

Oct 9, 2019

Thomas J. Engels
Acting Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857 U.S.A

RE: Rural Access to Health Care Services Request for Information (RFI)

Dear Mr. Engels:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input on the Health Resources and Services Administration's (HRSA) Rural Access to Health Care Services request for information (RFI). The RFI solicits comments on access to care in rural areas, including: identifying core services needed in rural communities; outlining approaches and considerations for delivering those services; and examining access and quality in the rural context.

Access to health care is an essential component of maintaining good health and well-being; in rural communities, individuals depend upon their hospital as an important – and often only – source of care. However, the recent trend of increased rural hospital closures threatens the availability of health care services across the country. The AHA has long recognized the significant pressures on rural health care providers. In 2016, we issued a report identifying nine strategies to ensure access to essential services in vulnerable communities, and earlier this year, we released a report outlining the challenges facing rural hospitals as well as policy recommendations to address them. Most recently, we have assembled a group of rural hospital leaders to identify sustainable payment and care delivery models for the future of rural health care. As concern over rural health care access grows, interest in identifying the most crucial services for these communities also is increasing, and the AHA applauds the Administration's attention to advancing rural health.



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As HRSA and the Department of Health and Human Services' (HHS) Rural Health Task Force continue their efforts to support health care in rural America, we urge the agencies to consider the following:

- **Reassessing the services considered to be “core” or essential over time is important in order to account for shifts in care delivery, advances in knowledge and practice, and other developments in the health care field;**
- **Community characteristics, needs and preferences should always be considered when recommending services to be made available;**
- **Any policy approaches to improve access to care in rural areas must allow for flexibility and promote community-driven solutions; and**
- **Federal agencies should use a “rural lens” when developing regulatory actions – not only when reviewing them after they have already been formed.**

We also encourage HRSA and the HHS Rural Health Task Force to support much needed changes to current regulations that impede access to care, including:

- Offering regulatory flexibility to allow providers to “co-locate” or share treatment space as a means to fill gaps in patient access to care;
- Issuing a permanent enforcement moratorium on the 96-hour condition of payment for critical access hospitals;
- Finalizing the Centers for Medicare & Medicaid Services' proposal to change the minimum level of supervision for outpatient therapeutic services from “direct” to “general” supervision; and
- Creating a “safe harbor” under the Anti-kickback Statute and reforming the Stark law to foster and protect arrangements that promote access and value-based care.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

