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### Rural Health Panel

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December 14, 2016

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-5517-FC

P.O. Box 8013

Baltimore, MD 21244-8013

By electronic submission at <https://www.regulations.gov/comment?D=CMS-2016-0060-3944>

RE: 42 CFR 414 and 495. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models.

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to questions posed by CMS in the Final Rule with comment period regarding MACRA and the Quality Payment Program. 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).

MACRA will be influential in continued efforts to enhance access to care and population health for patients living in rural areas. However, rural hospitals, physicians, and patients face ongoing and distinct challenges that can interrupt or preclude access to essential medical services. Therefore, the following comments should be fully considered before implementation of new physician payment approaches.

#### **Implementation of Cross-Cutting Measures in the MIPS Program**

Although we applaud CMS for their continued and dedicated efforts to improve population health, additional measures requiring reporting may preferentially burden rural providers with fewer performance measuring and reporting resources. Cross-cutting measures selected should be germane for primary care practices which provide most population health-related care in rural areas.

### **CEHRT and the advancement of Health IT Measurements**

We commend CMS for encouraging continued innovation in health IT by providing bonuses in the advancing care information performance category when physicians use functions included in CEHRT. Still, rural healthcare providers continue to struggle with health IT challenges. Since rural providers may lag in CEHRT adoption due to, for example, a lack of dependable access to broadband internet that is necessary for timely and reliable health information exchange, achieving clinical practice improvement bonuses should not be dependent on CEHRT use.

### **Virtual Groups and EHR Platforms**

We agree with CMS that virtual groups will face health IT challenges when reporting and submitting data. Although virtual groups may develop more frequently in rural areas, available measuring and reporting resources may be fewer. Consequently, CMS should encourage provider collaboration by via common EHR platforms. Provider participation percent thresholds in virtual groups should increase over time.

### **Advanced APM Requirements**

The burden of meeting different Advanced APM requirements is particularly significant for smaller practices (like the burden of performance reporting). CMS should actively work with state Medicaid agencies and commercial payers to design a common process for determining Advanced APM eligibility.

### **“Topped Out” Measures**

CMS should carefully evaluate potentially “topped out” measures prior to discontinuation to ensure that rural provider improvement has been recognized.

Sincerely,

The Rural Policy Research Institute Health Panel

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