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Rural Health Clinic Participation in the Merit-Based Incentive Payment System and Other Quality Reporting Initiatives: Challenges and Opportunities

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INTRODUCTION

Rural Health Clinics (RHCs) are an important source of primary care in underserved rural communities with more than 4,200 RHCs providing primary care services to rural Medicare and Medicaid beneficiaries in 44 states.¹ With the growing emphasis by third party payers on the quality rather than the volume of care provided, health care providers are increasingly encouraged and, in some cases, required to participate in quality reporting programs. However, RHCs have largely been excluded from such programs under Medicare. RHCs were ineligible to participate in the Centers for Medicare & Medicaid Services' (CMS) quality reporting and practice transformation initiatives including the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Payment Program (meaningful use).² Similarly, RHCs are exempt from participation in the Merit-Based Incentive Payment System (MIPS) prescribed by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).³ While RHCs are exempt from mandatory participation in MIPS, CMS's 2016 final rules for MIPS and Alternative Payment Models (APM) incentives under the Medicare Physician Fee Schedule (PFS) allow them to do so on a voluntary basis.⁴ However, they will not be eligible for payment incentives (or subject to penalties) for doing so. The exclusion of RHCs from CMS's quality reporting programs and value-based initiatives may potentially create a perception among consumers and policymakers that RHCs are unable to meet the requirements of these initiatives and are providing lesser quality care than larger, urban-based clinicians.

In light of the growing emphasis on quality reporting, it is important to understand factors influencing RHC readiness to participate in quality reporting including MIPS, Medicaid, and commercial payer quality reporting programs. This brief discusses MIPS within the context of past and current RHC quality reporting initiatives, and assesses options for encouraging RHCs to voluntarily participate in MIPS. To inform this brief, we conducted an extensive review of the MACRA legislation and regulations, the limited number of published reports and studies on RHC quality reporting, and CMS RHC billing manuals. We also reviewed advisory documents, consulting analyses, and other professional literature and monitored relevant listservs. Key informant interviews were conducted with representatives from the National Association of Rural Health Clinics, the National Organization of State Offices of Rural Health, State Offices of Rural Health (SORHs), state RHC associations, RHCs, consulting organizations, and RHC quality reporting initiatives.

Highlights

- With the growth in quality reporting and value-based payment systems, Rural Health Clinics (RHCs) not participating risk being left behind in the evolving healthcare marketplace.
- Although exempt from mandatory participation in the Merit-Based Incentive Payment System (MIPS), RHCs may voluntarily report quality data but are not subject to MIPS payment adjustments.
- Revised Medicare coding requirements may reduce barriers to RHC participation in MIPS.
- RHCs face increasing quality reporting and value-based reimbursement requirements of State Medicaid programs, commercial payers, and employers.
- Lessons from RHC quality initiatives highlight the importance of identifying a core set of RHC-relevant measures, the need for technical assistance and leadership to support RHC engagement, and the value of a quality improvement network for benchmarking and shared learning.

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OVERVIEW OF THE QUALITY PAYMENT PROGRAMS IMPLEMENTED UNDER MACRA

MACRA replaced the Medicare Sustainable Growth Rate payment system, which determined how clinicians were paid under Medicare Part B, with a new Quality Payment Program (QPP).⁵ The goal was to establish a sustainable Part B clinician payment update program that rewards high quality care. Beginning in 2017, the QPP established two quality payment pathways to demonstrate the provision of high quality and high value care – APMs and MIPS.⁴

APMs are payment approaches that incentivize clinicians to provide high-quality, cost-efficient care. Advanced APMs exempt participants from MIPS requirements and provide a five percent annual bonus payment in 2019 to clinicians that participate in CMS-approved qualified or “advanced” APMs above CMS defined threshold levels. Advanced APMs require participants to use Certified Electronic Health Record Technology, be reimbursed for services on quality measures comparable to those in MIPS, and bear more than nominal financial risk for losses.⁴

MIPS replaces and combines elements of earlier CMS quality reporting and incentive programs including PQRS, value modifiers, and meaningful use.³ A MIPS Composite Performance Score is calculated for participating clinicians based on their performance in the following categories: 1) quality (replacing PQRS); 2) advanced care information (replacing meaningful use); 3) clinical practice improvement (a new category under QPP); and 4) cost or resource use (replacing value modifiers that align the quality of care provided with the cost of that care).

