

Preliminary Comments Development Team (PCDT) Presentation:

**Encouraging Rural Participation in
Population-Based Total Cost of Care (PB-TCOC) Models**

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Objectives of This Theme-Based Meeting

- Examine challenges facing patients and health care providers in rural communities
- Identify care delivery models that are effective in addressing patient needs, improving outcomes, and encouraging value-based transformation in rural areas
- Explore options for encouraging participation of rural providers in population-based total cost of care (PB-TCOC) models and other alternative payment models (APMs)
- Identify financial incentives and mechanisms to increase participation of rural providers in APMs

Note: PTAC is using the following working definition for PB-TCOC models: A PB-TCOC model is an APM in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).

Background for this Theme-Based Meeting

- Rural providers face unique challenges and have been less likely to participate in Accountable Care Organizations (ACOs) and other population-based models.
- The Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) have developed several models and programs designed to encourage value-based transformation in rural areas.
- PTAC has deliberated on the extent to which 28 proposed physician-focused payment models (PFPMs) met the Secretary's 10 regulatory criteria. Eleven of these proposals either included or targeted rural populations.*
- *The goal for this meeting is to better understand these challenges and lessons learned from models and programs that have sought to address them.*

* Please see Appendix C for additional information.

Overview

- Definitions of Rural Care
- Challenges Affecting Rural Patients and Providers
- Challenges Affecting Rural Participation in Alternative Payment Models
- Innovative Approaches For Supporting Rural Value-Based Care Transformation
- Lessons Learned About Rural Participation in Alternative Payment Models

Preliminary Working Definition of Rural Area

- Variety of definitions for determining what constitutes a **rural area**
 - Definitions are used for various purposes such as grants, public policy, and research.
 - Criteria include geography, population size, population density, proximity to metropolitan areas, and geographic remoteness.
- PTAC is using the following working definition:
 - The Office of Management and Budget (OMB) identifies metropolitan areas as counties with 50,000 or more people, and rural areas as counties with **fewer than 50,000 people**.
 - The U.S. Department of Agriculture's (USDA's) nine Rural-Urban Continuum Codes (RUCCs) can be used to further identify differences in rural counties based on population size and proximity to metropolitan areas.

Preliminary Working Definition of Rural Providers

- PTAC is using the following working definition of rural providers:
 - Rural providers are providers, including independent practitioners and other types of providers, that are physically located in rural areas.
- PTAC is aware that some rural areas also have access to providers that are located in urban or suburban communities.

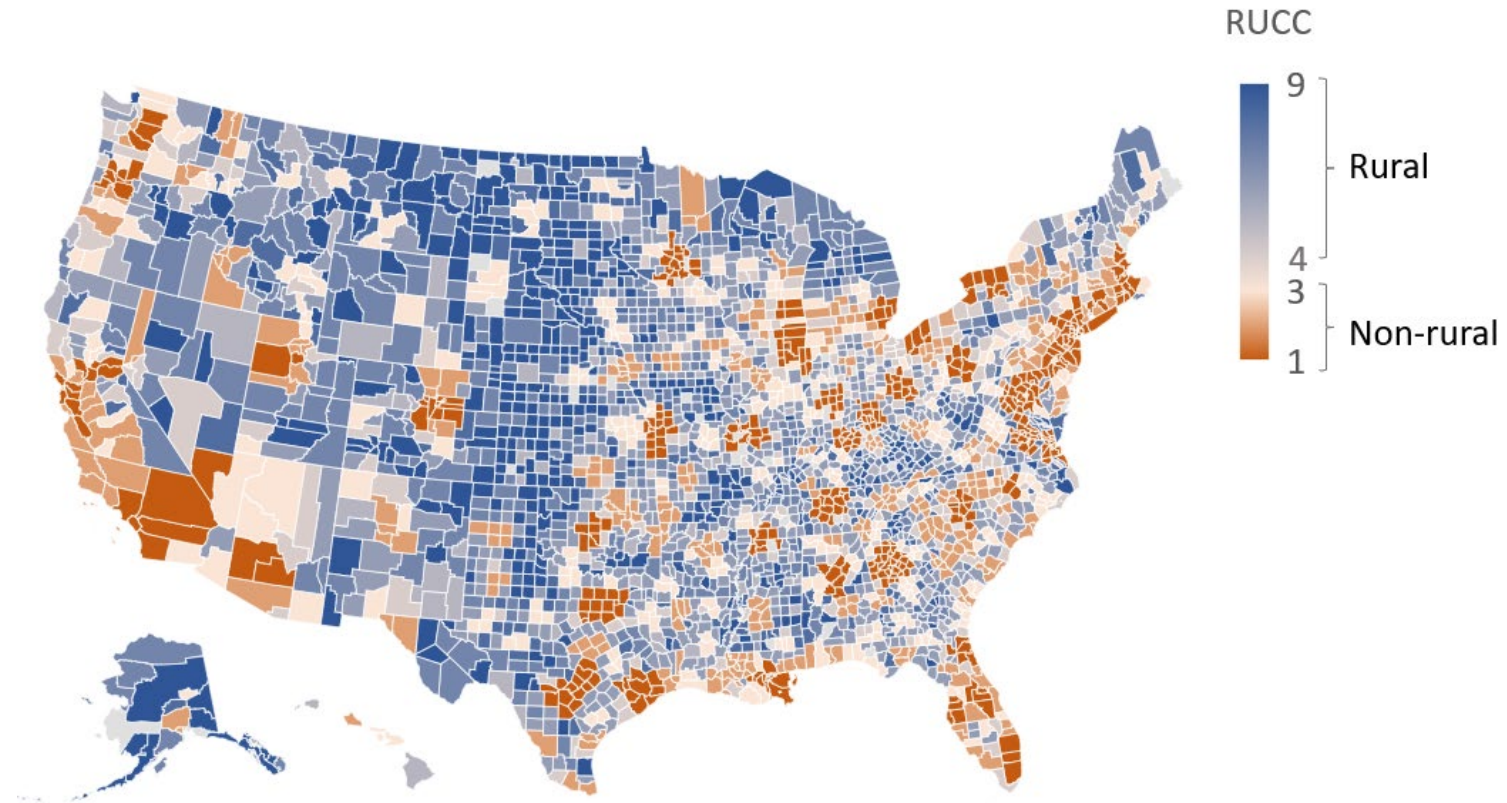
Geographic Distribution of Rural Areas by RUCC Code

