

# PREVENTION & CHRONIC CARE IN RURAL HEALTH CLINICS

From Screening to Sustainability:  
Quality Measures that Earn Incentives



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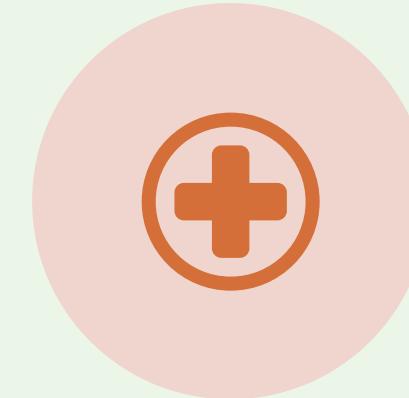
# QUALITY DRIVES RHC SUSTAINABILITY: WHERE THE DOLLARS COME FROM



HITTING PERFORMANCE BENCHMARKS QUALIFIES CLINICS FOR PAYOR INCENTIVES



CHRONIC CONDITIONS =  
HIGH COSTS, HIGH  
UTILIZATION



STRONG QUALITY  
PERFORMANCE STRENGTHENS  
NEGOTIATING POWER AND  
PATIENT RETENTION

# MAJOR PAYOR INCENTIVE PROGRAMS (RHC-RELEVANT)

Program	How It Pays	Common Measures	RHC Tips
Medicaid Managed Care (MCO) Quality Pools / Withholds	Bonus pool or withhold tied to plan quality; clinics share via contracts	Hypertension (HTN) control, HbA1c control, eye exam, CKD screening, immunizations	Ask to be included in pool distribution; align workflows and data to plan specs
Patient Care Medical Home (PCMH) Recognition (NCQA/State)	Not a direct payment—often unlocks/boosts per member per month (PMPMs) and pay for performance (P4P) tiers	Access/continuity, care coordination, chronic bundle (HTN, HbA1c, eye exam, chronic kidney disease (CKD), immunizations)	Confirm PCMH-linked PMPMs and pool inclusion; align registries, same-day access, team huddles; verify stacking with chronic care management (CCM) / principal care management (PCM) and RHC rules
Medicare Advantage (STAR-Aligned Incentives)	Plan receives STAR bonuses; often funds provider incentives to lift scores	Colorectal cancer & breast screening, HbA1c, blood pressure control, statin use, medication adherence	Request clinic-level incentive terms; send monthly dashboards to plan
Commercial Pay-for-Performance (P4P)	Per-measure bonuses or scorecard payouts	HTN control, diabetes bundle, depression screen/follow-up, tobacco counseling	Negotiate clear targets and payout schedule; validate measure definitions
Accountable Care / Value-Based Arrangements	Shared savings (sometimes downside risk) tied to total cost & quality	Avoidable ED/hospital use + core quality set	Start upside-only; focus on HTN, diabetes, CKD to impact total cost of care
Care Management Stipends (CCM/PCM, PMPM)	Monthly per-member payments for enrolled high-risk patients	Care plan documentation, monthly outreach time thresholds	Stand up CCM/PCM for DM/CKD/HTN; track time and enrollment rigorously
State / Regional Quality Programs & Grants	Equipment support or performance bonuses via state initiatives	Tele-retina volume, vaccination rates, screening completion	Leverage for start-up costs (retinal camera, BP cuffs); sustain via incentives



# HTN CONTROL IMPROVES OUTCOMES & UNLOCKS INCENTIVES

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**Measure:** Controlling High Blood Pressure (HEDIS) – % of adults 18–85 with diagnosed hypertension whose blood pressure was adequately controlled (<140/90).

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**Incentive Potential:** Medicaid managed care and commercial payors tie bonus pools to this measure. Higher performance can mean shared savings, per-member-per-month payments, or quality incentive checks.

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**RHC Sustainability Impact:** Reduced ER visits and strokes → lower total cost of care. Positions RHC as a high-value partner for contracts.



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# HbA1C CONTROL + EYE EXAM = BIG INCENTIVE WINS



**Measure 1:** HbA1c Poor Control (>9%) – % of patients 18–75 with diabetes whose most recent HbA1c >9% (lower is better).



**Measure 2:** Eye Exam for Patients with Diabetes (HEDIS) – % of adults 18–75 with diabetes who had a retinal or dilated eye exam.



**Incentive Potential:** Bonus payments for HbA1c control. Some payors fund retinal camera purchases or reimburse tele-retinopathy screening tied to contracts.



