DRAFT Recommendations

Make participation in CMS quality improvement programs mandatory for all rural providers

As mentioned earlier, many rural healthcare providers are systematically excluded from participation in various CMS quality improvement programs.[a] Specifically, CAHs are not mandated to report quality measure data for the Hospital Compare program, although they can *voluntarily* submit data for public reporting through this program. CAHs, are, however, completely excluded from the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs because they are not paid under the Medicare's hospital PPS. Likewise, clinicians who practice solely in RHCs and CHCs are not eligible to participate in the Physician Quality Reporting System (PQRS), Physician Compare, or Value-Based Physician Modifier programs.[b] Moreover, rural providers in these or other settings (i.e., small hospitals or small practices) may be excluded from participation in these programs on a measure-by-measure base due to low case-volume.

However, the Committee recommended that CMS should not only allow participation in quality initiative programs for all rural providers, but should make such participation mandatory.

Make the case why this is important.

- because otherwise, rural providers are "left behind" in terms of federal programs/disrespect
- rural residents don't have the information to choose their providers
- Other??

Implications for low case-volume

Add text

Use a phased approach to transition between program types

The Committee recognized that requiring participation of all rural providers across the various CMS programs cannot and should not be implemented immediately, due to a variety of factors including the relative inexperience of many rural providers in federal quality measurement efforts, constrained resource 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,

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[a] Rural providers are included in the CMS "Meaningful Use" programs. Also, rural providers who are part of Accountable Care Organizations are included in the Medicare Shared Savings Program.

[b] 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 they have reassigned his/her billing rights to the CAH.

starting with inclusion in pay-for-reporting programs and gradually transitioning to public reporting and then, perhaps, to pay-for-performance.

Such a phased approach would be consistent with past CMS policy for providers in other settings. In the PPS hospital setting, as well as for clinicians paid through the Medicare Physician Fee Schedule, CMS initially instituted pay-for-reporting programs to incentivize providers to report quality data on a set of performance measures. For hospitals, CMS later began to publicly report measure results in order to provide information to consumers, payers, purchasers, and other stakeholders to help inform their decisionmaking regarding healthcare issues. Subsequently, CMS implemented a value-based payment program whereby providers receive incentives based on their performance on certain quality and cost measures. Most recently, CMS has changed the incentive structure so that negative payment adjustments are applied if providers fail to report quality data, reach a performance threshold, or show improvements in their performance score. CMS has implemented a similar, though not quite identical path, for clinicians, as well as for providers in other post-acute care/long-term care settings. For PPS hospitals, this transition from pay-for-reporting to value-based purchasing has been underway for more than a decade.

Implications for low case-volume

Add text

Question for the Committee: Does a phased approach from P4R to PR to P4P make sense for CAHs, given the fact that many CAHs already publicly report?

Design new programs or modify existing programs to better accommodate rural providers

The Committee also made several recommendations regarding how the new programs can be designed—or existing programs modified—to better accommodate rural providers. These are described below.

Use a core set of measures, along with a menu of optional measures

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 CAHs provide surgical care while others do not; similarly, some providers have may serve a substantial number of patients with diabetes, while others may serve very few.

To address this challenge, Committee members recommended use of a core set of measures (ideally, no more than 10-20) for use in CMS programs that is supplemented by a menu of optional measures that can be used as applicable. Measures in the core set should be cross-cutting rather than disease-specific (e.g., address primary and preventive care), while measures in the optional set would allow the flexibility needed to tailor measurement based on the types of patients served and the types of services offered. Moreover, the number of measure 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.

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 have the same low case-volume challenges (although they also recognized the potential data collection burden of 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 (e.g., medical record abstraction, claims-based, etc.), so that the burden of data collection is not concentrated on very few individuals. This recommendation is particularly relevant for very small practices who have limited staff (e.g., nurses), who have the expertise to abstract data for measurement but must also provide direct patient care.

Implications for low case-volume

Measures included in such a core set should be broadly applicable 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. 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 measurement.

Apply equal weights to the core and optional measure sets and to the individual measures within the sets

Committee members noted that differential weighting schemes used in some current CMS programs may be particularly problematic for rural providers with low case-volume. For example, if a provider does not have a high enough case-volume to report on one measure in a particular measure domain, the other measures in that domain are given more weight; this problem is compounded if no measures in a particular domain can be reported, as all weight is then given to the remaining domain(s). Thus, the Committee recommended applying equal weight for measures in both the core and optional measure sets, and equal weight for the various measures within the sets.

Implications for low case-volume

As noted earlier, the low case-volume challenge should be mitigated for most rural providers through use of appropriately populated core and optional measures sets. For those providers who still might be unable to report on some of the measures in those sets, add more here…

Question for the Committee: Is this the right recommendation? Or should the recommendation be more along the lines of using caution when interpreting such scores, as they are many be weighted

more heavily on certain domains/measures for many rural providers (particularly those with small patient volumes).

