



June 27, 2016

Centers for Medicare & Medicaid Services,

SUBJECT: Comments on the Proposed Rule for Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) – *file code: CMS-5517-P*

To Whom it May Concern:

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

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

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

Sincerely,

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Comments on the Proposed Rule for Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM)

Introduction

Beginning in 2019, the Centers for Medicare and Medicaid Services (CMS) intends to make a payment adjustment to each Merit-Based Incentive Payment System (MIPS) eligible provider based on a composite performance score compiled from four performance categories:

- Quality;
- Resource use;
- Clinical practice improvement activities; and
- Advancing care information efforts around electronic health record (EHR) and related technology.

The Notice of Proposed Rulemaking (NPRM) published by CMS on May 9, 2016 sets out the framework for implementation of this new system as well as guidance for how eligible providers can be exempted from MIPS by participation in alternative payment methods.

Within this NPRM there is limited consideration of rural provider issues. An earlier initiative commissioned by the Department of Health and Human Services from the National Quality Forum (NQF) developed specific recommendations for how pay-for-performance mechanisms should be implemented for rural providers. The NQF Report on Performance Measurement for Rural Low-Volume Providers (NQF Report) sets out both overarching and specific approaches for how rural provider performance measurement should be handled. It should be noted that the NQF Report also makes recommendations about rural performance measures of domains other than quality, including cost.

NOSORH notes that some rural providers are exempted from the MIPS pay-for-performance system. Most eligible providers at federally qualified health centers, rural health clinics and Method I Critical Access Hospitals are not covered by the NPRM. Other rural providers will be exempted through participation in an alternative payment method. Nonetheless, there are many eligible providers in rural practices who could be adversely affected by the proposed rule as currently outlined in the NPRM. In addition, there are potential benefits for including, in the future, exempted providers in an appropriate pay-for-performance system. The MIPS rule needs to acknowledge the differences of low-volume rural providers if pay-for-performance is to be effective in rural areas without damaging the rural health safety net.

Key Issue: Development of Rural Relevant Performance Measures

Comment: The NQF Report notes the need to develop rural-specific measures to judge the performance of rural providers. In addition the NQF Report comments on the need to develop methods for adjusting these measures to take into account the low-volume practices of many rural providers. These are important considerations which will assure that the performance of rural providers is assessed accurately.

The NQF Report states:

"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."

The NQF Report recognizes that not all performance measures can be implemented appropriately in rural provider practices. This applies to clinical process and clinical outcome measures. This also applies to cost measures:

"...**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.

The low patient volume in rural practices can lead to small numbers of measurable conditions for all but the most general measures. If measures based upon small numbers are suppressed, rural providers will be measured on a **subset** of the measures used for larger, urban practices. This could create an 'apples and oranges' situation where rural and urban providers cannot be directly compared. The NQF Report specifically mentions the problem with these weighting adjustments:

"(NQF) ...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."

The NQF Report suggests the creation of two categories of measures to be included in composite scores - **core measures and optional measures**. It suggests that **core measures be the bulk of a composite score and that all providers be scored on the same number of measures using the same weights for each measure**. It highlights the problems created in the Hospital Acquired Condition Reduction Program where many rural hospitals could not be measured on some of the

component measures. Rebalancing of weights to a more limited number of measures creates a very different composite scoring approach for rural hospitals.

NOSORH's recommendations for MIPS mirror those of NQF. An overarching recommendation is provided below and more specific recommendations are presented subsequently.

Recommendation: NOSORH recommends that the NQF Report suggestions be included within MIPS guidance. **Appropriate rural-specific quality measures must be developed, including both mandatory core measures and elective supplementary measures.** These measures must be assessed in a manner which adjusts for the low-volume considerations in rural practices, and should include rural specific measures for quality, resource use, clinical practice improvement and advancing care information use.

Key Issue: Rural-Specific Standards and Peer Group Comparisons

Comment: The NQF Report notes the need to establish rural peer groups for comparison purposes. This reflects an understanding that the **performance of rural providers can best be assessed in comparison to similar groups of other rural providers.** In addition, the NQF notes the need to establish rural-specific standards for performance measurement. The aim is to create an evaluation matrix specific for rural providers.

Rural-specific evaluation standards are particularly important in the cost and information technology domains of MIPS. As noted by NQF, low-volume rural providers have significantly different cost functions than do high-volume urban providers. Rating rural provider cost on an urban standard is inappropriate. Separate rural cost standards are needed to appropriately judge performance in this domain.

Similarly, there is a distinct technology gap between rural and urban communities. Many rural communities have limited access to high-speed broadband - a service needed for consumer participation in online health information systems. If rural providers are scored in comparison to urban providers on the rate of consumer online activity, they will likely be at a disadvantage. Rural specific scoring standards for consumer online activity should be created, reflecting the broadband realities of these communities.

Recommendation: NOSORH recommends that MIPS guidance follow the recommendations of the NQF Report and **establish rural peer groups and rural-specific standards for assessment of rural provider performance in all domains.**

Key Issue: Risk Adjustment Methods for Rural-Specific Factors

Comment: The MIPS will utilize measures of the Value-Based Payment Modifier Program

(VBPMP). The VBPMP uses a form of risk adjustment for performance measures - risk adjustment which accounts for differences in the case mixes of different provider practices. This is an attempt to achieve more accurate comparisons between providers by accounting for differences in each practice's patient population. While this approach is helpful, it does not fully account for factors which can distort the comparison.

The NQF Report notes that additional risk adjustment factors are needed which adjust for differences in community sociodemographic factors. NQF identifies specific risk adjustment factors, including:

- income,
- education level,
- insurance status
- distance to referral hospital,
- time of travel to referral hospital or physician office,
- availability of other healthcare resources in the area ,
- shortage area designations defined by the Health Resources and Services Administration (HRSA),
- frontier area designations,
- housing security, and
- food security.