Fifteen percent of the U.S. population (46.3 million) lives in rural areas.

63 percent of U.S. counties are designated as rural areas.

Some counties include both rural and non-rural areas.*

U.S. Counties By 2013 Rural-Urban Continuum Codes



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* See Appendix A for additional information.

Reference: The USDA's RUCC files are publicly available from: <https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/>.

Rural Areas Vary Based on Population Size and Proximity to Metropolitan Areas

Half of all rural counties have 2,500 to 19,999 residents, and a third have less than 2,500 residents
 Half of all rural counties (48 percent) are not adjacent to metropolitan areas

RUCC Code Description	Counties	Population
Urban (non-metro) population of 20,000 or more		
RUCC 4: Adjacent to a metro area	10.8%	29.8%
RUCC 5: Not adjacent to a metro area	4.7%	11.0%
Subtotal	15.5%	40.9%
Urban (non-metro) population of 2,500 to 19,999		
RUCC 6: Adjacent to a metro area	30.0%	31.6%
RUCC 7: Not adjacent to a metro area	21.9%	17.6%
Subtotal	51.9%	49.2%
Completely rural (non-metro) population less than 2,500		
RUCC 8: Adjacent to a metro area	11.1%	4.6%
RUCC 9: Not adjacent to a metro area	21.4%	5.4%
Subtotal	32.6%	10.0%
Total (all rural areas)	1,974	46,051,072

Regional Differences Among Rural Areas – Population Size & Adjacency to Metropolitan Areas

Nearly half of all rural counties in the West North Central region have less than 2,500 residents, and nearly two-thirds of all rural counties in the West North Central region are not adjacent to a metropolitan area.

Geographic Region	Urban (non-metro) population of 20,000 or more (RUCC 4 and 5)	Urban (non-metro) population of 2,500 to 19,999 (RUCC 6 and 7)	Completely rural or less than 2,500 urban (non-metro) population (RUCC 8 and 9)	Not Adjacent to a Metropolitan Area (RUCC 5, 7 and 9)
New England (CT, ME, MA, NH, RI, VT)	27%	58%	15%	42%
Middle Atlantic (NJ, NY, PA)	41%	50%	9%	20%
East North Central (IN, IL, MI, OH, WI)	23%	60%	17%	34%
West North Central (IA, KS, MN, MO, NE, ND, SD)	9%	41%	49%	64%
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	17%	57%	27%	26%
East South Central (AL, KY, MS, TN)	13%	52%	35%	46%
West South Central (AR, LA, OK, TX)	11%	62%	26%	46%
Mountain (AZ, CO, ID, NM, MT, UT, NV, WY)	15%	49%	36%	68%
Pacific (AK, CA, HI, OR, WA)	26%	40%	34%	56%

Diversity Among Rural Providers

- Rural providers differ in the services that they offer, and in statutory requirements.
 - Some rural providers have special payment rates and methodologies created by statute.
- Rural providers may have different resources depending on their relationship with a nearby hospital or integrated delivery system.

Types of Providers Serving Rural Areas	
Critical Access Hospitals (CAHs)	Sole Community Hospitals
Federally Qualified Health Centers (FQHCs)	Behavioral health offices or clinics
Rural Health Clinics (RHCs)	Independent Practice – Not Hospital Affiliated
Rural Emergency Hospitals (REHs)	Independent Practice – Hospital-Subsidized
Freestanding Emergency Departments (FSEDs)	Hospital-Owned Practice
Medicare-Dependent Hospitals	Integrated delivery networks serving rural areas

Differences between Rural and Urban Areas

- Compared to non-rural counties, rural counties had:
 - **Lower Income** - On average, per capita income in rural areas is \$9,242 lower than the average per capita income in the U.S., and Americans living in rural areas are more likely to live below the poverty level.
 - **Higher Uninsured Population:** Rural areas had larger proportions of adults under the age of 65 years without insurance (12.7 percent vs. 10.6 percent, respectively).
 - **Older population** – 17.5 percent of the rural population is 65+ compared to 13.8 percent in urban areas.
 - **Decreasing life expectancy** – Life expectancy for rural county residents declined between 2010 and 2019 (by 0.2 years for women and 0.3 years for men) compared to modest increases for urban counties (0.55 years for women and 0.29 years for men).

