system is changing in rural communities and we urge the committee to think beyond the payment programs of today – but rather what is needed in the next 3 to 5 years to support quality improvement and public reporting under new models of care.

CHA agrees that geographic isolation, small practice size, heterogeneity and low case volume are barriers to measurement for rural providers. The committee can not underestimate the challenge of measure development, data collection and reporting that is eluded to when the report discusses various ways in which these providers are paid.

For years, CMS has tried to apply physician measures used in PQRS to the outpatient quality reporting

program and they have yet to be successful. The challenge has always been that these providers maintain different medical records, different billing systems, and employ totally different data collection methods. This makes apples to apples comparisons impossible. Further it creates costly administrative burden on providers. We are seeing this play out now in the post-acute care setting where CMS is adopting standardized sets of measures across all settings in fulfilling the requirements under the IMPACT Act. This approach will likely have many unintended consequences that are unknown at this time. Further this standardization, we believe in some instances will jeopardize valid and reliable measures already collected in those settings (e.g. functional assessment measures).

Measures should be developed and tested for the setting in which they are to be used. The committee should stress the need for alignment without the need for standardization. Standardization assumes everyone must collect the same data the same way so you can compare all settings on the same exact measure. CHA does not believe standardization is needed in this area, rather alignment across a core set of measures that can be augmented for the setting or in this instance the unique nature of the delivery system in which it is assessing. CHA urges the committee to push for alignment not standardization.

Further the committee report only briefly touches on alignment with the private sector; rather there is greater focus on the internal CMS alignment of programs. CHA urges the committee to say more about the need for greater alignment of measures with private payers and consider recommendations to HHS that would make rural measurement a key factor in the development of the QHP quality reporting system as well as the newly proposed Medicaid Managed Care QRS.

As noted in our general comments, CHA supports the recommendations of the committee, but with the need for greater clarity regarding mandatory participation in existing or newly developed programs. Further, we believe strongly that the committee should prioritize their recommendations, and clearly state that until such time as sufficient measures are developed and endorsed participation will be voluntary rather than mandatory. CHA

supports incentivizing and not penalizing rural providers at this time and we support a very strategic staged approach to implementation. We would urge the committee to consider a timeframe for implementation of these recommendations and encourage HHS to engage stakeholders at every step in the process.

>Committee Response

Thank you for your comment. In the draft report, the Committee noted that one assumption was that the design of current programs should not constrain its recommendations, implicitly suggesting that new programs and/or modification of existing programs may be needed in order to implement the recommendations. However, the Committee has modified the report to explicitly state that its recommendations can be used to enhance existing CMS quality improvement programs, create completely new programs designed specifically for rural providers, or both. The Committee also modified the report to make it clearer that uptake of the various supporting recommendations would be needed prior to mandating participation in CMS programs. In addition, the Committee included recommendations regarding a timeline for implementation of several of our recommendations. Finally, the Committee agrees that it may not always be possible to use identical measures across settings and has modified the report to clarify that alignment of measurement concepts also is needed.

Center for Rural Health

Jill Bullock

I think quality reporting for rural hospitals is a good thing. However, measures should be in line with rural healthcare. Many Critical Access Hospitals are reporting, but go through such hoops to report 0 cases. The Medicare Beneficiary Quality Improvement Project is aligning measures for small hospitals, but the reporting mechanism is all over the place making it very confusing for all involved. I also think that Indian Health Services measures that are reported to GPRA should be aligned with all rural hospitals or count as reporting for rural hospitals.

>Committee Response

Thank you for your comment. The Committee agrees that alignment of measures is needed and will expand the language to mention IHS measures.

Cheyenne Regional Medical Center

Brianna Chavez

Performance Measurement For Rural Low-Volume Providers

Public Comment Invitation -

Comments Provided by Cheyenne Regional health system, Cheyenne, WY 82001

June 25, 2015

Comments below are referencing Recommendations as those appeared in the National Quality Forum document with their pagination.

