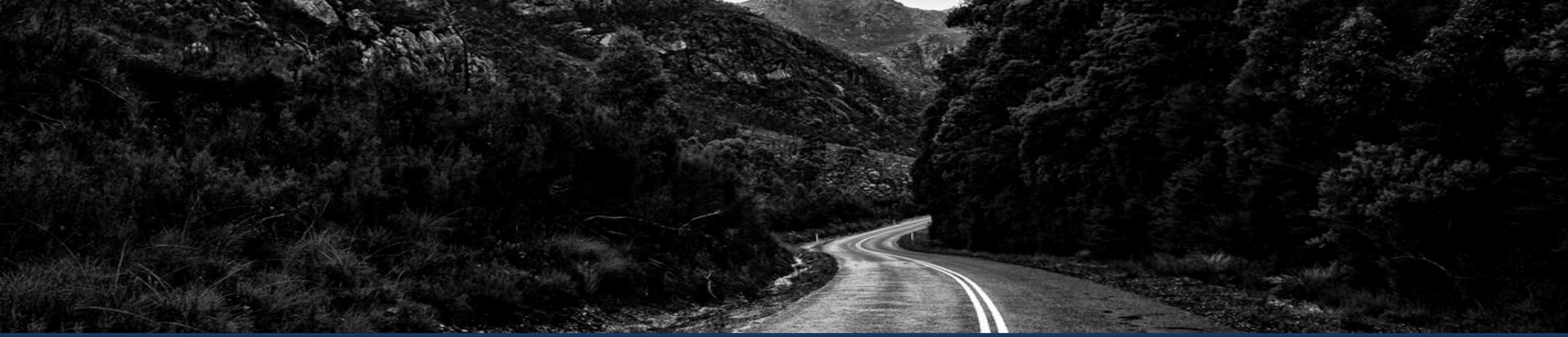

Missouri
Quality Measurement for RHCs

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Overview

- Legislative Change
- Why Quality Measurement is Important
- Implementing Quality Measurement Processes
- Questions

LEGISLATIVE CHANGE

New RHC Reimbursement Methodology

- On December 27, 2020, the President signed into law, the "*Consolidated Appropriations Act, 2021 (CAA)"* which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2019, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
    a) In 2021, after March 31, at $100 per visit;
    b) In 2022, at $113 per visit;
    c) In 2023, at $126 per visit;
    d) In 2024, at $139 per visit;
    e) In 2025, at $152 per visit;
    f) In 2026, at $165 per visit;
    g) In 2027, at $178 per visit;
    h) In 2028, at $190 per visit;
    i) In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
  - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2019, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
- Since the final legislation varied greatly from the RHC Modernization Act and due to the impact on provider-based RHCs (PB-RHC), efforts are underway to change certain provisions
  - On April 14, 2021, the President signed H.R. 1868 into law which fixed some of the grandfathering issues caused through the change of the RHC reimbursement methodology in the Consolidated Appropriations Act, 2021

WHY QUALITY MEAUREMENT IS IMPORTANT

Why Should RHCs Monitor and Report Quality

"It doesn't matter what I believe. It only matters what I can prove!"

Tom Cruise's character in A Few Good Men

Why Quality Measurement is Important and Lessons Learned

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- **The Why:**
  - Research demonstrates that health care frequently fails to meet the current standards of quality care
  - Errors, suboptimal management of disease, and overutilization/underutilization of services occur when evidence-based health care is not provided
  - The consequences include higher mortality, increased morbidity, decreased quality of life, higher costs of care
  - Low-quality care and inconsistencies in quality are linked to health care disparities
  - Failure to measure quality suggest that the extent of these issues are not understood at the practice-level

- **Lessons Learned:**
  - Public reporting adds value
  - Reports must be designed carefully - the presentation of information affects how it is interpreted and used
  - Collaboration is essential - involving the public and private sectors as well as purchasers and providers
  - State/local efforts have been successful - scale is manageable and local providers can account for factors that affect performance
  - Automated data collection is needed – manual collection is possible but burdensome

