National Rural Health Association

October 31, 2022

Submitted electronically via email.

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks,

The National Rural Health Association (NRHA) thanks you for the opportunity to provide comments on the current state of the Medicare and CHIP Reauthorization Act (MACRA) and related payment mechanisms. NRHA stresses the importance of the rural perspective in this program and in any resulting legislation aimed at improving MACRA.

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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

In general, NRHA asks that Congress be inclusive of rural providers in any future legislation meant to improve MACRA's effectiveness. Despite being reimbursed under alternative payment methodologies, rural providers should not be left out of the conversation on MACRA reforms. Providing exemptions from MIPS participation or reporting may not be the best means of addressing rural practice challenges. Exemptions from MIPS may exclude rural Medicare beneficiaries and providers from a payment system designed to reward providers for maximizing health care value, potentially having negative unintended consequences to rural beneficiaries in the long term.

To date, rural providers including small physician practices, Rural Health Clinics (RHCs), and rural Federally Qualified Health Centers (FQHCs) have not been involved in MACRA in a significant way. For RHCs and FQHCs specifically, it is difficult for them to participate in MACRA due to structural challenges. Small rural providers face difficulties participating in value-based payment initiatives due to alternative payment methodologies, low patient volumes, quality reporting alignment, and resource limitations. Congress should account for rural relevant factors like small sizes and low patient volumes, metrics, and the types of services provided if rural participation is to grow.

Low-Volumes: Ultimately, a move away from volume-dependent payment policies is needed to encourage rural participation. The low volume thresholds deter rural participation in a value-based payment system. Small, rural providers are excluded from involuntary participation due to the low-volume thresholds. Further, RHCs and FQHCs submit a relatively low number of Physician Fee Schedule claims billed outside of their respective reimbursement systems, creating little incentive to participate for those services.

Relatedly, clinicians must meet certain thresholds to become qualifying 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 APM entity, 75% of practices must utilize certified electronic health record (EHR) technology. These thresholds are a barrier as many rural participants do not meet the percentages. The percentages should not be increased in order to ensure continued participation and encourage new participants to join.

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Additionally, 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.

Quality Measures: Rural providers face a heightened administrative burden because their quality reporting requirements do not align with the MIPS program. While HRSA is working towards alignment of the UDS and CMS eCQM system, reporting to both for FQHCs is overly burdensome, especially when done in a voluntary, non-incentivized manner. While some early efforts have been made to pilot quality reporting in RHC settings, currently most have little to no incentive to participate this MACRA programs. Furthermore, adequate rural representation during planned consultations with stakeholders on MACRA measures could go a long way in ensuring that the measures developed are sensitive to the unique context of rural practice.

Technical Assistance: Small rural providers have often struggled with implementing pay-for-performance programs due to lack of the technical infrastructure and support needed for successful implementation.[1] 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. Any MACRA reforms should be inclusive of the way care is provided in rural areas and provide additional resources for safety net providers. Rather than providing exemptions, rural providers could be provided with incentives and support to adopt the tools necessary for meaningful participation in MACRA programs.

Rural Beneficiary Demographics: MACRA reform should also incorporate more opportunities to address health equity and social determinants of health (SDOH) affecting rural patients. Generally rural populations are older, sicker, and poorer than their urban counterparts and are uniquely impacted by SDOHs because of geography. For example, rural residents face more challenges related to access to health care and transportation. MACRA reforms should take into account the SDOH that affect underserved groups that make up the patient populations of qualifying alternative payment model (APM) participants.

Payment Incentives: NRHA believes that Congress should address other specific reforms to the existing MACRA framework. First, the 5% APM incentive payments for qualifying APM participants are slated to expire at the end of performance year 2022 and should be extended for at least two years. Incentive payments aid clinicians when they move from fee-for-service into an APM with upfront costs, investments in staff, technology, and data analysis. In the face of the COVID-19 pandemic, increasing health care costs, and workforce challenges, clinicians need incentive payments to remain in APMs.

The conversion factor update for physician payment is currently frozen at 0% through 2025. Given the current inflationary environment, and projections that health care costs will skyrocket within the next year, Congress should build in an inflation update in the conversion factor update. Health care inflation is hurting rural providers, especially small practices, and clinicians should be paid to match inflation.

Ultimately, primary care clinician participation in MACRA is important because primary care clinicians are fundamental to many health reform models, including establishing patient-centered

[1] 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 (Nov. 2018) https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/MIPS%202018.pdf.

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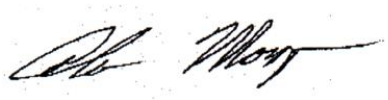
medical homes and attributing enrollees to accountable care organizations. Furthermore, primary care clinicians are a critical source of health care provision for rural Americans. To realize MACRA goals, CMS could consider updates that specifically advance primary care clinician participation. Furthermore, CMS could develop MACRA related models and programs that specifically include non-metropolitan primary care clinicians.

We appreciate Congress' willingness to reexamine the effectiveness of MACRA and support future rural friendly changes to the program. 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 Coordinator (amckinley@ruralhealth.us).

Sincerely,



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