MEDPAC

Advising the Congress on Medicare issues

Medicare's measurement of rural provider quality

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September 5, 2024

Presentation roadmap

1. Commission's prior work on quality measurement
2. Medicare's current quality reporting programs and rural providers
3. Initiatives to improve measurement of rural providers' quality of care
4. Discussion

MedPAC's principles for quality measurement (2018)

- Quality measurement should be patient oriented, encourage coordination across providers and time, and promote relevant change in the nature of the delivery system
- Quality measurement should not be unduly burdensome for providers
- Medicare quality programs should include population-based measures such as outcomes, patient experience, and value
  - Providers may choose to use more granular measures to manage their own quality improvement

Source: MedPAC 's June 2018 report to the Congress

MedPAC's principles for quality measurement (2018) (con't)

- Medicare quality programs should give rewards based on clear, absolute, and prospectively set performance targets
- The Medicare program should take into account, as necessary, differences in a provider's patient population, including social risk factors
  - Because adjusting measure results for social risk factors can mask disparities in clinical performance, Medicare should account for social risk factors by directly adjusting payment through peer grouping
- Medicare should target technical assistance resources to low-performing providers

Source: MedPAC June 2018 report to the Congress

Commission's principles for rural quality of care (2012)

- Expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver
- All providers should be evaluated on the services they provide – emergency and nonemergency alike – and the quality of the services should be collected and reported publicly

Source: MedPAC 's June 2012 report to the Congress.

Medicare's current quality reporting programs and rural providers

Quality payment programs can create incentives to furnish efficient, high-quality care

- Pay-for-reporting programs
  - Providers (or accountable entities) that report designated quality measures are financially rewarded (or not penalized)
  - The Congress has enacted Medicare quality reporting programs for FFS provider types that account for a large majority of services
  - CMS publicly reports quality results on Care Compare website
- Pay-for-performance programs
  - Adjust provider payment upward or downward based on performance on quality measures
  - Now programs for hospitals, clinicians, SNFs, HHAs, dialysis facilities, ACOs, and MA plans

Note:, SNF (skilled nursing facility), HHA (home health agency), ACO (accountable care organization), MA (Medicare Advantage).

Important to measure the quality of rural providers; however, there are practical challenges

- Important to measure the quality of care furnished by rural providers to monitor performance, publicly report information to patients and payers, and incentivize high-quality care
- Practical challenges in measuring some individual rural providers; all are broader limitations in measuring the quality of smaller providers
  - *Low-population density*: May not have enough patients to produce reliable and valid measure results
  - *Heavier burden*: Limited time, staff, and resources for quality reporting

Many rural providers participate in quality reporting

- Some rural providers are not required to participate in Medicare quality reporting programs
  - Excluded in legislation because paid outside of traditional payment systems (e.g., paid on a cost basis)
  - Program rules defined by CMS (e.g., measure-specific minimum case counts needed to produce reliable and valid results)
- But many rural providers report quality results to CMS and meet program rules for public reporting of at least some quality measures
- During MedPAC site visits, leadership of rural providers cited the value of voluntarily reporting to gain experience with measurement and improvement

Hospital quality reporting programs

Program	Quality measures	Required participants	Rural provider participation
Inpatient QRP	36 measures including readmissions, mortality, and patient experience	Hospitals paid under PPS	99% of CAHs voluntarily report measures; 83% had sufficient volume for public reporting of at least the readmissions measure
Outpatient QRP	19 measures including imaging for low back pain, patient experience, and "left before being seen in ED"	Hospitals paid under PPS	99% of CAHs voluntarily report measures; 71% had sufficient volume for public reporting of at least the "left before being seen in ED" measure
REH QRP	4 measures that are part of outpatient QRP including "time spent in ED"	All designated REHs	All REHs (data collection began in 2024)

Note: QRP (quality reporting program), PPS (prospective payment system), CAH (critical access hospital), ED (emergency department), REH (rural emergency hospital). The percentages of providers that meet the requirements for public reporting meet CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of eligible cases for readmissions is 25 index admissions. Where feasible, we highlighted reporting of readmissions measure results, because it is a claims-based outcome measure, which is consistent with the Commission's principles for quality measurement.

Sources: CMS final rules for inpatient and outpatient prospective payment systems for fiscal year 2025. CMS publication on REH quality measures for coverage year 2024. MedPAC analysis of Care Compare data.

Post-acute care quality reporting programs

Program	Quality measures	Required participants	Rural provider participation
Skilled nursing facility QRP	16 measures including change in mobility and readmissions	SNFs paid under PPS (freestanding, hospital-based, PPS hospital with swing beds)	80% of freestanding and hospital-based SNFs in rural areas have at least readmissions results publicly reported; 17% of PPS hospitals with swing beds have at least readmissions result publicly reported; CAH swing beds do not report data
Home health QRP	21 measures including improvement in management of medication and patient experience	HHAs paid under PPS (free-standing, hospital-based)	87% of HHAs with the majority of their patients in rural areas have at least readmissions results publicly reported

Note: QRP (quality reporting program), SNF (skilled nursing facility), PPS (prospective payment system), CAH (critical access hospital), HHA (home health agency). The percentages of providers that meet the requirements for public reporting meet CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of eligible cases for CMS readmissions is 25 index admissions. Where feasible, we highlighted reporting of readmissions measure results, because it is a claims-based outcome measure, which is consistent with the Commission's principles for quality measurement. For brevity, we did not include Medicare QRPs for inpatient rehabilitation facilities and long-term care hospitals.

