MBQIP Talking Points

Note: This list of summary statements is intended as a resource to help equip state Flex program staff with talking points to help address concerns and encourage participation in quality reporting and improvement programs. It is not comprehensive, and program staff should always tailor information as appropriate for the Critcal Access Hospital (CAH) environment in their state.

Three main points are offered, with supporting comments for each:

- CAHs are affected directly and indirectly by the rapidly changing health care payment and delivery environment
- Although CMS has not mandated CAH quality reporting, other programs are driving measurement and reporting
- CAHs are increasingly in the spotlight of federal policy makers, and there is recognition that quality measurement is necessary, but can be challenging in a rural environment

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CAHs are affected directly and indirectly by the rapidly changing health care payment and delivery environment

Significant efforts are underway to fundamentally change the way health care is provided and paid for in the United States. The U.S. Department of Health and Human Services (HHS) launched a delivery system reform initiative to accelerate improvements to our health care delivery system, with specific goals in adopting value-based care and payments announced in January 2015.

- A critical component of the changing health care environment is to accelerate adoption of reimbursement models that reward value, with an emphasis on quality and care coordination. Alternative payment models, such as accountable care organizations, are one key component, with HHS setting targets of 50 percent of Medicare fee-for-service payments through these new models by 2018. **However, incentives linked to quality of care metrics also are growing exponentially, with an HHS goal of 90 percent of Medicare FFS payments linked to quality by 2018.**
- Paid under a cost-based reimbursement model aimed at stabilizing financing for safety net care, **CAHs are excluded from most quality reporting and incentive programs and care coordination payments linked to current fee-for-service payment structures (i.e. prospective payment system - PPS).**
- Although some CAH leaders may breathe a sigh of relief that they have been excluded from many of these changes, they are not immune to the impacts. Value-based reimbursement models nearly all include incentives related to performance on quality metrics as well as reducing overall costs by improving care coordination and reducing hospitalizations and emergency department utilization. **Even if the CAH isn't directly participating in value based reimbursement, it is likely that affiliated providers and partners have reimbursement tied to quality and cost goals.**
- Providing evidence of high-quality care delivery necessitates participation in quality reporting programs, as **partners, payers and consumers will – and should – demand evidence that the quality of care provided in a small, rural hospital is equivalent to, if not better than, those same services in an urban setting.**

- **One of the first steps in the transition to value-based reimbursement models is often related to quality reporting** and the ability to demonstrate quality, efficiency, and strong patient experience.
- Despite the challenges, many rural communities are stepping up to the opportunities of delivery system reform. Although considered voluntary by CMS, **nearly 90% of CAHs nationwide participate in public reporting of at least some quality metrics.** *[Insert state data here.]*
- CMS is leading the way in implementation of many value based payment methods, but a **growing number of state Medicaid programs and commercial payers are implementing quality incentive programs and and alternative payment models** which provide opportunities and/or requirements for CAH participation.
- Although CMS does not currently mandate quality reporting by CAHs, it **cannot be considered optional for CAHs in order to keep pace** in an environment that is rapidly shifting to focus on value.

Although CMS has not mandated CAH quality reporting, other programs are driving measurement and reporting.

- Hospitals must publically report HCAHPS data to Hospital Compare to be eligible for Small Hospital Improvement Program (SHIP) funding (*Note:* SHIP funds can be used to cover the costs of a HCAHPS vendor)
- CAHs are required to participate in MBQIP in order to receive or participate in Flex funded activities.
    - MBQIP includes a sub-set of CMS hospital quality measures that are relevant for the volume and services of the majority of CAHs. With the exception of the Emergency Department Transfer Communication measure, all of the MBQIP required measures align with other CMS hospital quality reporting programs.
- In June 2016, CMS released a proposed rule to update the CAH Conditions of Participation. One aspect of the proposed rule refines the language related to implementation of a Quality Assessment and Peformance Improvement (QAPI) program. The proposed language indicates that CAH adherence to the requirements of MBQIP is one such way that the CAH's QAPI program data collection requirements can be satisfied.

Critical Access Hospitals are increasingly in the spotlight of federal policy makers, and there is recognition that quality measurement is necessary, but can be challenging in a rural environment

- In 2014 the Department of Health and Human Services (HHS) contracted with the National Quality Forum (NQF) to convene a multistakeholder Rural Health Committee to **identify challenges in healthcare performance measurement for rural and low volume providers and to make recommendations for meeting these challenges, particularly in the context of CMS pay-for-performance programs**.
- The NQF Rural Health Committee Final Report, was released in September 2015. The overarching recommendation from the Committee was to **make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers**.

- The NQF Rural Health Committee encouraged a phased approach for full participation across quality program types, and offered several supporting recommendations to ease the transition to mandatory participation:
    - Development of rural relevant measures
    - Alignment of measure reporting efforts across Federal programs
    - Process for measure selection that addresses key issues related to rural participation such as low case volume
    - Include rural considerations in design of pay for performance programs such as incentivizing rather than penalizing rural providers, and allowing for potential grouping of rural providers to help off-set issues related to small numbers.

Additional considerations

HCAHPS:

- **CAHs historically have better patient experience scores** than larger urban hospitals and need to participate in HCAHPS to demonstrate patient experience as a rural strength.
- HCAHPS is a highly weighted component of calculating Hospital Value-Based Purchasing (VBP) scores, which results in incentives or penalties for PPS hospitals**. The gap between rural and urban hospitals on HCAHPS scores is decreasing** as larger facilities have focused on improvement efforts with the connection to Hospital Value-Based Purchasing (VBP).

Outpatient/Emergency Department Measures:

- Stabilization and transfer of patients in emergency situations is a fundamental role of CAHs in serving as a health care safety net for rural communities. **It is essential that CAHs are able to demonstrate quality performance in this key area of care delivery.**
- Improved transitions of care is a key component of increasing the quality, effectiveness, and efficiency of health care services. Effective transfer of patient information from the Emergency Department to the next site of care can foster continuity of patient care and help to reduce errors, improve outcomes, and increase patient and family satisfaction. **The Emergency Department Transfer Communication (EDTC) measure allows CAHs to evaluate and improve the effectiveness of that important role.**

Participation in CDC National Healthcare Saftey Network (NHSN)

- More than 1000 CAHs are now registered with the CDC NHSN program. CAHs report rates of healthcare worker influenza vaccination through NHSN as a mandatory MBQIP measure, but can also submit data on a variety of health care acquired infection (HAI) measures through that system which is of growing importance with the increasing national focus on antibiotic stewardship. **Implementation of an antibiotic stewardship program is a new requirement in the proposed rule updating CAH Conditions of Participation.**

Other

- Critical access hospitals across the country of all sizes, independent and system affiliated, are reporting and excelling across all MBQIP domains.
    - MBQIP Monthly has highlighted **numerous CAHs with average daily census values ranging from less than one to over ten that are successfully reporting and performing with excellence in every MBQIP domain.** Many CAHs are also participating in other

programs, such as the CMS Partnership for Patients Hospital Improvement and Innovation Network (HIIN).

- Excellence in national quality reporting and improvement programs can be an attractive recruiting point for quality health care professionals, whereas non-participation may attract health care professionals that are not as dedicated to high quality patient care.
- There is growing recognition of disparities between rural and urban communities in health status and mortality. Rural populations are frequently older, sicker, and poorer than their urban counterparts. It is vital to be able to demonstrate the quality of health care provided to rural populations, who are already at greater risk for death or disability.

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