CHAPTER 6

Medicare's measurement of rural provider quality

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Chapter summary

The Commission supports Medicare's measurement of the quality of care furnished by providers to monitor performance, inform patients and payers, and encourage the provision of high-quality care. The Commission has published principles for measuring quality in Medicare; for instance, quality programs should focus on measures tied to clinical outcomes, patient experience, and value, and quality measurement should not be unduly burdensome for providers.

Because of low patient volumes in many rural health care settings, there are practical challenges in measuring some individual rural providers' quality of care and in holding these providers accountable in quality reporting programs. For example, low patient volume means that it is difficult to produce reliable and valid estimates on quality measures for some rural providers. In addition, low-volume providers may have limited staff and funds available for quality-improvement activities (including unduly burdensome data collection and reporting).

The Commission acknowledged these difficulties when it established specific principles to guide expectations about quality in rural areas. These principles were developed with hospitals in mind but could be applied to other providers. First, expectations for quality of care in rural

In this chapter

and urban areas should be equal for the nonemergency services that rural providers choose to deliver. Second, all providers should be evaluated on the services they provide—emergency and nonemergency alike—and the quality of the services should be collected and reported publicly.

Because of the Commission's continued interest in rural provider quality, we expanded our reporting of provider quality to include comparisons of rural and urban areas, where relevant and available, in our March 2025 report on the adequacy of payments in the fee-for-service (FFS) payment systems. In general, the comparisons of provider quality in rural and urban areas were mixed across and within settings. For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, the quality results were similar.

The Congress has enacted pay-for-reporting quality programs for FFS provider types that account for a large majority of services furnished to Medicare beneficiaries. In these programs, providers that successfully report designated quality-measure data are financially rewarded (or not penalized). CMS uses the quality data to publicly report provider performance on the Care Compare website to hold providers accountable to consumers and encourage improvement. Some rural providers are not required to participate in the Medicare quality payment programs; however, the majority of rural providers do have at least some Medicare quality results publicly reported.

We reviewed FFS Medicare's requirements for the quality reporting programs and participation by rural providers. To determine participation by rural and urban providers, we used Care Compare data files. Hospitals, clinicians, and inpatient rehabilitation facilities had comparable shares of rural and urban providers with publicly reported quality results. Rural skilled nursing facilities and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts; in contrast, rural home health agencies and hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts. Policymakers could consider future work to understand these differences and reduce them, if feasible.

Medicare Advantage (MA) plans, Part D plans, and accountable care organizations (ACOs) are also required to report quality-measure data to CMS. Many of the quality measures are calculated based on the experience of a sample of patients across participating providers. Beneficiaries residing in rural areas who are assigned to ACOs or are enrolled in MA plans may or may not be

included in the quality-measure results that CMS currently collects for those entities because of sampling methodologies.

There are several federal and stakeholder initiatives to drive improved quality measurement of rural providers, including identifying and developing metrics that are most relevant for rural providers and making technical assistance available to rural providers for quality measurement and improvement. For example, the federal Medicare Beneficiary Quality Improvement Project helps critical access hospitals report measures for CMS quality reporting programs and use that data to guide quality improvement efforts. The Commission will continue to monitor the implementation and effectiveness of these initiatives. ■

Rural communities across the U.S. are diverse in terms of income and demographics. For example, though residents of rural areas have lower average incomes relative to the national average, the range of rural incomes across the country is wide, and some rural areas have average incomes that exceed national averages.[1] What most rural areas have in common is low population density, resulting in low patient volumes for local health care providers and longer travel times for services. Population density is often too low to support certain specialized services, meaning that rural beneficiaries must travel farther for some types of care, especially for some specialized services. Beneficiaries in our annual focus groups who live in rural areas largely seem to accept that residing in a rural area often means forgoing easy local access to a wide range of health services (NORC at the University of Chicago 2024).

About 17 percent of Medicare beneficiaries reside in rural areas (Medicare Payment Advisory Commission 2024a). These beneficiaries may accept limitations on the types of services to which they have easy access, but they should not have to compromise on the quality of care they receive. The Commission has maintained that expectations for quality of care in rural and urban areas should be equal for the nonemergency services that rural providers choose to deliver, and we have continuously supported appropriate and effective measurement of the quality of care that both rural and urban beneficiaries receive. The goal of quality measurement is to improve the quality of care delivered to patients—and, ultimately, to improve the health of individuals and communities—using tools that help providers quantify and track processes, outcomes, and other factors related to providing high-quality care.

The Medicare program, like many other health care purchasers, uses provider-level quality measures to monitor provider performance, publicly report information to patients and payers, and incentivize high-quality care. The Congress has established pay-for-reporting quality programs for fee-for-service (FFS) provider types that account for a large majority of services furnished to Medicare beneficiaries and pay-for-performance (i.e., value-based purchasing) programs for some FFS provider types. In addition, Medicare requires Medicare Advantage (MA) plans, Part D plans, and accountable care organizations (ACOs) to submit quality results to CMS and applies financial incentives based on their quality performance. However, some rural providers are not currently required to participate in Medicare's quality programs, which may impact the availability of quality information to monitor provider performance.[2]

In this chapter, we review the Commission's prior work on quality measurement, including the Commission's principles for rural quality of care, and present information on the inclusion of rural providers in current Medicare FFS and MA quality programs.

MedPAC's principles for and prior work on quality measurement

The Commission has developed a general set of principles for measuring quality in the Medicare program and has made several recommendations based on these principles to improve Medicare's quality programs. These include recommendations that the Congress eliminate the Merit-based Incentive Payment System (MIPS) for clinicians and replace Medicare's current quality programs for inpatient hospitals, skilled nursing facilities (SNFs), and MA plans with programs that focus on measures of outcomes, patient experience, and value. The Commission also established a set of principles in 2012 to guide expectations for the quality of care in rural areas. First, expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. Second, all providers should be evaluated on the full range of services they provide (emergency and nonemergency alike), and the quality measures for the services should be collected and reported publicly. In our March 2025 report on the adequacy of FFS payments, we compared measures of provider quality by geographic area. In general, the comparisons of rural and urban quality results were mixed across and within settings: For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, there was little or no difference between rural and urban quality.

MedPAC principles for quality measurement

The Commission has recommended that Medicare link payment to quality of care to reward accountable entities and providers for offering high-quality care

to beneficiaries. However, the Commission has also expressed concern that Medicare's quality-measurement programs are "overbuilt," relying on too many measures (Medicare Payment Advisory Commission 2018a). For example, CMS's current measure inventory includes 517 measures (Centers for Medicare & Medicaid Services 2025d). Also, many of these measures focus on processes that are not associated with meaningful outcomes.

The proliferation of measures has resulted in an increase in providers' burden to collect the data, confusion among consumers and purchasers who see conflicting measure results, and operational difficulties among payers. One study of the volume and cost of quality reporting at an academic medical center identified 162 unique quality metrics, which required an estimated $5 million in personnel costs to prepare and report (Saraswathula et al. 2023). Another study estimated that physicians and their staff spend, on average, 785 hours per physician per year dealing with various payers' quality-measure reporting programs and that physicians could care for an additional nine patients per week if they did not have these obligations (Casalino et al. 2016).

The overabundance of measures led the Commission to formalize, in our June 2018 report to the Congress, a general set of principles for measuring quality in the Medicare program (Medicare Payment Advisory Commission 2018a). We apply these principles in (1) modeling the redesign of quality payment (or value-based purchasing (VBP)) programs; (2) assessing the adequacy of Medicare payments (taking into consideration quality of care and identifying efficient providers); and (3) commenting on CMS's proposals for quality measurement. Among the principles:

- Quality measurement should be patient oriented, encourage coordination across providers and time, and promote relevant change in the delivery system.
- Quality measurement should not be unduly burdensome for providers; for instance, Medicare quality programs could remove "topped out" measures.[3]
- Medicare quality programs should include population-based measures tied to clinical and functional outcomes, patient experience, and value (e.g., Medicare spending per beneficiary, measures of services that have little or no clinical benefit). Providers may choose to use more granular measures to manage their own quality improvement.
- Medicare should target technical assistance resources to low-performing providers.

MedPAC recommendations to redesign some of Medicare's quality payment programs

Elements of Medicare's current quality programs are inconsistent with the Commission's principles for measuring quality. As a result, we have made several recommendations for improvement. First, in 2018, the Commission recommended that the Congress eliminate the Merit-based Incentive Payment System (MIPS) for clinicians because it impedes progress toward high-value care (Medicare Payment Advisory Commission 2018b). In our March 2019 report to the Congress, we recommended replacing four of Medicare's current hospital quality programs with a single, outcome-based hospital value-incentive program (VIP) (Medicare Payment Advisory Commission 2019). The Commission recommended in the June 2020 report that the Congress replace the MA quality-bonus program (QBP) with an MA–VIP that is consistent with our principles (Medicare Payment Advisory Commission 2020). In our June 2021 report to the Congress, we recommended that the Congress eliminate the current SNF–VBP program and design a new SNF–VIP that aligns with the Commission's principles for quality measurement (Medicare Payment Advisory Commission 2021). These value-incentive programs would be an improvement over the current programs because they focus on measures of outcomes, patient experience, and value.

MedPAC's support for efforts to align quality measures across programs

In recent years, the Commission has supported several of CMS's efforts to improve its quality programs. CMS has constructed various frameworks of quality measurement to drive care improvement for patients covered across federal programs. The goal of these frameworks is to guide CMS as it develops new quality measures, designs public reporting of quality payment programs, and provides technical assistance for quality improvement. These frameworks consistently focus

on (1) alignment of measures across programs and (2) prioritization of outcome measures. For example, the agency has worked with the Core Quality Measures Collaborative, a broad-based coalition of health care workers, to develop core sets of measures that align quality assessment across payers (Jacobs et al. 2023, Partnership for Quality Measurement 2024). These efforts to streamline quality measures across payers, which decreases provider burden, aligns with the Commission's principles for quality measurement.