Risk adjustment which considers these factors can compensate for differences found in rural and urban communities. Of great significance is shortage area designation. Health provider shortages can have a significant impact on the ability of a rural clinician/practice to achieve key performance targets. In a real world example, think about a two physician rural family practice which is the sole provider of primary care in a remote community where a minimum of four physicians would be needed to de-designate a current Health Professional Shortage Area. 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, communities with health provider shortages can have a demonstrable impact on the quality of rural practices. A risk adjustment mechanism is needed which will specifically adjust performance measures for providers in shortage areas.

Recommendation: NOSORH recommends that the MIPS guidance follow the recommendations of the NQF Report and **establish risk adjustment mechanisms which include rural-specific factors**. NOSORH recommends that additional risk adjustment mechanisms give proper emphasis

to the implications of health workforce shortage areas. This will assure that accurate performance assessments can be conducted for rural providers.

Key Issue: Medicare Low-Volume MIPS Exemption

Comment: The NPRM permits an exemption from MIPS for providers who have less than or equal to \$10,000 in Medicare charges and less than or equal to 100 Medicare patients. This is a very low criterion for small volume Medicare practices. The Medicare charge portion of the criterion might only exclude providers for whom Medicare represents less than 1-2% of total revenue. It is important for CMS to consider the potential effect of the MIPS proposal on providers with low Medicare volume, particularly those in rural and underserved areas.

There are several likely impacts of the proposed low-volume criterion for MIPS exemption:

- Rural providers with low Medicare volume slightly above the criterion level may find that the costs of reporting and managing MIPS exceed any positive incentive. This could lead these providers to opt out of Medicare participation.
- Similarly, low Medicare volume rural providers may continue participation in Medicaid, but may accept payment disincentives without making significant changes in their operations. These providers may find inadequate cost-benefit in a full commitment to the MIPS. This could result in reduced Medicare revenue in rural practices which are already financially fragile.

Neither of these two impacts will lead to improved access to services or improved quality of services for Medicare beneficiaries.

Recommendation: NOSORH recommends that CMS **raise the volume criterion for exemption from MIPS** to a level where the cost of managing performance monitoring and improvement is more commensurate with the potential benefit to be gained from payment incentives. NOSORH also recommends that the **volume exemption criterion for rural underserved areas be set at an even higher level** to assure that MIPS does not endanger the financial stability of rural safety net practices or reduce access to services for rural Medicare beneficiaries.

Key Issue: Alternative Payment Models Eligible for MIPS Exemption

Comment: The NPRM proposes exemption from MIPS participation for providers participating in eligible Alternative Payment Models (APMs). The NPRM also provides a 5% annual payment incentive for providers participating in these APMs. Under the NPRM, however, eligible APMs are limited exclusively to several models requiring downside financial risk for participating providers.

Acceptance of downside risk should not be a requirement for exempting rural providers from MIPS on the basis of participation in exempted APMs. Downside risk may be inappropriate for

rural providers with limited resources and small operating margins. Inappropriate assumption of risk could threaten practice stability.

There are multiple performance improvement oriented APMs which emphasize upside-gainsharing incentives without inappropriate financial risk assumption. The Health Care Planning Learning and Action Network (HCPLAN) sets out multiple types of these APMs in Category 3 of its Alternative Payment Models Framework. These include:

- Bundled payment programs with upside incentive only,
- Episode-based payments for procedure-based clinical episodes with shared savings only, and
- Primary Care Patient Centered Medical Homes with shared savings only.

APMs with upside-gainsharing only should be included in the categories of APMs eligible for MIPS exemption and automatic annual payment incentives.

Recommendation: Extend MIPS exemption to providers participating in **all Alternative Payment Methods defined in Category 3 of the HCPLAN Alternative Payment Models Framework.** Exemption should include all upside-gainsharing only models defined in the Framework, including patient-centered medical home models, bundled payment models and episode of care models.

Key Issue: Voluntary Reporting by Exempt Rural Providers

Comment: The NPRM solicits public comment on the feasibility and advisability of voluntary reporting in the MIPS program for entities such as Rural Health Clinics (RHCs) and/or Federally Qualified Health Centers (FQHCs). This voluntary reporting can be useful, particularly if linked to the development of rural-specific measures and standards for the assessment of rural provider performance. NOSORH believes that this type of voluntary reporting is feasible and should be encouraged. Voluntary reporting could be expanded into a pay-for-reporting system such as that recommended for low-volume rural providers in the NQF Report.

Many exempted providers, including those at FQHCs, RHCs and Critical Access Hospitals (CAHs) have implemented electronic health records and related technologies. Some are already using these systems to report on their performance. For example, FQHCs have long reported their performance to the Health Resources and Services Administration (HRSA) under its Uniform Data System (UDS) reporting process. The UDS report covers areas including clinical services, clinical quality and cost. Similarly, many CAHs report under the Medicare Beneficiary Quality Improvement Project (MBQIP) of the Federal Office of Rural Health Policy (FORHP). Under both of these systems aggregate performance data is used to track and guide efforts to improve health safety net performance. It should be noted that under both the UDS and MBQIP the individual data related to specific FQHCs and CAHs are kept private. Data is released only on an aggregate basis.

Permitting voluntary reporting of data by exempted rural providers could create the basis for development of rural-specific performance measures and standards. It would not create substantial additional burdens for many rural safety providers.

Recommendation: NOSORH recommends that CMS **create a system permitting the voluntary reporting of performance information by exempted providers**. NOSORH further recommends that the **data reported be used to help define rural-specific measures and standards** for these providers and for all rural providers. Under this system **data should be released only on an aggregate basis**, protecting the privacy of individual entities reporting.