Make participation in CMS quality improvement program mandatory - Page 11

We recommend a phased measurement implementation: develop pay-for-reporting infrastructure, followed by a transition to public reporting and then a pay-for-performance framework. Allow rural providers to gain understanding and expertise with reporting mechanisms and quality measures before penalties are implemented.

Resources are extremely constrained in rural / frontier communities: reporting utilities, training, measure and reporting technology updates are resourced by very limited staffing capacities.

Use measures for rural providers that explicitly address low case-volumes - Page 13

We agree and support that measures created should allow rural physicians to explicitly address low-case volumes.

The NQF committee did not recommend measures for population health and wellness. We urge the committee to reconsider this recommendation. We recommend refocusing measures that allow for capturing care continuums that are extending across multiples access points to care, and include community health resources utilizations.

We recommend measures that include care plan, care coordination, extension of the care continuum between acute, ambulatory, primary care, and community health resources referral, as rural/frontier care providers are in key position to connect clinical and community based resources when creating care plans for their patients. We refer to stated principle in Table 1. on page 17 to support our recommendation, where the committee states that "support the aim of

creating and maintaining healthy communities may be particularly salient.”

Use guiding principles for selecting quality measures – Page 14

Add additional Principle (in Table 1.) to measure the delivery of care along a continuum of care, including acute, ambulatory, and specialty referrals as guided by the patients individual care plans.

Consider Measures that are used in Patient-Centered Medical Homes models – Page 19

We concur with the Committee’s recommendation to build upon the existing work with PCMHs and utilize measures already rolled out for rural providers in order to reduce the burden of data collection.

In addition to the preventive measures noted in the Committee’s recommendation, we are in support of developing measures that capture the patient population risk stratification work of PCMHs, and the high risk / rising risk management of chronic conditions that PCMHs have been excelling.

Create a MAP workgroup to advise CMS on the selection of rural-relevant measures – Page 20

We see the need for the extension of a MAP effort and Cheyenne Regional is interested in participating in the work of said group to provide feedback on frontier care delivery objectives.

Fund development of rural-relevant measures - Page 22

In terms of patient hand-offs and transitions, our work with the CMS CMMI Innovation Award allowed us to gage that a significant portion of our target population did get referred within state boundaries yet across geographical boundaries often covering long distances. Measures should help to assess the timeliness of the hand offs, the connection between care providers, and the effectiveness of provider- patient communications across geographic boundaries.

On the recommendation of telehealth measures, we would like to see measures assessing the clinical utility of telehealth / telemedicine. While the infrastructure roll out seems to have been occurring across rural areas, our experience suggests that clinical adoption is difficult to track and can only be partially pieced together from payers’ claims data.

Create incentive payments, not penalties- Page 24

Agree with incentives for rural providers to participate in such a program, and recommend no penalties in the initial roll out of the program. Penalties may be phased in over time.

Additional Recommendations

Value Based Purchasing did elevate quality on the inpatient and acute care side of care delivery. We see the need to develop a value based payment program for PCMH/Outpatient/Rural Providers.

We recommend that frontier providers be allowed to use CAHPS- alternative surveys when small practice based providers find the limitations of their resources prohibitive of developing and implementing a comprehensive CAPHS survey.

>Committee Response

Thank you for your comment. While the Committee did not make recommendations regarding specific measures (including those for population health), it did note the utility of population health measures and recommended additional development of such measures. Also, while the Committee did not add an additional principle for measure selection, it did include note the need for measures that can be used across multiple healthcare settings across the continuum of care in the section on alignment. While the Committee agrees on the importance of community health resources and the need include them in quality measurement and improvement efforts, members believe it is beyond the scope of this report to make additional recommendations related to this issue beyond those already made regarding measures of population health and wellness of the community. Finally, the Committee decided not to modify our recommendations regarding the CAHPS surveys but members noted that some rural providers have found ways to make fielding the survey more economical by sharing vendor services.

