National Rural Health Association

Dr. Elizabeth Fowler
Director, Innovation Center
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Administrator Brooks-LaSure and Deputy Administrator Fowler,

The National Rural Health Association (NRHA) is writing to express our serious concerns over rural provider participation in the recently announced Making Care Primary (MCP) model from the Innovation Center (CMMI). NRHA has long advocated for including rural health clinics (RHCs) in value-based care arrangements and we are disappointed to see their continued exclusion from primary care models.

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.

NRHA strongly opposes CMMI's decision to exclude RHCs from participating in MCP. Time and again rural providers are excluded, explicitly or implicitly, from participating in demonstration models that shift care delivery and payment towards value-based care. RHCs were not allowed to participate in the Comprehensive Primary Care Plus (CPC+) model and NRHA expected that RHCs would be included in the next iteration. NRHA celebrates the successes of other small rural providers in CPC+ and we believed that RHCs inclusion in future models would be the next logical step to expand value-based care to rural providers. **We are deeply disappointed in CMMI's choice to once again omit RHCs from population health efforts.**

Further, NRHA disagrees with CMMI's explanation as to RHC exclusion. In a communication between CMMI and NRHA, CMMI explained that "many 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." While that statement may be true for some RHCs, early adopters would very much like to participate in this type of demonstration. To date there have been numerous RHC quality reporting initiatives attempting to further RHC participation in population health efforts.[1] Exclusion from MCP is a missed opportunity for them.

Importantly, MCP is a voluntary model. RHCs that do not have the ability to "collect and report certain quality measures" would simply not participate. On the contrary, many provider-based RHCs likely have the capacity and interest in the opportunity to engage in value-based payment efforts, and would greatly benefit from the payment structure, increased resources, and ability to address patients' health-related social needs. As you know, Federally Qualified Health Center (FQHCs) have benefited from millions of dollars and years of technical assistance around quality

[1] Initiatives include but aren't limited to: Maine Rural Health Research Center pilot test of RHC quality measures; Practice Operations National Database (POND) program; Quality Health Improvement (QHi); and Michigan's Rural health Clinic Quality Networks.

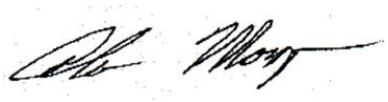
reporting while RHCs have had no such support. This had led many RHCs to take it on themselves to move towards reporting. Yet CMMI decided to shut out all RHCs from MCP on the basis that some may not be able to comply with the requirements of a voluntary program.

CMMI also noted that RHCs' special payment structure is "operationally" incompatible with the MCP model. NRHA acknowledges that the RHC all-inclusive payment methodology would require CMS to develop a mechanism to handle RHCs reimbursement, however the Agency was able accommodate FQHC alternative payment methodologies when creating the model. **NRHA is frustrated by the lack of consideration for rural providers** and believes that CMMI could have found a way to fit RHCs into the model if rural health care was truly a priority for the Administration. **NRHA is hopeful that CMMI will include rural stakeholders in its development of future RHC-specific value-based care models.** We would be happy to be a partner and voice for rural providers at CMMI in future endeavors.

RHCs are a bedrock of the rural health safety net. Over 5,300 RHCs across 45 states provide vital access to primary care services to rural residents. RHCs serve 37.7 million patients per year which is more than 11% of the entire population and over 60% of the 60.8 million Americans that live in rural areas.[2] **To meet the Administration's goals of 100% participation in value-based care by 2030, CMMI and CMS must make their models and demonstrations rural-friendly** and cannot continue to exclude critical rural safety-net providers and their patient populations.

We thank CMS and CMMI for their continued commitment to furthering value-based care. NRHA hopes that moving forward the agency will consider the importance of including rural providers and their beneficiary population. If you have any questions, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley, at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[2] National Association of Rural Health Clinics, 60% of Rural Americans Served by Rural Health Clinics (Apr. 7, 2023), https://www.narhc.org/News/29910/Sixty-Percent-of-Rural-Americans-Served-by-Rural-Health-Clinics.