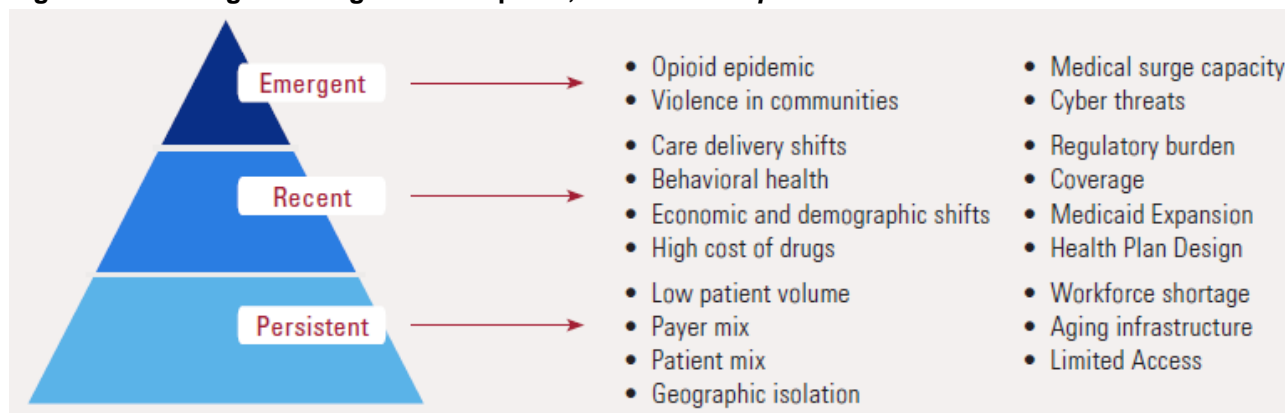
Enclosure

ACCESS TO CARE IN RURAL COMMUNITIES

Access to health care is an essential component of maintaining good health and well-being; in rural communities, individuals depend upon their hospital as an important – and often only – source of care. However, the recent and concerning trend of increased rural hospital closures threatens the availability of health care services across the country. As of September, 113 rural hospitals have closed since 2010, forcing many people in rural communities to travel even farther to receive care that they need, and in some cases causing people to delay or forgo care entirely. Most strikingly, one recent study found that rural hospital closures were associated with higher local mortality.¹ Simply put, the loss of a rural hospital can be devastating to the individuals living in these communities. Concerns for these areas are growing as significant pressures on the health care sector continue.

The AHA's Rural Report, released in February 2019, outlines the numerous challenges facing rural hospitals. These challenges, which are listed in Figure 1, contribute to closures and ultimately diminish access to care. Some challenges are thought to be *persistent*, insofar as they are characteristic of serving rural populations. Others reflect more *recent* changes in care delivery, financing, policy, and society. Still others represent *emergent* issues - more immediate concerns that may arise with little warning and/or require major shifts in attention and resources.

Figure 1: Challenges Facing Rural Hospitals, AHA Rural Report



As rural hospitals work to tackle persistent issues such as low patient volume and a reliance on government payers, they also must address recent challenges, including the shift from inpatient to outpatient care, and more emergent issues such as the opioid crisis and even natural disasters. While some rural hospitals continue to thrive despite these unrelenting obstacles, others find that the cumulative burden of persistent, recent and emerging challenges threaten their ability to maintain access to services. For more discussion of these challenges and AHA's recommendations on policy approaches to

¹ Gujral, K & Basu, A. (2019). Impact of Rural and Urban Hospital Closures on Inpatient Mortality. NBER Working Paper No. 26182. Accessed at: <https://www.nber.org/papers/w26182>

address them, please view the full report, available at <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

AHA Task Force on Ensuring Access in Vulnerable Communities. Recognizing the impact of limited access, the AHA gathered a group of hospital leaders in 2015 to address the challenges they face and examine ways in which hospitals can help ensure access to health care services in vulnerable communities. That group – the Task Force on Ensuring Access in Vulnerable Communities (“the Task Force”) – explored both rural and urban access concerns, noting that there are service availability challenges shared between the two types of communities. AHA and the Task Force acknowledged that there is a range of health care services needed, and the ability of individuals to obtain access to health care services varies widely across communities. Thus, what is considered “essential” or “core” may vary depending on community characteristics. However, the Task Force believed that access to a baseline level of high-quality, safe and effective services must be protected and preserved.

The services identified by the Task Force are summarized below. The full description of each service is available at <https://www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf>.

Figure 2: Essential Health Care Services, Ensuring Access in Vulnerable Communities Task Force

Service	Description
<i>Primary Care</i>	Includes not only the diagnosis and treatment of acute and chronic conditions, but the provision of a continuum of care in a manner that is accessible, comprehensive and coordinated.
<i>Psychiatric and Substance Abuse Treatment</i>	Includes a spectrum of acute and chronic mental health and substance use disorder services, such as psychiatric and substance use treatment, counseling and psychotherapy.
<i>Emergency and Observation Services</i>	Emergency services include evaluation and/or treatment of medical conditions that require immediate and unscheduled medical care. Observation includes hospital outpatient services that help a physician decide if the patient needs to be admitted as an inpatient.
<i>Prenatal Care</i>	Includes preventive health care and regular check-ups to treat and prevent potential health problems throughout the course of the pregnancy.
<i>Transportation</i>	Includes both medical and personal transportation to allow patients to access care at hospitals and other health care facilities.
<i>Diagnostic Services</i>	Includes testing services that are necessary for the provision of primary health care and provide practitioners with information about the presence, severity and cause of illnesses and diseases in patients.
<i>Home Care</i>	Includes a wide range of health care services that can be given for an illness or injury and allows patients to stay in their home, with the goal of assisting patients in regaining independence.
<i>Dentistry</i>	Includes preventive and basic dentistry services, including prophylactic cleanings and X-rays, for individuals of all ages.
<i>Robust Referral Structure</i>	Referrals that provide access to the full spectrum of health care services needed for individuals in the community.

