NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

July 20, 2023

Elizabeth Fowler, Ph.D., J.D.
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Dr. Fowler:

On behalf of the National Association of Rural Health Clinics, we are writing in reaction to the recently announced "Making Care Primary" model which excludes Rural Health Clinics (RHC) from participation. While we disagree with some of the rationale provided by your team in justifying the exclusion, we also acknowledge that the Making Care Primary model and RHC reimbursement structures are not compatible. Ultimately, we believe that our exclusion from the Making Care Primary model only **underscores the need for CMMI to create a value-based care model specifically for RHCs.**

We inquired with your team as to why RHCs were excluded from the model and received the following response:

> Based on findings from stakeholder interviews and research, we found that many Rural Health Clinics (RHCs) currently lack the infrastructure to collect and report certain quality measures necessary to participate in the model. Therefore, holding RHCs (at the individual RHC level) accountable for cost and quality outcomes would not be appropriate. For example, RHCs are exempt from the merit-based incentive payment system (MIPS) and do not engage in regular mandatory quality reporting, unlike Federally Qualified Health Centers (FQHCs), which report quality measures to the Health Resources Services Administration annually. RHCs are also paid on a different basis, using a different system than FQHCs and other facility-based and freestanding primary care practices, and we are not able to operationally accommodate another payment system in this model at this time. CMMI is working to design other opportunities for RHCs to participate in value-based care.

Our experience is that the majority of RHCs do collect and do report quality measures to Medicaid and/or commercial payers. As an example, Texas RHCs participate in the Rural Access to Primary and Preventive Services (RAPPS) Program which features a set of rotating quality measures that are reported to the State. Furthermore, CMS reported that 2,240 RHCs participate in the Medicare Shared Savings Program as of January 1, 2023. We believe that CMMI should reevaluate their research regarding the capability of RHCs to collect and report quality measures.

NARHC agrees with CMMI that the RHC reimbursement structure is unique and fundamentally different from our FQHC and traditional physician office peers. Furthermore, we acknowledge

that accommodating the unique RHC reimbursement into most CMMI models is operationally difficult if not impossible. **As such, we urge CMMI to consider crafting a model specifically for RHCs, and no other facility type.**

We are heartened to read that "CMMI is working to design other opportunities for RHCs to participate in value-based care." However, if the model is primarily designed for fee-for-service providers or FQHCs, and RHC eligibility to participate is simply tacked on, we fear that the uniqueness of RHC reimbursement may limit the utility of, and participation in, the model.

In August of 2022, we responded to the Primary Health Care RFI issued by the Office of the Assistant Secretary for Health and provided similar commentary. As we mentioned then, we believe that a successful quality or value-based model would be:

1-Simple to participate in; and
2-Designed to work with the current RHC payment mechanisms.

1-Simplicity of Participation

Any RHC quality program should be simple to explain and simple to participate in. As HHS is striving to streamline MIPS via the MVP program, similar concepts should be applied to a RHC quality program. Ideally, RHCs would focus their efforts on small subset of easily reported outcomes-based measures. The focus should be on improving patient outcomes, not mastering (and keeping up to date with) reporting rules and strategies.

In this spirit, CMS should create measures for RHCs that can be easily reported through Medicare Part A claims on a UB-04 form (as they did for Medicare Part B claims). While it may be infeasible to report certain outcomes measures through the UB-04 form, NARHC continues to hear from our community that claims-based reporting is superior to registry-based reporting.

2-Cohesion with the RHC payment model

RHCs are paid by Medicare through a single All-Inclusive Rate (AIR) for every RHC encounter throughout the year. This AIR payment is based on the RHC's costs per visit and is subject to certain upper-payment limits (or caps) depending on whether the RHC is grandfathered or not. In the RHC payment model, Medicare reimbursement for face-to-face encounters does not vary from code to code. As we alluded to above, RHCs bill Medicare on a UB-04 form, not a 1500.

We believe that any successful RHC quality program would incentivize improved patient outcomes by augmenting this core payment mechanism, not replacing it. For example, a simple one to two percent adjustment to an RHC's AIR based on their quality performance would provide significant motivation to the RHC community to participate in the value-based program.

We fully understand that identifying outcomes-based quality measures that can be easily reported is easier said than done. Should CMMI like to pursue this concept further, NARHC would be happy to work with stakeholders to further solidify feasible, outcomes-based, quality measures that can be easily reported by RHCs.

Your consideration of these comments is appreciated. Should you have any questions or need any additional information, please do not hesitate to contact Nathan Baugh or Sarah Hohman at (202) 544-1880.

Sincerely,

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