How Does MIPS Apply to RHCs?

RHCs are exempt from mandatory participation in MIPS (and any payment adjustments that might result) because they are reimbursed by Medicare for a defined package of RHC services using a Part A reimbursement methodology rather than the Part B PFS.ⁱ Claims from RHC clinicians for services not part of the defined RHC benefit (such as inpatient hospital services) are reimbursed under the Part B PFS and are subject to MIPS and relevant payment adjustments unless exempted under the low volume threshold.^{ii,4,6}

Although the final rules allow for RHC voluntary reporting of quality data through MIPS, RHCs that choose to report will not be subject to any positive or negative payment adjustments.⁴

How are RHCs Reimbursed by Medicare?

RHCs are paid an all-inclusive per-visit rate by Medicare using Part A cost-based claims methodology rather than through the Medicare PFS.⁷ RHCs submit claims for RHC services using CMS 1450: UB-04 Universal Billing Form and a defined set of revenue and procedure codes.^{8,9} Services provided to Medicare beneficiaries not included in the package of RHC services are submitted using CMS 1500: Health Insurance Claim Form and Health Care Common Procedure Coding Systems (HCPCS) codes. These claims are paid under the Part B PFS.

OTHER PUBLIC AND PRIVATE REPORTING INITIATIVES

In addition to MIPS, state Medicaid programs and other private sector payers are rapidly moving to implement quality reporting, value-based purchasing initiatives, and/or advanced payment models (Appendix).¹⁰ For example, state Medicaid managed care programs often have significant quality measurement requirements.^{11,12} Given the high volume of Medicaid enrollees served by RHCs, this is an area that will drive RHC quality reporting in the future. Private payers and quality organizations are also implementing their own quality reporting and value based payment models such as the Maine Patient-Centered Medical Home Pilot¹³ and Blue Cross Blue Shield of Michigan’s efforts to encourage primary care practices to pursue PCMH recognition.¹⁴ Both of these programs include RHCs as participants. Additionally, the Washington State Health Care Authority (WA HCA) has developed an alternative value-based payment model for RHCs and Federally Qualified Health Centers (FQHCs) known as APM4 that aligns with Washington State’s value-based purchasing model and applies solely to Medicaid managed care enrollees.¹⁵ As some payers require participation in quality reporting or value-based initiatives as a condition of payment and more are likely to do so,¹⁰ RHCs should prepare to participate in these programs and demonstrate the quality and value of their care.

ⁱ Participation in MIPS and prior CMS quality reporting and practice transformation initiatives is predicated on reimbursement for professional services under the Medicare Part B PFS.^{2,3}

ⁱⁱ The minimum threshold for the 2017 reporting period (used to adjust 2019 PFS payments) includes billings for Medicare Part B allowed charges less than or equal to \$30,000 per year or seeing 100 or fewer Medicare Part B patients.⁴ For the 2018 reporting period (used to adjust 2020 PFS payments), the minimum threshold was raised to Part B billings of less than or equal to \$90,000 per year or 200 or fewer Medicare Part B beneficiaries. This increase in the minimum threshold reduces the likelihood that many RHCs will be required to participate in MIPS in 2018.⁶

CHALLENGES FOR RHC PARTICIPATION IN QUALITY REPORTING

RHCs face a number of challenges that complicate their ability to engage in quality reporting initiatives. In a recent project to pilot RHC-relevant quality measures, a survey of participating RHCs identified the following barriers to participation in MIPS and other quality reporting programs:

- The lack of guidance from CMS on how RHCs could voluntarily participate in MIPS;
- The added costs associated with retrieving and reporting quality data;
- The additional workload that pulls staff away from other patient care obligations;
- The difficulty of extracting data from paper records for RHCs without an EHR; and
- The costs incurred by RHCs with EHRs for additional reporting modules or custom programming to retrieve quality data.¹⁶

A number of respondents expressed concern that the costs associated with quality reporting and participation in MIPS would stress already financially vulnerable RHCs. These barriers were confirmed through our interviews with RHC stakeholders.¹⁶

OPTIONS TO SUPPORT RHC PARTICIPATION IN QUALITY REPORTING

Notwithstanding barriers to RHCs participation in quality reporting, it is also important to identify opportunities to support their participation in these initiatives. The following sections review each of these opportunities and discusses the support needed by RHCs.