The Task Force's work established a foundation for developing strategies that reform health care delivery and payment, and provided opportunities to choose different options to support these services based on community needs, support structures and preferences. Nine strategies emerged from the Task Force, including:

- **Strategies addressing social determinants of health**, including screening patients to identify unmet social needs, providing navigation services to assist patients in accessing services and encouraging alignment between clinical and community services to ensure they are available and responsive to patient needs;
- **Global budget payments**, which provide a fixed amount of reimbursement for a specified population over a designated period of time;
- **Inpatient/outpatient transformation**, which involves a hospital reducing inpatient capacity and enhancing outpatient services to a level that closely reflects the needs of the community;
- **Emergency medical center models**, which allows existing facilities to eliminate inpatient acute care but maintain emergency, transportation, and outpatient services, and other types of care to meet a community's needs;
- **Urgent care centers**, which maintain an access point for urgent medical conditions that can be treated on an outpatient basis;
- **Virtual care strategies**, including telehealth technologies that offer benefits such as immediate, 24/7 access to clinicians, the ability to perform high-tech monitoring and less expensive and more convenient care options for patients;
- **Frontier health system strategies**, which provide a framework for coordinated health care as individuals move through primary and specialty services;
- **Rural hospital-health clinic integration**, which supports partnerships between hospitals and clinics that could facilitate coordination of primary, behavioral and oral health and allow for economies of scale between both organizations; and
- **Indian health services (IHS) strategies**, including partnerships between IHS and non-IHS providers aimed at increasing access to care for Native American and Alaska Native Tribes, improving the quality of care and promoting care coordination.

More on each strategy is available at <https://www.aha.org/issue-landing-page/2016-11-16-ensuring-access-vulnerable-communities-taskforce-report-and-resources>.

Revisiting Essential Services for Rural Communities. As communities and the health care sector both evolve, it is important not only to identify but also to revisit those services that are considered essential. Recently, AHA's new Future of Rural Health Care Task Force, a group of AHA members that was formed this year to develop care delivery and financial models with the objective of meeting long-term needs of rural communities, took the opportunity to discuss the essential services for vulnerable communities identified in 2015. While broad agreement over the original listing remained, several observations from this group and other rural AHA members illuminate the value of reassessing services considered to be "core" or essential as communities, research and the services themselves can change over time.

One theme that arose from examining the 2015 list of essential services is that some services may have initially been limited in scope. For example, as more is understood about behavioral health and the services used to address those needs, focusing on *psychiatric and substance use treatment* may restrict service offerings. Instead, using *behavioral health services* as the benchmark may encourage a more inclusive set of services to meet a larger range of community needs. Similarly, while there is still strong consensus that *prenatal care* be available in all communities, *maternal health care* may be more suitable to include in a list of essential services because it is comprised of services that span the prenatal and postpartum periods. A recent study by the Centers for Disease Control and Prevention (CDC) found that roughly one third of maternal deaths occur between 1 week and 1 year after giving birth, underscoring the significance of access to high-quality postnatal care.² **As these examples show, reassessing core or essential services over time is important in order to account for shifts in care delivery, advances in knowledge and practice, and other developments in the health care field. An overreliance on what is considered core/essential at only one point in time may preclude communities from accessing the types of care they will need in the future.**

In addition, the Future of Rural Health Care Task Force also acknowledged that some of the strategies developed by the 2015 Task Force may now be considered as essential services themselves. For example, several members identified social services and telehealth – which were captured in the *addressing social determinants* and *virtual care* strategies in the 2015 report – as crucial for rural communities. Thus, approaches to maintaining access to essential services may even become essential themselves over time, as successful interventions become more widespread.