In addition, although CMS has been shifting focus from process measures to outcome measures in some of the Medicare quality programs, the Commission has called for more work to develop measures tied to clinical outcomes and patient experience. For example, we recommended that the Secretary finalize the development of and begin to report patient-experience measures for SNFs (Medicare Payment Advisory Commission 2021). The Commission has also discussed developing new outcome measures for ambulatory surgical centers (ASCs), including surgical-site infections occurring at ASCs, specialty-specific clinical guidelines to assess whether services provided in ASCs are appropriate, and a claims-based outcome measure for cardiology services (Medicare Payment Advisory Commission 2025).

MedPAC principles for rural quality of care

In 2012, the Commission established a set of principles to guide expectations for the quality of care in rural areas (Medicare Payment Advisory Commission 2012). These principles generally focused on hospital quality but could serve as the basis for evaluating the quality of other providers. First, expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. That is, if a provider has made a discretionary decision to provide a service, that provider should be held to a common standard of quality for that service, whether the service is provided in an urban or a rural location. Note, however, that emergency services in urban and rural areas may be subject to different quality standards to account for different levels of staff, patient volume, and technology. For example, a patient may present with a heart attack with a significant blockage, in which case the standard of care is angioplasty and a stent in a catheterization lab. Such care is readily available in catheterization labs in urban areas. However, small rural hospitals, which may be too far from the nearest catheterization lab to safely transport heart attack patients (even by helicopter), may be forced to use a thrombolytic to treat the blockage. We would not expect equal outcomes in this emergency situation, and the relevant quality benchmark for emergency care should be that of either other small hospitals or the expected outcomes given additional transportation time if the small rural hospital no longer offered emergency care.

Second, all providers should be evaluated on the full range of services they provide (emergency and nonemergency alike), and the quality measures for the services should be collected and reported publicly. The Commission specifically applies this principle to hospitals—that all hospitals should be subject to public disclosure of their performance scores in order to give rural and urban patients equal access to information. This information includes measures common among rural and urban providers as well as measures that are specific to rural providers' scope of practice, such as timely communication of patient information after a transfer.

MedPAC reporting on the quality of rural providers

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional FFS payment systems. To determine an update recommendation, we estimate the adequacy of FFS Medicare payments to providers in the current year by considering (1) beneficiaries' access to care, (2) the quality of care, (3) providers' access to capital, and (4) how Medicare payments compare with providers' costs. Beyond questions of payment updates, we consider how payment rates may affect providers' ability to serve Medicare beneficiaries based on geographic, demographic, and other characteristics.

The Commission has a long history of monitoring rural beneficiaries' access to care and developing recommendations designed to preserve or improve that access (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2018a, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2001). Because of the Commission's continued interest in rural-provider quality, where relevant and available,

TABLE 6–1

Comparing rural quality-measure results with those in urban areas: Findings from MedPAC's 2025 fee-for-service payment-adequacy analyses

Provider type	Quality measures	Rural quality compared with urban
Hospitals	Risk-adjusted mortality rate	Higher (worse)
	Risk-adjusted readmission rate	Lower (better)
	Patient experience	Higher (better)
Physician and other health professionals	Risk-adjusted rate of ambulatory care–sensitive hospitalizations	Similar
	Risk-adjusted rate of ambulatory care–sensitive ED visits	Higher (worse)
	Patient experience	Similar
	Annual flu vaccination	Lower (worse)
Outpatient dialysis facilities	Share of beneficiaries on hemodialysis and peritoneal dialysis receiving adequate dialysis	Similar
	Hemoglobin status of dialysis beneficiaries	Similar
	Patient experience	Similar
Skilled nursing facilities	Risk-adjusted rate of discharge to the community	Lower (worse)
	Risk-adjusted potentially preventable readmission	Similar
	Case-mix-adjusted registered nurse staffing	Higher (better)
	12-month nursing staff turnover	Lower (worse)
Home health agencies	Risk-adjusted rate of discharge to the community	Similar
	Risk-adjusted potentially preventable readmission	Similar
	Patient experience	Higher (better)
Inpatient rehabilitation facilities	Risk-adjusted rate of discharge to the community	Similar
	Risk-adjusted potentially preventable readmission	Similar
Hospice providers	Patient experience	Higher (better)

Note: ED (emergency department). "Similar" rural and urban measure results are those that are within a 3 percent difference. CMS has used a difference of 3 percent as a threshold for "practical significance" in quality-measure comparisons (Centers for Medicare & Medicaid Services 2024m). Because these analyses were conducted as part of MedPAC's assessment of the payment adequacy of Medicare's fee-for-service prospective payment systems (PPSs), only providers that participate in the relevant PPSs are included. As a result, critical access hospitals, which provide care mainly in rural areas and are not paid under the inpatient PPS, are excluded. Results from skilled nursing stays provided in hospitals in rural areas, which are not paid under the skilled nursing facility PPS, are also excluded. Rural home health and hospice providers are defined by the share of beneficiaries treated who reside in rural areas, not the location of the provider.

Source: Medicare Payment Advisory Commission 2025.

we added reporting of provider quality by geography to our March 2025 report on the adequacy of FFS payments. Table 6-1 summarizes the findings from these analyses. In general, the comparisons of rural and urban quality results were mixed across and within settings: For some quality measures, rural quality was better than urban; for others, urban quality was better; and for others, there was little or no difference between rural and urban quality.

Medicare's current quality reporting programs and rural providers

Quality payment programs are intended to create incentives for providers to furnish efficient, high-quality care. There are broadly two types of quality payment programs. The first are pay-for-reporting programs in which providers (or the accountable

entity) that successfully report designated quality measures are financially rewarded (or not penalized). The second type are pay-for-performance programs (e.g., VBP programs). Typically, these programs adjust payments to a provider upward or downward based on its performance on quality measures. A provider's performance during an assessment period is compared either with that of other providers or with some performance scale and then converted to a provider-specific payment adjustment. This payment adjustment is applied to all payments for that provider in a later fiscal year. The quality data from both types of programs can be used for public reporting of provider performance to hold providers accountable to consumers and encourage improvement.

Medicare has generally taken a phased approach by implementing provider-based pay-for-reporting (or penalty for nonreporting) programs before pay-for-performance programs. The Congress has enacted quality reporting programs for FFS provider types that account for a large majority of services furnished to Medicare beneficiaries. The Congress has also implemented several pay-for-performance programs that tie FFS payment to a provider's performance on quality standards. As required by law, CMS reports data from those quality programs on the Care Compare websites as summary star ratings and as detailed measure results. In addition, CMS requires ACOs to report quality-measure results and uses those results in determining participating providers' shared savings and losses. Finally, as mandated by Congress, CMS collects quality-measure results from MA and Part D plans and has implemented a quality-bonus program for MA plans. All these quality payment programs have generally focused on process measures in their early stages, but programs have begun to include more measures of outcomes and patient experience over time (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2018). (See text box on types of quality measures and their data sources, p. 310.)

Some rural providers are currently not required to participate in the Medicare quality reporting programs. Rural providers may be excluded from quality programs in legislation because they are paid outside of traditional payment systems (e.g., providers that are paid on a cost basis) or because of program rules defined by CMS (e.g., minimum case counts).[4]

Most rural areas have low population density, resulting in low patient volumes for local health care providers. As a result, some rural providers do not have enough patients to produce reliable and valid measurement results. In addition, quality measurement may create a heavier burden for rural health care providers than for their urban counterparts. Many rural providers are small and may have limited time, staff, and finances available for quality-improvement activities, including data collection, management, analysis, and reporting. People who work in small hospitals and practices often have multiple, disparate responsibilities (e.g., direct patient care, business and operational responsibilities) that compete with quality-improvement activities (National Quality Forum 2015, Rural Health Information Hub 2024). Even with these challenges, the majority of rural providers do have at least some Medicare quality results publicly reported.

The Commission recognizes that there are practical challenges in measuring some individual rural providers' quality of care and holding these providers accountable in quality reporting programs. But we also maintain that it is important to evaluate providers on the quality of services they offer and to hold all providers accountable, through public reporting, for the care they provide to Medicare beneficiaries. Many of the challenges are broader limitations in measuring the quality of smaller providers and are not unique to rural providers.

In this section, we review the requirements of quality reporting programs and participation by rural and urban providers, including hospitals, clinicians, SNFs, home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), dialysis facilities, and hospices. To determine participation by rural and urban providers, we used Care Compare data files, which CMS makes publicly available.[5] We also focused on reporting outcome measures, such as readmission rates and patient-experience measures, consistent with the Commission's principles for quality measurement.

Table 6-2 (p. 311) summarizes the comparisons of rural and urban providers with publicly reported Medicare quality results. Hospitals, clinicians, and IRFs had comparable shares of rural and urban providers

Types of quality measures and their data sources

Measures used to assess and compare the quality of health care organizations broadly apply to the categories described below (Centers for Medicare & Medicaid Services 2025a, Centers for Medicare & Medicaid Services 2024g).

Structure measures assess features of a health care organization or clinician relevant to their capacity to provide good health care. Examples include use of electronic health record technology that meets health information technology criteria and implementation of quality-improvement activities. Data sources can include attestations from the health care organization.

Process measures focus on steps that should be followed to provide good care. These steps can assist in maintaining, monitoring, or improving patients' health status. Examples include breast cancer screening and medication review. These measures are based on patient information that can be found in administrative data (e.g., claims and encounter data) but generally also require clinical information from medical records.