For rural providers, payment programs should 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. Moreover, 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 can therefore be considered part of the nation's healthcare safety net. The Committee agreed that quality program policies should be crafted so as not to potentially compromise this safety net through application of payment penalties. Accordingly, Committee members recommended that CMS payment incentive programs for these rural safety net providers should be designed to provide "bonus" payments only, not penalties. Such a policy would incentivize improvement but would preserve the rural providers' safety net role in the communities they serve.

Question for the Committee: Did full Committee reach consensus that this should be a recommendation?

Implications for low case-volume

None.

Reward improvement

Because quality measurement and reporting may be a new endeavor for many rural providers, the Committee agreed that pay-for-reporting programs should incorporate an improvement component, whereby providers are eligible to receive some additional payment, even if not attaining a particular measurement threshold. This recommendation would be more critical if CAHs, RHCs, and CHCs were required to participate in pay-for-performance programs without a gradual transition from pay-for-reporting programs and public reporting. Incorporation of an improvement component is already a part of the design of at least one CMS quality improvement program.

Question for the Committee: Does this recommendation make it sound like rural providers are unable to meet thresholds?

Implications for low case-volume

Showing statistically significant improvement can be difficult, if not impossible, when case-volume is low. Thus, the threshold for determination of statistical significance would have to be carefully considered.

Fund additional work to consider how peer groups 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. The Committee acknowledged the difficulties in identifying appropriate comparison groups for rural providers due to the heterogeneity of the patients,

service offerings, and circumstances. 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. There was less enthusiasm for comparison across provider type (e.g., CAH to CAH) because of heterogeneity within provider types (e.g., a 5-bed CAH may be much different than a 25-bed CAH) or lack thereof (e.g., there may be few real differences in primary care provided by RHCs, CHC, 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 recommended that CMS fund additional work to consider how appropriate comparison groups for rural providers should be defined and used.

Implications for low case-volume

Add text

Consider allowing voluntary, informal groupings of 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 consider allowing rural providers to establish informal 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.

Implications for low case-volume

Add text

Select and use measures that are relevant and meaningful for diverse rural providers

One of the key measurement challenges for rural providers identified by the Committee is that many measures used in CMS quality programs focus on conditions or services that are infrequently addressed by many rural providers, thus exacerbating the low case-volume problem. Thus, the Committee recommended that for quality improvement programs that include rural providers, measures that are relevant and meaningful should be selected and used.

Use principles for selecting measures that are relevant for rural providers

The Committee did not perceive creating lists of specific measures for use in CMS accountability programs as within their purview during this current project, particularly as the specific measures may vary based on provider (hospital vs. clinician) and use (e.g., pay for reporting vs. for performance), and because measures may "transition" from one use to another over time as experience builds. However,

Committee members did identify several principles that should be used by CMS to select measures that are appropriate for rural healthcare providers. Note that the Committee made additional, separate recommendations related to many of these principles.

- ***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.
- ***Be evidence-based*.** Measures should be supported by empirical evidence demonstrating clinical effectiveness and a link to desired health outcomes.
- ***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.
- ***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.
- ***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.
- ***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 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 vs. outcome measures); however, the Committee did not reach consensus on this aspect of selection.
- ***Address areas of risk for patients***. The Committee noted that some care processes should "just happen" regardless of provider, patient, or size of patient panel and these should be prioritized for selection into quality improvement programs.
- ***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 thus these should be considered for selection into programs for rural providers.
- ***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 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).
- ***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.

- ***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.
- ***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 local access to care***. Need Committee help with this one.

It should be noted that many of the principles for selection articulated by the Committee 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 above principles also are consistent with criteria used by the Measure Applications Partnership (MAP), an NQF-convened mulitstakeholder 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 assist the MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs.

Consider measures that are used in PCMH 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 patient centered medical homes (PCMH), 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.

Implications for low case-volume

Add text

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

Under the assumption that CMS eventually will mandate participation of CAHs, RHCs, and CHCs in their quality improvement programs, 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 the Measure Applications Partnership (MAP). The MAP utilizes 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 hospital, 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. This Rural Health Workgroup would function in a manner similar to that of the MAP Duals Workgroup. Add in a little more about the Duals work

If possible, add in a little about the composition of the proposed committee…at minimum, they would reflect the providers included in the programs (e.g., CAHs, etc.) and reflect at least some of the diversity of the rural population (e.g., frontier, rural-adjacent, perhaps even geographical differences).

