National Rural Health Association

June 14, 2024

The Honorable Ron Wyden
Chairman
U.S. Senate Committee on Finance
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate Committee on Finance
Washington, D.C. 20150

Dear Chairman Wyden and Ranking Member Crapo,

The National Rural Health Association (NRHA) appreciates the opportunity to provide feedback on the Finance Committee's white paper, *Bolstering Chronic Care through Medicare Physician Payment*. Closing disparities in primary care access and availability for rural beneficaries through payment reform is critical and we look forward to working alongside the Committee to further their work in this space.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

The Government Accountability Office (GAO) projected a shortage of 20,000 rural primary care physicians by next year.[1] The maldistribution of primary care clinicians leads to worsening health disparities between urban and rural beneficiaries given that the supply of primary care physicians is shown to be associated with better population health.[2] NRHA appreciates the Committee's efforts to improve chronic care management through primary care payment and access for rural beneficiaries.

**Rural Participation in QPP**

MACRA made major changes to the way that clinicians are paid by implementing the Quality Payment Program (QPP), which includes two tracks: Advanced Alternative Payment Models (A-APMs) and the Merit-Based Incentive Payment System (MIPS). The QPP move helped shift the Physician Fee Schedule (PFS) away from fee-for-service to pay-for-performance.

Small rural providers have often struggled with implementing pay-for-performance programs due to lack of the resources, infrastructure and technical support needed for successful implementation.[3]

[1] Government Accountability Office, *Physician Workforce:* https://www.gao.gov/assets/gao-17-411.pdf.
[2] The National Academies of Sciences, Engineering and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, May 2021, https://nap.nationalacademies.org/resource/25983/Highlights_High-Quality%20Primary%20Care-4.23.21_final.pdf.
[3] Abiodun Salako, et al., *Changes to the Merit-based Incentive Payment System Pertinent to Small and Rural Practices*, *2018,* RUPRI Center for Rural Health Policy Analysis, University of Iowa (Nov. 2018) https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/MIPS%202018.pdf.



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Rural uptake of A-APMs has been lower than their urban counterparts.[4] In 2018, 11% of rural primary care clinicians and specialists participated in Medicare A-APMs compared to 16.6% of metropolitan clinicians.[5] Rural providers have seen success participating in Accountable Care Organizations (ACOs). As of January 2024, rural participation in the Medicare Shared Savings Program (MSSP) includes over 2,500 RHCs and 513 CAHs.[6]

Higher proportions of rural providers participated in MIPS with 25% participating in MIPS A-APMs with one-sided risk and 49% participating in MIPS only with pay-for-performance risk. In the QPP, rural providers lag behind urban providers in accepting two-sided risk and assume one-sided risk at roughly the same rate.[7] However, in both rural and urban areas, a higher proportion of primary care providers accept two-sided risk compared to specialists.[8]

The flexibility built into the MIPS program is essential to providers—particularly those in small and rural practices—as they transition to a pay-for-performance system. To reduce burden, MIPS participating small and rural providers that meet certain criteria have fewer reporting requirements. Those who do not bill over $90,000 in Part B services or provide care to 200 or less Part B beneficiaries are not required to participate in MIPS. Certain rural providers like Rural Health Clinics (RHCs) are exempt from MIPS reporting due to their All-Inclusive Rate (AIR) payment methodology, but can participate voluntarily. In addition, RHCs, Federally Qualified Health Centers (FQHCs), and critical access hospitals (CAHs) are not able to participate in some A-APMs because of their specific payment models. Exclusion from value-based programs impedes many rural health care organizations' ability to transform by decreasing opportunities for early learning in quality improvement and data reporting.

In the absence of mandates to participate, many rural providers voluntarily transition to value-based care delivery. As the health care delivery system continues to move towards value over volume, it is critical that rural providers are not left behind. A qualitative analysis of four high-performing rural MSSP ACOs identified several common factors that attributed to their success including: prior collaboration experience, clinical leadership, shared governance, care coordination service lines, data access and analysis.[9] [10] In order to transition from volume to value-based care delivery, providers must have the opportunities, tools, and resources to successfully participate. Congress must address the following QPP structural barriers to support rural clinicians in their transition to value.

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[4] Xi Zhu, et al., *Financial Risk Acceptance among Rural Health Care Providers Participating in the Quality Payment Program*, RUPRI Center for Health Policy Analysis, University of Iowa (Mar. 2023), 1, https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Financial%20Risk%20Assumption%20in%20QPP.pdf.
[5] *Id.*
[6] https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf
[7] *Id.* at 4.
[8] *Id.*
[9] Success was defined as performing in the third or fourth quartiles of both financial and quality performance.
[10] Thomas Vaughan, Keith Mueller, & Clinton MacKinney, *High-Functioning Rural Medicare ACOs – A Qualitative Review*, RUPRI Center for Rural Health Policy Analysis, University of Iowa (Feb. 2021), 3-4, https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/High-Perf%20Rural%20ACOs.pdf.

*Resource Limitations:* Assistance for small and rural providers is key to help with the transition to pay-for-performance programs. Rural providers need support to adopt the necessary changes for meaningful participation in MIPS or other A-APM programs.

- *Upfront Capital:* Rural providers are much less able to absorb upfront costs associated with updating their infrastructure and expanding the staff time needed for value-based activities.
- *Staffing:* Generally, rural providers have fewer staff members that can dedicate time to monitoring and pursuing performance improvement strategies like care coordination and chronic disease management. Relatedly, they are less likely to have staff members with the requisite expertise in quality improvement, population health management, and systems change.

