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November 2, 2015
Centers for Medicare and Medicaid Services Department of Health and Human Services
Attention: CMS—3321—NC
P.O. Box 8012
Baltimore, MD 21244-8016
By electronic submission at http://www.regulations.gov

Re: 42 CFR Part 414 [CMS–3321–NC], Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased offer comments regarding the Proposed Rule to implement reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments, as required by the Affordable Care Act.

The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we will limit our comment to rural-specific issues.

The comments numbered 2 through 8, below, address concerns that CMS has identified as priority category 1 in the comment period extension. The additional comments from the Panel are not in response to priority questions, but nevertheless have important policy implications for rural areas.

Background: Section 1848(q)(11) of the Act, as added by section 101(c) of the MACRA, provides for technical assistance to MIPS EPs in small practices and practices in health professional shortage areas (HPSAs)…the section requires the Secretary to… offer guidance and assistance to MIPS EPs in practices of 15 or fewer physicians with priority given to such practices located in rural areas, HPSAs (as designated under section 332(a)(1)(A) of the PHSA), and medically underserved areas, and practices with low composite scores).

Comment 1: RUPRI encourages a two-step process for determining when technical assistance to small practices is appropriate. The Panel suggests recognizing HPSAs as the first qualifier for potential technical assistance and then determining whether to extend assistance based on the size of the

practice at issue. CMS should extend assistance to practices with 10 or fewer physicians in order to be consistent with other rules regulations. CMS has used 10 or fewer physicians for similar assistance programs in the past, namely for the regional extension center program. Further, later in this RFI, creation of a virtual group is allowed for groups of fewer than 10 eligible providers.

Question: Should there be limitations, such as that MIPS EPs electing a virtual group must be located within a specific 50 mile radius or within close proximity of each other and be part of the same specialty?

Comment 2: We do not think geography should be a factor in virtual group election. Having a geographic limit would not produce any specific benefits and would only make participation in this program more difficult for rural providers. Further, no geographic limitation was set for the establishment of ACOs.

Question: Should we require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?

Comment 3: We encourage CMS to require reporting mechanisms that include the ability to stratify data by socioeconomic status as well as the other demographic characteristics listed.

Question: What considerations should be made as we further implement CAHPS for all practice sizes.

Comment 4: Providers will face many resource barriers to CAHPS participation. The vendors used by providers must be certified, requiring significant financial resources for implementation. The Panel is also concerned about the sample size required for effective CAHPS participation and what resources may be required to reach a large enough population.

Question: What are the potential barriers to successfully meeting the MIPS quality performance category?

Comment 5: There are many potential barriers to meeting the quality performance category. One such barrier includes the difficulty of data collection, and lack of access to Medicare claims data and current PQRS levels of participation, which could be necessary for collaboration at the local level. Further, some providers may have difficulty accessing health IT and other financial and personnel resources necessary to effectively report quality measures.

Question: CMS seeks comment on the clinical practice improvement activities categories.

Comment 6: The Panel applauds CMS for including progressive suggestions for including care beyond office visits in performance evaluations. The Panel particularly supports the subcategories of Promoting Health Equity and Continuity, Social and Community Involvement, and Achieving Health Equity.

Question: How should the clinical practice improvement activities performance category be applied to EPs practicing in these types of small practices or rural areas? Should a lower performance threshold or different measures be established that will better allow those EPs to reach the payment threshold?

Comment 7: Small practices should not be subject to a lower performance threshold, but small practices could perhaps benefit from a phase in approach, or a performance threshold that is proportional to the size and resources of the practice at issue.

Question: Should the performance score for EHR technology performance be based solely on full achievement for meaningful use?

Comment 8: Full achievement of meaningful use is too difficult for rural providers to attain. CMS should consider a tiered approach to encourage the use of health information technology by rural providers. It will be difficult for providers to feel incentivized to work towards more comprehensive health information technology if it is an all or nothing approach as there are many barriers to full implementation for rural providers.

Question: Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid Incentive Programs or should CMS consider other requirements around certified health IT capabilities? And would certification of additional functions or interoperability requirements in health IT products (for example, referral management or population health management functions) help providers succeed within APMs?

Comment 9: Adding new requirements for certified health IT capabilities will only complicate the current system. The Panel advocates for the same certified EHR technology currently required for the Medicare and Medicaid Incentive Programs. However, the Panel does support the incorporation of population health functions into existing EHR systems. This function should not be incorporated in the form of an add-on, but should instead be part of the existing system. Further, the Panel recommends incorporating socio-economic status indicators into existing EHR systems.

Question: What existing educational and assistance efforts might be examples of "best in class" performance in spreading the tools and resources needed for small practices and practices in HPSAs? What evidence and evaluation results support these efforts?

Comment 10: The Panel approves of prioritization for rural areas when providing technical assistance. Some examples of "best in class" programs are Medicare QIO Technical Assistance and HIT Regional Extension Centers. The notable features of these programs are described as follows:

Medicare QIO Technical Assistance
In a longstanding program to improve the quality of care for Medicare beneficiaries across the country, CMS contracts with organizations with a presence in every state to provide quality improvement technical assistance and support. The Quality Innovation Network Quality Improvement Organizations (QIN-QIOs) are a logical mechanism for providing technical assistance for MIPS, leveraging an existing national program and infrastructure with a proven track record of success. An example of QIO demonstrated success is in the are of care transitions. A study of QIO care transitions was report in the *Journal of the American Medical Association* in 2013, "Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries". In the study, hospitalizations and rehospitalizations among Medicare patients declined nearly twice as much in communities where Quality Improvement Organizations (QIOs) coordinated interventions that engaged whole communities to improve care than in comparison communities, and reduced rehospitalizations for Medicare patients by almost six percent in 14 select communities nationwide. http://jama.jamanetwork.com/article.aspx?articleid=1558278&resultclick=3

Subsequently, CMS spread the care transitions program from the 14 pilot sites to all QIOs across the country. A methodology paper was published in the Joint *Commission Journal on Quality and Safety* in 2014 offers more specificity on how one QIO provided technical assistance to achieve significant reduction in unnecessary re-hospitalizations. The article cites technical assistance approaches such as peer-to-peer networking and collaboration between hospitals facing similar issues, statewide resources, collaborating, and support for system improvements have led to improved discharge planning, better management of care transitions and medications, engaged patients and families, and lower readmission rates.
http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000005/art00002

HIT Regional Extension Centers
As a result of the 2009 federal HITECH Act, the federal Office of the National Coordinator for HIT developed the HIT Regional Extension Center (HIT REC) program to provide technical assistance to small and rural practices across the country to advance their use of EHR (electronic health record) technology to meet Meaningful Use requirements and prepare for the transition from volume to value. The ONC contracted with 62 HIT RECs from 2010-2016, and the results are impressive, including as noted on the ONC website, "As of August 2015, Over 157,000 providers are currently enrolled with a Regional Extension Center. Of these, more than 146,000 are now live on an EHR and more than 116,000 have demonstrated Meaningful Use." There has been an especially strong focus on small and rural providers in the HIT REC program. https://www.healthit.gov/providers-professionals/regional-extension-centers-recs

Sincerely,

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