QUALITY MEASUREMENT IN RURAL HEALTH CLINICS

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

October 2024

NACRHHS

National Advisory Committee on Rural Health and Human Services

EDITORIAL NOTE

In April 2024, The National Advisory Committee on Rural Health and Human Services (NACRHHS or "the Committee") convened for its 94th meeting in Austin, Texas to discuss quality measurement and reporting in Rural Health Clinics (RHCs).

Throughout the meeting, the Committee engaged with subject matter experts and local community stakeholders on ways to support RHCs in their transition to value-based care (VBC). As part of the meeting, Committee members heard from the Clinical Administrator of Sudan Medical Clinic, in Sudan, TX and visited Ascension Seaton Healthcare Center in Burnet, TX (a summary of the visit to Ascension Seaton Healthcare Center can be found in the Appendix).

This policy brief presents the benefits and challenges of quality measurement and reporting in RHCs that were examined during the Austin meeting, as well as the Committee's policy recommendations to the Secretary of the Department of Health and Human Services, to support quality measurement and reporting efforts in RHCs.

ACKNOWLEDGEMENTS

The Committee would like to thank the speakers at the meeting for providing contextual information regarding quality measurement in Rural Health Clinics. These individuals are: Lindsey Nienstedt (Federal Office of Rural Health Policy); Albert Ruiz (Texas State Office of Rural Health); Kelsey Beggs (Sudan Medical Clinic); and Quang Ngo (Texas Organization of Rural & Community Hospitals (TORCH) Foundation).

The Committee would also like to thank the leadership and staff at Ascension Texas that shared their experiences with us. In addition to Lindsey Nienstedt, the Committee extends its appreciation to Alixandria James and Oksanna Samey, Truman-Albright Fellows with the Federal Office of Rural Health Policy, for coordinating the meeting and drafting this policy brief.

POLICY RECOMMENDATIONS

Recommendation 1: The Secretary should work with Congress to provide grants to State Offices of Rural Health to support a new state program, similar in structure to the Rural Hospital Flexibility Grant Program and the Small Hospital Improvement Program. The new program would provide technical assistance on quality reporting and other services to support the transition of Rural Health Clinics to Value Based Care.

Recommendation 2: The Department of Health and Human Services should conduct studies that analyze the policy implications of prohibiting Rural Health Clinics and Federally Qualified Health Centers from billing for multiple visits in one day (same-day billing), specifically as it relates to Annual Wellness Visits.

EXECUTIVE SUMMARY

As of March 2024, there were more than 5,200 active federally-designated Rural Health Clinics (RHC) nationwide, providing primary care and preventive health services in underserved rural areas.[1] Results from a 2022 survey conducted by the National Association of Rural Health Clinics (NARHC) show that RHCs serve approximately 37.7 million patients per year.[2] RHC serve a high proportion of rural Medicare and Medicaid beneficiaries, and they receive an enhanced payment rate. RHCs are an integral part of the rural health safety net for vulnerable populations and underserved communities, along with other safety net facilities such as Federally Qualified Health Centers (FQHCs) and Critical Access Hospitals (CAHs).[3]

Over the last decade, many health care facilities have begun taking part in Value Based Care (VBC) and quality reporting programs. The driving force behind this shift is the Centers for Medicare & Medicaid Services (CMS)'s goal of having 100 percent of Traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030.[4] However, rural providers' participation has been lower than those in urban areas.[5] One rural facility type – the Rural Health Clinic (RHC) – has fallen significantly behind in value-based care transition, despite providing important safety net services for more than 60 percent of rural Americans and 11 percent of the total US population.[6]

During their April 2024 meeting in Austin, Texas, members of the National Advisory Committee on Rural Health and Human Services (NACRHHS) discussed the future of quality reporting for RHCs with Texas-based care providers and administrators, community members, and other value-based care stakeholders. Committee visited Ascension Seaton Healthcare Center (Ascension), a provider-based RHC, and spoke with leadership at the Burnet, TX campus. A representative of the Sudan Medical Clinic, an independent RHC in Sudan, Texas presented to the committee in Austin. Taking the information from these sources together, the Committee has put forth two recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS). These new recommendations build on recommendations made by the Committee in 2017, while also factoring in new considerations relating to billing practices and federal support programming for quality reporting.