Florida Hospital

John Hood

I’m writing on behalf of Adventist Health System (AHS) to share our comments on the Performance Measurement for Rural Low-Volume Providers Draft Report for Comment.

AHS includes 44 hospital campuses located across 10 states and comprises more than 8,000 licensed beds. Our organization provides inpatient, outpatient and emergency room care for four million patient visits each year and our flagship facility, Florida Hospital, is the nation's largest provider of Medicare services. In addition, AHS operates a Critical Access Hospital (CAH) in Wauchula, Florida.

AHS commends the Committee on this report. We believe that the draft report correctly identifies the key quality measurement issues for rural providers. Addressing these issues will be very difficult and will require a great deal of creativity. As the Committee appropriately notes, there are significant differences between rural communities across the United States. A rural community in Appalachia may not be comparable to a rural community in Iowa or to a rural community in New York. These differences will make broad comparisons difficult.

In the draft report, the Committee lists a series of guiding principles for selecting quality measures that would be relevant for rural providers. We think that designating discrete regions of the country, so that some degree of homogeneity of geographies and populations can be established, may be a good first step in the process of creating a model to meaningfully measure rural provider quality. For instance, the rural hospitals in upper New York State could be treated as one group, rural hospitals in the Midwest as another group and the hospitals in rural Tennessee and Kentucky as a third group.

We also think that it would be important, before undertaking the development of measures, to use available Centers for Medicare and Medicaid Services (CMS) data to geographically compare the nature of diseases treated by rural providers. This analysis could then inform the evaluation or development of quality measures.

We concur with the Committee's finding that low case-volume is a significant challenge to rural provider measurement. We have found that the low volume of care provided by rural hospitals makes it difficult to gather adequate sample sizes of data to generate reliable metrics and draw meaningful conclusions. This is especially true when considering measures related to specific diseases.

AHS agrees with the Committee's recommendation

to use measures for rural providers that are broadly-applicable across rural providers and measures that reflect the wellness of the community. We have found that a significant amount of care in rural areas is provided by home health care agencies. We think that population-based measures that incorporate physician, hospital and outpatient care may be more feasible, valid and reliable than a series of individual measures tied to specific providers or settings. This approach could encourage greater care integration between providers and may be a better starting point than trying to take a measurement system that is more applicable to high-volume providers and trying to adapt it for the rural community.

We are concerned about the Committee's recommendation that participation in CMS quality improvement programs be made mandatory for all rural providers. While we agree that all providers should engage in quality improvement efforts, we think it is premature to mandate the participation of the rural health care provider community. We believe that there is a need for a greater understanding of the unique needs of rural providers and the communities they serve. Prior to mandating quality reporting, we think that the Department of Health and Human Services (HHS) should convene a working group made up of representatives from CMS, the National Quality Forum (NQF), the National Rural Health Association (NRHA) and other organizations that represent rural providers and communities. This working group could determine a reasonable starting point for rural providers to engage in quality measurement and reporting. AHS supports the idea of including rural providers in a pay-for-reporting program after there is a determination of what is to be reported. We also favor efforts to develop rural-relevant Electronic Clinical Quality Measures (eCQM) that can extract necessary quality information from presently available Electronic Health Record (EHR) data sets without adding overly burdensome reporting requirements on rural providers. However, phasing in any eCQM requirements will need to be aligned with efforts to ensure that rural providers have access to EHRs.

The draft report recommends the use of measures for rural providers that explicitly address low case-volume. This presents a challenge because a low volume of cases means that there will be a significant

amount of variation in the measurement. This was recognized early in the establishment of the Value-Based Purchasing (VBP) Program. One way to address low-volume may be to aggregate the data of several rural facilities, such as CAHs and Rural Health Clinics (RHCs), that are operated by a particular system. This would enable an evaluation of the quality of the services the system provides in rural areas. There may be some concern that hospital-based RHCs may have an advantage on some measures and a disadvantage on others. However, this ability to assess quality could be helpful when valid and reliable evaluations of individual facilities are not feasible.