Another theme identified while revisiting the 2015 essential services is that rural communities have diverse needs and opportunities. While an inventory of core services offers a baseline of care to be available in all communities, still other services may be considered essential in some areas but not in others. Approaches to improving access that work in rural New England may not be successful in Frontier states given their variable circumstances. **Community characteristics, needs, and preferences should always be considered when recommending services to be made available.** In addition, the definition and parameters of “community” can vary. For example, in light of the quality and efficiency gains associated with higher volumes, some rural providers are testing regionalization models in which particular services are provided by certain providers within a determined distance. This means that a service may not be available within an immediate area but is accessible for the broader community. For some, this may be a more preferable or appropriate means of organizing care and making it accessible, especially if some providers would not be able to sustain the regionalized service on their

² CDC. (2019). CDC Vital Signs: Pregnancy-related deaths. Accessed at <https://www.cdc.gov/vitalsigns/maternal-deaths/pdf/vs-0507-maternal-deaths-H.pdf>

own. **Overall, any policy approaches to improve access to care in rural areas must allow for flexibility and promote community-driven solutions.**

REGULATORY AND CONTEXTUAL FACTORS THAT MAY LIMIT RURAL HEALTH CARE ACCESS

According to “Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers,” [a study conducted](#) by the AHA, the nation’s hospitals, health systems and post-acute care providers spend \$39 billion each year on non-clinical regulatory requirements. These costs include the staff required to meet the demands of the regulations concerning physicians, nurses, legal, management, health information technology professionals and others. While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher. As such, complying with regulations could result in reduced local access to services. The Centers for Medicare & Medicaid Services (CMS) has acknowledged the regulatory burden on providers and continues to review the effectiveness of current regulation through its Patients over Paperwork initiative.

Beyond the costs of compliance, some existing regulations can impede access to care in rural areas because they do not take the unique rural context into consideration, including low availability of certain services, clinician recruitment challenges, and limited staff and resources. **We continue to encourage HRSA, as well as CMS and other federal agencies, to use a “rural lens” when developing regulatory actions – not only when reviewing them after they have already been formed.** Some specific examples of particularly problematic regulations for rural hospitals are described below.

Co-location. Many hospitals share treatment space with other providers in order to offer a broader range of medical services and better meet patient needs. In rural areas, hospitals may lease space to visiting specialists several days per month to make certain services locally available. These types of agreements are crucial for those small and rural hospitals that may have limited clinical staff and/or rely on visiting physicians to provide specialty services (e.g., cardiology, oncology) that would otherwise require patients to travel long distances in order to obtain such care. Recently, CMS issued draft guidance on allowing hospitals to co-locate with other hospitals and health care entities and sought public comment on that draft guidance. AHA submitted a [letter](#) in response to the draft guidance and encouraged the agency to make several revisions so that co-location arrangements can enable hospitals to serve their patients in a more efficient and effective manner. **Flexibility should be offered to providers who wish to share treatment space as a means to fill gaps in patient access to care.**

96-hour Condition of Payment. Critical access hospitals (CAHs) must maintain an annual average length of stay of 96 hours as a condition of participation in the Medicare program, yet some may offer certain critical medical services that have standard lengths of stay

greater than 96 hours. In recent years, CMS enforced a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This additional step and limitation drives CAHs to eliminate “96-hour-plus” services, reducing local access in rural areas and forcing patients to travel longer distances for care. The AHA appreciates CMS’s recognition that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services to rural America. **We continue to recommend that CMS issue a permanent enforcement moratorium on the 96-hour condition of payment. The AHA also will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs, and we urge CMS to work with us to support that effort.**

Direct Supervision. Current policy requires direct supervision by a physician for outpatient therapeutic services provided by CAHs and small (i.e., fewer than 100 beds) rural hospitals. As a result, a physician must be “immediately available” for even the lowest risk outpatient therapeutic services, such as the application of a splint to a finger. Given physician shortages in rural areas, this policy can have a significant impact on access as some hospitals may limit their hours of operation or reduce services due to their inability to meet this requirement. In recent years, CMS had applied an enforcement moratorium on the direct supervision requirement. **Within the past few months, CMS went further by proposing to change the minimum level of supervision to general supervision, rather than direct supervision, for outpatient therapeutic services. The AHA strongly supports this proposal, as we have repeatedly urged CMS for such a solution to this critical issue for rural hospitals.**

