May 29, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Attention: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244-8013

**RE: Request for Information on Medicare Advantage Data**

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 5,500 federally certified Rural Health Clinics (RHC), we are pleased to provide the following brief comments in response to the Centers for Medicare and Medicaid (CMS) *Request for Information on Medicare Advantage Data.*

This RFI response contains feedback on data collection points of interest, NARHC has also compiled the Rural Health Clinic perspective of the larger impacts of Medicare Advantage on the 38.7 million rural Americans who receive their care in RHCs. We hope that this will enhance CMS' understanding of how Medicare Advantage plans often create challenges for RHCs such as contracting and reimbursement challenges and prior authorization and other administrative burdens. These challenges threaten access to care for RHC patients.

**Access to Care Implications**

Supplemental Benefits

> Many beneficiaries elect to enroll in Medicare Advantage because of lower premiums and access to supplemental benefits not typically offered in traditional Medicare, including vision, dental, and hearing coverage. However, there is limited to no publicly available data on how access to these supplemental benefits varies in urban and rural settings, nor on utilization of supplemental benefits by beneficiaries. **NARHC requests increased transparency of this data.**

Provider Directories

> **NARHC requests improved accuracy of provider directories to support RHC patients in understanding what providers are in- and out-of-network for their MA plans.** While NARHC appreciates CMS efforts to reduce inaccurate and sometimes predatory marketing by MA plans, many beneficiaries are still unaware that they have enrolled in an MA plan versus traditional Medicare, and the responsibility falls on the RHC to educate their patients on in/out-of-network providers, the benefits available to patients, etc.

**Contracting and Reimbursement Challenges**
The RHC program incentivizes providers to practice in rural areas through two major benefits: enhanced Medicaid reimbursement and enhanced traditional Medicare reimbursement.

Operating as an RHC provides no benefit relative to Medicare Advantage (MA) reimbursement. This fact stands in contrast to Federally Qualified Health Centers (FQHCs), who receive supplemental payments from Medicare which make up the difference between what traditional Medicare would pay and what the Medicare Advantage plans contract with them for. This policy ensures that FQHCs are not disadvantaged if their patients are increasingly enrolled in Medicare Advantage plans.

As Medicare Advantage enrollment now exceeds traditional Medicare enrollment, RHCs are facing increasing financial strain from MA plans who are spreading rapidly in certain rural markets and refuse to pay RHCs the All-Inclusive Rate (AIR) that traditional Medicare does. In a recent NARHC survey, 48% of RHC respondents indicated that MA reimbursed them slightly (18.4%) or significantly (29.5%) less than traditional Medicare.

Additionally, RHCs must negotiate contracts with each and every Medicare Advantage plan and are reimbursed according to the terms of that contract. Some RHCs are able to negotiate reimbursement comparable to traditional Medicare but many RHCs have little leverage to walk away from the negotiating table in areas where Medicare Advantage plans have significantly increased enrollment. These negotiation challenges also may increase pressures on RHCs to consolidate as oftentimes larger systems have more negotiating power.

These data points are of significant concern to RHCs. Without adequate reimbursement, RHCs will no longer be able to provide essential outpatient services in rural, medically underserved communities across the country.

While we are advocating for a legislative fix to this payment issue, **NARHC requests increased transparency of payment rates from Medicare Advantage plans to safety-net providers, including Rural Health Clinics and Critical Access Hospitals (CAHs).** The only data currently available is survey and anecdotal data. As more eligible Medicare beneficiaries elect to enroll in Medicare Advantage over traditional Medicare, **some** entity must remain responsible for the higher cost of providing care in rural areas, whether this responsibility now falls to the MA plans themselves, or whether CMS will continue to bolster the rural safety-net to ensure its long-term sustainability.

Increasingly, due to the low contracted rates, some providers are choosing to not contract with Medicare Advantage plans. While this is a difficult decision based on its potential impacts to patients, this 2015 CMS document appears to grant certain protections to out of network providers, saying that these non-contracted providers must be paid "at least the original Medicare rate for Medicare covered services." However, the document is outdated and semi-unclear. In the section specific to RHCs, beginning on page 25, it is unclear what types of MA plans "must pay 80% of the allowed charge, plus 20% of the actual charge.." The following section for FQHCs

provides a breakdown of what different plan types are required to pay these safety net providers, however no similar detail is included in the RHC setting.

Furthermore, a 2007 letter from the CMS Center for Beneficiary Choices directs MA organizations operating PFFS plans exclusively through deemed providers to pay providers "not less than the payment rates established under Medicare when they reimburse deemed and noncontracting providers." Again, this document does not specify if the standard is applied broadly or only to specific types of MA products. **NARHC asks for an updated, revised for clarity "MA Payment Guide for Out of Network Payments" document, as well as issue additional guidance on RHC reimbursement protections.**

**Prior Authorization and Administrative Burdens**

Like nearly all providers across the country who contract with Medicare Advantage plans, Rural Health Clinics feel immense administrative burden associated with the stringent prior authorization utilized by MA plans. Again, NARHC is appreciative of the efforts by CMS to lessen these impacts and reduce the waiting time as well as increase transparency on the cause for denials, however particularly for rural patients with transportation challenges, any prior authorization timeline longer than real-time decisions significantly delays and interrupts access to care.

RHCs consistently report the need, but not the financial resources, to hire additional administrative staff to process prior authorizations, as well as track down reasons for denials, including for previously approved care. It is essential that CMS continue to increase the transparency around these barriers and burdens, and hold plans accountable for negative impacts to the health of the patient resulting from their delays and denials.

The expansion of MA plans presents significant impacts to RHCs and the communities they serve. NARHC appreciates CMS' attention to these impacts and would be happy to work with CMS to provide additional insight in order to protect the sustainability of the RHC program throughout this growth. Your consideration of these comments is appreciated. Should you have any questions or need any additional information, please do not hesitate to contact Sarah Hohman or Nathan Baugh at the contact information listed below.

Sincerely,

*Sarah Hohman*

Sarah Hohman
Director of Government Affairs
National Association of Rural Health Clinics
Sarah.Hohman@narhc.org
202-543-0348

*Nathan Baugh*

Nathan Baugh
Executive Director
National Association of Rural Health Clinics
Nathan.Baugh@narhc.org
202-543-0348