RURAL HEALTH CLINIC OVERVIEW

Legislative History

The Rural Health Clinic (RHC) Program was established in December 1977 by the Rural Health Clinic Services Act, P.L. 95-210.[7] Prior to the Act, rural areas faced an inadequate supply of physicians serving Medicare and Medicaid beneficiaries, and low patient volumes meant that reimbursement rates were often insufficient for rural clinics.[8] To address both issues, the Act aimed to increase the utilization of nurse practitioners (NPs) and physician assistants (PAs) in RHCs by establishing an enhanced Medicare and Medicaid reimbursement rate.[9] The rate not only applied to physicians, but also to NPs and PAs.[10] This "team-based care" approach to rural health systems originally failed to increase participation in the RHC program, largely due to concerns about the complexity of the RHC certification process and persisting state-level legislative barriers.[11] By the early 1990s, however, combined efforts between state and federal legislators removed many of the barriers to participation, and RHC program grew quickly. RHCs have since expanded to include services of certified nurse midwives (CNMs), clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors to thousands of rural residents under an enhanced reimbursement rate. [12]

Certification, Structure and Payment

To be certified as an RHC by CMS, a clinic must have a quality assessment and improvement plan and meet all federal and state requirements, including location, staffing, and health care services requirements. More specifically, an RHC must: [13]

- Be located in an area defined by the US Census Bureau as non-urbanized [14] (an area that is *not* "a densely settled territory that contains 50,000 or more people")
- Be located in an area currently designated by the Health Resources & Services Administration within the last 4 years as a Primary Care Geographic Health Professional Shortage Area (HPSA), a Primary Care Population Group HPSA, a Medically Underserved Area (MUA), or a Governor-Designated Shortage Area and Secretary-certified Shortage Area (GDSA)
- Post operation days and hours
- Employ at least one NP or PA
- Have an NP, PA, or CNM working at least 50 percent of the time during operational hours.

RHCs can operate as either independent or provider-based facilities. Independent RHCs are freestanding clinics or office-based practices that can be for-profit, not-for profit, or publicly owned. Provider-based RHCs operate as an integral and subordinate part of a hospital, skilled nursing facility, or home health agency participating in the Medicare program. [15] Most provider-based RHCs are owned by hospitals; therefore, they reflect the ownership structure of their parent hospitals as either not-for-profit or publicly owned facilities. RHCs are reimbursed by Medicare through an All-Inclusive Rate (AIR) as opposed to traditional Fee-for-Service (FFS) payments. The AIR is billed by encounter, which means the RHC receives one payment for all qualified services provided during a visit. By contrast, FFS pays for each individual service provided.[16] The RHC AIR, or RHC cost-per-visit rate, is calculated by dividing allowable RHC costs by the total number of RHC visits. As stated in the Medicare Benefit Policy Manual, allowable RHC costs include practitioner costs, overhead, equipment, supplies, personnel, and other costs incident

to the delivery of RHC services. The AIR is subject to payment limits, meaning that the RHC will not be paid more than the set limit, regardless of the actual cost of services or number of services provided during a visit.[17] For 2024, the RHC payment limit is $139 per visit.[18] While qualified primary care and preventive RHC services are covered under the AIR, some services, such as chronic care management, are paid under the Physician Fee Schedule and billed on a separate form, the CMS-1500. For most RHC services, Medicare beneficiaries are responsible for paying their Medicare Part B deductible and coinsurance.[19]

PATHS TOWARDS QUALITY REPORTING

Rural Safety-Net Facilities and Quality Reporting

Like Federally Qualified Health Centers (FQHCs) and Critical Access Hospitals (CAHs), RHCs are CMS-designated, safety-net facilities that share a mission to improve access to care for underserved populations, including rural communities and receive an enhanced payment rate.[20, 21] According to the Institute of Medicine (IOM), a safety net facility must "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations." [22]

The growing emphasis on accountable care, pay-for-performance, and other VBC incentives has heightened the importance of quality reporting in these safety-net facilities. Many health care providers are now required to participate in quality reporting, especially as insurers are focusing on paying for value rather than volume of care. Physicians that are linked to the Medicare physician fee schedule are required to participate in the Merit-Based Incentive Payment System (MIPS), [23] a quality reporting program. Although FQHCs and CAHs are not always compelled to participate in quality reporting via MIPs, these safety net facilities frequently participate in other reporting initiatives. RHCs often do not.