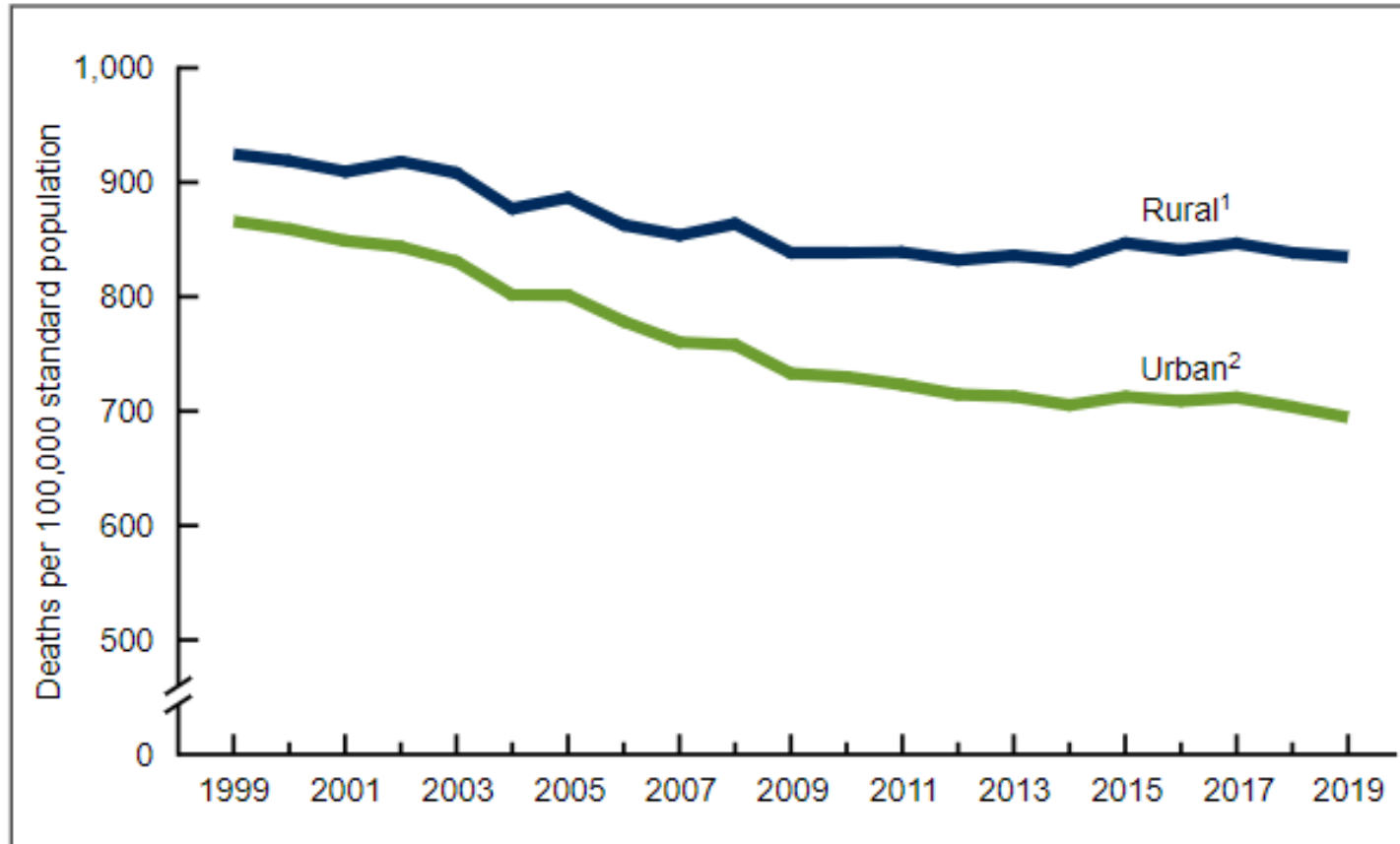
Differences between Rural and Urban Areas, Continued

- Compared to non-rural counties, rural counties had:
 - **Fewer Primary Care Providers:** Rural areas had fewer primary care providers (PCPs) per 100,000 people (37.9 vs. 52.9, respectively).*
 - **Fewer Specialists:** Rural areas had 46.5 specialists per 100,000 people, while urban areas had 146.4 specialists per 100,000 people.*
 - **Reduced Broadband Access** - Less than 70 percent of rural households have access to high-speed internet compared to 85 percent of households in large metropolitan areas.
 - **Lower Medicare Advantage (MA) Enrollment** – Fewer rural beneficiaries are enrolled in MA (40 percent vs. 44 percent in micropolitan areas and 53 percent in metropolitan areas), but the share of eligible rural beneficiaries enrolled in MA plans has nearly quadrupled since 2010.