Demand for Primary Care and Pressures to Report

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- **Rising Demand for Primary Care:**
  - 46% of Americans have one or more chronic conditions
  - U.S. adults get only 55% of recommended care
  - Long term sustainability of hospitals and health systems depends on the strength of their primary care systems
  - Primary care plays an central role in many health system and practice transformation initiatives:
    - CMS's Medicare Shared Savings Program, readmission penalty, and hospital value-based purchasing programs
    - Patient-centered medical homes, accountable care organizations
    - Chronic care management and behavioral health integration services

- **Pressures to Report:**
  - An essential part of transformation activities
    - Patient-Centered Medical Homes (PCMH)
    - Accountable Care Organizations (ACOs)
  - Pay for Performance - demonstrating value
  - Meaningful use of electronic health records
  - CMS Merit-Based Incentive Payment Systems (MIPS)
  - Growing expectation of health plans and employers
  - Opportunities for benchmarking
  - Participation in collaborative QI initiatives

RHC Reporting Issues

- RHCs are exempt from participation in MIPS but may do so on a voluntary basis
- RHC eligible professionals who voluntarily report to MIPS are not eligible for payment adjustments
- HCPCS Reporting Requirement for RHCs
- Some commercial and Medicaid managed care plans require PCMH recognition as a condition of panel eligibility
- Data Fatigue:

The typical reporting process leaves little time for **actual performance improvement**

IMPLEMENTING QUALITY MEAURE PROCESSES

A Quality Measurement Solution

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The **Plan-Do-Study-Act** Model has been adapted, digitized and simplified for Rural Health Clinics

P What are we trying to improve or change?

D What action steps are we going to take?

S What was the impact of our work?

A How can we apply and spread our learnings?

Hierarchy of Quality Measurement

- **Structural Measures**
  - The foundation of QM - evaluates infrastructure/capacity of health care organizations to provide care (e.g., equipment, personnel, or policies)
  - Examples - % of providers using an electronic health record, % of diabetics tracked in a patient registry, staff to patient ratio

- **Process Measures**
  - The building blocks of QM that focus on evidence-based steps that should be followed to provide good care
  - When executed well, increases the likelihood of a desired outcome
  - Examples – medication reconciliation, colorectal cancer screening, use of aspirin for patients presenting with ischemic vascular disease

- **Outcome Measures**
  - Evaluate/assess the results of care on a patient's health, such as clinical events, recovery, or health status
  - Outcome measures are slots into which process blocks fit
  - Outcomes can be positive or negative
  - Intermediate outcome measures measure results that lead to longer-term outcomes
  - Process and outcome measures go hand in hand as improving a process can result in an improved outcome
  - Examples – optimal asthma control, long-term complications of diabetes, controlling high blood pressure

Hierarchy of Quality Measurement

- **Patient-Reported Outcome Performance Measures and Experience of Care Measures**
  - Measure patient's health status, quality of life, health behavior, or experience of care using information provided by a patient
  - Provide insight into the quality of care received by patients
  - Research demonstrates that patients who have a positive health care experience are often more engaged in their care, which leads to improved health outcomes
  - Examples – Consumer Assessment of Healthcare Providers and Systems (CAHPS): patient experience, gains in patient activation scores at 12 months, depression remission at 12 months

- **Resource Use/Cost/Efficiency Measures**
  - Measure/assess the cost of care, resources used to provide care, inappropriate use of resources, or efficiency of care delivered
  - Important for RHCs participating in accountable care organizations or other value-based initiatives
  - Examples – total per capita costs, avoidance of antibiotics for adults with acute bronchitis, episode=based cost measures

- **Composite Measures**
  - Combines individual measures to produce one result that gives a more complete picture of quality for a specific area or disease
  - Examples – comprehensive diabetes care, substance use screening and intervention, optimal vascular care

Choosing Quality Measures: What to Measure?