Stark Law and Anti-Kickback Statute. These laws were intended to prevent fraud and abuse and govern financial arrangements between physicians and hospitals. However, they do not reflect how care is delivered today, including value-based and coordinated care. While not intended by the laws, the potential for violating these statutes may be higher for rural hospitals in light of their unique conditions. For example, limited patient volume may necessitate the need to share specialists with non-affiliated hospitals; as a result, ongoing patient referrals to these facilities could implicate the Anti-Kickback Statute. Similarly, recruiting physicians to rural communities typically involves higher salary offers, which can lead to compliance concerns related to the Stark law’s “fair market value” provision. **Policymakers should remove barriers to service availability and care transformation in rural areas. For example, a “safe harbor” under the Anti-Kickback Statute should be created and the Stark Law and certain civil monetary penalties should be reformed to foster and protect arrangements that promote value-based care.**

Other Contextual Limitations. Outside of complying with specific regulations, contextual factors associated with rural hospitals may also stymie local access by limiting advancement opportunities for these providers. For example, care transformation models

and other demonstrations often require a minimum service volume to participate. As a result, rural providers may not meet eligibility criteria for participating in testing new models of care. Similarly, low patient volume can be a hindrance to demonstrating quality since rural providers may not have the case thresholds to be able to obtain statistically reliable results for some performance measures. See the “Rural Quality Measurement” section below for more discussion on examining care quality in the rural context.

In addition, limited staffing and resources may limit the potential of rural providers to successfully apply for grants, even when funding opportunities are available. In many cases, small rural hospitals do not have dedicated grant writers or support staff; as a result, they may require outside technical assistance to complete a successful application, or even miss out on a grant opportunity due to lack of available staff to search for opportunities. Others may not have the resources to obtain and/or report data needed for applications or grant requirements. **Given the circumstances of rural hospitals, granting agencies and organizations should ensure that:**

- **funding opportunities are very well communicated to target participants;**
- **grants are released in a time frame that does not overwhelm providers and allows ample time to apply;**
- **applications are simple and include clear instructions with templates/examples;**
- **technical assistance is available for applicants, especially those who are low-resourced or have limited experience in grant writing; and**
- **data requirements for applying for and participating in the grant program are not overly burdensome.**

RURAL HEALTH CARE WORKFORCE

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. While almost 20% of the U.S. population lives in rural areas, less than 10% of U.S. physicians practice in these communities.³ Health care professional shortages are troublingly widespread across rural America. As of November 2018, two-thirds of the nation’s 6,941 primary care Health Professional Shortage Areas (HPSAs) were in rural or partially rural areas.⁴ Some rural providers utilize locum tenens arrangements to help with temporary physician and other professional absences, but the benefit of such arrangements is limited because Medicare restricts payment for locum tenens clinicians to only 60 days.

³ Johnt E. K., Nguyen N., Samson W. L., Snyder E. J. (2016). Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives. ASPE Office of Health Policy. Accessed at: <https://aspe.hhs.gov/system/files/pdf/211061/RuralHospitalsDSR.pdf>

⁴ Health Resource & Services Administration. (2018). Data Warehouse. Accessed at: <https://data.hrsa.gov/hdw/Topics/shortageareas.aspx>

Nurse practitioners, midwives and physician assistants have helped to address the shortages. In fact, nurse practitioners and physician assistants currently account for 19% and 7%, respectively, of the primary care workforce and contribute substantially to the total supply of primary care visits.⁵ However, many state licensure laws limit the ability of advanced practice clinicians to practice at the top of their license, thus limiting the services they may offer to patients. Physician supervision regulations also may hinder maximal use of advanced professional staff.