For example, neither RHCs nor FQHCs are required to submit quality data through MIPS. Both FQHCs and RHCs, receive enhanced reimbursement from Medicare and Medicaid. These facilities are typically participants in the HRSA Health Center Program, as either HRSA-funded grantees under Section 330 of the Public Health Service Act, or "look-alikes" that meet program requirements but do not receive HRSA grant funding. [24] A central requirement of the HRSA Health Center Program (and a condition to receive funding) is reporting quality measures and other data using the Uniform Data System (UDS).[i, 25]

Likewise, CAHs are excluded from many federal quality reporting programs because they receive cost-based reimbursement. [26] However, the Medicare Beneficiary Quality Improvement Project (MBQIP) offers CAHs a method to participate in quality reporting by assisting them in quality data reporting through workshops and other support activities.[27] As a result, although quality reporting through the program is voluntary, MBQIP-participating CAHs have a near 100 percent quality reporting rate.[28] Both

[i] The UDS is a data reporting platform for Community Health Centers and not a formal value-based care model, but it is a critical component of value-based care initiatives within the HRSA Health Center Program.

MBQIP and the HRSA Health Center Program make clear that with support, the rates of quality reporting in safety net facilities can increase. RHCs lack the support afforded to CAHs, FQHCs and other similar safety net facilities.

Rural Health Clinic Participation in Value-Based Programs and Models

A primary goal of the Department of Health and Human Services (HHS) is to move as many clinicians as possible into alternative payment models. In the strategic objectives for the Quality Payment Program, CMS recognizes the opportunity to collaborate with the clinical community to advance policy that pays for what works to create a simpler, sustainable Medicare program.[29] Rural safety-net facilities, such as FQHCs and CAHs, have demonstrated that they can participate in some alternative payment models because they do get other federal support to do so. RHCs, however, do not receive federal grant support to support quality reporting.

RHCs have been historically exempt from Medicare's value-based payment programs, such as MIPS, because they are paid differently than other clinicians and have low patient volumes.[30] RHCs can voluntarily participate in MIPS and receive a score, however, this will not have any impact on their cost-based reimbursement, as MIPS is only required for clinicians who bill under the Physician Fee Schedule (PFS).[31]

In addition, RHCs have been excluded from some Innovation Center Alternative Payment Models, including those that require quality reporting from providers, such as the Primary Care First model and Making Care Primary model. [32] The majority of VBC Medicare models available to providers are designed for the traditional FFS settings and are not easily adaptable to the RHC AIR.

There are a few VBC Medicare models that RHCs may choose to participate in that provide ways to adapt the RHC AIR, and for each of these, some form of quality reporting is required. These models include the Medicare Shared Savings Program (SSP), the Accountable Care Organizations Realizing Equity, Access, and Community Health (ACO REACH) model, and the upcoming States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. As of January 1st, 2024, there are 480 ACOs nationwide with 10.8 million assigned beneficiaries. FQHC and RHC participation in the SSP has increased over the last several years, with 2,571 RHCs and 5,948 FQHCs participating as of January 2024.[33] Additional information on RHC participation in these models can be found in the Appendix.

Quality Reporting Challenges

The current shift toward VBC – and RHCs' slow transition towards quality measurement – has put RHCs at risk of being "left behind in the evolving health care marketplace." [34] This risk is coupled with the possible misperceptions among consumers and policymakers that RHCs are unable to meet the requirements of VBC and the idea that RHCs provide lower quality care than larger urban-based clinicians. [35]

Awareness and Incentivization

RHCs face several other obstacles to their participation in value-based programs, especially those related to reporting quality measures. First, a key component of value-based programs is to incentivize improving quality of care, meaning that payments are tied to quality reporting and performance. Unlike FFS payments, the RHC AIR is unique in that the payment amount is determined by statute, so it does not easily lend itself to adjustments. Next, not all RHCs may understand how value-based payment works, and they may not be aware of opportunities in their service areas. In 2018, 43.0 percent of RHCs surveyed had very little knowledge about accountable care organizations (ACOs), and many reported being only "moderately willing" to join one. [36]

During their meeting, the Committee heard perspectives from both an independent RHC and a provider-based RHC that corroborate these themes. Kelsey Beggs, the Clinical Administrator of Sudan Medical Clinic, an independent RHC in Sudan, TX, described the RHC VBC learning curve and shared some of the most significant challenges their RHC faced in adopting a VBC model. These challenges included:

- the lack of financial incentives for VBC for small clinics
- a lack of hospital support as an independent clinic
- a broadly disbursed local Medicare population in a large geographic service area
- limited statistics on effectiveness, due to lack of general RHC program data reporting requirements; and,
- gaining buy-in from patients, staff, and some community and health care partners moving to a VBC model.

Despite these difficulties, the Committee learned that some independent RHCs want to engage in VBC models, that VBC is possible in an RHC with some structural changes, and that a recognized balance for VBC is needed for RHCs to be able to maintain operations – even though they understand the extra time and effort required for meaningful RHC participation.