Intermediate outcome measures assess the change produced by a health care intervention that leads to a long-term outcome. "Diabetes care: Blood sugar controlled" is an example of an intermediate outcome measure in which the related outcome of interest would be "better health status for beneficiaries with diabetes." Like process measures, these measures are based on patient information found in administrative data but generally also require clinical information from medical records.

Outcome measures focus on the health status of a patient (or change in health status) resulting from health care—desirable or adverse. Examples include hospital readmission rates (lower rates represent better outcomes) and patient reporting of maintained or improved health status. These measures are based on patient information found in administrative data but generally also require clinical information from medical records or patient surveys.

Patient-experience measures reflect patients' perspectives on the care they received (for example, the ease of getting needed care and seeing specialists). The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of patient-experience surveys administered to Medicare beneficiaries and other patients to gather information on respondents' personal experiences of interacting with their health plan and health care providers. CAHPS results are used to measure quality from the patient's perspective across several measures, including getting appointments and care quickly and the patient's overall rating of their health plan.

Access measures reflect processes and issues that could create barriers to receiving needed care. "Plan makes timely decisions about appeals" is an example of an access measure. These measures are based on information collected by the Medicare program or providers.

Cost/resource use measures count health services (in terms of units or dollars) applied to a population or event (including diagnoses, procedures, or encounters). A resource-use measure counts the frequency of use of defined health system resources. Some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use. An example of a cost/resource use measure is Medicare spending per beneficiary. These measures are based on administrative data. ■

with publicly reported quality results. Rural SNFs and dialysis facilities had lower shares of providers with publicly reported quality results compared with their urban counterparts, whereas rural HHAs and hospices had higher shares of providers with publicly reported quality results compared with their urban counterparts. Policymakers could consider future work to understand these differences.

TABLE 6–2

Comparing the shares of rural and urban providers with publicly reported Medicare quality results, by provider type

Provider type	Finding
Hospital	Comparable shares of rural and urban PPS hospitals had publicly reported quality results.
Clinician	Comparable shares of eligible rural and urban clinicians reported data for MIPS, which CMS uses for public reporting of quality results.
Skilled nursing facility	Lower share of rural SNFs had publicly reported quality results compared with urban SNFs.
Home health agency	Higher share of rural HHAs had publicly reported quality results compared with urban agencies.
Inpatient rehabilitation facility	Comparable shares of rural and urban IRFs had publicly reported quality results.
Hospice	Higher share of rural hospices had publicly reported quality results compared with urban agencies.
Dialysis facility	Lower share of urban dialysis facilities had publicly reported quality results compared with rural dialysis facilities.

Note: PPS (prospective payment system), MIPS (Merit-based Incentive Payment System), SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility). "Comparable shares" are within 10 percentage points of each other.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024 (Centers for Medicare & Medicaid Services 2024a).

In this section, we also discuss quality reporting and rural providers for ACOs, MA plans, and Part D plans.

Measuring the quality of rural hospitals (inpatient, outpatient, and rural emergency)

Medicare has two quality reporting programs for acute care hospitals: the Hospital Inpatient Quality Reporting Program (IQRP) and the Outpatient Quality Reporting Program (OQRP).[6] Under these programs, hospitals receive a 2 percentage point reduction in payment for failing to successfully report quality-measure data. By law, the hospital QRPs exclude facilities that are not paid through inpatient or outpatient prospective payment systems (PPSs), such as the roughly 1,370 critical access hospitals (CAHs) that primarily operate in rural areas (see Chapter 7 of this report for more information about CAH payments).[7] About 700 PPS hospitals (slightly less than a quarter of all PPS hospitals) are located in rural areas and included in the quality programs.

There are 36 quality measures in the IQRP and 15 in the OQRP for fiscal year (FY) 2025; these 51 measures across the two programs are mainly based on coverage year 2023 performance (Table 6-3, p. 312) (see Table 6-A1 (pp. 324–325) and Table 6-A2 (p. 326) in the appendix for the full list of measures and data sources).[8] Hospitals report about half of those measures to CMS (e.g., patient-experience surveys, health care–associated infections, medical record–abstracted measures), while the other half are claims-based outcomes (e.g., rates of readmissions and mortality) or cost measures that CMS calculates. CMS determines a minimum number of eligible cases that a provider must have for a given measure result to be publicly reported on the Care Compare website. If a provider's number of cases is too low for a measure, then the result may be too unreliable to use to assess performance. In these instances, CMS does not display the provider's measure result on Care Compare but adds a footnote on the website that the "number of cases/patients is too few to report" (Centers for Medicare & Medicaid Services 2025g). CMS uses other footnotes on Care Compare when a provider's measure results are not included on the website (e.g., "results are not available for this reporting period").[9]

TABLE 6–3

Public reporting of rural and urban hospital quality in FFS Medicare, 2024

Medicare quality reporting program	Quality measures	Public reporting of rural hospital quality	Public reporting of urban hospital quality
Inpatient QRP	36 measures, including readmission, mortality, and patient experience	97% of PPS hospitals in rural areas had publicly reported readmission rates; 80% had patient-experience results publicly reported. 82% of CAHs had readmission measure results publicly reported; 23% had patient-experience results publicly reported.	97% of PPS hospitals in urban areas had publicly reported readmission rates; 89% had patient-experience results publicly reported.
Outpatient QRP	15 measures, including patient experience and whether patient left before being seen in ED	79% of PPS hospitals in rural areas had the ED throughput measure publicly reported. 49% of CAHs had the ED throughput measure publicly reported.	73% of PPS hospitals in urban areas had the ED throughput measure publicly reported.
Rural emergency hospital QRP	4 measures that are part of Outpatient QRP, including time spent in ED	Data collection began in 2024, and results have not yet been publicly reported.	N/A

Note: FFS (fee-for-service), QRP (Quality Reporting Program), PPS (prospective payment system), CAH (critical access hospital), IPPS (inpatient prospective payment systems), ED (emergency department), N/A (not applicable). The QRPs require hospitals to submit quality data, which CMS uses to publicly report hospital quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. Where feasible, we highlighted outcomes and patient-experience results consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) Close to a quarter (or about 700) of IPPS hospitals are located in rural areas. There are about 1,350 CAHs included in this analysis.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

Although CAH payments are not impacted by whether the CAH reports IQRP or OQRP data, CAHs are encouraged to voluntarily submit measure data for public reporting on Care Compare (Centers for Medicare & Medicaid Services 2024f). During interviews with leadership of several CAHs that were voluntarily reporting IQRP and OQRP measures, they cited the value of voluntarily reporting in order to gain experience with quality measurement.

In our review of the Care Compare data CMS publicly reported as of December 2024, we found that no PPS hospital or CAH had publicly reported data for all 51 IQRP or OQRP measures. This finding likely results from a combination of factors, including not having minimum case counts, exceptions for measures that are not applicable to the services the hospital provides, and hospitals' electing to suppress a measure from being publicly reported. Thus, for the analysis of shares of hospitals with publicly reported data, we focus on public reporting of specific measures as opposed to reporting the complete measure set.

Most CAHs voluntarily opted to participate in the IQRP or OQRP, meaning they reported at least some of the 51 measures to CMS for public reporting. This finding is

consistent with results reported by the Medicare Rural Hospital Flexibility (Flex) Program (Lahr et al. 2023).[10] Also, comparable shares of rural and urban IPPS hospitals had publicly reported results.

In December 2024, 82 percent of CAHs had their claims-based readmission rate publicly reported on Care Compare, compared to 97 percent of urban and rural IPPS hospitals (Table 6-3). These hospitals participated in the IQRP and met the minimum case requirement of 25 eligible cases for the measurement year for public reporting. For the patient-experience measures, many CAHs did not report the measures to CMS or did not meet the minimum case requirements for public reporting (which is a minimum of 25 completed surveys for a four-quarter period). Only about a quarter (23 percent) of CAHs had patient-experience results publicly reported. (The Flex Program collects patient-experience results directly from CAHs and reports that 95 percent of CAHs are collecting patient-experience surveys.) By contrast, 89 percent of urban IPPS hospitals and 80 percent of rural IPPS hospitals met the minimum survey requirements and had results publicly reported on Care Compare. Leadership at one CAH we visited in the summer of 2024 recounted receiving only one completed patient-experience survey in a months-long period. Although the CAH leadership said the information was helpful for their own quality-improvement activities, the CAH did not meet the CMS minimum for public reporting.

For the OQRP measure of median time from emergency department (ED) arrival to departure, almost half (49 percent) of CAHs had a result reported on Care Compare, meaning they chose to participate in the program and met minimum case requirements for public reporting (Table 6-3). This share is less than the 73 percent of urban IPPS hospitals and 79 percent of rural IPPS hospitals that had the median time for ED arrival and departure publicly reported.

The rural emergency hospital (REH) is a new Medicare provider type, effective January 1, 2023 (Medicare Payment Advisory Commission 2024b). The Congress established REHs to respond to concerns about rural hospital closures and give rural communities a new provider type to support access to emergency care. When an eligible facility converts to an REH, it must provide ED services and observation care and is allowed to provide additional outpatient medical and health services if elected by the REH and if these services do not exceed an annual per patient average length of stay of 24 hours.

Beginning in 2024, REHs must report data for the REH Quality Reporting Program, which includes four measures from the OQRP (Table 6-3) (see Table 6-A3, p. 327, in the appendix for the full list of measures and data sources). CMS intends to publicly report these results after completion of a data-collection period, provided that sufficient case volumes are achieved.

