

## MBQIP Talking Points

Updated May 2020

*Note: This list of summary statements is intended as a resource to equip state Flex program staff with talking points to convey the importance of participating in quality reporting and improvement programs and help address questions and concerns. It is not exhaustive nor state-specific, and program staff should always tailor information as appropriate for the critical 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 the Centers for Medicare & Medicaid Services (CMS) has not mandated CAH quality reporting, other programs are driving measurement and reporting.
- CAHs are increasingly in the spotlight of federal policymakers, 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 have been underway over the past decade to fundamentally change the way health care is provided and paid for in the United States. According to the [Healthcare Payment Learning & Action Network](#), by 2018, more than 90 percent of Traditional Medicare and 60 percent of payment across all payers was linked to quality and value.

- A critical component of the changing health care environment is to accelerate adoption of payment and reimbursement models that reward value rather than volume, with an emphasis on quality and care coordination. Alternative payment models (APMs), such as accountable care organizations (ACOs), are the leading example of the shift to value.
- More recently, there has been increased focus on moving beyond models that have financial incentives for quality and value, to models that include a component of downside financial risk. CMS has outlined a goal to have 50 percent of traditional Medicare and Medicare Advantage payments in models with downside risk by 2022, and 100 percent by 2025. Medicaid and other payers are expected to follow in this direction as well.
- Paid under a cost-based reimbursement model aimed at stabilizing financing for safety net care in rural communities, CAHs are excluded from the mandatory CMS quality reporting and incentive programs that are linked to current fee-for-service payment structures (e.g., Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, etc.). CAHs are also not eligible for participation in many of the demonstration programs that are available through the Center for Medicare and Medicaid Innovation (CMMI).
  - The FORHP funded [Rural Health Value](#) team maintains a Catalog of [Value-Based Initiatives for Rural Providers](#) that summarizes rural-relevant, value-based programs currently or recently implemented by the Department of Health and Human Services (HHS).

- Some CAH leaders may feel relieved to be excluded from many of these programs. However, they are not immune to the impacts. Nearly all value-based reimbursement models, including those in Medicaid and commercial payer arrangements, 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 a CAH isn't directly participating in value-based reimbursement, affiliated providers and partners likely 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.
- Many rural health care organizations are stepping up to the opportunities for delivery system reform. Although considered voluntary by CMS, nearly 90 percent of CAHs nationwide participate in public reporting of at least some quality metrics, and more than 400 CAHs (nearly one third) are participating in Medicare ACOs.
- Although CMS does not currently mandate quality reporting by CAHs, it cannot be considered optional for CAHs to keep pace in an environment that has rapidly shifted to focus on value.

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

- CAHs are required to [participate in MBQIP](#) 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. Except for the Emergency Department Transfer Communication and antibiotic stewardship implementation measures, all of the [MBQIP core measures](#) align with other CMS hospital quality reporting programs.
- CMS is leading the way in implementation of many value-based payment methods. Still, a growing number of state Medicaid programs and commercial payers are implementing quality incentive programs and alternative payment models which provide opportunities and/or requirements for CAH participation. Several states are also exploring opportunities related to value-based reimbursement models, such as the [Pennsylvania Rural Health Model](#), which uses a global budget as a mechanism to stabilize funding for rural hospitals while increasing access and improving quality.
- CAHs and other small, rural hospitals must publicly 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 an HCAHPS vendor*).
- In September 2019, CMS published a [final rule](#) that included updates to the CAH Conditions of Participation. One aspect of the proposed rule refines the language related to implementation of a Quality Assessment and Performance Improvement (QAPI) program. In the final rule, CMS actively encourages CAHs to “utilize the technical assistance and services for CAHS that are available through the State Flex Programs, including MBQIP.”

**Critical access hospitals are increasingly in the spotlight of federal policymakers, and there is recognition that quality measurement is necessary, but can be challenging in a rural environment.**

- The Department of Health and Human Services (HHS) has been contracting with the National Quality Forum (NQF) to convene a series of multi-stakeholder Rural Health Workgroups 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 initial [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 Committee encouraged a phased approach for full participation across quality program types and offered several supporting recommendations to ease the transition to mandatory participation.
  - In 2017, NQF launched a Measures Application Partnership (MAP) Rural Workgroup that continues to make recommendations, including a [core set of rural relevant measures](#) released in 2018, and a technical expert panel report identifying strategies for [addressing low-case volume in health care performance measurement](#) that was released in 2019.

**Additional considerations**

*HCAHPS:*

- CAHs historically have better patient experience scores than larger urban hospitals and can benefit from participating 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 advantage that CAHs have had is diminishing, as larger facilities have focused on improvement efforts that align with the financial incentives for improved scores.

*Outpatient/Emergency Department Measures:*

- Stabilization and transfer of patients in emergencies is a fundamental role of CAHs in serving as a health care safety net for rural communities. CAHs must be able to demonstrate quality performance in this crucial 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 the CDC National Healthcare Safety Network (NHSN)*

- More than 1250 CAHs (or nearly 95%) are now registered with the CDC NHSN program.
- CAHs report rates of healthcare worker influenza vaccination through NHSN as an MBQIP core measure. They also complete the NHSN Annual Facility Survey as a means for monitoring implementation of antibiotic stewardship, also an MBQIP core measure. This measure and related activities complement a 2019 CMS [final rule](#) that formalized requirements for an antibiotic stewardship program as a CAH condition of participation.

- CAHs can also submit data on a variety of healthcare-associated infection (HAI) measures through NHSN, which is of growing importance with the increasing national focus on antibiotic stewardship.
- The COVID-19 pandemic has brought infection control to the forefront for all health care facilities, including CAHs. Participation in MBQIP offers opportunities for support with NHSN enrollment. Many state Flex programs are supporting CAHs with their COVID-19 efforts.

### *Other*

- CAHs 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 more than ten that are successfully reporting and performing with excellence in every MBQIP domain. Many CAHs are also participating in other programs.
- Excellence in national quality reporting and improvement programs can be an attractive recruiting point for quality health care professionals.
- As a North Carolina Rural Health Research and Policy Analysis Center brief showed, 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.