The experiences of Sudan Medical Clinic seem to challenge the idea that RHCs are fundamentally disinterested in value-based care. The cause of RHCs' low VBC participation rates may not be that these facilities don't want to take part, but rather, that they lack the incentives and support to make participation feel worthwhile.

Billing and Codes

Billing codes present the another missed opportunity to boost value-based care participation in RHCs. RHCs have specific billing guidelines for claims under the AIR system, which mean they are only required to report the appropriate revenue code for medical and mental health services. Unlike RHCs, when FQHCs bill for Medicare, they must report all services provided during the visit by listing the appropriate Healthcare Common Procedure Coding System (HCPCS)/Common Procedures Terminology (CPT) code. The additional revenue lines with detailed HCPCS/CPT codes are for information and data gathering purposes rather than billing. These lines including reporting quality data. Therefore, while coding for FQHCs allows for quality data to be collected, there is little information on the experiences of RHCs participating in ACOs, how they are reporting quality data to their ACO, or the extent of the burden of collecting and reporting data.

One known reporting challenge RHCs face is the use of Common Procedure Terminology (CPT) Category II codes. Part B providers often use CPT Category II codes to report quality measures. These codes are

supplemental tracking codes that can be used for performance measurement and are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. [37] The NARHC has indicated that RHCs are unable to use CPT Category II codes on their claims because CMS does not recognize them, despite there being no CMS technical preclusion from including CPT Category II codes on Medicare claims.[38]

During the NACRHHS meeting, Committee members heard firsthand how CPT Category II code-related challenges affect RHCs. Stakeholders told the Committee that this disconnect results in the rejection of the entire Medicare claim by Medicare Administrative Contractors (MACs). To avoid this outcome, RHC staff must manually review each patient's medical record to check if the performance measure was achieved, taking up valuable clinical time and delaying payment.[39]

Same-day billing is a related challenge because it limits an RHC's access to the important quality performance measures and data required to participate in VBC programs. Same-day billing describes the practice of counting multiple visits on the same day as separate visits, allowing each visit to be billed for and reimbursed. For RHCs and FQHCs, encounters with more than one health practitioner and multiple encounters with the same practitioner that take place on the same day and at a single location (i.e., multiple visits in one day) generally constitute a single visit.

Same-day billing and VBC are closely intertwined, and both need to be understood in order to fully grasp the complexity of the RHC environment and the Medicare beneficiaries receiving care. There are two visit types, the Initial Preventative Physical Examination (IPPE) and the Annual Wellness Visit (AWV), that are important to understand. An additional AIR payment may be paid for an IPPE given by a RHC practitioner to a patient on the same day as a primary or preventative services visit.[40] An IPPE (i.e., ("Welcome to Medicare" visit) occurs within the first 12 months following Part B coverage enrollment and is an introduction to Medicare and covered benefits, focused on health promotion and disease prevention and detection. Part B beneficiaries are allowed one IPPE in their lifetime. The AWV is covered once annually for patients who have received their IPPE at least 12 months prior. The AWV is a face-to-face visit to develop or update a personalized prevention plan and perform as health risk assessment for beneficiaries. The IPPE and AWV cover many similar components and risk assessments [41]; however, unlike the IPPE, the AWV cannot be billed as a separate RHC visit on the same day as a primary or preventative services visit. The AWV can only be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner.[42]

FQHCs and other facilities can work around this AWV restriction. For FQHCs, if an IPPE or AWV occurs on the same day as another medical visit, the FQHC is eligible to receive a payment higher than their base rate. The FQHC higher payment rate is calculated by applying the geographic adjustment factor of 1.3416 (or 34.16 percent) to the local FQHC base payment rate.[43] Other facility types under the Medicare Physician Fee Schedule receive an additional payment on the same day as an AWV for an evaluation and management (E/M) service if the portion of the visit is medically necessary reasonable to treat the patient's illness or injury or to improve the functioning of a malformed body part. Cost-sharing for patients will apply, just as it would for routine E/M visits without the AWV.[44]

In contrast, RHCs are not eligible for the geographic adjustment factor and are unable to receive reimbursement for the Annual Wellness Visit (AWV) in conjunction with another service provided on the same day. The RHC visit falls under the AIR, regardless of the number of services performed. As a result, RHCs can either perform the AWV on the same day as the other service and not receive AWV payment, or have the patient return for a separate AWV visit.