The draft report suggests that consideration should be given to the development of ratio measures or measures that use continuous variables. Variable data allowances may be essential for the measurement of rural providers given the heterogeneity of facilities, geographies and patient populations. However, the limitations of such approaches need to be clearly understood especially if they will impact provider payments and will be used to compare providers.

We support the suggestion included in the draft report that rural providers be compared to themselves and measured on improvement. As noted by the Committee there is significant heterogeneity across rural areas in the United States. It may be an impossible task to try to normalize the rural providers so that meaningful comparisons can be made.

The draft report includes a recommendation that consideration be given to measures that are used in Patient-Centered Medical Home (PCMH) models. Given the nature of rural patient populations being seen in rural areas, and the delivery systems that are available to these populations, this idea is one that needs to be explored further. This may create a basis for comparison across geographic areas.

We strongly support the creation of a MAP work group to advise CMS on rural-relevant measures. The makeup of this work group should have significant representation of rural providers.

We strongly support the idea of funding development for rural-relevant measures, creating payment programs that include incentive payments but not penalties for rural providers and the offering of rewards from providers based on achievement or improvement.

We strongly support the efforts by the NQF to develop meaningful measures of quality for the portion of the health care system that serves rural America. We strongly urge the NQF and measure developers to take into consideration the significant differences between rural communities.

>Committee Response

Thank you for your comment and your support of the Committee's work. The Committee agrees that comparisons of rural providers should be equitable and recommended that additional work be funded by HHS to consider how such groups can be established. In general, however, members did not favor comparison of providers solely on a regional basis. To address concerns about mandating rural providers to participate in CMS quality programs, the Committee re-ordered its recommendations so as to better emphasize that mandatory participation is contingent the uptake and implementation of other its recommendations, including those that address the low case volume issue. The Committee agrees that aggregating data from several rural providers can help to address the low case volume problem and this is reflected in the recommendation to encourage voluntary groupings of rural providers for payment incentive purposes. Finally, the Committee agrees that there are limitations with ratio and continuous measures that must be understood and has modified the report to better reflect this concern.

IA Rural Quality Improvement Group

Gloria Vermie

Initial Comment: "Really understand"- The report reflects a framework for the quality improvement facets of rural healthcare. Small rural health providers in IA are moving fast to keep pace with health care transformation. That being stated; it is imperative that at the national level there is a knowledgeable, realistic, and accurate understanding of rural hospital operations and how low volume health care professionals deliver services.

Recommendation: Initiate mandatory CMS quality improvement programs with the caveat to allow a phased approach. Comment: "Use appropriate measures" & "provide effective low cost collection systems". Currently hospitals are reporting to national systems that do not recognize/account for

low volumes. The hospitals do so at a financial and human resources cost that is not always beneficial. Using data collections that are feasible for rural health systems and measures that address low case-volume including alternate/optional measurers will result in valuable data for CMS and usable data reports for providers. Comment: "Measured progress" A phased approach is forward thinking but will require monitoring and flexibility. As low volume providers move to value-based payments, the data will allow benchmarking of the care provided. As national quality reporting expands, seek expert advice by convening groups that represent different providers types, national geographic regions, state government and organizations as well as academic rural health researchers.

>Committee Response

Thank you for your comment and your support of the Committee's work.

John A. Martin Primary Health Care Center

Sandra Kammermann

"In general technology, the overall cost of it and the time training staff is a problem for many rural providers. In addition, there is a lack of IT support personnel readily available in rural areas. Thus the health professionals of the practice become the IT support for the practices.

My recommendation after 23 years in the field is that the timelines be expanded for providers in rural areas. Need to give them more time to accomplish these same goals that can more easily be reached in a larger metropolitan area with numerous resources."