References: Pollard, K., and Martinez, M. Digital Divide in High-Speed Internet Access Leaves Rural Areas Behind. Population Reference Bureau. <https://www.prb.org/articles/digital-divide-in-high-speed-internet-access-leaves-rural-areas-behind/>; The USDA's RUCC files are publicly available from: <https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/>; HRSA publicly available data file: <https://data.hrsa.gov/topics/health-workforce/ahrf>; Report: MA Enrollment Has Quadrupled in Rural Communities Since 2010. MedCity News. <https://medcitynews.com/2023/09/medicare-advantage-rural-enrollment-metropolitan-micropolitan/>.

* Source: NORC analysis of 2021-2022 AHRF and 2013 RUCCs. See Appendix A, Slide 39 for more information.

Age-Adjusted Death Rates by Urban-Rural Classification: United States, 1999–2019



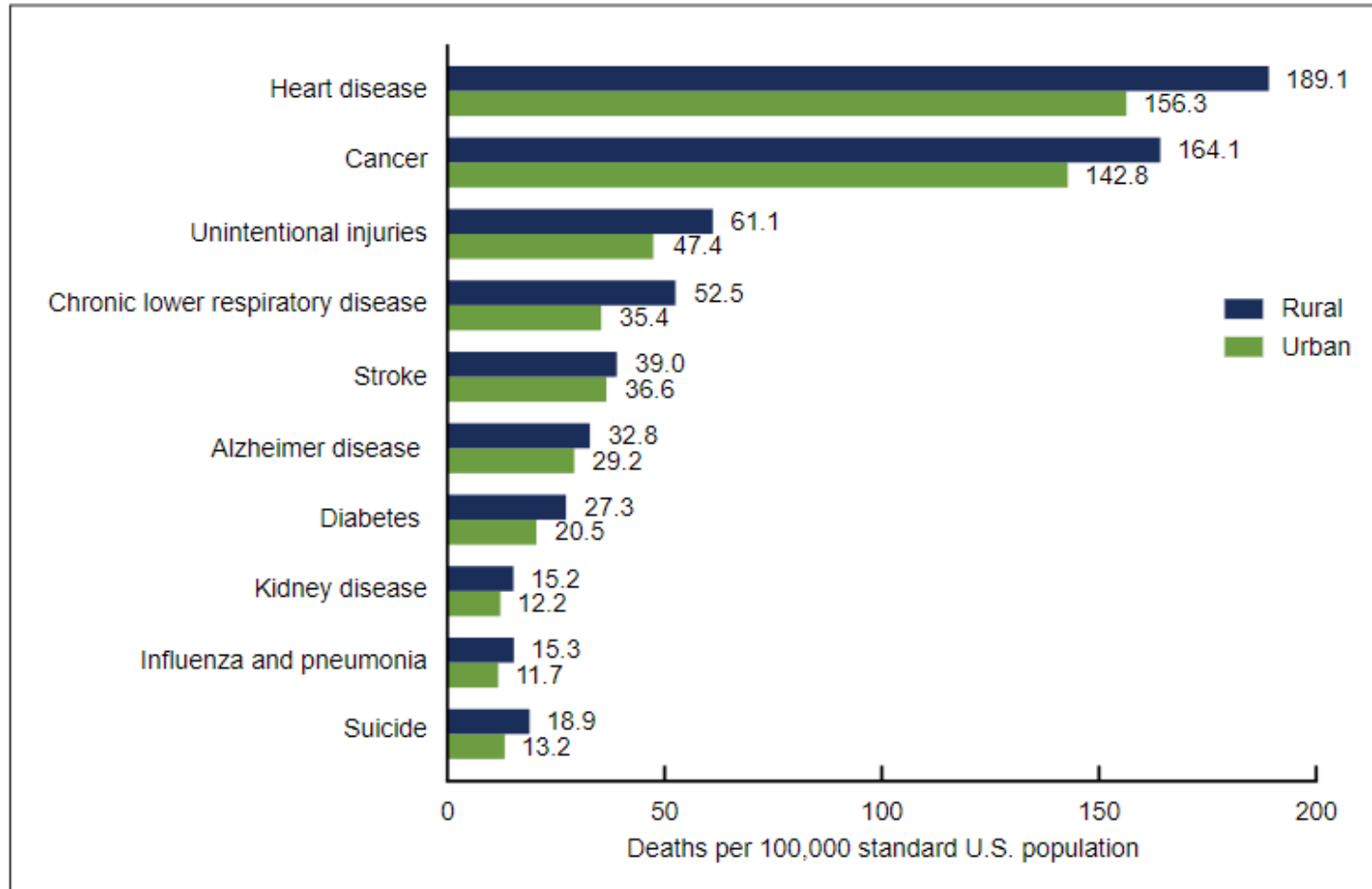
¹Significant decreasing trend from 1999 through 2010; stable trend from 2010 through 2019 ($p < 0.05$).

