January 30, 2025

To: Medicare Payment Advisory Commission

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

Re: NARHC Comments Regarding the January 17 Public Meeting on Reducing Beneficiary Cost-Sharing for Outpatient Services at Critical Access Hospitals

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 January 17, 2025 discussing rural hospital and clinician payment policy. We appreciate the Commission's intent to ensure beneficiaries receiving care from rural, safety-net providers are treated equitably, but hope to provide an RHC specific perspective and clarifying commentary on a variety of statements made during this meeting.

It is important for the Commission, both Commissioners and staff to have a proper use of terminology to avoid confusion. Specifically, the term "rural health center" is incorrect and has been interpreted in the past by the government to refer to rural Federally Qualified Health Centers not CMS-certified Rural Health Clinics. We understand that the staff presentation and previous reports use the proper term, but we emphasize that someone should briefly correct the record during the oral discussion if the term "rural health center" begins to be used.

Conflating and confusing Rural Health Clinics with FQHCs or rural "health centers" is one of the reasons policymakers continue to underinvest in rural outpatient safety-net providers. Unlike FQHCs, RHCs are not eligible for any of the $5.6 billion in Section 330 grant funding, do not receive a Medicare Advantage wrap payment, and RHC patients do not have their Medicare deductibles waived as FQHC patients do.

We believe it is imperative for the Commissioners to understand the distinctions and disparities between the RHC and FQHC programs as they consider recommendations to the RHC coinsurance policy. In discussing a vote to change Critical Access Hospital coinsurance policy, Commissioners and staff were careful to consider the financial impacts to CAHs, which we agree will be neutral if not slightly positive. We ask that this same consideration be given to RHCs in discussing a change to RHC coinsurance policy which as the staff and discussion indicated would have negative impacts on some RHC financials.

Specifically, in the spirit of ensuring rural and urban Medicare beneficiaries have equitable cost-sharing obligations, we ask that MedPAC simultaneously consider a policy recommendation that waives the Part B deductible for RHC services as FQHC policy already does.

We also note that the RHC payment policy changes made in late 2020 appear to be misunderstood by some Commissioners. We hope that this can be rectified because an understanding of RHC payment policy is fundamental to understanding the RHC coinsurance data presented by staff.

In particular, the data presented at this meeting estimates beneficiary coinsurance as a share of estimated All-Inclusive Rates (AIRs) per visit. However, given the widely variant AIRs across RHC types (specified vs. nonspecified) this is a misleading representation of charges across RHC provider types. Commissioners may be interested to see an apples-to-apples comparison of charges for the most common CPT codes across RHC provider types expressed not as a percentage of an RHC's AIR reimbursement but rather as average charge amounts by RHC type.

The way the data was presented makes it appear that nonspecified and independent RHCs charge significantly more for services than specified RHCs. However, this may not necessarily be the case or may be significantly less exaggerated when directly comparing charges for the most common CPT codes across RHC categories.

On one hand, there was some acknowledgement that the reimbursement for independent RHCs in 2020 was incredibly low. A commissioner acknowledged that when it came to independent RHCs, "we were underpaying them so egregiously where they were having to charge the beneficiaries more." As an example, in 2020, the national Medicare allowable for a 99214 CPT code was $110.43 whereas the independent RHC cap was $86.31. As such an independent RHC basing their charges on the Medicare allowable would have charges greater than their reimbursement and thus coinsurance greater than 20% of their total payment, not because they were charging the patient unreasonable prices but only because their reimbursement from Medicare was so low.

The payment changes that were signed into law at the end of 2020 allowed the independent RHC payment policy to once again be a benefit relative to traditional offices reimbursed through the physician fee schedule. By incrementally adjusting the cap of $86 in 2020, to $190 by 2028, independent RHCs are now able to survive, and continue to provide care to rural, medically underserved communities across the country.

It is important to note that the FQHC base payment in 2025 is $202.65.

Furthermore, the 2020 changes protected "specified" RHCs by grandfathering those RHCs in at their 2020 reimbursement rates. This change subjected these RHCs to a cap for the first time ever protecting the integrity of the RHC cost-based reimbursement while ensuring no RHC saw payment cuts.

None of these payment changes impacted beneficiary cost-sharing in RHCs.

Therefore, we strongly disagree with a Commissioner's comments that "there was a major change on how they paid rural health clinics, and this is mentioned in the report, but it has increased the cost to the beneficiaries dramatically." This is incorrect.

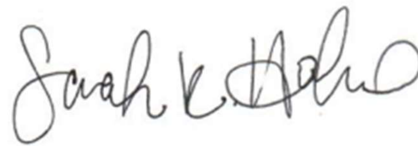
Rather, RHC charges and the corresponding cost-sharing obligations have always been completely disassociated from the RHC's all-inclusive rate as MedPAC staff pointed out in their presentation.

In fact, the payment changes made in 2020 capped, for the first time ever, specified RHCs with higher than average reimbursement rates. Prior to the payment changes those RHCs had no limits. By asking previously uncapped RHCs to grow no faster than MEI, Congress protected the integrity of the RHC program and created savings for Medicare. While this meant less revenue growth for many RHCs, it helped fund an 8-year increase to the limits for independent RHCs that were suffering under completely uncompetitive caps in 2020.

As MedPAC considers a recommendation to change RHC coinsurance policy, it is important for the Commission to have a full understanding of RHC payment policy, and how it compares to traditional FFS and FQHC policy. Furthermore, we believe that if MedPAC moves forward with a recommendation on RHC coinsurance, it should also recommend waiving the Part B deductible for RHC services because that is critically important in establishing cost-sharing equity between urban and rural Medicare beneficiaries receiving care from safety-net providers.

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

Sincerely,



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