I wholeheartedly agree with the point made about small practice size with limited time, staff and/or finances available for all the QI activities. There is a limited supply of staff with the skills/knowledge/training to do the jobs we are asking them to do. There is also a high turnover rate among these employees because the ones that can obtain jobs that are higher paying leave soon. Others get frustrated with the extremely rapid change in systems we are asking them to learn. Thus we spend a lot of time orienting and training new employees.

In addition, the rapidly increasing expense of the technology we are implementing is very difficult to

budget. The MU funds have been helpful but they do not begin to cover all the staff training time, equipment, software, backups, security systems, etc that need to be put in place. This lack of financial resources to implement what we know needs to be done is discouraging and frustrating.

We understand the value of Quality Improvement projects and measurement to encourage change; however, we feel the requirements to be involved in QI and the changes that are being asked are on a timeline that is much too fast for many practices in a rural area. When you consider the lack of resources in terms of personnel, funding, technology, etc, rural providers are being asked to do a lot in a short period of time. Recommend that the timelines be slowed down....give the rural providers longer to meet the markers. This is important to be realistic about what can be done, especially when reimbursement of providers is moving toward being based on QI.

We recommend you do relax requirements to use CAHPS surveys due to time and expense and literacy levels in some rural areas.

>Committee Response

Thank you for your comment. The Committee agrees that a phased approach is needed for including CAHs, RHCs, and CHCs in CMS quality improvement programs and has offered some suggested timeframes for implementation of several of its recommendations. However, members noted that not all rural providers need an expanded timeline for participation.

National Organization of State Offices of Rural Health

Nathaniel Baugh

The National Organization of State Offices of Rural Health (NOSORH) thanks the National Quality Forum Rural Health Committee members for their work on this report. We believe that the report emphasizes a number of important concepts for the rural community that deserve to be highlighted.

Particularly, we commend the Committee for recognizing that rural quality payment programs must create incentives but not penalties for rural providers. Downward adjustments or penalties would greatly discourage rural providers from participating,

and could force many providers to close or reduce the amount of services offered. As such, we wanted to underscore the Committee's emphasis that mandatory participation in CMS quality programs for rural providers must be contingent upon the "uptake of several of the other Committee recommendations, particularly those related to measure selection and use, payment incentive options, and alignment."

NOSORH agrees with the Committee's recommendation that "HHS provide additional financial or other resources to assist rural providers in their data collection and reporting activities" Furthermore, NOSORH concurs that "many rural providers will continue to require technical assistance in order to facilitate their participation in federal programs." As the administrators of the Flex program, the State Offices of Rural Health (SORHs) understand how critical and important technical assistance programs are for rural providers struggling to adopt new programs. NOSORH notes that because SORHs already provide technical assistance programs, they are well suited to align the new technical assistance authorized by the MACRA legislation with ongoing efforts by HRSA and CMS as the Committee suggests.

NOSORH is pleased to see that the Committee recognizes access to care and timeliness of care as important measures of quality. We also believe that this concept of access to care needs to be further explored and studied as the Committee suggests. We appreciate the Committee's understanding of the heterogeneous nature of rural providers, evident by their suggestion to have a core set of measures alongside a menu of optional measures for rural providers to choose from. Too often rural health policy is lumped together despite the vast variety of needs in different rural areas, and the approach discussed in the report would provide much needed flexibility for rural providers. Nevertheless, the core measures used must be chosen very carefully with appropriate consideration given to low-volume providers.

Identify Core Measures Based Upon the Reality of Rural Health Services:

Issue: Many of the endorsed candidate measures in the NQF Environmental Scan do not work well for low-volume rural health services. For example, two

of the measures included from the Hospital Acquired Condition Reduction Program are not an effective measure for IPPS rural hospitals. Based upon a NOSORH study, less than one-third of all rural IPPS hospitals had sufficient volume to be assessed on a measure of a Central Line-Associated Bloodstream Infection (CLABSI) measure in the program. Less than two-thirds of all rural IPPS hospitals have sufficient volume to be assessed on a measure of Catheter-associated Urinary Tract Infections (CAUTI). This low level of applicability would compromise the usefulness of these measures as core quality indicators for rural hospitals. Similar issues exist for the candidate clinician/practice measures, many of which pertain only to specialty practices which do not exist in smaller rural communities.