²Significant decreasing trend from 1999 through 2019, with different rates of change over time ($p < 0.05$).

NOTES: Urbanicity of county of residence is based on the 2013 NCHS Urban-Rural Classification Scheme for Counties; see Data source and methods. Access data table for Figure 1 at: <https://www.cdc.gov/nchs/data/databriefs/db417-tables.pdf#1>.

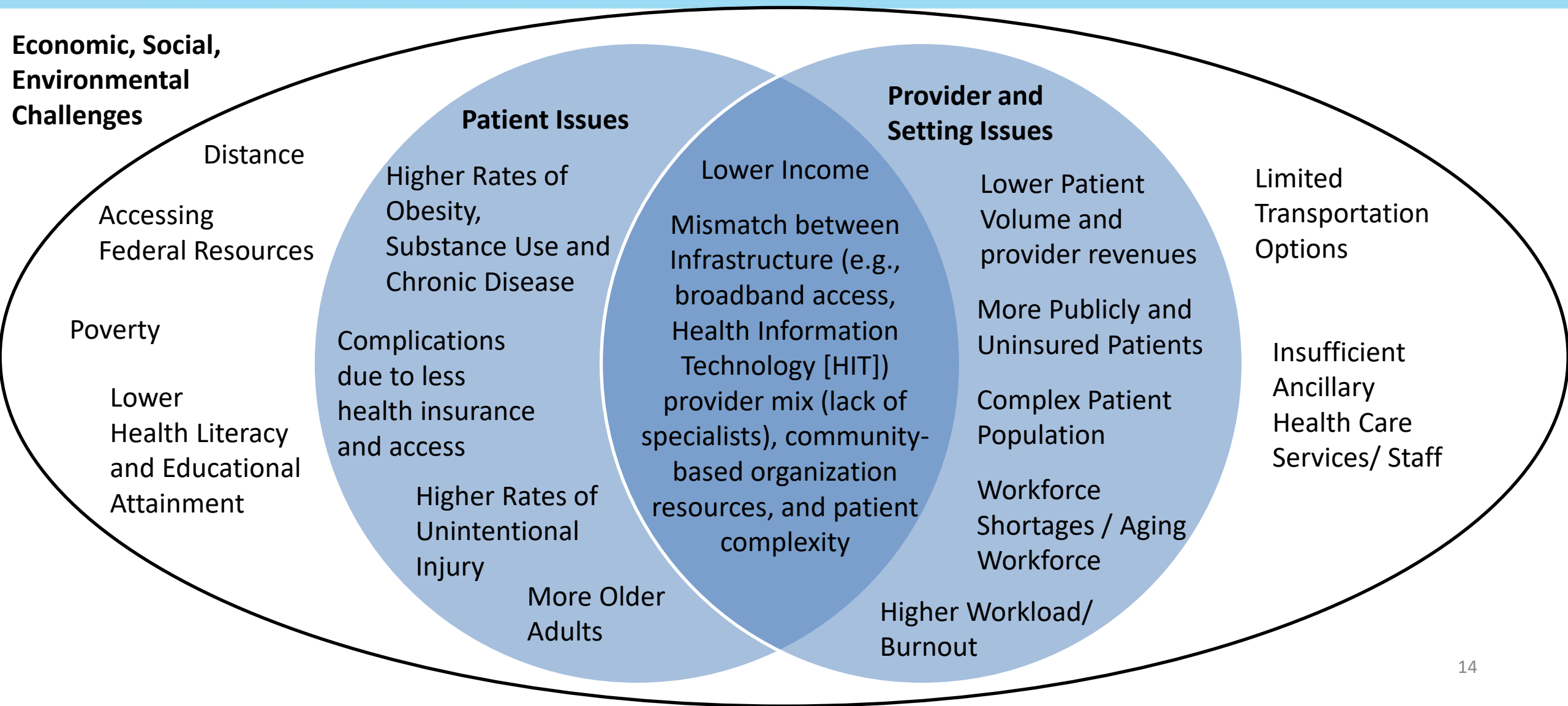
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Age-Adjusted Death Rates for the 10 Leading Causes of Death by Urban-Rural Classification: United States, 2019



NOTES: Urbanicity of county of residence is based on the 2013 NCHS Urban-Rural Classification Scheme for Counties; see Data source and methods. Causes of death are ranked according to the number of deaths for the total population. Rates for all causes in rural areas were significantly higher than rates in urban areas ($p < 0.05$). Access data table for Figure 3 at: <https://www.cdc.gov/nchs/data/databriefs/db417-tables.pdf#3>. SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Overview of Issues Affecting Rural Healthcare Systems, Settings, Providers, and Patients



