Statement for the Record

of the

National Association of Rural Health Clinics
1009 Duke Street
Alexandria, VA 22314

to the

United States House of Representatives
Energy and Commerce Commitee
Subcommittee on Health

Checking-In on CMMI: Assessing the Transition to Value-Based Care

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On behalf of the over 5,500 Rural Health Clinics (RHC) across the nation, the National Association of Rural Health Clinics (NARHC) sincerely appreciates the opportunity to provide a statement for the record following the recent Subcommittee on Health's hearing on CMMI.

The RHC program, first created in 1977, provides outpatient care for over 60% of rural America and 11% of the entire country (approximately 38.7 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America.

NARHC supports the efforts of Congress and CMS to increase health care quality, while reducing cost. Primary, outpatient care is an essential component of this effort. However, the unique mechanisms of RHC reimbursement have made it difficult and/or impossible for RHCs to participate in Medicare quality programs. The majority of current quality initiatives available to providers are designed for traditional fee-for-service (FFS) settings and do not translate well into the RHC space. Therefore, the adoption of quality initiatives in the RHC setting has been thwarted. This can be changed for the better and we are committed to discussing alternatives to this paradoxical issue. Clinicians that bill exclusively through the RHC payment methodology should have an opportunity to participate in quality programs. **We believe that this would be best achieved through the design of a quality payment program designed specifically for RHCs.**

To that end, we believe that for an RHC-specific quality program to be successful, it must 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. Ideally, RHCs would focus their efforts on a 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.

Further, these measures should be easily reported through Medicare Part A claims on a UB-04 form. 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 CMS 1500.

We believe that any successful RHC quality program would incentivize improved patient outcomes by augmenting this core payment mechanism, not replacing it. 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. Populations served by RHCs experience a myriad of additional factors that present challenges to their access to care and health outcomes. A specific model that accounts for these factors and provides further opportunities to improve upon them would be especially valuable.

We look forward to continuing to engage both Congress and CMS in efforts to design an RHC specific value-based care program. We believe that such a quality reporting program could be implemented in a cost neutral way that would improve efficiency and encourage improved value-based care across the entire RHC program.

The National Association of Rural Health Clinics thanks the House Energy and Commerce Subcommittee on Health for organizing this hearing to evaluate the work of CMMI and be more involved in ongoing value-based care discussions. We hope that the above statement helps illuminate the impacts and potential impacts of CMMI and their programs on the 5,500 Rural Health Clinics across the country. Should the Subcommittee have any questions, the NARHC is happy to serve as a resource. Please contact us by phone at (202) 543-0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.