Comment: As suggested in the report, core measures appropriate for low-volume rural health services should be based upon the actual experience of those services. For clinician measures, this will likely mean an emphasis on measures appropriate for generalist primary care practices, which predominate in smaller rural communities. For inpatient facilities, this will likely mean emphasis on measures related to the procedures actually conducted in small rural facilities.

Recognize Impact of Provider Shortage on Quality:

Issue: Health provider shortages can have a significant impact on the ability of a rural clinician/practice to achieve key quality measures. In a real world example, a two physician rural family practice is the sole provider of primary care in a remote community where a minimum of four physicians would be needed to de-designate the current HPSA. The physicians in this example are working overcapacity - with potentially twice as much demand for service as they are able to provide. In this situation, the local physicians have stated that they give highest priority to demands for service from patients with highest acuity needs. Some services, including some prevention services, are given lower priority, and may be postponed or forgone. To the degree that the services can be provided by non-clinicians, practices can be organized to improve service quality. Even with these adjustments, however, health provider shortages can have a demonstrable impact on the quality of rural practices.

Recommendation: Risk adjustment mechanisms

for rural health services quality should include appropriate consideration of the impact of health provider shortages in rural communities.

>Committee Response

Thank you for your comment and for your support of the Committee's recommendations.

RUPRI Health Panel at U of Iowa

Keith Mueller

Comment: The RUPRI Panel strongly supports the Committee, the work they did, and the process used in creating this report. We welcome it as an essential presentation of the rural interests in performance measurement. The Committee has laid the groundwork for continuing a crucial discussion about developing reliable and valid indicators of rural provider performance that consider differing circumstances in rural places (e.g., population characteristics, , and distance to care) as well as variations in provider definitions (e.g, scope of services and volume considerations).

Comment: The Committee makes an important point on page 6 of the report; that rural providers are excluded from incentive and reporting programs because those programs are tied to payment systems (i.e., IPPS) not applicable to a large proportion of rural providers. The current Medicare payments to all types of rural providers are designed to be a reasonable approach to provide access in rural places. Any incentive, should be built on top of these payment policies, not replace them. Programs concerning quality should be open to all providers.

Comment: The Panel supports the Committee's recommendation to make participation in quality improvement programs mandatory for all providers, and we support the phased approach for full participation, which allows flexibility in the timing of transition for rural providers at different levels of quality reporting. We commend the Committee's illustration (page 13) describing different incentive levels based on a range of performance that includes simply reporting scores publicly for transparency to accountability for achievement/improvement.

Comment: The Panel supports creating a Rural Health Workgroup within the Measure Applications Partnership (MAP). We believe the workgroup

should translate the results of research into payment incentive policies sensitive to the principles articulated by the Committee. Their deliberations should provide the venue for merging what methodologists develop as a means of measuring and assessing services in low volume situations with policy and practice stakeholders' perspectives regarding what is feasible. One approach would be for the Workgroup to support simulations testing to determine likely consequences of implementing new measures.

Comment: The Panel agrees with the Committee that rural providers should be encouraged to establish collaborative groups that include clinicians and health care organizations in rural communities. We would extend this logic of inclusiveness to other community-based organizations and stakeholders that contribute to the health of populations and therefore achieving both personal health and healthy community goals.

Comment: The RUPRI Health Panel supports the Committee's recommendation to use measures that address low case-volume. Refining measures to use in low volume situations requires research to develop measures that may include techniques such as population-specific risk adjustment, using counts, using the full range in continuous variables, and using ratios, all of which the Committee recognizes. We recommend forming a committee that focuses on fostering and reviewing research to identify and implement valid and reliable methods for low volume cohorts. While we favor inclusion of measures sensitive to low volume, we do not favor rural measures completely different from urban measures. Rural providers deliver many of the same services as urban does.