Measuring the quality of rural clinicians

In its annual assessment of payment adequacy for clinician services, the Commission has noted that it is difficult to assess the quality of clinician care for several reasons (Medicare Payment Advisory Commission 2025). The difficulty extends to the quality of clinician care in both urban and rural areas. First, Medicare does not collect beneficiaries' clinical information (e.g., blood pressure, lab results) or patient-reported outcomes (e.g., improving or maintaining physical and mental health) at the FFS-beneficiary level. Second, CMS measures the performance of clinicians using the MIPS, which, in March 2018, the Commission recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). For example, MIPS allows clinicians to choose which measures of quality and improvement activities they will report from a catalog of hundreds of measures, which makes it harder to compare clinicians because they are not being evaluated on the same measure set; for some measures, only a few clinicians may report. Third, for claims-based measures, Medicare's "incident to" policies obscure who actually performed a service because a substantial portion of services performed by advanced practice registered nurses (APRNs) and physician assistants (PAs) appear in claims data to have been performed by physicians. As noted above, in June 2019, the Commission recommended requiring APRNs and PAs to bill the Medicare program directly. Finally, there is the matter of small numbers of cases for measuring individual clinicians, a perennial issue in quality measurement for clinician services because it can make the results at the individual clinician level unreliable. Acknowledging all these challenges in measuring the quality of clinician care and our standing recommendation to eliminate MIPS, we present information on the program here

TABLE 6–4

Participation of rural and urban clinicians in the Merit-based Incentive Payment System, 2022

MIPS measures	Rural clinician participation	All clinician participation
100s of measures across four categories: quality, improvement activities, promoting interoperability, and cost; clinicians select a small set of quality and improvement-activity measures to report	94% of MIPS-eligible clinicians in rural areas submitted MIPS data.*	94% of MIPS-eligible clinicians in rural areas submitted MIPS data.*

Note: MIPS (Merit-based Incentive Payment System). MIPS is a program that adjusts Medicare Part B payments for eligible clinicians based on their performance in four categories: quality, cost, promoting interoperability, and improvement activities. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) do not have Medicare-specific quality reporting programs, but FQHCs are required to report quality data to other federal agencies. We compare rural clinician and all clinician participation in MIPS because that is the method CMS uses in the Quality Payment Program Experience report.
* Clinicians who bill exclusively through FQHC and RHC payment models may voluntarily report on measures and activities under MIPS but are not subject to a payment adjustment.

Source: Centers for Medicare & Medicaid Services 2025e, Centers for Medicare & Medicaid Services 2024a.

because it is the basis for data CMS publicly reports on Care Compare on clinician quality.

In 2017, CMS launched the Quality Payment Program (QPP) to provide clinicians with incentives to perform well on quality measures (MIPS) or to participate in advanced alternative payment models (A–APMs). (Examples of A–APMs include accountable care organization (ACO) models that require providers to take on a specified minimum level of financial risk.) Under current law, starting in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians in A–APMs and by 0.25 percent per year for all other clinicians (Medicare Payment Advisory Commission 2025).

Under the QPP, clinicians remaining in traditional FFS Medicare (i.e., not joining an A–APM) are subject to additional reporting and payment requirements through MIPS. (MIPS is a pay-for-performance program, but we include it in this chapter because the program's quality measures are used for public reporting by CMS.) MIPS is a system that calculates individual-clinician-level or group-level payment adjustments based on performance across four performance categories—quality, improvement activities, interoperability improvement, and cost. Clinicians select a small set of measures of quality and improvement activity to report, from a list of hundreds of measures that apply to different specialties or clinical conditions (Table 6-4). MIPS-eligible clinicians receive a MIPS payment adjustment—positive, negative, or neutral—based on their performance across the categories in a prior year.

To account for the issue of few cases with which to measure clinician quality, MIPS excludes clinicians who do not meet low-volume thresholds of Part B–covered services. In 2022, clinicians were required to participate in MIPS if they billed more than $90,000 for Part B–covered professional services, saw more than 200 Part B patients, and provided more than 200 covered professional services to Part B patients. Also, clinicians who bill for Medicare Part B services exclusively through federally qualified health center (FQHC) or rural health clinic (RHC) payment methods (i.e., all-inclusive payment) may voluntarily report on measures and activities under MIPS but are not subject to a payment adjustment.[11] However, if a clinician practices in an RHC or FQHC and also provides services that are billed under the fee schedule for physician and other health professional services, then payment for those services could be eligible for MIPS payment adjustments.

In 2022, the rate of reporting for MIPS-eligible clinicians was high, including clinicians in rural areas. Ninety-four percent of all MIPS-eligible clinicians (who are therefore required to participate), as well as MIPS-eligible clinicians in rural areas, actively submitted data (Table 6-4) (Centers for Medicare & Medicaid Services 2024l). The roughly 6 percent of MIPS-eligible clinicians who did not report may still have been scored on administrative claims measures that are automatically calculated by CMS for the quality and cost-performance categories. Rural clinicians engaged (i.e., reported data) in MIPS in 2022 received a mean payment adjustment of 2.04 percent, which was slightly lower than the mean for all engaged MIPS-eligible clinicians, 2.40 percent. (Both groups had a minimum payment adjustment of −9 percent and maximum of 8.26 percent.) The share of MIPS-eligible clinicians in rural practices receiving an exceptional payment adjustment (38 percent) was consistent with MIPS-eligible clinicians overall (42 percent).[12] Nonreporting rural clinicians received a mean MIPS payment adjustment of −3.8 percent, which was slightly lower than the mean payment adjustment of −3.4 percent for all nonreporting MIPS-eligible clinicians. (Both groups had a minimum payment adjustment of −9 percent and maximum of 0 percent.)

Measuring the quality of rural skilled nursing facilities

The SNF Quality Reporting Program (SNF–QRP) requires SNFs to submit quality data, which CMS uses to publicly report SNF quality performance on the Care Compare website. Freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed hospitals (e.g., PPS hospitals, including those in rural areas, that furnish post-acute care in swing beds) that do not report complete SNF–QRP data receive reduced payment updates. By law, the QRP excludes facilities such as CAHs that are not paid through the SNF–PPS.[13]

In FY 2025, there are 15 quality measures in the SNF–QRP. SNFs report about three-fourths of the measures to CMS (e.g., measures based on the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument and personnel vaccination rates), while the other quarter consists of claims-based outcome measures (e.g., readmission rates) or cost measures that CMS calculates (Table 6-5, p. 316) (see Table 6-A4, p. 328, in the appendix for the full list of measures and data sources). CMS determines a minimum number of eligible cases that a provider must have for the measure result to be publicly reported. If a provider has too few cases, then the measure result may be too variable to reliably assess performance and is not reported on Care Compare. Also, if a provider does not report a measure result to CMS, then the provider does not have a publicly reported result for that measure.

Close to a third of freestanding, hospital-based, and non-CAH swing-bed facilities (about 4,700) are located in rural areas. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that SNFs in rural areas had fewer quality data publicly reported than SNFs in urban areas. Forty-five percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in rural areas reported and met the minimum case count for all 15 SNF–QRP measures (Table 6-5, p. 316). This share is lower than the 65 percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in urban areas that had all 15 SNF–QRP measures publicly reported. For the claims-based outcome measure of potentially preventable postdischarge readmissions, CMS established 25 index admissions as the minimum number of eligible patients. Seventy-four percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in rural areas had the minimum case count for publicly reporting the readmission measure. By comparison, 87 percent of freestanding SNFs, hospital-based SNFs, and non-CAH swing-bed facilities in urban areas had the minimum case count for publicly reporting the readmission measure.

Almost all of the roughly 1,370 CAHs have swing beds, in which beneficiaries can receive acute or post-acute care. SNF swing beds in CAHs do not have to report data for the QRP, so none have reported all of the measures and/or met the minimum case count for all 15 SNF–QRP measures. However, 17 percent of CAHs with SNF swing beds in rural areas met the minimum case requirement for some measures and had readmission results publicly reported.

Measuring the quality of rural home health agencies

All Medicare-certified home health agencies (HHAs) are required to report data for the HH Quality Reporting Program (HH–QRP) or they receive a reduction in payment updates.[14] These data are used to publicly report HHA quality on the Care Compare website.

TABLE 6–5

Public reporting of rural and urban skilled nursing facility quality in FFS Medicare, 2024

SNF–QRP quality measures	Public reporting of rural SNF quality	Public reporting of urban SNF quality
15 measures, including potentially preventable 30-day postdischarge readmission measure	45% of freestanding and hospital-based SNFs and non-CAH swing-bed facilities in rural areas had all quality measures publicly reported. 74% of them had readmission results publicly reported. CAH swing beds are not required to report data to CMS, and no CAH swing beds have all quality measures publicly reported, but 17% of CAHs with SNF swing beds have a readmission result publicly reported.	65% of freestanding and hospital-based SNFs and non-CAH swing-bed facilities in urban areas had all quality measures publicly reported. 87% of them had readmission results publicly reported.

Note: FFS (fee-for-service), SNF (skilled nursing facility), QRP (Quality Reporting Program), CAH (critical access hospital). The SNF–QRP requires SNFs to submit quality data, which CMS uses to publicly report SNF quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure.. The minimum number of cases for CMS's readmission measure is 25 index admissions. We highlighted the readmission measure because this claims-based outcome measure is consistent with the Commission's principles for quality measurement. (See appendix for more details on measures included in some of the programs.) Close to a third (or about 4,700) of freestanding, hospital-based, and non-CAH swing-bed facilities are located in rural areas. Almost all of about 1,350 CAHs have swing beds, in which beneficiaries can receive acute or post-acute care.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

There are 22 quality measures in the 2025 HH-QRP (Table 6-6) (Centers for Medicare & Medicaid Services 2024h). HHAs report about three-fourths of the measures to CMS directly (e.g., through the Outcome and Assessment Information Set), while the other fourth consists of claims-based outcome (e.g., readmission rates) and cost measures that CMS calculates, plus the HH–CAHPS patient-experience survey (see Table 6-A5, p. 329, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases or patients for each measure to be publicly reported. If a provider's number of cases is too low, then the result may be too variable to reliably assess performance. Also, if a provider does not report a measure result to CMS, then the provider does not have a publicly reported measure result.