EHR Adoption by RHCs: EHRs are a necessary resource for participation in quality reporting. RHCs without an EHR are at a distinct disadvantage in their ability to participate in quality reporting or performance-based payment programs. Studies of EHR adoption by RHCs suggest that their rate of adoption is similar to private practice physicians with nearly 72 percent of RHCs reporting adoption of an operational EHR in 2013.¹⁷ Almost 11 percent had purchased but not yet implemented an EHR. Forty-four percent of RHCs without an EHR reported plans to purchase one within the next year. Although RHCs reported high levels of EHR adoption, they also reported challenges with extracting data for quality reporting purposes.¹⁷

RHC Participation in Patient-Centered Medical Home Models: Some Medicaid managed care programs and commercial payers encourage and, in some cases, mandate that clinicians obtain Patient-Centered Medical Home (PCMH) recognition as a condition of participation.^{13,14} Two defining characteristics of the PCMH model are its emphasis on public reporting and use of quality data to drive patient care.¹⁸ Although there is limited data on the number of RHCs recognized as PCMHs, studies have shown that RHCs are likely to have difficulty obtaining PCMH recognition through National Committee for Quality Assurance (NCQA) or other accrediting bodies.¹⁸ RHCs using an EHR performed best on PCMH standards related to recording demographic data and managing clinical activities. They performed less well on improving access to and continuity of services, supporting patient self-management skills, shared decision-making, implementing continuous quality improvement systems, and building practice teams.¹⁸ RHCs achieving PCMH recognition are likely to be better positioned to engage in public reporting.

CMS Coding Changes for RHCs: Medicare's RHC reimbursement methodology requires RHCs to bill for a defined package of services using revenue codes that reflect their all-inclusive per-visit rate.⁷ This method does not identify the component services provided to Medicare beneficiaries. In contrast, primary care clinicians reimbursed under the Part B PFS use one or more HCPCS codes that identify the individual professional services and procedures provided during a patient encounter. Effective April 2016, CMS changed RHC billing procedures to require RHCs to report the appropriate HCPCS code for each service rendered on their UB-04 claim forms along with the revenue and other required billing codes. These changes did not affect the RHC all-inclusive rate system.¹⁹

This coding change was designed to increase compliance with national coding standards, collect data on RHC services to better inform policies, increase the accuracy of RHC claims processing, and provide CMS with the same data submitted by other primary care providers. As such, it could facilitate RHC participation in MIPS if RHCs choose to do so, allow comparison of services provided by RHCs to those provided by other primary care providers, and potentially allow for the calculation of claims-based quality measures.^{19,20} Moving forward, CMS could explore ways for these data to be linked to MIPS reporting to facilitate RHC involvement.

Identifying a targeted set of core RHC-relevant quality measures: Identifying a standard set of core RHC-relevant quality measures represents another

opportunity to enhance RHC quality reporting. The adoption of a set of core measures would facilitate data collection and comparison across RHCs. The challenge is to identify relevant core measures given the range of quality measures available and the different practice patterns of primary care clinicians. CMS has identified 271 quality measures for MIPS, of which 55 are included in the specialty measures set for general practice/family medicine.²¹ Too many measure choices complicate efforts to collect data on RHC quality performance and limits the ability to use the data for benchmarking across clinics. Although the Maine Rural Health Research Center, Michigan RHC Quality Network, and Quality Health Indicators (QHi) (Appendix) have each identified core RHC measures, further work is needed to gain widespread support for a common set of measures. Moving forward, efforts to identify RHC-relevant quality measures should focus on the key activities of rural primary care practices and reflect the work of the National Quality Forum's Measures Application Process Rural Health Workgroup, which is currently working to develop a core set of rural-relevant quality measures for a wide range of rural providers.²²

Technical assistance and program support: Engaging RHCs in formal quality improvement initiatives represents another opportunity for expanding RHC quality reporting and improvement efforts. Prior work with RHCs on quality measurement and reporting has identified the need for ongoing technical assistance (TA) to assist RHCs with EHR adoption and meaningful use, PCMH recognition, and quality reporting.^{16,17,18,23} The 2017 National Advisory Committee on Rural Health and Human Services (NACRHHS) report on modernizing the Rural Health Clinic Program highlighted the need for TA to better prepare RHCs for quality reporting and engagement with the changing healthcare market place.²⁴ The NACRHHS recommended that the Secretary work with Congress to provide grants to SORHs to provide TA on quality reporting and other services to support the transition of RHCs to value-based care. The work of the Michigan RHC Network and QHi (Appendix) reinforces the value of SORHs as a resource for RHCs as well as the value of TA to engage RHCs in quality reporting. Michigan's work further demonstrates the value of a formal quality improvement network with designated staff and funding to engage participants and the importance of face-to-face meetings to sustain their participation. In addition, the National Organization of State Offices of Rural Health is working to cultivate the capacity of SORHs to work with RHCs in their states and has developed a resource toolkit to support those efforts.²⁵