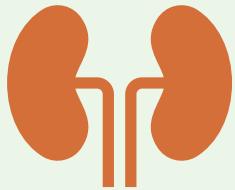
**RHC Sustainability Impact:** Closes quality gaps that unlock payor incentives, support risk-adjusted payments and improve patient retention.



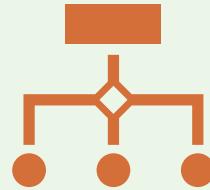
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# CHRONIC KIDNEY DISEASE (CKD) SCREENING & MANAGEMENT



**Measure:** CKD Screening in Patients with Diabetes – % of adults 18–85 with diabetes who received an eGFR and UACR test.



**Incentive Potential:** Medicaid plans add CKD screening to value-based contracts. Some commercial payors provide stipends for high-risk CKD patients.



**RHC Sustainability Impact:**  
Opens eligibility for CCM billing.  
Supports risk adjustment coding  
→ higher per-member payments.

# TOP 10 QUALITY METRICS LINKED TO INCENTIVE PAYMENTS

Metric	Definition	Incentives
Controlling High Blood Pressure (HTN)	Adults 18–85 with hypertension controlled <140/90.	Bonus pools, shared savings, per-member care management
Diabetes: HbA1c Poor Control (>9%)	Adults 18–75 with most recent HbA1c >9% (lower is better).	Direct bonuses, improved risk adjustment scoring
Diabetes: Eye Exam for Retinopathy	Annual retinal or dilated eye exam.	Reimbursement for tele-retinopathy, quality bonus payments
CKD Screening in Patients with Diabetes	Adults 18–85 screened with both eGFR + UACR labs.	Added to Medicaid and commercial value-based contracts
Colorectal Cancer Screening	Adults 45–75 screened with colonoscopy, FIT, or other approved methods.	Strong link to MA STAR ratings, bonus payments
Breast Cancer Screening	Women 50–74 screened with mammogram every 2 years.	Common in commercial contracts, affects STAR ratings
Childhood Immunization Status	Percent of children receiving all recommended vaccines by age 2.	Medicaid quality programs, pediatric bonus dollars
Depression Screening & Follow-Up	All patients 12+ screened annually with follow-up plan if positive.	Pay-for-performance in Medicaid and commercial ACO contracts
Tobacco Use Screening & Cessation Counseling	Patients screened and provided cessation intervention if needed.	Add-on dollars in preventive bundles and wellness incentives
Statin Therapy for Patients with Diabetes or ASCVD	Adults 40–75 with diabetes/ASCVD prescribed statin therapy.	Linked to MA and commercial payor contracts

# QUALITY IMPROVEMENT FRAMEWORK



USE PDSA CYCLES FOR  
RAPID TESTING



INTEGRATE QI INTO DAILY  
WORKFLOWS



ALIGN WITH PLAN  
QUALITY & INCENTIVE  
PROGRAMS (MEDICAID  
MCO, MA, COMMERCIAL)



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# QUALITY IMPROVEMENT- WORKFLOW RESOURCES



## Michigan RHC Quality Network

A network started by dedicated RHCs throughout Michigan with a goal to measure and improve the quality of care in Michigan RHCs.

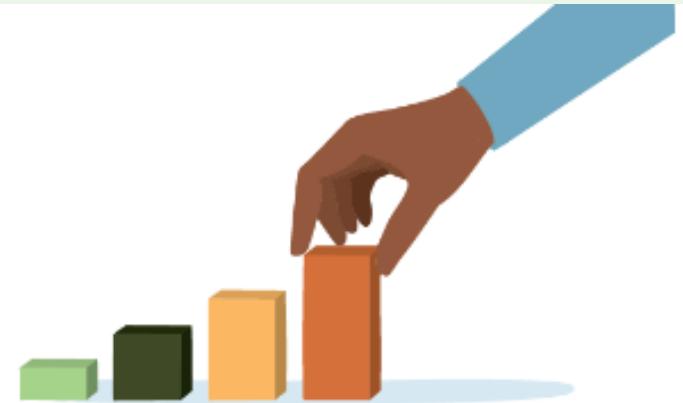
[Learn More](#)

## Quality Improvement Projects

Explore resources and educational materials to help your clinic manage chronic illnesses, such as chronic kidney disease.

[Learn More](#)

<https://mcrh.msu.edu/programs/primary-care>



# KEY TAKEAWAYS



Clinical quality improvement = financial strength



HTN, Diabetes, CKD are high-value focus areas



Align workflows with reimbursement opportunities



RHCs can be both safety net and financially sustainable



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