Challenges Experienced by Rural Health Care Systems, Settings, and Providers

- **Complex patient population** – Rural areas tend to have high rates of behavioral health conditions, substance use, and older adults as well as higher disease burden compared to non-rural areas.
 - 22.6 percent of non-metropolitan residents have 2-3 chronic conditions compared to 18.9 percent of metropolitan residents.
- **Higher rate of uninsured and publicly insured patients** – Rural patients under the age of 65 were 2.5-4 times more likely than their urban peers to be uninsured. Rural hospitals have a 20-percentage point higher rate of Medicaid patients.
- **Lower patient volume** – Low volumes can affect financial viability and reduce reliability and validity of performance measurement results and impact rural providers' ability to participate in CMS quality programs.
 - 47 percent of rural hospitals have 25 or fewer staffed beds
 - Over 100 rural hospitals closed between January 2013-2020, 11 rural hospitals have closed in 2023 and over 600 rural hospitals are at risk of closure
- **Lower earnings** – Rural PCPs tend to make 5 percent less than their urban counterparts

Challenges Experienced by Rural Health Care Systems, Settings, and Providers, Continued

- **Workforce shortages** – Patient-to-PCP ratio in rural areas is 40 PCP: 100,000 people compared to 53 PCP: 100,000 people in urban areas.
 - There is a lack of ancillary service providers, (e.g., lack of ambulance services, home health providers, dialysis services, behavioral health services, ambulatory surgery centers).
- **Higher workload** – Rural PCPs tend to work longer hours and complete more patient visits than their urban counterparts.
- **Challenges building economies of scale** – Limited financial resources in rural areas can challenge technological integration and other innovations.
- **Less Health Information Technology Infrastructure** – Rural areas experience lower HIT adoption rates due to limited financial resources and inconsistent broadband access.
 - Approximately 43 percent of RHCs report that costs for HIT improvements prevent their participation in ACOs.

Provider Capacity in Rural Areas

- Compared to non-rural areas, rural areas have fewer PCPs and specialists per 100,000 population.
 - PCPs: 37.94 per 100,000 population in rural areas versus 52.89 in non-rural areas.
 - Specialists: 46.46 per 100,000 population in rural areas versus 146.38 in non-rural areas.
 - Cardiovascular Disease (CVD) specialists: 1.10 per 100,000 population in rural areas versus 4.27 in non-rural areas.
 - Gastroenterology specialists: 0.47 per 100,000 population in rural areas versus 2.93 in non-rural areas.
 - Neurological surgery specialists: 0.17 per 100,000 population in rural areas versus 1.37 per 100,000 in non-rural areas.

Opportunities for Addressing Rural Workforce Challenges Through Alternative Payment Models

- Issue: Workforce shortages in rural communities
 - Increased rural provider burnout and turnover
 - Increased difficulty with recruiting and retaining providers in rural areas
 - Limited access to healthcare training and education in rural areas
- Strategies for addressing rural workforce challenges through the use of telehealth
 - ACOs can provide resources to support use of telehealth, assuming shared financial risk encourages providers to use telehealth only when it is cost-effective and to adopt higher-value telehealth applications.
 - Bonus payments for rural health providers to develop their telehealth infrastructure
 - Incentives for rural providers to increase their proportion of telehealth visits
 - Funds to provide rural patients with access to necessary telehealth technology (e.g., cellphones, facilities with tablets)

Opportunities for Addressing Challenges with Implementing and Using HIT and Data Analytics

- Issue: Rural providers encounter challenges when implementing and using HIT and data analytics
 - A lack of financial resources prevents many rural providers from adopting HIT infrastructure
 - Approximately 43 percent of RHCs report costs for HIT improvements prevent their participation in ACOs.
 - Many providers lack training on data analysis and decision support systems.
 - Patients may not engage with HIT due to a lack of broadband access or low digital literacy.
- Strategies for addressing HIT infrastructure challenges in rural areas
 - Funding HIT infrastructure
 - Provision of technical assistance
 - Value-based incentives for HIT engagement

Trends in Participation of Rural Providers in APMs

- Rural providers tend to participate in APMs at a lower rate than their metropolitan/non-rural counterparts.
 - A GAO analysis found that 11.9 percent of providers in rural and health professional shortage areas took part in advanced APMs in 2019, compared with 14.8 percent of providers in other areas.
- Physicians participating in advanced APMs in rural areas were most commonly in primary care specialties (e.g., family practice, internal medicine).

Challenges Affecting Rural Providers Participating and Transitioning into APMs

- Financial resources and risk management
 - Lack the capital to finance upfront costs of transitioning to APMs
 - Averse to financial risk or lack reserves to cover potential losses
 - Treat too few Medicare patients to justify investments in APMs, and lower patient volumes result in less predictable spending patterns, heightening financial risk
 - Less able to control cost of care because patients are often referred elsewhere for tertiary care
 - Lower patient volumes and less predictable spending patterns

Challenges Affecting Rural Providers Participating and Transitioning into APMs, Continued

- Data and HIT
 - Unable to conduct data analytics or financial modeling needed to provide value-based care
 - Complexity and cost of electronic health records (EHRs), or lack of high-speed internet, hinder EHR adoption
 - Lack of EHR interoperability and staff training
 - Weakness of health information exchange between providers inside and outside the community
- Staff resources and capabilities
 - Lack staff members capable of managing the transition to or participation in APMs
 - Lack of capital to manage building a population-based, team-based approach (care coordination, case management)
 - Lack awareness of APMs