When the Committee visited Ascension Seaton Healthcare Center (Ascension) in Burnet, TX, a provider-based RHC, and met with Ascension's administrative and clinical leadership, the impact of billing restrictions on quality reporting became evident. Provider-based RHCs like Ascension are a part of a larger health system than independent RHCs, so they may be better positioned and receive support to participate in quality reporting. Among RHC staff however, there is still frustration with the RHC encounter-based payment system. This system only allows RHCs to be reimbursed for one visit, per-patient, per-day, and results in increased patient visits. Although Ascension leadership told they Committee that they believe their RHC patients prefer care that is value-based over the traditional fee-for-service model, same-day billing restrictions continue to stand in the way of providing value-based care.

Both Sudan Medical Clinic and Ascension discussed the difficulties of requiring patients to returning for a separate AWV visit. RHC practitioners generally reported difficulty convincing RHC Part B beneficiary patients to return to the RHC for their AWV, and thus, RHCs are left without the important quality performance measures required for VBC. In other words, the Committee found that value-based care becomes more difficult to accomplish when RHCs are not allowed to partake in same-day billing.

Additionally, as of July 1, 2024, CMS added a new Social Determinants of Health (SDOH) Risk Assessment as an optional, additional element of the AWV with additional payment and noted that the new SDOH Risk Assessment would enhance patient-centered care and support effective administration of the AWV. RHCs and FQHCs, however, are not eligible for the SDOH Risk Assessment additional payment but can provide the SDOH Risk Assessment as an optional, additional element of the AWV. Although not directly related to quality reporting, this billing issue provides an additional complication for RHCs to participate in VBC. At Ascension, leadership described their successful use the Social Determinants of Health screening provided via their electronic check-in system across the entire Ascension Seaton Highland Lakes organization, including their four RHCs in RHCs in the region. This means that Ascension can capture quality measures for all patients, regardless of facility type, which is a significant stride towards more robust participation in VBC. Overcoming the logistical challenges posed by the SDOH Risk Assessment, however, was only made possible by additional tools and support (e.g., Ascension's electronic health system), highlighting the importance of billing and technical assistance reforms.

Opportunities for Growth in RHC Quality Reporting

Electronic Health Records

In a 2015 report, the Maine Rural Health Research Center (RHRC) identified several opportunities and recommendations to better support RHC participation in quality reporting. [45] The report encourages RHCs to adopt Electronic Health Records (EHRs). RHCs with EHRs, as opposed to those RHCs who have not adopted EHRs, are at an advantage in their ability to participate in quality reporting or performance-

based payment programs because they have a standardized way to quickly access data. The timeliness and availability of data enables providers to streamline the clinician's workflow and support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.[46]

Quality Measures for RHCs

A second opportunity for RHCs pursuing quality reporting is the identification of a targeted set of core RHC-relevant quality measures. This would standardize data collection allowing comparison across RHCs. While not RHC-centered, in 2022, the National Quality Forum compiled a list of quality measures to advance rural priorities.[47] These measures recognize some of the key challenges of quality measurement for rural providers, such as low patient volume.

Technical Assistance and Programmatic Support

Given the RHC quality reporting challenges, the Maine RHRC points out the need for more technical assistance (TA) and program support opportunities. Engaging RHCs in formal quality improvement initiatives (i.e., EHR adoption and meaningful use) will allow for the expansion of RHC quality reporting and improvement efforts. The Maine RHRC report identified several areas of interest for TA support, including data extraction, reporting, analysis, benchmarking, and decision making. Of note, a 2017 National Advisory Committee on Rural Health and Human Services (NACRHHS) report on modernizing the Rural Health Clinic program also suggested that the Secretary of Health and Human Services work with Congress to provide grants to State Offices of Rural Health (SORHs) to provide TA on quality reporting and other services to support the transition of RHCs to VBC.[48] This assistance continues to be needed, and the Committee reaffirmed the importance of these support systems in their 2024 policy recommendations.

POLICY RECOMMENDATIONS

The need for TA on quality reporting for RHCs was recognized by the Committee in 2017 and the current membership continues to encourage the Secretary to provide this assistance, which is needed to help move RHCs to VBC. Many RHCs lack the administrative capacity to respond to emerging changes in the health care environment, which has become increasingly focused on quality and value as a determinant of payment. RHCs may be unprepared to take on the risk required under new payment models or may not be seen as attractive partners to larger groups like accountable care organizations (ACOs). FQHCs, which share many characteristics with RHCs, have been aided in their ability to respond to these sorts of emerging challenges. The funding and program support FQHCs receive due to their statuses as HRSA grantees under Section 330 of the Public Health Service Act has been critical in their successful transition towards value-based care. HRSA emphasizes quality reporting by Community Health Centers, and using that data makes program and clinical changes which improve patient outcomes. There is no comparable support available to RHCs.