Clinical workforce shortages exist across specialties, but the limited number of behavioral health providers is particularly striking.⁶ In fact, a 2016 JAMA study found that mental health conditions were responsible for nearly 80% of telemedicine visits among rural Medicare beneficiaries from 2004- 2013, highlighting both the scarcity of behavioral health specialists and a need for innovative solutions.⁷ Practice restrictions may exacerbate behavioral health specialist shortages. For example, state licensure restrictions may prohibit a practitioner from caring for a patient who resides just over a state border, despite the nearest in-state clinician being more than one hundred miles away. Limits on the medication-assisted therapy (MAT) prescribing for substance use disorder also cap the number of patients a clinician can serve. Some approaches to resolving these issues include: easing licensure restrictions to allow for multi-state practice and programs that can share resources; allowing other types of practitioners and paraprofessionals to train and provide behavioral health services; and collaborating with universities and hospital systems to provide telephonic assistance where broadband-based virtual communications are challenging.

Some existing programs work to ameliorate rural workforce deficits by incentivizing clinicians to work in rural areas. These include the Conrad State 30 and the National Health Service Corps programs, which are administered by federal agencies with funding from Congress. In addition, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 established a loan repayment program for substance use disorder treatment professionals in mental health professional shortage areas or counties hardest hit by drug overdoses. Continued support for these programs is important to address workforce gaps in rural areas. Yet despite the promise of these programs, with only one percent of medical residents and fellows indicating a preference for practicing in a small town or rural area,

⁵ Green LV, Savin S, Lu Y. Primary care physician shortages could be eliminated through use of teams, nonphysicians, and electronic communication. *Health Aff (Millwood)*. 2013;32(1):11-19.

⁶ Johnson S. (2018 June 25) New study reveals alarming shortage of mental health professionals in rural America. Big Think Smarter Faster. Accessed at: <https://bigthink.com/stephen-johnson/new-study-reveals-alarming-shortage-of-mental-health-professionals-in-rural-america>

⁷ Mehrotra A., Jena A B., Busch A B., Souza J., Uscher-Pines L., and Landon B E. (2016). Utilization of Telemedicine among Rural Medicare Beneficiaries. *JAMA Network*. Accessed at: <https://jamanetwork.com/journals/jama/fullarticle/2520619>

designers of rural recruitment programs will have to consider additional, unique ways to attract the next generation of clinicians.⁸

In addition, advancements in telehealth can address workforce challenges by connecting patients and their providers to specialists in other locations; however, state licensure restrictions often limit the reach of telehealth services. In response, many states have enacted legislation supporting the Interstate Medical Licensure Compact, which expedites the licensure process for physicians wishing to practice medicine in multiple states.⁹ **These recruitment and retention programs are important to support a sustainable rural health care workforce; however, we urge HRSA and other agencies to develop additional solutions to address workforce shortages and challenges in rural areas.**

RURAL QUALITY MEASUREMENT

The AHA welcomes HRSA's continued interest in understanding the best ways to measure quality in rural communities. Indeed, HRSA funded the National Quality Forum's (NQF) 2015 report on rural quality measurement, which helped advance the health care field's understanding of the complex, nuanced issues involved with measuring quality in the rural context. The 2015 report significantly influenced the NQF's 2018 recommendations for core sets of rural-relevant quality measures that the AHA largely supports. As HRSA considers ways to enhance provider, patient and policymaker understanding of rural quality, we offer several overarching recommendations.

First, measuring and improving quality in the rural context likely will require a balanced combination of community and provider-level assessment. To sustain access to care in rural communities, the AHA believes that hospitals and other providers must work collaboratively with the communities they serve to identify their greatest health and health care needs. Those efforts will require providers and communities alike to have access to actionable, easy to understand data. That is why we are pleased that HRSA is considering ways of leveraging data from national surveys and datasets like the National Health Interview Survey, the National Healthcare Quality and Disparities reports and others to inform stakeholder efforts. At the same time, rural providers are eager to use measures as tools to identify ways of improving their care and benchmarking it against other rural providers. For these reasons, HRSA should continue to support efforts that identify meaningful quality measures for rural providers, and address the complex methodological challenges of implementing provider-level quality measures in a rural context, as described below.