*Patient Volumes:* Beyond the capacity of rural providers, low patient volumes pose a barrier. A move away from volume-dependent payment policies in the FFS space could be beneficial for rural providers that have to spread high unit costs across a lower volume of patients. However, programs within the QPP frequently exclude providers with low volumes. While certain rural providers may not currently be ready to participate in MIPS, or future involuntary programs, there is concern about exclusions leave out providers and rural beneficiaries from a system that rewards better care delivery and health outcomes. QPP programs need to be adaptable to allow rural delivery systems to be successful in the evolving payment landscape.

*Qualifying Thresholds:* In A-APMs, clinicians must meet certain thresholds to become qualifying A-APM participants and earn the incentive payments. Currently participants must meet a 50% Medicare Part B payment threshold and see 35% Medicare patients to receive incentive payments. Additionally, within an A-APM entity, 75% of practices must utilize certified electronic health record (EHR) technology. These thresholds may create barriers to participation as many rural participants do not meet the percentages.

The decision to exclude small practices from MIPS was made to avoid undue quality reporting burden. However, raising the low-volume thresholds in 2018 has further limited the number of rural primary care clinicians required to participate. Qualifying percentages should not be increased in order to ensure continued participation and encourage new participants to join. NRHA suggests that Congress grant authority to the Secretary of Health and Human Services to set qualifying participant thresholds, especially for small, rural safety net providers.

*Rural-relevant measures:* When rural providers participate in value-based care, the performance measures used in the program may not be rural relevant and therefore do not reward value in the rural setting.

The Small, Underserved, and Rural Support (SURS) program created by MACRA expired in February 2022 despite the need for the program to continue.[11] Congress should act to reauthorize the SURS program. Assistance and resources, like those provided in SURS, should be prioritized to ensure that rural providers take advantage of opportunities to participate in value-based care.

[11] H.R. 5935, the *SURS Extension Act*, introduced in the 118th Congress would extend this program to reauthorize funds for CMS to contract with quality improvement organizations that provide technical assistance in MIPS and A-APMs for practices with 15 or fewer providers.

**Changes to current Physician Fee Schedule.**

NRHA supports the following changes to the Medicare PFS. These policies will improve the PFS for all clinicians and beneficiaries, particularly those serving rural areas.

*Conversion factor and budget neutrality*

In the Consolidated Appropriations Act, 2024 Congress partially fixed the drastic payment cut finalized in the calendar year 2024 PFS final rule. The cut was reduced to -1.69% for the remainder of the calendar year. However, this did not address the 2025 payment rate and therefore clinicians will face the same payment cut absent congressional action. **NRHA urges Congress to consider a longer-term fix to the PFS in a manner that provides greater certainty for rural clinicians moving forward.**

The PFS is constrained by the budget neutrality mandate. Any increase of over $20 million must be offset by cuts elsewhere in the PFS. The $20 million threshold has not been updated for inflation since its inception. In contrast, payment systems for hospitals, skilled nursing facilities, and others account for inflation in their annual payment updates. Further, when CMS overestimates utilization it is not invested back into the PFS, which effectively can result in a payment cut. **Congress must update the budget neutrality threshold to at least $53 million and allow for regular updates that more accurately reflect practice cost inflation.**

*Payment incentives*

Congress should address the bonus payments for qualifying A-APM participants (QPs). Currently, QPs can receive a 3.5% incentive payment through performance year 2023/payment year 2025 and after this period the bonus payments are slated to expire. Previously, QPs received a 5% incentive payment. The 5% payment incentive should be restored following the expiration of the 3.5% payment as these incentives aid clinicians when they move from fee-for-service into an A-APM with upfront costs, investments in staff, technology, and data analysis.

*Hybrid payment*

A larger overhaul of the PFS is necessary to adequately support rural patients and providers and incentivize primary care. With the correct supports for rural providers, NRHA supports transitioning from the current FFS model to a population-based prospective payment hybrid payment model. This model would provide payment to practices each month to deliver primary care coupled with FFS payment for other services. A hybrid model must include upfront and ongoing investments to participants and guardrails to protect quality and access in rural communities.

A hybrid model should invest in primary capacity and pay for services that are tailored to the needs of the patients and community. This would help to move away from the incentives to maximize billing that exist in the FFS environment. Additionally, a hybrid model should focus on the following:

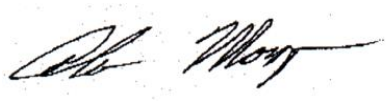
- Incorporating payment that would support behavioral health screening and referrals and screening for social determinants of health (SDOH). NRHA members have noted that they do

not screen for SDOH because it is not reimbursable. Another barrier to screenings is the lack of resources or organizations that providers can make referrals to in rural communities. While payment would not fix this issue, it would help to facilitate uptake of screenings in rural settings.

- Tiering the value of payment based on the scope of services provided and making higher tier payments available for clinicians that address beneficiaries' SDOH or integrate behavioral health into primary care. For example, community health integration services would be paid at a higher tier.
- Payment that reflects beneficiaries' social and clinical risk. Rural beneficiaries tend to be older, sicker, and poorer than their urban counterparts.[12] Therefore providing care to rural beneficiaries is generally expensive.
- Allowing for cost-sharing waivers for primary care services reimbursed through the hybrid payment system. This would increase affordability and access for rural beneficiaries.

We appreciate Congress' willingness to reexamine the effectiveness of the PFS and support future rural friendly changes to the clinician payment. We look forward to working with members of Congress on this issue. If you have any questions, please contact Alexa McKinley, NRHA's Government Affairs and Policy Director (amckinley@ruralhealth.us).

Sincerely,



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[12] Randy Randolph, et al., *Rural Population Health in the United States: A Chartbook*, North Carolina Rural Health Research Program, University of North Carolina at Chapel Hill, 1 (2023), https://www.shepscenter.unc.edu/product/rural-population-health-in-the-united-states-a-chartbook/.