The Committee also notes that small rural hospitals were facing similar challenges to RHCs in the early 2000s until revisions to the Rural Hospital Flexibility Grant Program and the Small Rural Hospital Improvement Program specifically focused resources on quality reporting and performance

improvement. These HRSA grants are administered through State Offices of Rural Health, which provide support and TA.

Given the lack of federal support for quality reporting in RHCs and the challenges presented by same-day billing restrictions, the Committee issued two recommendations to bolster RHC participation in value-based care.

> **Recommendation One:** The Secretary should work with Congress to provide grants to State Offices of Rural Health to support a new state program, similar in structure to the Rural Hospital Flexibility Grant Program and the Small Hospital Improvement Program. The new program would provide technical assistance on quality reporting and other services to support the transition of Rural Health Clinics to Value Based Care.

This recommendation is a standing recommendation from the Committee's first report on value-based care in RHCs, published in 2017. The Committee reissues this recommendation with new information about the effectiveness of the Rural Hospital Flexibility Grant Program and the Small Hospital Improvement Program, which have significantly improved quality reporting in CAHs and small rural hospitals in the last seven years. The Committee revisits this recommendation to emphasize how integral state-level support programs are to accelerating the transition to value-based care.

> **Recommendation 2:** The Department of Health and Human Services should conduct studies that analyze the policy implications of prohibiting Rural Health Clinics and Federally Qualified Health Centers from billing for multiple visits in one day (same-day billing), specifically as it relates to Annual Wellness Visits.

The Committee issues Recommendation Two in order to address concerns about same-day visit restrictions and CPT Category II codes. Committee members repeatedly noted that RHC providers feel that difficulties with billing and codes impede their ability to transition to VBC. The Committee urges the Department of Health and Human Services to research these prohibitions. This will allow the Department to better understand the barriers created by billing and work to improve them.

CONCLUSION

Since their creation in 1977, RHCs have become the first point (and in many cases, the only point) of health care access for thousands of rural Americans. For the RHC providers and the patients that they serve, RHCs act as the foundation of rural communities and provide a high level of care despite limited resources. Ensuring that RHCs continue to meet the needs of their patients will require these facilities to take part in value-based care and quality reporting programs.

The April 2024 Meeting of the National Advisory Committee on Rural Health and Human Services is the second time that the Committee has focused on value-based care in RHCs, allowing the Committee to examine the effectiveness of recent policy, discuss the impacts of advancements in technology, and

analyze the issue with a renewed commitment to improving support programs. While this policy brief and its accompanying recommendations take an important step forward in addressing the challenges RHCs face in participating in quality reporting programs, RHCs will continue to lag behind in the value-based care transition if swift action is not taken. Other critical safety-net rural health providers, such as FQHCs and CAHs, have their own designated grant-supported quality reporting activities; however, none exist for RHCs.

In the coming years, CMS aims to have 100 percent of traditional Medicare beneficiaries in an accountable care relationship with their providers, which will undoubtably entail the reporting of quality measures.[49] Moreover, the transition to paying for value over volume is occurring in Medicare Advantage, Medicaid, and private insurance.[50] Policy changes will be needed to include RHCs in value-based payment programs and support them as they work towards reporting quality measures. The Committee's recommendations are intended to guide those changes and ensure a successful transition to value-based programs.

