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May 18th, 2017

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850
By electronic submission at http://www.regulations.gov

RE: 42 CFR Part 405, 412, 413, 414, 416, 486, 488, 489, and 495 – Medicaid Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (HER) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices.

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to the proposed rule to revise the Medicare hospital inpatient prospective payment systems (IPPS) for FY 2018. Our comments are limited to rural-specific issues and are structured to parallel general questions posed, or issues stated, by CMS (not technical comments regarding specific sections of the proposed rule). The Panel applauds the focus of this proposed rule on Medicare IPPS because Medicare policies have a disproportionate impact on rural beneficiaries, hospitals, and communities.

Question: *How can several quality programs, including the Hospital-Acquired Condition (HAC) Reduction Program, the Inpatient Quality Reporting (IQR) Program, and the Hospital Value-Based Purchasing (VBP) Program, account for social risk factors?*

Rural residents are generally older, poorer, and less likely to have sufficient physicians to care for them, therefore, they are more likely to experience the negative aspects of many of the contributing social factors listed in the proposed rule.[1] Though many areas outside of rural communities experience health inequalities, there are significant differences on the impact level. The barriers that exist in rural communities, such as limited public transportation options and fewer choices to acquire healthy food, can exacerbate the impact of these challenges.[2]

We support risk adjusting quality measures when there is evidence that accounting for social and other factors affects these measures and could make a difference in assessing provider performance.[3] While we support the use of the proportion of dual-eligible as a proxy for socioeconomic status as an interim strategy for the readmissions measure, we encourage CMS and others to continue to work on developing more precise approaches to risk adjustment to account for social factors in the rural context. Specifically, the September 2015 National Quality Forum (NQF) report on Performance Measurement for Rural Low-Volume Providers pages 15-16, lists some of the rural relevant factors and speaks to the need to look more broadly than socio-economic status.[4] The following are among the rural-relevant factors in the NQF's report be considered in potential risk-adjustment methodologies:[5]

- Distance to referral hospital
- Time of travel to referral hospital or physician office
- Availability of other healthcare resources in the area (e.g., primary care provider density, availability of home health, nursing facilities, or hospice)
- Shortage area designations defined by HRSA (i.e., Health Professional Shortage Area, Medically Under-Served Areas, Medically Under-Served Populations)
- Frontier area designations
- Housing security
- Food security

Question: *Proposal to modify the CY 2017 CQM reporting requirements for the Medicare and Medicaid EHR Incentive Programs.*

We support CMS's assertion that a reduction in the reporting period and reducing the number of CQMs requiring electronic reporting from 8 to 6 will ease the burden on data submitters for all eligible hospitals including rural and critical access hospitals. However, there is still a need for more appropriate rural-relevant measures reflection of the volume and services in rural and CAHs. Furthermore, an expanded universe of measures appropriate for rural and low-volume hospitals should be reflected in reporting requirements. The Panel would like to refer readers to the same NQF listed above (rural, low-volume providers). In addition, the Panel encourages further harmonization of CQM measures with MBQIP (the Medicare Beneficiary Quality Improvement Project). Currently, there are three CMQs, which are part of the MBQIP measure set, and there is an opportunity for a more coordinated effort across programs.

Sincerely,

The Rural Policy Research Institute Health Panel

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Timothy D. McBride, PhD
Charlie Alfero

[1] Social Determinants of Health for Rural People, https://www.ruralhealthinfo.org/topics/social-determinants-of-health (July 29, 2016).
[2] Social Determinants of Health for Rural People, https://www.ruralhealthinfo.org/topics/social-determinants-of-health (July 29, 2016).
[3] National Quality Forum, *Performance Measurement for Rural Low-Volume Providers: Final Report*, file:///Users/winnieuluocha/Downloads/rural_final_report.pdf (September 14, 2015).
[4] National Quality Forum, *Performance Measurement for Rural Low-Volume Providers: Final Report*, file:///Users/winnieuluocha/Downloads/rural_final_report.pdf (September 14, 2015).
[5] National Quality Forum, *Performance Measurement for Rural Low-Volume Providers: Final Report*, file:///Users/winnieuluocha/Downloads/rural_final_report.pdf (September 14, 2015).