- **Choose Measures That:**
  - Are relevant to your RHC and the patients you serve
  - Address perceived or known gaps in care
  - Align with practice goals
  - Align with nationals/regional quality initiatives such as MIPS or Medicaid managed care quality reporting requirements
  - Are important to patients

- **Focus on Process and Outcomes Measures:**
  - Outcome measures are typically viewed as the gold standard in quality measurement
  - Process measures, based on scientific evidence which links them to effective outcomes, are often more useful for performance management in primary care
  - For purposes of day-to-day quality measurement and management - focus on process and outcome measures

Issues to Be Considered

- **Which aspects of care do you want to assess?**
  - Process (e.g. prescribing, investigations, interactions between providers and patients)?
  - Outcomes (e.g. mortality, morbidity or patient satisfaction)?

- **Whose perspective is being prioritized?**
  - Different stakeholders will have different perspectives on the quality of care
  - For example, patients may emphasize good communication skills while managers may emphasize data on efficiency

- **What supporting information or evidence is required?**
  - Primary care is somewhat different than other specialty services
  - Consider the type of indicator, the method of combining evidence, and expert opinion for performance measurement

Pros and Cons of Process Measures

- **Pros**
  - Readily measured
  - Easily interpreted without the need of case-mix adjustments
  - Smaller sample sizes are required
  - Unobtrusive (assessed using administrative or medical records)
  - Action oriented (easy to address failures in processes of care)
  - Coverage (captures aspects of care valued by patients)

- **Cons**
  - Salience (processes of care may have little meaning to patients)
  - Specificity (often specific to a single disease or type of care)
  - Ossification (may stifle innovation)
  - Obsolescence (may decline as technology changes)
  - Adverse behavior (may be easily manipulated)

Pros and Cons of Outcome Measures

- **Pros**
  - Focuses attention towards patient rather than the service
  - Goals focused on the end results of care
  - Meaningful (may be more meaningful to some users)
  - Encourages innovation to improve patient care and experience
  - Far sighted (focused on long term strategies)
  - Less open to manipulation

- **Cons**
  - Measure definition can be difficult
  - Attribution (influenced by factors outside of control of providers)
  - Requires larger sample size and longer time frame
  - Interpretation may be difficult for complex conditions
  - Ambiguity (good outcomes may be achieved despite poor processes of care)

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Performance Ratios

A critical few metrics, structured in the form of ratios across a targeted set of categories, provides a 360º view of RHC performance

Staffing Metrics	Clinic Value
Gross Charges per Total Staff	$ 118,095
Net Revenue per Total Staff	$ 87,619
Patient Visits per Total Staff	998
Clinical Staff Ratio	71.4%
Gross Charges per Clinical Staff	$ 165,333
Gross Charges per Non-Clinical Staff	$ 413,333

Performance Metrics	
Clinic Profit Margin	-6.52%
Clinic Profit Margin per Patient Visit	$ -5.73
Clinic Profit Margin per Total FTE	$ -5,714
Expense per Patient Visit	$ 93.6
Expense per Total FTE	$ 93,333

Productivity Metrics	
Work RVUs per FTE Physician	3,278
Work RVUs per FTE APP	5,000
New Patients per FTE Physician	122
New Patients per FTE APP	325
Panel Size per FTE Physician	1,389
Panel Size per FTE APP	1,500

Compensation Metrics	
Salary per FTE Physician	$ 139,063
Salary per FTE APP	$ 115,000
Variable Compensation per FTE Physician	$ 23,438
Variable Compensation per FTE APP	$ 25,000

Quality Metrics	
NQF #0018 Controlling Blood Pressure	79.6%
NQF #0028 Tobacco Screening	85.9%
NQF #0038 Childhood Immunizations	35.3%
NQF #0059 HbA1c Poor Control (>9%)	93.6%
NQF #0419 Documentation of Medications	75.9%

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Staffing Metrics

An RHC's most important asset is its people. **Staffing Metrics** allow clinic leaders to evaluate the number, profile and cost effectiveness associated with clinical and non-clinical team members.

Ratios that factor in **Total Staff** provide a way to normalize the data among clinics of different sizes

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Note the distinction between **Gross Charges** and **Net Revenue**. The latter describes the actual cash received for services rendered and typically is a more valid unit of analysis

Gross Charges describe the full, retail price of clinical services. Think of it as a car's Manufacturer's Suggested Retail Price (**MSRP**) in the sense that it is typically a higher price, and a starting point for actual cost

Productivity Metrics

How effectively a clinic utilizes its resources can be a major driver of overall financial performance. **Productivity Metrics** allow clinic leaders to evaluate the amount of clinical output relative to staffing and overhead inputs.