Other options to support RHC quality reporting: Other vehicles for engaging RHCs in quality improvement and measurement include participation in (1) accountable care organizations, (2) public and private quality reporting programs (e.g. Quality Improvement Organizations, PCMH initiatives), and (3) incentive programs implemented by state Medicaid and commercial insurance plans (Appendix). RHC participation in these programs may be necessary to ensure reimbursement, receive incentive payments, and/or avoid payment penalties. Although the requirements may vary across these different performance reporting programs, participation will help to build and sustain the capacity of RHCs to prepare for and engage in the evolving movement towards value- and performance-based payment systems.

CONCLUSIONS

As discussed, many public and private payers have created incentives for RHCs to report quality data. The challenge is that these initiatives operate separately using different sets of measures based on the specialties of the providers and the needs of the payer. Although RHCs may be participating in these initiatives, little information is available on their level of participation or the quality performance of participating clinics. As a result, we have little ability to examine the quality performance of RHCs or assess the impact of the program on patient care.

This lack of consistent data on RHC quality performance is a major problem for RHCs and their supporters, making it very difficult to develop legislative and policy support for this important rural primary care program. It is crucial that RHC leaders and program officials endorse a consistent message regarding the importance of RHC participation in public reporting initiatives as well as the use of this information for internal quality improvement efforts.

The fact that some RHCs are participating in state and private quality reporting and value-based payment programs suggests that it is possible to encourage RHC participation in MIPS or another national level reporting system. One approach might be to develop a standardized measurement system specifically for RHCs, similar to the Medicare Beneficiary Quality Improvement Program developed for Critical Access Hospitals (CAHs) under the Medicare Rural Hospital Flexibility Program.³⁰ This would provide a national program to collect and evaluate data on the quality performance of RHCs. To support this effort, further work is needed to identify a consistent core set of quality measures relevant to the needs of RHCs.

The development and dissemination of guidance to support RHC participation in CMS quality reporting initiatives is also needed, along with engagement processes that reflect the realities of quality reporting by RHCs and other small primary care providers. Finally, funding for state-level TA and other support resources is needed to engage RHCs in quality reporting initiatives, encourage their sustained participation, and support them in retrieving and publicly reporting quality data as well as using that data to benchmark and improve their quality performance. Failure to address these issues risks leaving RHCs behind in the evolving value-based healthcare marketplace.

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Appendix. Past and Current RHC Quality Improvement and Reporting Initiatives

Maine PCMH Pilot: Maine's PCMH Pilot, a combined effort of the Maine Quality Forum, Maine Quality Counts, the Maine Health Management Coalition, and the Maine Medicaid program, was implemented in 2010 and included both RHCs and FQHCs.¹³ The PCMH Pilot involved rigorous quality data collection efforts and the use of these data to evaluate the quality of services and the impact of the Pilot.

Blue Cross Blue Shield of Michigan (BCBSMI): BCBSMI has actively encouraged primary care practices to pursue PCMH recognition for the past nine years. As of July 2017, close to 4,700 physicians in 1,709 practices (representing 81 of Michigan's 83 counties) have been designated as PCMHs by BCBSMI.¹⁴ RHCs are eligible to participate in the program but there is little data on the extent of their participation. Some practices, such as the Schoolcroft Memorial Hospital Rural Health Clinic in the Upper Peninsula, have publicized their designation as a PCMH.²⁹

Washington State Health Care Authority (WA HCA): The WA HCA has developed an alternative value-based payment model for RHCs and FQHCs known as APM4.¹⁵ APM4 aligns with Washington State's value-based purchasing model and applies solely to Medicaid managed care enrollees. The model converts Medicaid encounter-based rates to a baseline per member, per month rate which is directly linked to quality performance measures. Future adjustments to this rate will be based on quality performance monitored by seven quality measures focused on diabetes care, controlling high blood pressure, managing anti-depressants, childhood immunization status, well child visits, and medication management for asthma. Sixteen clinics began testing the APM4 payment model on July 1, 2017.

