NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

March 21, 2024

To: Medicare Payment Advisory Commission

From: The National Association of Rural Health Clinics (NARHC)

Re: NARHC Comments Regarding the March 7 Public Meeting on Rural Hospital and Clinician Payment Policy

On behalf of the National Association of Rural Health Clinics (NARHC) we are pleased to provide the following comments to the Medicare Payment Advisory Commission (MedPAC) regarding the public meeting held on March 7, 2024 discussing rural hospital and clinician payment policy.

We hope to provide clarifying commentary on a variety of statements made during this meeting.

On Comparing Medicare Upper Payment Limits to Urban PFS Reimbursement

In discussing the Medicare payment reforms for Rural Health Clinics (RHCs), MedPAC staff noted that the:

> …payment rate per visit for independent RHCs is set to increase from $86 in 2020 to $190 in 2028. These rapid increases are likely to maintain or potentially increase access to clinician care in rural areas, and will result in fee-for-service Medicare paying much higher rates for primary care in many rural areas than in urban areas.

First, it should be noted that the dollar figures referenced are **upper payment limits** not rates. Independent, or to be more precise non-grandfathered RHCs, would still need costs per visit at or above the upper payment limits in order to receive that amount from Medicare.

Second, NARHC believes that the assertion that Medicare would be paying much higher rates for primary care in rural areas than in urban areas is misleading as it compares RHC payments to physician fee schedule payments instead of Federally Qualified Health Center (FQHC) payments, the dominant safety net provider in urban settings. Indeed, FQHCs already have a base payment rate of $195.99 in 2024.

MedPAC commissioners may benefit from seeing a comparison of rural safety-net providers to urban safety-net providers. This comparison would show that independent RHCs receive **lower** payments than FQHCs in urban areas.

On the Relationship Between Prices and Cost-Based Reimbursement

In the first round of questions a commissioner indicated that when "Medicare sets a price for a Critical Access Hospital or Rural Health Clinic everyone pays that price, generally."

NARHC disagrees with this general assertion. Medicaid reimbursement in most states is not based on Medicare prices (or reimbursement). Medicare Advantage reimbursement is often lower than traditional Medicare reimbursement. Indeed, early results from an active survey NARHC is conducting show that –

> Relative to Traditional Medicare, RHC Medicare Advantage contracts reimburse:
>
> | | |
> |---|---|
> | Significantly (20% +) More | **4%** |
> | Slightly (5-20%) More | **7%** |
> | Roughly the same (+/- 5%) | **39%** |
> | Slightly (5-20%) Less | **20%** |
> | Significantly (20% +) Less | **28%** |
>
> *Source: Preliminary Results from NARHC 2024 Policy Survey (closing in March 2024)*

While some commercial plans may negotiate payment based on the RHC's All-Inclusive Rate payment rate, most commercial plans pay RHCs a percentage of the physician fee schedule allowable and do not treat Rural Health Clinics different than any other clinician office.

On Rural Health Clinic Payment Reform Increasing Prices

One commissioner stated:

> So the policy on rural health clinics that was passed, that dramatically increased the prices of rural health clinics, was one that was done basically without participation from the National Rural Health Association, many stakeholders, and it's a bad policy. It's a really bad policy. We're fixing these prices for primary care at ridiculous rates, and in my rural health clinic the rate is over $500. You said the average was $226. Well, you know, I'm twice that average in my community. So my coinsurance on that is $100. And so no I have lots of access, right. I can get an appointment any time I want.
>
> So I think that we have to really look at this rural health clinic policy that's been passed, and we need to make comments on it because I think it's very bad for the beneficiaries, and it was done without any sort of transparency with stakeholders, that I am aware of.

NARHC appreciates the opportunity to clarify several pieces of this statement.

First, the word "price" in this context conflates RHC *reimbursement* with RHC *total charges to a patient*.

The policy passed by Congress in 2020 dramatically reformed the RHC <u>reimbursement</u> policy but it did not change the fact that Medicare coinsurance has always been based on RHC total charges to a patient. As MedPAC staff plans to explore further, RHC total charges to a patient have nothing to do with Medicare reimbursement to the RHC.

It is important to note that RHC prices are not fixed. The commissioner noted that the RHC in their community received an All-Inclusive Rate over $500. NARHC believes that the commissioners should be educated on the fact that the payment reforms passed in 2020 are the only reason that this particular clinic's rates are subject to any kind of a limitation at all. Indeed prior to the payment reforms, certain RHCs were fully exempt from upper payment limits. Today, the only reason there is any limitation on the Medicare rates at this commissioner's RHC came from the 2020 payment reforms.

Further, the RHC Medicare reimbursement reforms were critical to the long-term sustainability of the RHC program. Congress has recognized since the RHC program was created in 1977 the importance of incentivizing providers to practice in rural areas and the value of using reimbursement rates to achieve this. However, the disparity between the RHC independent cap and the average uncapped all-inclusive rate was drawing scrutiny amongst policymakers. The final reforms were budget neutral and ensured that no RHC saw a reduction in Medicare reimbursement, "grandfathering" the existing provider-based cost-based reimbursement rates, while creating a level playing field for all RHCs going forward and broadly protecting the safety-net provider type that provides care to over 37 million patients across the country.

Next, regarding the example of coinsurance, unless the charges were also exactly $500, the example is incorrect. As MedPAC intends to study further, coinsurance is based on charges not the RHC's All-Inclusive Rate reimbursement.

NARHC would be happy to fully explain the changes made in this law, which we proudly supported, to the Commission for clarity. Again, we emphasize that beneficiary cost-sharing has always been de-linked from RHC reimbursement, and therefore, if the Commission chooses to address RHC co-insurance policy, can do so without changing the RHC Medicare payment methodology that is a critical element of the safety-net structure. Revisiting the RHC reimbursement changes made in 2020 would not address the concerns about coinsurance.

On Medicare Beneficiary Cost-Sharing Equity

NARHC believes it is important for the commissioners to know that current Medicare policy exempts FQHC services (but not RHC services) from the Medicare deductible. This policy is enumerated in Section 1833(b)(4) of the Social Security Act.

We request that as MedPAC broadly studies payment equity for beneficiaries that they consider aligning RHC deductible policy with that of other safety-net providers and exempt RHC services from the Medicare deductible.

On the Proliferation of Medicare Advantage Plans in Rural Areas

NARHC agrees with the commissioners' commentary about the negative impacts of the proliferation of Medicare Advantage plans in rural areas. Not only are Medicare Advantage plans paying less than traditional Medicare in roughly half of RHCs (2024 Policy Survey), but the administrative burden of prior authorization, claims delays and denials, etc. across many different MA plans is becoming increasingly difficult to manage.

We thank MedPAC for their continued important work and the opportunity to comment on the above issues. Please don't hesitate to contact Sarah Hohman at Sarah.Hohman@narhc.org with any questions or to discuss further.

Sincerely,

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