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. **95% of Kansas CAHs have participated in public reporting of quality metrics.**
- 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 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.

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a nation-wide initiative of the Federal Office of Rural Health Policy and the Rural Medicare Flexibility program (FLEX to support Critical Access Hospitals in reporting rural – relevant quality data measures and adopting proven clinical delivery models to drive quality and performance.

The Federal Office will aggregate this quality data reporting by the Critical Access Hospitals to build a national database to demonstrate the effectiveness of rural health quality improvement initiatives.