ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
1	Alabama Office of Primary Care and Rural Health	Carolyn Bern	Our providers felt that swing beds should be included in the measures.	Pending Committee discussion
2	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 pursing 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.	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
3	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.	Thank you for your comment. We know that rural providers are not necessarily employed in CAHs, RHCs, or CHC and are not always low-volume providers. We will modify the report to make this more clear.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
4	American Academy of Pediatrics (AAP)	Lisa Krams	"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	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
			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.	

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
5	American Hospital Association	Akinluwa Demehin	(Part 1 of 2) 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.	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
6	American Hospital Association	Akinluwa Demehin	(Part 2 of 2) 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.	The Committee agrees with your suggestion regarding the creation of a MAP workgroup for rural providers and will update the report accordingly.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
7	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.	Thank you for your comment. We agree that care alternative delivery options such as telehealth/telemedicine can help to increase access to specialty care for rural patients and 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 would be out of scope.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
8	America's Health Insurance Plans	Carmella Bocchino	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.	Thank you for your comment. Although we made recommendations regarding use of a core measure set and development of rural-relevant measures, we did not intend to imply that a separate set of measures be used for rural providers. We will modify the report to make this more clear. Regarding the points on stratified measurement targets and looking at higher incidence conditions/procedures: These will be discussed during the Committee's post-comment call on July 29.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
9	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.	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
10	Arkansas Dept of Health	Kimberly Armstrong	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 if 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.	Thank you for your comment and your support of the Committee's recommendations.
11	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.	Thank you for your comment. One of the Committee's assumptions is that the design of current

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
			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.	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. We will modify the report to make this more explicit.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
			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.	

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
12	California Hospital Association	Alyssa Keefe	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.	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
13	California Hospital Association	Alyssa Keefe	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.	Pending Committee discussion
14	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.	Thank you for your comment. The Committee agrees that alignment of measures is needed and will expand the language to mention IHS measures.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
15	Cheyenne Regional Medical Center	Brianna Chavez	(Part 1 of 5) 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. <u>Make participation in CMS quality improvement program mandatory - Page 11</u> 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.	Thank you for your comment.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
16	Cheyenne Regional Medical Center	Brianna Chavez	(Part 2 of 5) 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."	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. Regarding the point about inclusion of community health resources: Pending Committee discussion.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
17	Cheyenne Regional Medical Center	Brianna Chavez	(Part 3 of 5) 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.	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
18	Cheyenne Regional Medical Center	Brianna Chavez	(Part 4 of 5) 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.	Thank you for your comment.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
19	Cheyenne Regional Medical Center	Brianna Chavez	(Part 5 of 5) 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.	Pending Committee discussion

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
20	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.	Thank you for your comment. 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.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
21	Florida Hospital	John Hood	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.	Thank you for your comment.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
22	Florida Hospital	John Hood	Adventist Health System Comment 1 of 3 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.	Per population-based measures: The Committee recommended additional development of population health measures, noting the utility of such measures for rural providers, particularly those with low case-volumen. Per mandatory participation: Pending Committee discussion.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
23	Florida Hospital	John Hood	Adventist Health System Comment 2 of 3 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.	Thank you for your comment. The Committee agrees that aggregating data from several rural providers can help to address the low case-volume problem and that there are limitations with ratio and continuous measures that must be understood. We will modify the report to better reflect these points.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
24	Florida Hospital	John Hood	Adventist Health System Comment 3 of 3 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.	Thank you for your comment and your support of the Committee's recommendations.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
25	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.	Thank you for your comment and your support of the Committee's work.
26	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."	Thank you for your comment. The Committee agrees that a phased approach to participation in CMS quality improvement programs is needed, but noted that not all rural providers need an expanded timeline for participation.

ID	Commenter Organization	Commenter Name	Comment	DRAFT Committee response
27	John A. Martin Primary Health Care Center	Sandra Kammermann	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.	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.
28	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 deserves 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	Thank you for your comment and for your support of the Committee's recommendations.

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			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.	

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29	National Organization of State Offices of Rural Health	Nathaniel Baugh	<u>Identify Core Measures Based Upon the Reality of Rural Health Services</u>: 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 a 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. <u>Recognize Impact of Provider Shortage on Quality</u>: 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.	Pending Committee discussion

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30	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	Pending Committee discussion

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			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.	
31	RUPRI Health Panel at U of Iowa	Keith Mueller	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	Pending Committee discussion

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			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.	
32	RUPRI Health Panel at U of Iowa	Keith Mueller	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	Thank you for your comment and for your support of the Committee's recommendations. Please note additional population health work conducted by NQF, including 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

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			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 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).	population health coalitions and references several sources that describe relevant research and policy recommendations in this area.
33	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 (MICAH QN). Representing all 36 CAHs, the MICAH QN has demonstrated that rural providers value the opportunity to be included in quality measurement. In this spirit the MICAH QN appreciates the opportunity to comment on the NQF report. The MICAH 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 MICAH 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 MICAH QN has prompted all MI CAHs to participate in:MBQIP Public Reporting HCAHPS BCBS (P4P) – The MICAH 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 MICAH 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 MICAH QN supports a variety of recommendations, all which have the following themes alignment and rural relevancy.	Thank you for your comment and your support of the Committee's recommendations.

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			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 MICAH 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 MICAH 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 MICAH QN would appreciate the opportunity to be active participants as this process moves forward. Respectfully, The MICAH QN Executive Committee & Barb Cote President	

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34	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.	Thank you for your comment. The Committee acknowledges that its recommendations are quite comprehensive, as befitting the objectives of the project. Members will discuss potential areas for prioritization and "next steps".
35	Van Buren County Hospital	Jim Carle	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.	Thank you for your comment.

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36	Van Buren County Hospital	Jim Carle	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.	Pending Committee discussion