Implications for low case-volume

Add text

Use measures that explicitly address the challenge of low case-volume

The key measurement challenge facing rural providers, no matter the setting, is the likelihood of low case-volume for many measures used in current CMS quality improvement programs. Consequently, potential solutions to this problem were weaved throughout many of the Committee's recommendations. Additional recommendations by the Committee specific to this challenge included:

- ***Use 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. As noted earlier, such measures should be considered for use in core and optional measure sets available to rural providers.
- ***Consider measures that reflect the wellness of the community***. Such population-based measures by definition do not assess performance of individual providers but nonetheless can be used for quality improvement purposes at the provider level. These types of measures also address one of the triple aims of the National Quality Strategy (i.e., increasing the health of the population). Because the denominator for these kinds of measures is a particular sub-population (e.g., community, region, age-based group, etc.) there would be no difficulty in terms of case-volume.
- ***Reconsider exclusions for existing measures***. Many measures, often for valid reasons, exclude large numbers of patients. For example, the HCAHPS measures exclude patients who are residents of 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, the exclusion of these patients exacerbates the low case-volume challenge, as potentially many otherwise eligible patients are not surveyed.
- ***Consider development and use of measures that are constructed using continuous variables.*** Measuring an aspect of care using a continuous variable rather than a binary variable will require a small sample size to detect meaningful differences between providers. An example of this type of measure would be assessing the time until a medication is given rather than just whether or not a medication was given. Note, however, that care should be taken when considering such measures for rural providers (particularly timing measures), as the environmental context could potentially may invalidate comparisons between providers; also, such measures are sensitive to outliers.
- ***Consider development and use of 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 number is the number of bloodstream infections but the demonimator may be the number of days where 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.

Question for the Committee: Have you thought of other potential solutions to the low case-volume problem?

Fund development of rural-relevant measures

The Committee recommended that CMS fund the development of measures that are relevant to, and appropriate for, rural providers (particularly for low-volume providers). The Committee identified the following topic areas as some of the most relevant and impactful for rural providers at this time:

- Patient hand-offs and transitions (including timeliness)
- Alcohol/drug screening
- Telehealth/telemedicine
- Accessibility/timeliness
- Community getting care in a timely manner
- Access to care measures
- Cost measures
- Population health at the geographic level
- For hospitals: procedures (e.g., OT/PT/imaging)
- Advance directives/end-of-life measures
- Additional measures for specialists
- Patient out-of-pocket costs
- Measures for patients with multiple chronic conditions
- Appropriateness of diagnostic and therapeutic services

Committee members emphasized that the intent behind this list is to encourage research and development of measures that can be used to populate the previously-recommended core and optional measure sets for rural providers. However, they reiterated their earlier caution that development of new measures should not lead to an increased measurement burden. The Committee also cautioned that measures created for the topic areas included above 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, and others may become appropriate for such programs only after providers gain experience with them in other ways.

Questions for the Committee: The above topic areas were discussed but may not reflect priorities for future measure development (particularly those in red font). Also, some measures already exist for many of these topics, so need to decide if they truly reflect gaps in measurement. We will discuss at length in web meeting.

Implications for low case-volume

Add text

Pursue continued alignment of measurement efforts

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

Specifically, the Committee emphasized the need for a uniform set of measures that can be used, at minimum, across HHS programs (particularly CMS and HRSA programs), and, to the extent possible, across other programs including those used by private payers, credentialing and accrediting bodies, etc. Members also noted a need for measures that can be used across multiple healthcare settings (e.g., in both ambulatory and hospital settings).

The Committee also recognized that data collection can be particularly burdensome to 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 (e.g., Hospital Compare, MBQIP, and TJC 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 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 QIO program under CMS, the Flex program under HRSA, etc.), they recommended that such resources be aligned across HHS to more efficiently and effectively provide support to rural providers. 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.

Finally, the Committee recommended that departments within HHS that work with rural providers (e.g., CMS, HRSA, etc.) collaborate to provide opportunities for rural health stakeholders to interact with and obtain information regarding HHS programs, policies, and initiatives relevant to quality measurement.

Question for the Committee: This last paragraph came from "reading between the lines". Is this something that members want to include?

Implications for low case-volume

Add text

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 2-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 or financially disadvantaged, the Committee applauded this change in policy, seeing it as a way to facilitate more valid comparisons among 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
- 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

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 many rural areas because weather can severely restrict travel) are appropriate for case-mix adjustment.

Relatedly, the Committee also recommended that at least one rural health expert be empanelled on the yet-to-be-formed NQF Disparities Committee, the formation of which was recommended by NQF's SDS Expert Panel. The work of the NQF Disparities Committee will be to 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 would 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 health care (for example, race and ethnicity data are collected by HRSA through the Uniform Data System).

Implications for low case-volume

Add text

Additional recommendations

The Committee provided several additional recommendations that could potentially mitigate other measurement challenges faced by rural providers, 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, 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. Members recommended that a similar tool/process could be developed to allow reporting of CAHPS data to CMS.

- ***Facilitate quicker and broader access to Medicare data for quality improvement purposes***. Committee members applauded "feedback reports" provided as part of the Value-Based Payment Modifier program (for clinicians) 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 their 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 and reduce the overall cost to Medicare. Committee to help improve this section.
- ***Facilitate inclusion of CMS data into all-payer databases***. (Committee to provide more information on why this would be useful for rural providers)
- ***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). Committee to decide if they want to include this as a recommendation, given the logistical constraints of claims processing and other data collection, particularly as reducing the cycle time may require more frequent data collection by rural providers.