In 2024, 15 percent of HHAs were classified as majority rural (i.e., beneficiaries residing in rural counties accounted for 50 percent or more of the 30-day periods of care delivered by the agency). Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that HHAs with a majority of patients residing in rural areas had more quality data publicly reported than HHAs with a majority of patients residing in urban areas (Table 6-6). Fifty-eight percent of the HHAs with a majority of patients residing in rural areas reported and met the minimum case count for all HH–QRP measures, compared with 39 percent of majority-urban HHAs. Ninety percent of HHAs with a majority of their patients residing in rural areas had the minimum case count for publicly reporting the readmission measure. This figure is higher than the 63 percent of agencies with the majority of their patients residing in urban areas that had the minimum case count for publicly reporting the readmission measure. Fifty-eight percent of HHAs with the majority of their patients residing in rural areas reported HH–CAHPS patient-experience results to CMS and met the minimum requirement of 70 completed surveys for the results to be publicly

TABLE 6–6

Medicare's public reporting of rural and urban home health agency quality in FFS Medicare, 2024

HH–QRP quality measures	Public reporting of rural HHA quality	Public reporting of urban HHA quality
22 measures, including potentially preventable readmission rate and patient experience	58% of HHAs with the majority of their patients in rural areas had all quality measures publicly reported; 90% of them had readmission results publicly reported; and 58% had patient-experience results publicly reported.	39% of HHAs with the majority of their patients in urban areas had all quality measures publicly reported; 63% of them had readmission results publicly reported; and 40% had patient-experience results publicly reported.

Note: FFS (fee-for-service), HH (home health), QRP (Quality Reporting Program), HHA (home health agency). The HH–QRP requires HHAs to submit quality data, which CMS uses to publicly report HHA quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum requirement for publicly reporting the patient-experience measures is 70 completed surveys. We highlighted the readmission and patient-experience measures because they are outcome and patient-experience measures consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) In 2024, 15 percent of HHAs were classified as majority rural (i.e., beneficiaries residing in rural counties accounted for 50 percent or more of the 30-day periods of care delivered by the agency).

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

reported. This share is higher than the 40 percent of agencies with the majority of their patients residing in urban areas that had patient-experience results publicly reported. The lower shares of both urban and rural HHAs that did not have all measures publicly reported was mainly driven by the patient-experience survey. The HH–CAHPS survey has a minimum requirement of least 70 completed surveys over a given eight-quarter period for patient-experience results to be publicly reported, which smaller agencies—whether urban or rural—may not meet.

Measuring the quality of rural inpatient rehabilitation facilities

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF–QRP) requires IRFs to submit data that CMS uses to publicly report IRF quality performance on the Care Compare website. IRFs that do not report IRF–QRP data have a 2 percentage point reduction in their annual increase factor. There are 17 quality measures in the FY 2025 IRF–QRP (Table 6-7, p. 318). IRFs report about 80 percent of the measures to CMS (e.g., the IRF Patient Assessment Instrument (IRF–PAI) and personnel vaccination rates), while the other 20 percent consists of claims-based outcome measures (e.g., readmission rates) and cost measures that CMS calculates (see Table 6-A6, p. 330, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases that a provider must have for the measure result to be publicly reported. If a provider's number of cases is too low, then the measure result may be too variable to reliably assess performance.

In 2024, 13 percent of IRFs (or close to 140) were located in rural areas. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that IRFs in rural and urban areas had comparable quality data publicly reported. Eighty-eight percent of IRFs in rural areas reported and met the minimum case count for all 17 IRF–QRP measures, which is comparable with the 92 percent of IRFs in urban areas that had all IRF–QRP measures publicly reported (Table 6-7, p. 318). For the claims-based outcome measure of potentially preventable postdischarge readmissions, the minimum number of eligible patients is 25 index admissions. Ninety-five percent of IRFs in rural areas had the minimum case count for publicly reporting the readmission measure in December 2024. This share is comparable with the 97 percent of IRFs in urban areas that had the minimum case count for publicly reporting the readmission measure.

TABLE 6–7

Public reporting of rural and urban inpatient rehabilitation facility quality in FFS Medicare, 2024

IRF–QRP quality measures	Public reporting of rural IRF quality	Public reporting of urban IRF quality
17 measures, including potentially preventable readmissions	88% of IRFs in rural areas had all quality measures publicly reported; 95% of them had readmission results publicly reported.	92% of IRFs in urban areas had all quality measures publicly reported; 97% of them had readmission results publicly reported.

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), QRP (Quality Reporting Program). The IRF–QRP requires IRFs to submit quality data, which CMS uses to publicly report IRF quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of cases for CMS's readmission measure is 25 index admissions. We highlighted the readmission measure because this claims-based outcome measure is consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) In 2024, 13 percent of IRFs (or close to 140) were located in rural areas.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

Measuring the quality of rural hospices

The Hospice Quality Reporting Program (H–QRP) requires all Medicare-certified hospices to submit data for CMS, which are then publicly reported on Care Compare. Hospices that do not report H–QRP data have a 4 percentage point reduction in their annual increase factor. This penalty increased from 2 percentage points to 4 percentage points beginning in FY 2024 (Centers for Medicare & Medicaid Services 2024d).

There are four quality measures in the FY 2025 H–QRP. The measures are calculated using the Hospice Item Set that hospices report to CMS, patient-experience surveys collected by third-party survey vendors, and Medicare claims data (Table 6-8) (see Table 6-A7, p. 331, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases that a provider must have for the measure result to be publicly reported. If a provider has too few cases, then the measure result may be too variable to reliably assess performance.

About 12 percent of hospices (or close to 800) are classified as majority rural because more than half of the beneficiaries they serve reside in a rural area. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that hospices with a majority of patients residing in rural areas had more quality data publicly reported than hospices with a majority of patients residing in urban areas (Table 6-8). Seventy-four percent of majority-rural hospices reported and met the minimum number of eligible cases for all H-QRP measures to be publicly reported. This share is higher than the 42 percent of majority-urban hospices that had all H–QRP measures publicly reported. The lower shares of both urban and rural hospices that did not have all measures publicly reported was mainly driven by the patient-experience survey. For patient-experience results to be publicly reported, a facility must have at least 75 completed surveys over a given eight-quarter period. Smaller facilities—whether urban or rural—might not meet that minimum. Seventy-four percent of hospices with the majority of their patients residing in rural areas reported and had sufficient volume for patient-experience results to be publicly reported. This share is higher than the 43 percent of hospices with the majority of their patients residing in urban areas that did not report or did not meet the minimum case count for publicly reporting the patient-experience results.

Measuring the quality of rural dialysis facilities

The End-Stage Renal Disease Quality Incentive Program (ESRD–QIP) is a pay-for-performance program, which reduces payments to renal dialysis facilities that do not meet or exceed certain performance standards on applicable measures (Centers for Medicare & Medicaid Services 2023b). (The ESRD–QIP is included in this

TABLE 6–8 **Public reporting of rural and urban hospice quality in FFS Medicare, 2024**

H–QRP quality measures	Public reporting of rural hospice quality	Public reporting of urban hospice quality
4 measures, including patient experience	74% of hospices with the majority of their patients in rural areas had all quality measures publicly reported; 74% of them had patient-experience results publicly reported.	42% of hospices with the majority of their patients in urban areas had all quality measures publicly reported; 43% of them had patient-experience results publicly reported.

Note: FFS (fee-for-service), H–QRP (Hospice Quality Reporting Program). The H–QRP requires hospices to submit quality data, which CMS uses to publicly report hospice quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. CMS requires at least 75 completed surveys over a given eight-quarter period for patient-experience results to be publicly reported. We highlighted the patient-experience measure because this claims-based outcome measure is consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) About 12 percent of hospices (or close to 800) are classified as majority rural because more than half of the beneficiaries they serve reside in a rural area.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

chapter on quality reporting because most of the program's quality measures are used for public reporting by CMS.) The maximum payment reduction that CMS can apply to any facility is 2 percent. This reduction applies to all payments for services performed by the facility receiving the reduction during the applicable payment year.

There are 15 quality measures in the 2025 ESRD–QIP (Table 6-9, p. 320). Dialysis facilities report about three-fourths of the measures to CMS (e.g., information abstracted from medical records), while the other quarter are claims-based outcome (e.g., readmission rates) or cost measures that CMS calculates, plus the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH–CAHPS) patient-experience survey (see Table 6-A8, p. 332, in the appendix for the full list of measures and data sources). CMS also determines a minimum number of eligible cases or patients for each measure that a provider must meet for the result to be publicly reported. If a provider's number of cases is too low, then the result may be too variable to reliably assess performance.