Comment: The Committee recognized the importance of developing and using measures that reflect the wellness of the community, but wisely recommended not using such measures as pay-for-performance measures applied to rural providers at this time. We have a strong commitment to the importance of community health and recommend additional research and testing of pay-for-performance measures that reflect health systems' community engagement process. The engagement process should be linked to affecting population health outcome measures. We recognize that

achieving improvement in community wellness will require inter-organizational efforts incorporating human service agencies and others that interact with community members outside of clinical settings. Rural healthcare providers should be incentivized to participate in community efforts and to take a leadership role. Measures are available, including recommendations by the Institute of Medicine (report available as prepublication: “Vital Signs: Core Metrics for Health and Health Care Progress” from <http://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress>).

Comment: The Panel supports the Committee’s recommendation that core measures be cross-cutting rather than disease-specific.

Comment: The Panel concurs with the Committee recommendation to use measures from Patient-Centered Medical Home models as related to delivery of primary care services in rural places.

Comment: The Panel supports the Committee’s recommendation that pay-for-performance for rural providers should incorporate both an achievement component and an improvement component.

Comment: The Panel agrees with the Committee that component measures of composite scores must each be appropriate for rural providers.

Comment: The Panel supports the Committee’s recommendation to align measurement efforts.

Comment: The Committee’s suggested principles for selecting measures to assess performance of rural providers advance discussion considerably. We strongly endorse all of them, with these specific comments on select ones:

- Fair comparisons of rural providers are crucial.
- The principle that measures be related to “actionable activities for rural providers” is critical and reflects the challenge of developing outcome measures related to improving and sustaining optimal community health, but holding providers accountable for only those dimensions of achieving outcomes that are under their control. Related to our earlier comment on the use of community health measures, we concur that the ultimate goal should focus on outcomes rather than process. However, the use of community health measures should be applied only when clear pathways

between provider actions and those measures are well established.

- The Panel strongly supports the Committee’s statement that measures “‘topped out’ in some areas of the country may still offer opportunity for improvement in rural areas.”
- Data must be suitable for use in local quality improvement efforts, much more than simply fulfilling process accreditation, contracting or review organization requirements.
- It must be feasible for rural providers to collect the data to achieve measures. Feasibility of data collection should be a criteria used when establishing new performance indicators.
- Aligning measures across reporting programs is critical and should encompass programs across payers and others that influence rural provider actions (e.g., funders of special programs that require outcome measures that may overlap with measures used in payment incentives). Because rural providers often have fewer resources to respond to multiple measurement requirements, we strongly favor harmonizing measures and reporting within public policies, and across public and private payers.
- Supporting Medicare’s three-part aim includes, as recognized by the Committee, “measures that support the aim of creating and maintaining healthy communities.” Developing these measures should be accompanied by research and policy suggestions focused on how community coalitions are developed and successful. Achieving community health requires specific interventions and policy changes across sectors (e.g., health, human services, and economic development).

>Committee Response

Thank you for your comment and for your support of the Committee’s recommendations. The Committee discussed your suggestion of convening a committee focused on the low case volume problem, but ultimately agreed that the methodological options are fairly well-known and that judicious measure development and selection may be the best approach to mitigate that challenge. The Committee also appreciates your comment regarding the need for research and policy suggestions focused

on the development and success of community coalitions, and directs your attention to additional population health work conducted by NQF. This includes an on-going project to develop, test, and update its Community Action Guide, a resource designed to help communities initiate or improve population health programs. This Action Guide addresses many elements of effective cross-sector population health coalitions and references several sources that describe relevant research and policy recommendations in this area.