APPENDICES

A. RHC National Map
B. RHC Site Visit Profile
C. Value-Based Care Models and Programs

APPENDIX A: RHC NATIONAL MAP

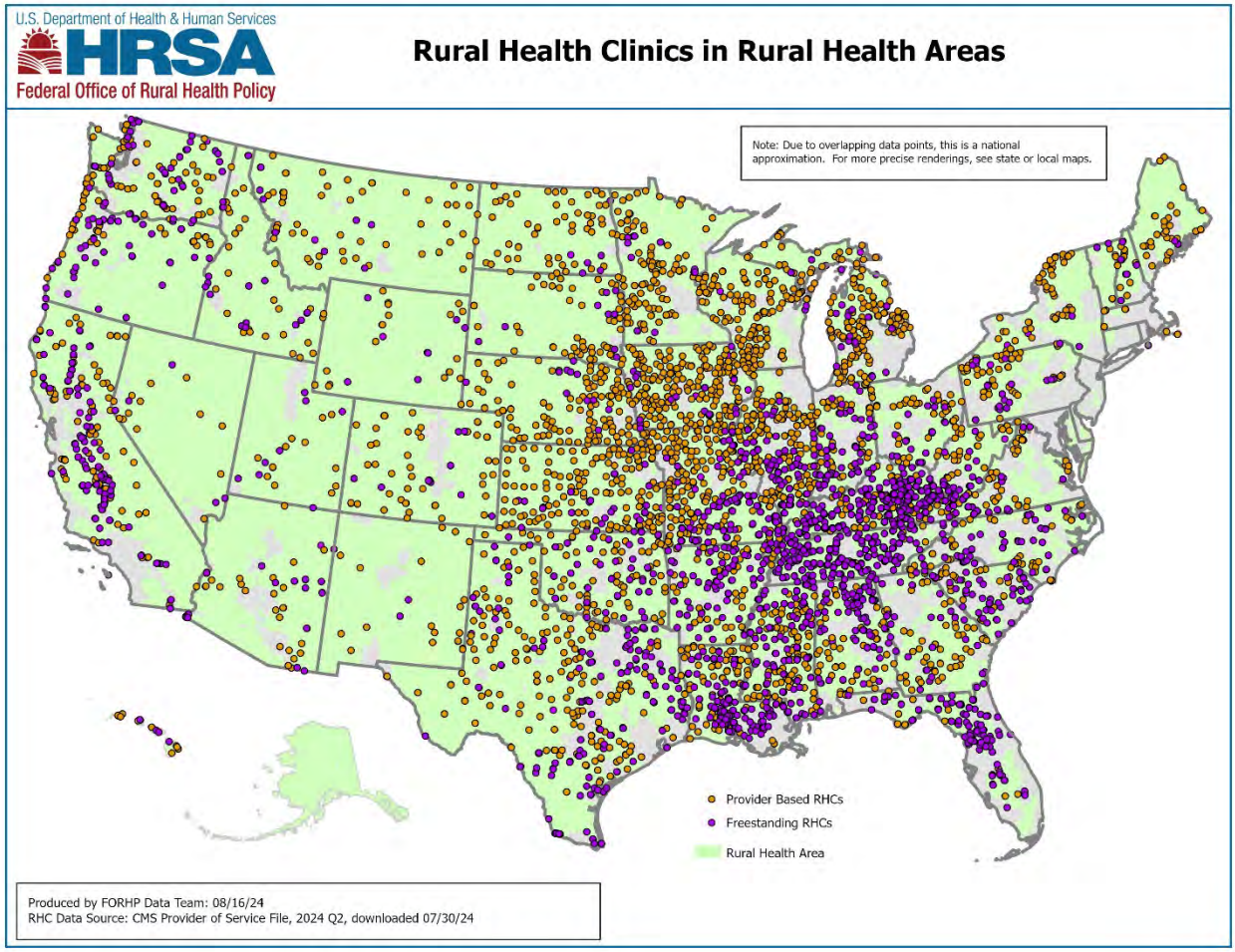

Figure 1: Map of all Rural Health Clinics (RHCs) in the United States, as identified by the Federal Office of Rural Health Policy. Provider-based RHCs are represented by orange points on the map. Freestanding RHCs are represented by purple points. Areas in green represent designated Rural Health Areas.

APPENDIX B: SITE VISIT PROFILE

In addition to hearing from the clinical director of an independent RHC during the meeting, the committee also visited the provider-based RHC as part of Ascension Seton Highland Lakes Hospital and Clinics in Burnet, Texas. VBC administrative burden, technical support, and financial solvability and were

common issues for the RHCs. Many of these concerns surrounded the cost of staffing, cost of electronic medical record systems, and the time between up-front costs and receiving payment.

Ascension Seaton Healthcare Center

Ascension Seaton Healthcare Center (Ascension) is in Burnet, Texas, approximately one hour northwest of the state capital, Austin. The committee members toured the 25-bed Critical Access Hospital, the provider-based Primary Care Clinic, and the Children's Care-A-Van (mobile RHC). Following the tour of the facilities, the committee members held a conversation with several of Ascension's administrative and clinical leadership to understand their experience with reporting quality measures. Provider-based RHCs, like Ascension, may be better positioned and receive more support to participate in quality reporting, because they are a part of a larger system. Ascension leadership noted that the Social Determinants of Health screening provided via their electronic check-in system, is used across the entire Ascension Seaton Highland Lakes organization, including their four RHCs in the region, allowing for the capture of quality measures for all patients regardless of facility type. However, Ascension reported frustrations with navigating the RHC encounter-based payment system, which only allows RHCs to be reimbursed for one visit, per-patient, per-day. Members of the clinical staff shared that several patients would come in for "sick visits" (i.e., medical visits) and would opt to receive their Annual Well Visit on the same day. Although the practitioner provided both the medical visit and the AWV, the RHC can only be reimbursed for one of the visits. The staff shared that because of copayments, transportation difficulties, etc., the patient burden is significantly decreased when they can provide the AWV and medical and/or mental health visits on the same day.