Challenges Affecting Rural Providers Participating and Transitioning into APMs, Continued

- Design and availability of models
 - Limited APM options due to models' participation restrictions (geographic, provider type, volume), lack of nearby ACOs or models appropriate for providers in rural, shortage, or underserved areas
 - Economies of scale, potential need for low volume adjustments
 - Struggle to adapt to changing model rules and regulations

Financial Risks and Challenges Faced by Rural Providers in PB-TCOC Models

- Challenges faced by rural providers
 - Attribution
 - Panel size
 - Validity of outcome data given limited information technology (IT) infrastructure and smaller population
 - Ability to take on risk
 - Relevant performance metrics
 - Quality performance measurement

Care Delivery Interventions to Support Value-Based Care Transformation in Rural Areas

- Types of care most difficult to provide in rural communities
 - Lack of post-discharge follow-up care (due to workforce availability, transportation issues)
 - Decreased access to mental health and substance abuse disorder treatment facilities, behavior health professionals
 - Fewer gastroenterologists, general surgeons, radiation oncologists and other specialists
 - Limited access to ancillary service providers (e.g., home health care, diagnostic testing, and dialysis services providers)
- Approaches to address the needs of rural communities
 - Audio and video visits, including the use of telehealth (where there has been high patient satisfaction)
 - Co-location of healthcare services
 - Leveraging pharmacists as care providers
 - Increasing value-based payment models in rural hospitals
 - Coordination with community-based organizations (e.g., supporting nutrition, housing)

Care Delivery Interventions to Support Value-Based Care Transformation in Rural Areas, Continued

- Strategies included in effective models that drive value-based care in rural areas
 - Promoting behavioral health care services
 - Supporting and encouraging care coordination across providers
 - Improving specialty integration
 - Expanding care networks or forming new entities

Incentives to Drive Value-Based Care Transformation Among Rural Providers

- Financial incentives to drive value-based care transformation among rural providers
 - Provide funding for start-up investment to incentivize coordination of care
 - Provide a fixed upfront payment regardless of patient volume to invest in high-quality primary and specialty care
 - Provide a per beneficiary per month care management fee (CMF) to increase access to care
- Quality incentives to drive value-based care transformation among rural providers
 - Payment tied to performance on quality measures
 - Adjust Medicare fee-for-service (FFS) payments based on performance against a set of quality measures, relative to their peers' performance
 - Performance impacts future payment adjustments

Challenges with Measuring Performance of Rural Providers in APMs

- Challenges affecting rural providers' participation in performance measurement:
 - Low case volumes place limitations on the calculation of reliable and valid performance measurement results
 - Staff shortages as well as limited funds and other resources
 - Limited staff with experience performing data extraction and analysis as well as using measurement results to inform quality improvement efforts
- Rural patients tend to be disproportionately impacted by health conditions, making performance comparisons between rural and non-rural settings difficult.

Strategies for Addressing Challenges Related to Measuring the Performance of Rural Providers

- Strategies to ensure that rural-relevant measures appropriately measure the performance of rural providers
 - Tailor performance measures to the type of rural provider or health care service offered
 - Modify measurement approaches for rural providers (e.g., electronic data collection)
 - Use risk adjustment to account for differences in risk factors within and across rural patient populations
- Considering how measuring the success of rural providers might differ from measuring the success of non-rural providers
 - Example: Emergency departments (EDs) are a critical source of after-hours care in rural markets. Reducing ED utilization may not adequately reflect value-based care transformation in rural markets.
- Potentially identifying other measures related to retention of rural providers in APMs and shared savings

Strategies for Addressing Challenges Related to Measuring the Performance of Rural Providers, Continued

- Examples of quality measures used in prior APMs that target rural providers
 - Utilization: Inpatient and ED visits for ambulatory care sensitive conditions, hospital readmissions, ambulance transports, average distance per ambulance transport, length of stay, telehealth encounters
 - Patient experience with care
 - Primary care and behavioral health integration: Influenza vaccination, screening for depression and follow-up plan, rate of adults with preventive care visits
 - Care coordination and care transitions: Follow-up after ED visits for patients with multiple chronic conditions
 - Substance use: Use of pharmacotherapy for opioid use disorder, use of opioids at high dosage in persons without cancer, risk of continued opioid use

Lessons Learned from CMMI Models that Targeted or Included Rural Participants

- Several CMMI models have either targeted or included rural participants.
- The models used a variety of payment mechanisms, including pre-paid shared savings, per beneficiary per month (PBPM) payments, global budgets, FFS payments, population-based payments, bundled payments, and performance-based payments.
- Specific lessons learned include:
 - Establishing longer on-ramps for rural practices interested in APM participation;
 - Developing APMs that specifically target rural settings;
 - Identifying suitable, risk-adjusted quality measures;
 - Providing risk protection caps on risk exposure;
 - Extending bonus payments for new Advanced APM participants; and
 - Decreasing qualifying participation thresholds for rural providers operating under APMs.