About 16 percent of dialysis facilities (or close to 1,200) are located in a rural area. Based on our analysis of the CMS Care Compare data reported as of December 2024, we found that dialysis facilities in rural areas had fewer quality data publicly reported than facilities in urban areas (Table 6-9, p. 320). Sixteen percent of dialysis facilities located in rural areas met the minimum case count for all ESRD–QIP measures. This share is lower than the 28 percent of dialysis facilities located in urban areas that had all ESRD–QIP measures publicly reported. Like HHAs and hospices, the lower shares of both urban and rural dialysis facilities that did not have all measures publicly reported were mainly driven by the patient-experience survey. The ICH–CAHPS has a minimum requirement of 30 completed surveys from two survey periods for results to be publicly reported, which smaller facilities—whether urban or rural—may not meet. For the claims-based outcome measure of standardized readmission rates, the minimum number of eligible patients is 11 index hospital discharges. Ninety-three percent of dialysis facilities in rural areas had the minimum case count for publicly reporting the readmission measure. This share is comparable to the 95 percent of facilities in urban areas that had the minimum case count for publicly reporting the readmission measure. Seventeen percent of dialysis facilities in rural areas had sufficient volume for patient-experience results to be publicly reported, which is lower than the 33 percent of facilities in urban areas that had the minimum case count.

Medicare's quality measurement for accountable care organizations

Medicare ACOs are models that hold groups of providers accountable for the total cost and quality of care furnished to a defined population of FFS

TABLE 6–9

Public reporting of rural and urban dialysis facility quality in FFS Medicare, 2024

ESRD–QIP	Public reporting of rural dialysis facility quality	Public reporting of urban dialysis facility quality
15 measures, including standardized readmission rate and patient experience	16% of dialysis facilities in rural areas had all quality measures publicly reported; 93% of them had a readmission rate publicly reported; 17% of them had patient-experience results publicly reported.	28% of dialysis facilities in urban areas had all quality measures publicly reported; 95% of them had a readmission rate publicly reported; 33% of them had patient-experience results publicly reported.

Note: FFS (fee-for-service), ESRD–QIP (End-Stage Renal Disease Quality Incentive Program). The ESRD–QIP requires dialysis facilities to submit quality data, which CMS uses to publicly report dialysis-facility quality performance on the Care Compare website. The shares of providers that meet the requirements for public reporting include those that reported the required data and met CMS's minimum case requirement (i.e., reliability standard) for the measure. The minimum number of cases for CMS's readmission measure is 25 index admissions. CMS requires at least 30 completed surveys from two survey periods for patient-experience results to be publicly reported. We highlighted the readmissions and patient-experience measures because these measures are consistent with the Commission's principles for quality measurement. (See appendix for more details of measures included in some of the programs.) About 16 percent of dialysis facilities (or close to 1,200) are located in a rural area.

Source: MedPAC analysis of Care Compare data published by CMS as of December 2024.

beneficiaries. Clinicians who meet participation thresholds for some ACOs designated as A–APMs do not need to participate in MIPS because their quality of care is assessed by the ACO.

Some ACOs participate in rural areas and are accountable for the quality of care provided to the beneficiaries assigned to their organization. As of January 1, 2025, more than half of all RHCs were participating in a Medicare Shared Savings Program (MSSP) ACO, as were more than half of FQHCs (including rural and urban FQHCs) and about a third of CAHs (Centers for Medicare & Medicaid Services 2025f). CMS also noted a 16 percent increase in the number of RHCs, FQHCs, and CAHs from 2024 to 2025 (Centers for Medicare & Medicaid Services 2025b). Increasing provider participation in value-based programs, such as ACOs, is consistent with the Commission's principles.

The Medicare program requires ACOs to report quality-measure results to CMS; the reported quality-measure results are used to calculate a quality-performance score, which is used to determine shared savings and losses. In 2024, ACOs participating in the MSSP, the largest Medicare ACO program, had the option to report clinical quality-measure results to CMS in two ways: (1) report 10 CMS web-interface measures or (2) report 3 electronic clinical quality measures (eCQMs), 3 MIPS clinical quality measures (CQMs), or 3 Medicare CQMs (Centers for Medicare & Medicaid Services 2024c).[15] Examples of these clinical measures include poor control of diabetes; screening for depression and follow-up; controlling high blood pressure; and tobacco use screening and cessation intervention. CMS selects a sample of an MSSP–ACO's assigned beneficiaries to use in calculating the MSSP–ACO's quality-measure results. ACOs work with their providers, which can include providers in rural areas, to gather the clinical documentation needed (e.g., screening results and lab values in medical records) for each measure, and they report results to CMS for scoring as part of the MSSP–ACO program. MSSP–ACOs must also collect patient-experience surveys from a sample of patients (which is different from the sample for the clinical measures) and are assessed on two claims-based measures (readmissions and admissions for patients with multiple chronic conditions). The rural providers that are part of those ACOs are also measured on the quality of care they provide. However, ACO quality measures may or may

not capture quality results for beneficiaries residing in rural areas who are assigned to ACOs because of the sampling approach to measurement.

Medicare's quality measurement for Medicare Advantage and Part D plans

As of 2024, more than half of eligible Medicare beneficiaries nationwide were enrolled in MA plans (Medicare Payment Advisory Commission 2025). MA enrollment patterns differ in urban and rural areas. In 2024, the majority (56 percent) of eligible urban beneficiaries were enrolled in MA compared with 47 percent of eligible beneficiaries residing in rural counties.[16] However, the growth of MA enrollment in rural areas has been faster in recent years. In 2024, MA enrollment in rural areas grew by 8 percent, compared with 6 percent growth in urban areas. The predominant plan type often differs between urban and rural areas as well. In 2024, 39 percent of rural MA enrollees were in HMO plans compared with about 59 percent of urban enrollees. By contrast, 58 percent of rural enrollees were in local preferred provider organizations compared with 40 percent of urban enrollees.

In 2006, CMS introduced the MA star-rating system to give beneficiaries information about the clinical quality, administrative capability, and patient experience that an enrollee can expect from a given MA plan. Medicare currently collects over 100 MA quality measures, 42 of which are used to determine a star rating from 1 to 5 for each MA contract (Centers for Medicare & Medicaid Services 2023c). These ratings are available on the medicare.gov Plan Finder website so that beneficiaries can compare plans. Twelve of these 42 measures are also used to calculate Part D star ratings that are displayed on the Plan Finder website for each Part D organization.

However, the Commission has determined that the current system for MA quality measurement and reporting is flawed and does not provide a reliable basis for evaluating quality across MA plans (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019). Nonetheless, these measures are the basis for the MA quality-bonus program, which increases MA payments (and program spending) by about $15 billion annually.

A primary flaw of current MA quality reporting is that quality results for MA are reported on a contract-wide basis, and those results are used to determine the star ratings for all plans offered under the contract.[17] MA contracts often cover wide geographic areas that include multiple diverse health care markets. In January 2024, over half of MA enrollees were in contracts that spanned two or more states. A third of MA enrollees were in multistate MA contracts that spanned noncontiguous states. The largest MA contract, with 2.6 million enrollees, had over 1,000 MA enrollees in each of 46 states and over 20,000 enrollees in each of 30 states. Another multistate contract had about 200,000 enrollees in Florida; 100,000 enrollees in Indiana; 70,000 enrollees in Arizona; and 40,000 enrollees in Oregon. The star ratings for such contracts reflect performance averaged across different service areas and thus are unlikely to accurately reflect plan quality in any one of those areas.

Plan sponsors rely exclusively on administrative data (such as encounter data) as the source for many measures, but there are some "hybrid" measures for which MA organizations can or must use both administrative data and data collected from a sample of enrollee medical records (e.g., data on breast cancer screening or diabetic A1c control). To report data for hybrid measures, MA organizations collect data for a random sample of 411 enrollees, chosen at the contract level.[18] Like many of the ACO measures previously described, MA plans work with providers (including those that furnish care in rural areas) to gather the information on this sample of enrollees to report the measure. However, because of the sampling approach at the contract level, MA quality measures may or may not capture quality results for beneficiaries residing in rural areas who are enrolled in MA plans.

Initiatives to improve measurement of rural providers' quality of care

While acknowledging the limitations in measuring quality of care for many small providers, including those in rural areas, we have identified several federal and multistakeholder initiatives to improve quality measurement, including identifying and developing metrics most relevant for rural providers and furnishing technical assistance to rural providers. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Identifying and developing metrics that are most relevant for rural providers

Quality measurement among rural providers could be improved by focusing on metrics that are tailored to these providers and the concerns of patients treated by them. The metrics may differ in rural and urban areas, for example, because the types of care provided in smaller rural hospitals may differ from the types of care in larger hospitals. The National Quality Forum, funded by CMS, convened a multistakeholder Rural Health Advisory Group that identified the best available measures to address the needs of rural populations—scientifically valid measures that address conditions and topics important to rural patients and are resistant to low case-volume challenges (National Quality Forum 2022, National Quality Forum 2015). In 2022, the group identified 37 key rural measures, including 21 hospital-setting measures and 16 ambulatory care–setting measures. Many of the measures the advisory group selected are included in the various Medicare quality reporting programs that we described earlier in this chapter. The advisory group selected measures with a heavy emphasis on behavioral and mental health, substance use, infectious disease, access to care, equity, and social determinants of health. The measure list also addresses admissions, readmissions, and hospital visits; care coordination; dementia, diabetes, and hypertension; kidney health; maternal health; mortality; patient experience; preventive care; and patient safety. The advisory group also identified the gaps in the updated measure list, with calls for measure development in the following areas: intentional and unintentional injury, COVID-19, HIV, telehealth-relevant measures, cancer-screening measures, and cost measures. Most of the measures identified as key measures, as well as measurement gaps, are tied to clinical outcomes, patient experience, and value, and therefore align with the Commission's principles for quality measurement.

Federal initiatives to support rural quality-improvement efforts

The Commission has maintained that the goal of improved care should extend to all patients, regardless of health status, income, and race. Those expectations are more likely to be met if they are combined with additional resources to build a provider's ability to address particularly challenging environments for care delivery. Thus Medicare should target technical assistance to low-performing providers (Medicare Payment Advisory Commission 2018a). A number of federal programs and initiatives are available to help rural health care providers develop quality-improvement programs. We briefly describe two below. The Commission will continue to monitor the implementation and effectiveness of these initiatives.