Spectrum Health Reed City Hospital

Barb Cote

Michigan hosts one of the most effective and dynamic CAH quality networks in the nation; The Michigan Critical Access Hospital Quality Network (MICAQH QN). Representing all 36 CAHs, the MICAQH QN has demonstrated that rural providers value the opportunity to be included in quality measurement. In this spirit the MICAQH QN appreciates the opportunity to comment on the NQF report. The MICAQH QN is guided by the Executive Committee. Each Executive Committee member serves on one of four strategy groups, two of which relate directly to this comment. Clinical Quality Measures – Provides education and TA on clinical quality measures. Support P4P – Guide members in transition to the future of healthcare reimbursement. The MICAQH QN has been integral in advancing QI and value-based initiatives in MI CAHs including: Voluntary Peer Benchmarking – The 26 metrics have evolved from the process measure structures of the past, to the population health management systems of the future. All measures align with the NQS. Encouragement by the MICAQH QN has prompted all MI CAHs to participate in: MBQIP Public Reporting HCAHPS BCBS (P4P) – The MICAQH QN was instrumental in collaboratively defining the metrics for this program. Understanding that CAHs cannot be left out of the new HC delivery system, the MICAQH QN supports the recommendation of making CMS quality improvement programs mandatory, with the caveat to allow a phased approach for full participation across program types, and the caveat that this requirement is dependent on appropriate measures. In addition, the MICAQH QN supports a variety of recommendations, all which have the following

themes alignment and rural relevancy.

Use measures that address low case-volume

Use guiding principles for selecting quality measures that are relevant for rural providers Use a core set of measures, along with a menu of optional measures for rural providers

Ensure that the component measures are appropriate for rural (particularly low-volume) providers

Create a MAP workgroup to advise CMS on the selection of rural-relevant measures

Pursue alignment of measurement efforts for rural providers

Fund development of rural-relevant measures.

Understanding that the report made broad recommendations rounding moving CAHs along the P4P continuum, the MICAQH QN would like to stress that they would like to be active participants as this initiative moves forward, and specific measures are recommended. In closing, the MICAQH QN has experience in quality improvement, and understands that CAHs need to be included in the value-based system. With that support noted it is imperative that the measures associated with the value-based payments align with appropriate initiatives and are relevant to the care that is provided in a CAH. The MICAQH QN would appreciate the opportunity to be active participants as this process moves forward. Respectfully, The MICAQH QN Executive Committee & Barb Cote President

>Committee Response

Thank you for your comment and your support of the Committee's recommendations.

Van Buren County Hospital

Jim Carle

I believe the report provides a respectable framework for the quality improvement aspects of rural healthcare. I think it does less to provide focus as the report contains such a broad array of topics and ideas. Scope down the project and narrow the focus of the report on those things that will ultimately impact patient clinical outcomes. It is hard not to appreciate all the considerations that were taken into account.

One of the primary hurdles that rural entities face is the allocation of resources, both financial and

human. Adding the additional burden of a laundry list of quality indicators is hardly a solution. If there needs to be a focus, choose a few important metrics, measure outcomes instead of compliance with treatment recommendations and keep it simple. Many EMRs have the ability to let users mine data but that is not always an easy proposition so understanding the investment in time for data gathering is also important. The fewer the metrics that prove to have the greatest impact on quality outcomes in a rural setting should be the focus.

One of the first things to consider should be the incidence of any metric measurement that is common in the rural healthcare setting. CLABSI and VAP are rarely an issue in the rural setting due to the extremely low volume. On the other hand, HAI and Med errors are always of concern and worth measuring as they are common to all rural hospitals. Keep the list short and the significance of the measurement high.

As I read over the report again, it dawned on me that even in the event of low incidence measures, there are ways to make it worthwhile. In evaluating rural providers on low case volume measures, establish a minimum case threshold which would automatically include the data. Any providers not meeting this minimum threshold would be excluded and therefore not be eligible for any incentive or penalty based on that particular quality measure. The net effect would 0% on any reimbursement model.

>Committee Response

Thank you for your comment. The Committee acknowledges that its recommendations are quite broad, as befitting the objectives of the project. Members agree that low case volume and measurement burden are significant challenges for many rural providers and believe that several of the recommendations address these concerns.

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