Sources: CMS final rules for SNF prospective payment systems for fiscal year 2024, and home health for coverage year 2024. MedPAC analysis of Care Compare data.

Quality of clinician care in both urban and rural areas is difficult for Medicare to assess

- Medicare does not collect clinical information, patient experience, or patient-reported outcomes at the beneficiary level
- CMS measures the performance of clinicians using Merit-based Incentive Payment System (MIPS), which the Commission recommended eliminating because it is fundamentally flawed
- For claims-based measures, "incident to" policies obscure the ability to determine who performed a service
- Small number of cases for individual clinicians can make results unreliable and inequitable

Sources:, MedPAC March 2024 and 2018 reports to the Congress.

Clinician quality reporting program

Program	Quality measures	Required participants	Rural provider participation
Merit-based Incentive Payment System	100s of measures across four areas: quality, improvement activities, promoting interoperability, and cost	Clinicians not participating in A-APM who bill more than $90,000 for Part B–covered professional services, and see more than 200 Part B patients and provide more than 200 covered professional services to Part B patients	94% of MIPS-eligible clinicians in rural areas actively submitted MIPS data; clinicians who bill exclusively through FQHC and RHC payment models are not included in MIPS

Note: A-APM (advanced-alternative payment mode)l. MIPS (Merit-based Incentive Payment System), FQHC (federally qualified health center), RHC (rural health clinics). Federally qualified health centers and rural health clinics do not have Medicare-specific quality reporting programs, but FQHCs are required to report quality data to other federal agencies.

Sources: QPP 2022 Experience Report.

Quality reporting programs for accountable care organizations

Program	Quality measures	Required participants	Rural provider participation
Medicare shared savings program	Up to 10 clinical quality measures collected by the ACO, 2 claims-based outcome measure, and patient experience survey measures	All ACO participants	Beneficiaries residing in rural areas that are attributed to ACOs are included in the ACO's quality reporting; about 45% of RHCs participate in MSSP
ACO REACH	4 claims-based outcome measures including readmissions, and patient experience survey measures	All ACO participants	Beneficiaries residing in rural areas that are attributed to ACOs are included in the ACO's quality reporting; data collection began in 2024

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program), RHC (rural health clinics).

Sources: CMS's Shared Savings Program Fast Facts as of January 2023.

MA: Quality is reported at the contract level, which masks differences in underlying health care markets

- CMS collects MA quality measure results on a contract-wide basis and uses these results to determine a star rating for all plans under the contract
  - Largest MA contract (with 2.6 million enrollees):
    - Over 1,000 enrollees in each of 46 states
    - Over 20,000 enrollees in each of 30 states
- Commission recommended replacing the QBP with a value incentive program that would address its many flaws, including contract-level reporting (June 2020)

Note: MA (Medicare Advantage), QBP (quality bonus program).

Quality reporting for MA and Part D plans

Program	Quality measures	Required participants	Rural provider participation
MA star ratings	Based on 42 measures including process, intermediate outcome, outcome, patient experience, and access measures	MA contracts	MA enrollees residing in rural areas included in MA contract-level quality results
PDP star ratings	Based on 12 measures (subset of MA star rating measures) including process, intermediate outcome, patient experience and access measures	PDP contracts	PDP enrollees residing in rural areas included in PDP contract-level quality results

Note: MA (Medicare Advantage). PDP (Part D plan).

Sources: CMS' Medicare 2024 Part C and D star rating technical notes**.**

Initiatives to improve measurement of rural providers' quality of care

Identifying and developing metrics that are most relevant for rural providers

- National Quality Forum convened multi-stakeholder Rural Health Advisory Group
  - Identified best measures to address the needs of rural population (e.g., topics important to needs but also resistant to low case volume challenges)
  - Listed 37 key rural quality measures (21 for hospitals, 16 for ambulatory care settings)
    - Most included in Medicare quality reporting programs
    - Many tied to clinician outcomes, patient experience, and value and therefore consistent with MedPAC principles
  - Identified gaps for further measure development including intentional and unintentional injury, telehealth-relevant measures, cancer screenings

Sources: National Quality Forum. 2015. Performance measurement for rural low-volume providers. Washington, DC: NQF.
National Quality Forum. 2022. 2022 key rural measures: An updated list of measures to advance rural health priorities. Washington, DC: NQF.

Making technical assistance for quality measurement and improvement available to providers

- The goal of improved care should extend to all patients and is more likely to be met if combined with additional resources to build a provider's ability to address challenging environments for care delivery
- Programs available to help rural health care providers
  - Quality improvement organizations work directly with small rural providers and CAHs
  - HRSA's MBQIP helps CAHs report measures for CMS programs

Note: CAH (critical access hospital), HRSA (Health Resources and Services Administration), MBQIP (Medicare Beneficiary Quality Improvement Project).

Summary

- In principle, all providers should be evaluated on the quality of services they provide, and quality results should be publicly reported
- However, there are challenges in measuring the quality of small providers, many of which are rural providers
- Some federal and multi-stakeholder initiatives are intended to drive improved quality measurement of rural providers
- Many rural providers report quality information to the extent feasible, either at the provider level or as part of ACO and MA quality measurement

Discussion

- Questions?
- Feedback on materials?
- Potential future analytic work?