APPENDIX C: VALUE-BASED CARE MODELS AND PROGRAMS

Medicare Shared Savings Program

The Medicare Shared Savings Program (SSP) is a voluntary, alternative payment program that encourages groups of doctors, hospitals, and other health care providers to come together as an Accountable Care Organization (ACO) to provide coordinated, high-quality care to their Medicare beneficiaries.[51] As of January 1st, 2024, there are 480 ACOs nationwide with 10.8 million assigned beneficiaries. FQHC and RHC participation in the SSP has also increased over the last several years, with 2,571 RHCs and 5,948 FQHCs participating as of January 2024.[52] Under SSP, providers receive traditional FFS payments under Parts A and B (and RHCs receive their AIR), and CMS offers the ACO payment incentives in the form of shared savings to improve quality and control cost. Medicare SSP allows for multiple levels of ACO participation within a "basic" track and an "enhanced" track. The track and level of participation determine the relative percentage of shared savings split between the ACO and Medicare. While higher levels of participation may yield a higher reward, they also carry increased risk and require sharing in losses as well as savings. The ACO determines whether and how shared savings are distributed to participating providers. RHC payments are accounted for in the ACO shared savings/losses calculations.[53]

Beginning in 2024, several changes went into effect to increase participation of low revenue ACOs and facilities new to performance-based payments, which may include rural providers.[54] One such change is the Advance Investment Payment (AIP) option. AIP is open to low-revenue, basic track ACOs that are inexperienced with performance-based risk. It includes a one-time upfront payment of $250,000, plus a risk-adjusted per-member, per-month quality payment for up to two years. ACOs may use these funds

to build infrastructure, increase staffing, and promote health equity.[55] The advanced payments will be recouped from shared savings earned in an ACO's current and subsequent agreement period if a balance persists. Another change permits inexperienced ACOs to participate in one five-year agreement under a "one-sided" or "upside only" risk sharing agreement, meaning ACOs do not have to repay losses in exchange for a lower percentage of shared savings.[56]

Quality measurement is an important component of SSP. Participating ACOs must report quality data to CMS after the close of every performance year to be eligible to share in any earned shared savings and to avoid sharing losses at the maximum level. CMS measures every ACO's quality performance using standard methods.[57] To promote advancing health equity, CMS recently added a Health Equity Adjustment to the quality performance score. ACOs treating a high percentage of the underserved – defined as those who reside in areas with a high Area Deprivation Index ranking (a 1-100 ranked metric of neighborhood socioeconomic disadvantaged neighborhoods and individuals), are dually eligible for Medicare and Medicaid, or receive low-income subsidies through Medicare Part D – are eligible for up to 10 bonus points.[58]

ACO REACH Model

The ACO Realizing Equity, Access, and Community Health (REACH) model is testing a novel payment methodology to better support care for Medicare beneficiaries in underserved areas.[59] It debuted in 2023 as a redesigned version of CMS's Global and Professional Direct Contracting (GPDC) model. There are three types of ACOs in the REACH model: Standard ACOs have substantial experience serving Medicare FFS beneficiaries; New Entrant ACOs have with limited experience with Medicare FFS; and High Needs Population ACOs serve Medicare FFS beneficiaries with one or more of the High Needs eligibility criteria.[60] RHCs may be participating providers in any of these categories. REACH ACOs are required to meet specific quality improvement goals, and like SSP ACOs, performance is assessed at the ACO-level and includes a health equity adjustment.[61]

AHEAD Model

The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model is an upcoming total cost of care model wherein states, not ACOs, are responsible for both cost and care quality management.[62] In this model, selected state agencies will receive tools and resources from CMS to help move the health care system toward VBC. To this end, CMS has structured the model to encourage states to engage rural and safety net hospitals and primary care providers, including Critical Access Hospitals, Rural Emergency Hospitals, and Rural Health Clinics.[63] AHEAD will test new payment methods simultaneously for hospitals and primary care providers. Hospitals will receive global budgets, and primary care providers will receive a Medicare care management fee, or Enhanced Primary Care Payment (EPCP), and be required to participate in state-led Medicaid transformation efforts. Primary care practices will be responsible for reaching performance goals on model quality measures determined by CMS that fall into the broad categories of behavioral health, prevention and wellness, chronic conditions, and utilization.[64] A portion of the payment amount will be tied to quality measures and utilization – ranging from 5 percent of the EPCP in the first year to 10 percent of the EPCP by performance year 8. [65] The quality measures for primary care providers will be reported through electronic clinical quality measures (eCQMs) and claims.

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