⁸ Jones Sanborn B. (2018 July 20). Here's a look at where clinicians are flocking to new jobs and what practice settings they prefer. Healthcare Finance. Accessed at: <https://www.healthcarefinancenews.com/news/heres-look-where-clinicians-are-flocking-new-jobs-and-what-practice-settings-they-prefer>

⁹ Sullivan T. (2018 May 5). Interstate Medical Licensure Compact- Expands to 17 States. Policy & Medicine A Rockpointe Publication. Accessed at: <https://www.policymed.com/2016/06/interstate-medical-licensure-compact-expands-to-17-states.html>

In addition, HRSA’s efforts to support provider-level quality measurement in the rural context should be focused on the highest priority opportunities for improving care. 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. The resource constraints that affect all hospitals are especially acute for rural hospitals and other rural providers. Diverting nursing or physician time from the direct provision of care in these organizations should only be done when there is a reasonable expectation that the “juice is worth the squeeze.” To the extent that HRSA engages providers in measure-reporting activities, or supports the development of new measures, those efforts should be focused on meaningful priority areas. The NQF’s 2018 report provides carefully considered “core sets” of measures applicable to rural hospitals and clinicians that could form a basis for reporting efforts. HRSA also should consult CMS’s “Meaningful Measures” initiative priority list to ensure interagency alignment.

The AHA also cautions that mandatory rural provider participation in quality measurement and value programs likely is premature until the many technical problems of measuring the quality of rural low-volume providers are addressed.

Both NQF reports articulate the challenges that small case volumes, the vast heterogeneity of the services provide and geographic isolation post in measuring rural provider performance accurately. Indeed, Congress also understood the challenges of mandating participation in quality reporting and value for low-volume providers by excluding such providers from CMS’s hospital value programs, and including a low-volume threshold in the Merit-based Incentive Payment System (MIPS) for eligible clinicians. To be clear, rural providers support transparency; most CAHs have chosen to voluntarily report some data on CMS’s *Hospital Compare* website, and many have expressed their eagerness to share what they are doing to make care better and safer. However, we fear that without appropriate methodologies to account for these issues, the measures used in mandatory would be subject to significant statistical “noise.” Programs that intend to pay for performance may seem much more like a game of chance than well-designed public policy.

Measuring quality in post-acute care (PAC) settings remains exceptionally challenging in rural communities. The same issues in measuring quality in general acute care that affect rural providers – low volumes and staffing and resources that are not comparable to the average hospital – are exacerbated in PAC settings. Moreover, wide variation in patients and differences across the various PAC settings (i.e., skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health) make it even more difficult to assess quality overall. While all providers strive to provide the highest quality of care, the competitive edge that is also associated with higher quality is lost in rural communities where there may only be one PAC provider.

In light of these issues, PAC quality measurement (but not quality itself) in rural communities may lag behind those organizations who participate in the rigorous

Medicare quality reporting programs; rural-specific approaches to examining PAC quality may be necessary. In general, the quality measurement field in PAC is shifting its focus from process measures, which become quickly topped-out, to outcome measures that seek to determine how well PAC providers help their patients regain or achieve functional independence as defined by a setting's specific patient mix. As an example, inpatient rehabilitation facilities have more emphasis on rehabilitation for younger patients who have been injured than long-term care hospitals, who care for gravely ill – and often older - individuals who may be bed-bound and whose primary goal is to breathe without a ventilator. For rural providers, it may be more appropriate to consider measures that are cross-cutting since the diversity in provider types is limited. In addition, measures defined with a larger population would help assuage issues with low-volumes. For example, screening measures for depression, cognitive function, substance use, and pain are widely applicable and are based on validated tools. Process measures, too, may be helpful to monitor in order to identify opportunities for assistance for post-acute care providers: often, when process measures fall short, resource and staffing shortages are to blame. These measures can pinpoint what types of specific resources are needed in post-acute care facilities (lab versus nursing versus clerical).

Lastly, we urge HRSA to ensure its focus on quality measurement is balanced and coordinated with the other mechanisms for driving quality forward. To be sure, quality measures are vitally important tools for improving care. However, the development of a better quality measurement strategy alone would not be sufficient if the agency's goal is to advance quality in rural areas. The agency also should support the development of other tools, such as standards development, quality improvement collaboratives, and research into better measures and best practices. If well-aligned, HRSA's work on all of these approaches could be mutually-reinforcing, and accelerate quality in a cohesive fashion.