Relative Value Units (RVUs) represent a unit of analysis that reflects the amount of work effort associated with a specific service/CPT code. Work RVUs are commonly used to set productivity goals and compensation levels for providers.

Productivity Metrics	
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New Patient ratios serve as a signal for the health and growth of the clinic's market and ability to attract patients who received primary care from other practices.

Panel Size has emerged as a key variable in the development of provider compensation packages given the increased penetration of value-based payment models, population health management priorities and Accountable Care Organizations (ACOs).

Compensation Metrics

The linkage between performance and compensation is a management priority. **Compensation Metrics** allow clinic leaders to monitor the overall costs associated with provider salaries and variable compensation.

Total compensation generally can be divided into two major categories: **Salary** and **Variable Compensation**. The latter describes the "bonus" income or fringe benefits that the provider earns in addition to base salary.

Compensation Metrics

Salary per FTE Physician	$ 139,063
Salary per FTE APP	$ 115,000
Variable Compensation per FTE Physician	$ 23,438
Variable Compensation per FTE APP	$ 25,000

Common examples of **Variable Compensation** can be categorized into Productivity, Value-Based and Other.

During the past several years, the healthcare industry has seen a trend in provider compensation away from base salary toward packages that are richer with **Variable Compensation**, and the variable compensation component increasingly includes Quality metrics.

Quality Metrics

RHCs exist to provide access to high quality primary and specialty care to rural communities. **Quality Metrics** allow clinic leaders to determine the caliber of clinical care provided by the RHC's professional staff.

The **National Quality Forum** is responsible for coordinating the development and ratification of clinical quality measures. The following five NQF metrics have been identified via research by John Gale from the Maine Rural Health Research Center as the most rural relevant.

Quality Metrics	
NQF #0018 Controlling Blood Pressure	79.6%
NQF #0028 Tobacco Screening	85.9%
NQF #0038 Childhood Immunizations	35.3%
NQF #0059 HbA1c Poor Control (>9%)	93.6%
NQF #0419 Documentation of Medications	75.9%

We encourage RHCs to track a small number of relevant metrics for all the clinic's patients, and to ideally have those metrics monitored at the provider-specific level.

The PQRS and then MIPS public reporting programs for physician practices included 100+ potential measures, most of which were relevant to large urban practices and multi-specialty practices. Few of the metrics were rural relevant and/or valid for small volume clinics.

AAFP 2019 Quality Measurement Principles

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1. **Quality Versus Performance Measurement**
    I. Quality measurement accelerates internal clinical improvement
    II. Performance measurement serves several purposes
        a. Provides data for value-based programs
        b. Supports patient decisions about cost and quality of health care
        c. Drives allocation of resources to community and population health needs

2. **Quality Improvement Integration**

3. **Identify Targeted Set of Universal Performance Measures**
    I. Focus on measures that:
        a. Matter most to patients
        b. Have the greatest impact on better health and health care
        c. Best lower costs

AAFP 2019 Quality Measurement Principles

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4. **Performance Measure Application**
    I. Applied at the clinic level to encourage share accountability and team-based care

5. **Primary Care Measurement**
    I. Focus on important aspects of primary care
        a. Access/first contact
        b. Comprehensiveness
        c. Coordination
        d. Patient engagement
        e. Continuity of care
        f. Care management

6. **Redesign Health IT**
    I. To better support quality and performance measurement

Conclusions

- Internal quality reporting is crucial to managing an RHC’s quality
- Public reporting is necessary to let others know how good your quality is
- It is becoming an expectation of participation for inclusion in provider panels
- It will increasingly be the cost of participating in evolving payments
- It is not too late to start but don’t delay
- Leadership is needed to encourage participation at the practice, state, and national levels

QUESTIONS

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Maine Rural Health Research Center

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