Quality-improvement organizations (QIOs) work with health care facilities and providers on behalf of CMS to improve health care delivery and ensure high-quality, cost-efficient care (Centers for Medicare & Medicaid Services 2024k).[19] Twelve quality-innovation networks–QIOs (QINs–QIOs) work directly with nursing homes, health care providers, and partnerships for community health serving rural and underserved areas to improve the quality and safety of care for Medicare beneficiaries. The QINs–QIOs help health care providers with quality initiatives by promoting evidence-based improvement strategies and supporting peer-to-peer learning. The work of QIOs is state focused and organized under regional contracts. Nine hospital quality-improvement contractors work directly with small rural and critical access hospitals to improve health care quality and safety for Medicare beneficiaries. During interviews with leadership of several CAHs, we heard some positive feedback about technical assistance provided by local QIOs to help improve readmission and sepsis rates.

The Health Resources and Services Administration created the Medicare Beneficiary Quality Improvement Project (MBQIP) to help CAHs report measures for CMS's quality reporting programs and use those data for improvement (Lahr et al. 2023). Specifically, the MBQIP aims to capture measurement data in the most relevant areas, including patient safety, inpatient and outpatient care, patient engagement, and care transitions. CAH quality-measure reporting across these domains has generally increased under the MBQIP, and CAH performance on some measures has improved. For example, under patient safety, in 2022, 91 percent of reporting CAHs fulfilled the seven antibiotic stewardship core elements, compared with 80 percent of reporting CAHs in 2019. ■

APPENDIX 6–A

Quality measures included in Medicare fee-for-service quality reporting programs

TABLE 6–A1

Hospital Inpatient Quality Reporting Program measures for the FY 2025 payment update (cont. next page)

Measure	Source
National Healthcare Safety Network measures	
Influenza vaccination coverage among health care personnel	NHSN
COVID-19 vaccination coverage among health care personnel	NHSN
Claims-based complications and death measures	
Death rate among surgical inpatients with serious treatable complications (CMS recalibrated death rate among surgical inpatients with serious CMS PSI-04 treatable complications)	Claims
Hospital 30-day, all-cause, risk-standardized mortality rate following acute ischemic stroke	Claims
Hospital-level risk-standardized complication rate following primary elective total hip arthroplasty and/or total knee arthroplasty	Claims
Claims-based coordination of care measures	
Hospital-wide all-cause unplanned readmissions measure	Claims
Excess days in acute care after hospitalization for acute myocardial infarction	Claims
Excess days in acute care after hospitalization for heart failure	Claims
Excess days in acute care after hospitalization for pneumonia	Claims
Claims-based efficiency and payment measures	
Hospital-level, risk-standardized payment associated with a 30-day episode of care for acute myocardial infarction	Claims
Hospital-level, risk-standardized payment associated with a 30-day episode of care for heart failure	Claims
Hospital-level, risk-standardized payment associated with a 30-day episode of care for pneumonia	Claims
Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip arthroplasty and/or total knee arthroplasty	Claims
Medicare spending per beneficiary: Hospital	Claims
Chart-abstracted clinical process of care measures	
Elective delivery	Chart abstraction
Severe sepsis and septic shock management bundle (composite measure)	Chart abstraction
Structural measures	
Maternal morbidity structural measure	Web-based tool
Hospital commitment to health equity*	Web-based tool
Electronic clinical quality measures	
Admit decision time to ED departure time for admitted patients	EHR
Exclusive breast milk feeding	EHR
Discharged on antithrombotic therapy	EHR
Anticoagulation therapy for atrial fibrillation/flutter	EHR
Antithrombotic therapy by the end of hospital day	EHR
Discharged on statin medication	EHR
Venous thromboembolism prophylaxis	EHR
Intensive care unit venous thromboembolism prophylaxis	EHR
Hospital harm: Severe hypoglycemia*	EHR
Hospital harm: Severe hyperglycemia*	EHR
Cesarean birth*	EHR
Severe obstetric complications*	EHR
Safe use of opioids: Concurrent prescribing	EHR

TABLE 6–A1

Hospital Inpatient Quality Reporting Program measures for the FY 2025 payment update (cont.)

Measure	Source
Patient experience of care survey measure	
Hospital Consumer Assessment of Healthcare Providers and Systems survey	Patient survey
Hybrid measures	
Hybrid hospital-wide all-cause readmissions*	EHR and claims
Hybrid hospital-wide all-cause risk-standardized mortality*	EHR and claims
Process/structural measures	
Screening for social drivers of health*	Web-based tool
Screen positive rate for social drivers of health*	Web-based tool

Note: FY (fiscal year), NHSN (National Healthcare Safety Network), PSI (patient-safety indicator), ED (emergency department), EHR (electronic health record).
* Measure not publicly reported. .

Source: Centers for Medicare & Medicaid Services 2024e.

TABLE 6–A2

Hospital Outpatient Quality Reporting Program measures for the CY 2025 payment update

Measure	Source
MRI lumbar spine for low back pain	Claims
Abdomen CT: Use of contrast material	Claims
Cardiac imaging for preoperative risk assessment for noncardiac low-risk surgery	Claims
Median time from ED arrival to ED departure for discharged ED patients	Chart abstraction
ED: Patient left without being seen (numerator/denominator one time per year for the previous year)	Web-based tool
Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT or MRI scan interpretation within 45 minutes of arrival	Chart abstraction
Appropriate follow-up interval for normal colonoscopy in average-risk patients	Web-based tool
Cataracts: Improvement in patient's visual function within 90 days following cataract surgery*	Web-based tool
Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy	Claims
Admissions and ED visits for patients receiving outpatient chemotherapy	Claims
Hospital visits after hospital outpatient surgery	Claims
OAS–CAHPS*	Patient survey
COVID-19 vaccination coverage among health care personnel	NHSN
Breast cancer screening recall rates	Claims
STEMI*	eCQM

Note: CY (calendar year), CT (computed tomography), ED (emergency department), MRI (magnetic resonance imaging), OAS–CAHPS (Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems), NHSN (National Healthcare Safety Network), STEMI (ST-elevation myocardial infarction), eCQM (electronic clinical quality measure). Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.
* Hospitals may voluntarily submit data for CY 2025 payment determination but will not be subject to a payment reduction with respect to this measure during the voluntary reporting period. The STEMI measure is not publicly reported.

Source: Centers for Medicare & Medicaid Services 2025c.

TABLE 6–A3

Rural Emergency Hospital Quality Reporting Program measures for CY 2024

Measure	Source
Median time from ED arrival to ED departure for discharged ED patients	Chart abstraction
Abdomen CT: Use of contrast material	Claims
Hospital visits within seven days after hospital outpatient surgery	Claims
Facility seven-day risk-standardized hospital visit rate after outpatient colonoscopy	Claims

Note: CY (calendar year), ED (emergency department), CT (computed tomography). Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

Source: Centers for Medicare & Medicaid Services 2024n.

TABLE 6–A4 **Skilled Nursing Facility Quality Reporting Program for the FY 2025 payment update**

Measure	Source
Changes in skin integrity post-acute care: Pressure ulcer/injury	MDS
Percent of residents experiencing one or more falls with major injury (long stay)	MDS
Discharge mobility score for medical rehabilitation patients	MDS
Discharge self-care score for medical rehabilitation patients	MDS
Drug regimen review conducted with follow-up for identified issues	MDS
Transfer of health information to the provider post-acute care	MDS
Transfer of health information to the patient post-acute care	MDS
Discharge function score	MDS
Patient/resident COVID-19 vaccine	MDS
Medicare spending per beneficiary	Claims
Discharge to community	Claims
Potentially preventable 30-day postdischarge readmissions measure	Claims
SNF health care–associated infections requiring hospitalization	Claims
COVID-19 vaccination coverage among health care personnel	NHSN
Influenza vaccination coverage among health care personnel	NHSN

Note: FY (fiscal year), MDS (Minimum Data Set), SNF (skilled nursing facility), NHSN (National Healthcare Safety Network).

Source: Centers for Medicare & Medicaid Services 2024j.

TABLE 6–A5

Home Health Quality Reporting Program for the CY 2025 payment update

Measure	Source
Improvement in ambulation/locomotion	OASIS
Percent of residents experiencing one or more falls with major injury (long stay)	OASIS
Percent of patients with an admission and discharge functional assessment and a care plan that addresses function	OASIS
Improvement in bathing	OASIS
Improvement in bed transferring	OASIS
COVID-19 vaccine: Percent of patients/residents who are up to date	OASIS
Drug regimen review conducted with follow-up for identified issues: Post-acute care	OASIS
Discharge function score	OASIS
Improvement in dyspnea	OASIS
Influenza immunization received for current flu season	OASIS
Improvement in management of oral medications	OASIS
Changes in skin integrity post-acute care	OASIS
Timely initiation of care	OASIS
Transfer of health information to provider: Post-acute care	OASIS
Transfer of health information to patient: Post-acute care	OASIS
Acute care hospitalization during the first 60 days of HH	Claims
Discharge to community	Claims
Emergency department use without hospitalization during the first 60 days of HH	Claims
Total estimated Medicare spending per beneficiary (MSPB)	Claims
Potentially preventable 30-day postdischarge readmissions measure	Claims
Home health within-stay potentially preventable hospitalization	Claims
HH–CAHPS survey (experience with care) • How often did the HH team give care in a professional way • How well did the HH team communicate with patients • Did the HH team discuss medicines, pain, and home safety with patients • How do patients rate the overall care from the HHA • Will patients recommend the HHA to friends and family	Survey

Note: CY (calendar year), OASIS (Outcome and Assessment Information Set), HH (home health), CAHPS (Consumer Assessment of Healthcare Providers and Systems), HHA (home health agency).