RHC Focused Reporting Initiatives

Maine Rural Health Research Center (MRHRC): In 2012, the MRHRC undertook a multi-year study to identify a set of RHC-relevant quality measures and to pilot test the measures with a national cohort of RHCs.¹⁶ Working with a panel of RHC experts and stakeholders, the MRHRC study team identified five core and 13 optional measures that are actionable by RHCs and facilitate comparison across different types of primary care practices. The study team pilot tested the measures with a national cohort of 61 (56 provider-based and five independent) RHCs from November 2013 through September 2015. The Pilot demonstrated the utility of a targeted set of RHC-relevant quality measures focused on diabetes, blood pressure control, immunizations, medication management, and tobacco use interventions as well as the feasibility of an RHC quality measurement and benchmarking system. Study participants reported use of their quality data primarily for internal quality improvement. Reported barriers to participation included: difficulty extracting data from clinic records, limited staff time to collect and report data, overall clinic reporting burden, and the lack of financial and/or other incentives to participate in a quality measurement system. Primary challenges involved difficulty in recruiting RHCs to participate in the Pilot and maintaining their consistent engagement in the quality reporting process. Participants needed significant "on the ground" TA to support their engagement in the Pilot.

Quality Health Indicators (QHi): QHi is a quality and performance data reporting and benchmarking portal developed initially for CAHs and other small rural hospitals. It was modified in 2013 to support the quality reporting and benchmarking needs of provider-based RHCs owned by these hospitals.^{10,26} QHi allows participants to report performance data and benchmark themselves against self-defined peer groups in the areas of: 1) clinical quality; 2) employee contribution (e.g., staff turnover, average time to hire); 3) financial and operational performance; and 4) patient satisfaction. QHi staff provide users with education and TA on quality reporting issues to its users. QHi is used by over 300 small rural hospitals and 124 RHCs in 16 states including the Michigan Rural Health Clinic Network (described below) and the MRHRC study (described above). QHi staff described the difficulty of recruiting RHCs and maintaining their consistent participation and noted that the greatest challenge for participating RHCs has been extracting data from their EHRs (if they have one). They also noted that the primary incentive driving participants to collect and report quality measures is organizational leadership and support. QHi's experience demonstrates the need for ongoing TA and education to support the recruitment and engagement of RHCs in quality reporting and improvement.

Michigan Rural Health Clinic Network (MRHCN): To support the quality improvement efforts of provider-based RHCs owned by members of its CAH Quality Network, the Michigan Center for Rural Health (MCRH) developed an RHC quality network. MRHCN has enrolled 60 clinics during its three years of operation. Participants are asked to report three core quality measures. MCRH staffs the network and conducts quarterly face to face meetings of the participants to discuss core measures, review best practices implemented by Michigan RHCs, and discuss other RHC-related issues.²⁷ A subject matter expert presents on RHC quality and/or performance improvement topics at each meeting. Staff report that participating RHCs are fully engaged in network activities and have voted to establish a dues structure to sustain and enhance MRHCN's operations. Staff noted the importance of regular meetings to maintain the engagement of participants and the need for a formalized network to provide a consistent framework for data collection and benchmarking. Staff also noted the on-going challenge of engaging RHCs in quality improvement activities and maintaining consistent month to month reporting by participants.

Other Public and Private Reporting Involving RHCs

State Medicaid Reporting Issues: State Medicaid managed care programs often have significant quality measurement requirements.¹¹ Given the high volume of Medicaid enrollees served by RHCs, many RHCs are likely to participate in these reporting requirements. CMS has identified core sets of adult and children's health care quality measures for Medicaid-eligible enrollees. Although state reporting of these measures is voluntary, some states, such as Colorado and Ohio, are moving forward in this area.²⁸ A survey conducted by the Kaiser Family Foundation found that 36 state Medicaid programs required quality data collection and reporting in 2017, and an additional eight had new or expanded requirements in 2018.¹² Twenty-two state managed Medicaid programs had pay for performance initiatives in 2017, with five implementing or expanding such initiatives in 2018.¹³ Twenty-nine had performance-based capitation withholds or penalties in 2017 and five were implementing or expanding these initiatives in 2018.¹²

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