Source: Centers for Medicare & Medicaid Services 2024h.

TABLE 6–A6

Inpatient Rehabilitation Facility Quality Reporting Program for the FY 2025 payment update

Measure	Source
Changes in skin integrity post-acute care: Pressure ulcer/injury	IRF–PAI
Percent of residents experiencing one or more falls with major injury (long stay)	IRF–PAI
IRF functional outcome measure: Discharge mobility score for medical rehabilitation patients	IRF–PAI
IRF functional outcome measure: Discharge self-care score for medical rehabilitation patients	IRF–PAI
Drug regimen review conducted with follow-up for identified issues	IRF–PAI
Transfer of health information to the provider post-acute care	IRF–PAI
Transfer of health information to the patient post-acute care	IRF–PAI
Discharge function score	IRF–PAI
COVID-19 vaccine: Percent of patients/residents who are up to date	IRF–PAI
Catheter-associated urinary tract infection outcome measure	NHSN
Facility-wide inpatient hospital-onset *Clostridium difficile* infection outcome measure	NHSN
Influenza vaccination coverage among health care personnel	NHSN
COVID-19 vaccination coverage among health care personnel	NHSN
Medicare spending per beneficiary	Claims
Discharge to community	Claims
Potentially preventable 30-day postdischarge readmission measure	Claims
Potentially preventable within-stay readmission measure for IRFs	Claims

Note: FY (fiscal year), IRF–PAI (Inpatient Rehabilitation Facility–Patient Assessment Instrument), IRF (inpatient rehabilitation facility), NHSN (National Healthcare Safety Network).

Source: Centers for Medicare & Medicaid Services 2024i.

TABLE 6–A7

Hospice Quality Reporting Program for the FY 2025 payment update

Measure	Source
Hospice and palliative care composite process measure:	
Comprehensive assessment measure at admission	Chart abstraction
Hospice visits in last days of life	Claims
Hospice care index	Claims
Consumer Assessment of Healthcare Providers and Systems (CAHPS), hospice	Survey

Note: FY (fiscal year). Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

Source: Centers for Medicare & Medicaid Services 2024d.

TABLE 6–A8

End-Stage Renal Disease Quality Incentive Program payment year 2025 measures

Measure	Source
In-center hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH–CAHPS)	Survey
Standardized readmission ratio	Claims
Standardized hospitalization ratio	Claims
Percentage of prevalent patient waitlisted	Chart abstraction
Kt/V dialysis adequacy	Chart abstraction
Vascular access: Standardized fistula rate	Chart abstraction
Vascular access: Long-term catheter rate	Chart abstraction
Standardized transfusion ratio	Claims
Bloodstream infection	NHSN
Clinical depression screening and follow-up	Chart abstraction
Hypercalcemia	Chart abstraction
Ultrafiltration rate	Chart abstraction
Dialysis event reporting	Chart abstraction
Medication reconciliation	Chart abstraction
COVID-19 vaccination among health care personnel	NHSN

Note: NHSN (National Healthcare Safety Network). "Kt/V" refers to a measure of dialysis adequacy, specifically the efficiency of urea clearance, calculated as the product of dialyzer clearance (*K*), dialysis time (*t*), divided by the volume of urea distribution (*V*). Data sources listed in the tables are primary data sources. Other data sources may also be used to determine quality results. Chart abstraction involves reviewing medical records to collect data for specific quality measures, which providers then submit to CMS.

Source: Centers for Medicare & Medicaid Services 2022.

Endnotes

1 Using survey data from 2013 through 2017, the Census Bureau found that the median household income in mostly urban counties was higher than that of mostly rural counties ($60,000 vs. $47,000); however, the range in median household incomes across mostly urban counties ($21,000 to $130,000) and mostly rural counties ($20,000 to $95,000) was wide (Guzman et al. 2018). (The Census Bureau defines an area as "mostly rural" if most of its census tracts are not in urbanized areas (Ratcliffe et al. 2016).) In a separate analysis, the Census Bureau found that median incomes for rural households in the Northeast and Midwest were actually higher than those of their urban counterparts; in contrast, median incomes for rural households in the South and West were lower compared with urban households in the same regions (Bishaw and Posey 2016). One caveat is that the incomes used by the Census Bureau are not adjusted for the cost of living. An earlier study that compared rural and urban poverty rates found that the poverty rates—prior to any adjustment for the cost of living—were higher in rural areas, but after adjusting for the cost of living, poverty rates were lower in rural areas (Jolliffe 2006). We are not aware of any updates to this dated finding that adjusts rural and urban incomes or poverty rates by the cost of living.

2 In this chapter, "Medicare's quality programs" broadly refers to quality reporting programs and value-based pay-for-performance programs.

3 A quality measure may be considered "topped out" if performance is such that a large majority of providers or entities perform at or very near the top of the distributions; therefore, the majority of providers or entities can no longer improve their performance. For example, CMS defines topped-out clinician process measures as "those with a median performance rate of 95 percent or higher, while nonprocess measures are considered topped out if the truncated coefficient of variation is less than 0.10 and the 75th percentile and 90th percentile are within two standard errors" (Centers for Medicare & Medicaid Services 2024b).

4 CMS currently sets minimum case counts for each measure used in Medicare quality programs based on reliability or industry standards. If a provider does not meet the minimum case count for the designated reporting period, then the measure result is not publicly reported or scored. CMS employs some mechanisms to increase case counts for provider-level measure results in order to compensate for the effect of low volume on statistical reliability. One method is pooling the measurement data for low-volume providers over a number of years. MedPAC's chapter on ensuring reliable results for quality measures in a SNF–VIP describes the pros and cons of pooling quality data over time (Medicare Payment Advisory Commission 2021).

5 CMS reports Care Compare data on the Provider Data Catalog website (https://data.cms.gov/provider-data/).

6 There are also three hospital pay-for-performance programs: the Hospital Readmission Reduction Program (HRRP), the Hospital Value-Based Purchasing (VBP) Program, and the Hospital-Acquired Conditions Reduction Program (HACRP) (see the Commission's hospital *Payment Basics* for more information on the programs). Critical access hospitals cannot receive a penalty from the HRRP or the HACRP, nor do they receive a reward or penalty as part of the Hospital VBP Program.

7 CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs.

8 Nine of the FY 2025 IQRP measures and one of the FY 2025 OQRP measures are not publicly reported because they are new measures or there have been changes to the measure.

9 The footnote in Care Compare is applied when a hospital (1) elected not to submit data for the entire reporting period, (2) had no claims data for a particular measure, or (3) elected to suppress a measure from being publicly reported.

10 The Medicare Beneficiary Quality Improvement Project (MBQIP) focuses on quality-improvement efforts in the 45 states that participate in the Flex Program. Through Flex, MBQIP supports more than 1,370 small, mainly rural, hospitals certified as CAHs to voluntarily report quality measures that are aligned with those collected by CMS and other federal programs.

11 FQHCs are required to report to the Health Resources and Services Administration (HRSA) on a core set of measures each calendar year as defined by the Uniform Data System (UDS). HRSA uses UDS data to assess the impact and performance of the Health Center Program and to promote data-driven quality improvement. UDS data on health centers include patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues.

12 The MIPS exceptional payment adjustment is a positive payment adjustment for clinicians who demonstrate exceptional performance in MIPS, potentially exceeding

the standard bonus. However, for the 2025 payment year, there is no exceptional-performance adjustment because congressional funding for it expired after the 2024 payment year.

13 Under the SNF–VBP program, Medicare adjusts SNF payments based on quality performance prior to the fiscal year. In FY 2025, only one quality measure, readmission rate, is scored in the SNF–VBP, but the measure set will expand in future years. CAH swing beds are also excluded from the SNF–VBP program.

14 All Medicare-certified HHAs are also required to participate in the HH Value-Based Purchasing (HH-VBP) Program (the first payment year is calendar year 2025 based on 2023 performance). However, to account for HHAs with different volumes, HHAs are grouped into either small-volume or large-volume cohorts, and an HHA's performance is measured within its cohort (Centers for Medicare & Medicaid Services 2023d). Cohort assignment is based on unique HH–CAHPS survey–eligible beneficiaries for each HHA. The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique HH–CAHPS survey–eligible beneficiaries in the calendar year before the performance year. The larger-volume cohort is the group of competing HHAs that had 60 or more unique HH–CAHPS survey–eligible beneficiaries in the calendar year before the performance year. Grouping HHAs in cohorts that are of similar size and more likely to receive scores on the same set of measures is more equitable for purposes of setting quality-performance benchmarks and achievement thresholds and for determining payment adjustments.

15 CMS has set a goal of advancing quality measurement by transitioning quality measures used in its reporting programs to digital quality measures. Digital quality measures are organized as self-contained measure specifications and code packages that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems.

16 In 2023, 15 percent of MA enrollees and 20 percent of FFS enrollees resided in rural areas.

17 The contract is the agreement entered into between an MA organization and CMS. The contract is the administrative unit for various aspects of CMS's administration of the MA program, such as the collection and reporting of quality measures, the determination of network adequacy, and for auditing and compliance. An organization that has an MA contract can offer a single plan or multiple plans under the contract. Currently, MA contracts offer from 1 to 250 plans, with the median contract offering 4 plans.

18 These sampling requirements are specified by the National Committee for Quality Assurance.

19 Additionally, QIOs investigate complaints made by beneficiaries concerning quality of care.

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