Lessons Learned from Selected CMMI Models Relevant to Opportunities for Rural Provider Participation

Model	Lessons Learned	Years Active
Frontier Community Health Integration Project (FCHIP) Demonstration	<ul style="list-style-type: none"> • Increased payments for Part B ambulance transports and telehealth origination services • Patient satisfaction with telehealth was very high 	2016 - present
Vermont All-Payer ACO Model (VTAPM)	<ul style="list-style-type: none"> • Providing up-front funding and limiting downside risk • Different attribution mechanisms may be needed in rural communities to achieve scale 	2017 - present
Pennsylvania Rural Health Model (PARHM)	<ul style="list-style-type: none"> • Creation of the Rural Health Redesign Center Authority (RHRCa) helped foster relationships among participants, payers, and partners • Although global budgets provided stable cash flow, participants and payers found it challenging to monitor global budgets • Preliminary Medicare per member per month (PMPM) spending is below the national average for rural hospitals. • Eighty percent of participants improved avoidable utilizations, 83 percent improved their hospital-acquired condition reduction scores, and 100 percent maintained their CMS admission rates. 	2019 - 2024
Rural Community Hospital Demonstration	<ul style="list-style-type: none"> • Rural community hospitals may need support to update older capital infrastructure 	2004 - present
Next Generation Accountable Care Organization (NGACO)	<ul style="list-style-type: none"> • NGACOs serving rural areas used care management strategies such as telephonic engagement and embedded care management staff 	2016 - present

Lessons Learned from Selected CMMI Models Relevant to Opportunities for Rural Provider Participation, Continued

Model	Lessons Learned	Years Active
Community Health Access and Rural Transformation (CHART)	<ul style="list-style-type: none"> Attempted to increase financial stability for rural providers through new reimbursement processes that provide up-front investments and predictable, capitated payments, and remove regulatory burden by providing waivers that increase operational and regulatory flexibility for rural providers 	2021 – 2023* (Withdrawn)
Medicare Care Choices Model (MCCM)	<ul style="list-style-type: none"> Offered the option for eligible beneficiaries to receive supportive services at the end of life without forgoing payment for treatment of their terminal conditions. However, there were concerns that beneficiaries in rural areas might not receive the same set of services, due to higher travel costs. Impact analyses showed similar outcomes between rural and non-rural beneficiaries. 	2016 - present
Maryland All-Payer Model (MDAPM)	<ul style="list-style-type: none"> Hospital leaders in more rural or economically disadvantaged areas reported they would not be able to attract or retain enough hospitalists and certain types of specialists if they did not employ physicians 	2014 - 2018
Accountable Care Organization Investment Model (AIM)	<ul style="list-style-type: none"> Up-front payment of shared savings encouraged ACOs to form in areas with “greater health care needs and less access to accountable care.” As of 2020, 14 of the 47 AIM participants remained in the Medicare Shared Savings Program, and the ACOs remaining in the program “were larger and served less rural markets.” 	2015 - 2019

Note: CMMI announced that the CHART Model would end early on September 30, 2023, based on feedback received from model stakeholders, as well as a lack of hospital participation.

Rural Providers' Performance in APMs

- The ACO Investment Model (AIM; 2015–2019) decreased spending and maintained or improved quality of care in rural and underserved areas.
- Maryland's Total Patient Revenue (TPR; 2010–2014) global budget program for rural hospitals led to reductions in outpatient utilization but not inpatient utilization.
- Early results of the Pennsylvania Rural Health Model (PARHM; 2019–2024) show that preliminary Medicare PMPM spending is below the national average for rural hospitals. In addition, 80 percent of participants improved avoidable utilizations, 83 percent improved their hospital-acquired condition reduction scores, and 100 percent maintained their CMS admission rates.

Medicare Shared Savings Program (MSSP) Inclusion of Rural Providers

- The MSSP (2012-present) is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to give coordinated, high-quality care to their Medicare beneficiaries.
- Participants must have at least 5,000 attributed Medicare FFS patients and agree to participate for at least five years. In addition, FQHCs, RHCs, and CAHs are eligible to join an ACO under MSSP; FQHCs, RHCs, and some CAHs are also eligible to become their own ACO under MSSP.
- As of January 2023, 467 CAHs (approximately 35 percent of all CAHs) and 2,240 RHCs (approximately 51 percent of all RHCs) were participating in an MSSP ACO.

Lessons Learned and Development of The Advance Investment Payments (AIP), A New MSSP Payment Option

- Rural ACOs participating in MSSP were less likely to switch to two-sided risk than urban ACOs.
 - ACOs remaining in the AIM served less rural areas.
- CMS is offering a new payment option, the Advance Investment Payments (AIP), to encourage ACOs to form in rural and underserved areas.
 - The AIP offers eligible ACOs an upfront payment of \$250,000 and two years of quarterly payments to build the infrastructure needed to succeed in MSSP and promote equity by holistically addressing beneficiary needs, including social needs.
 - The AIP will be recouped from the ACO's shared savings.

PTAC Public Meeting Focus Areas

- Challenges Facing Patients and Providers in Rural Communities
- Provider Perspectives on Issues Related to Rural Providers' Participation in Population-Based Models
- Challenges with Measuring Rural Providers' Performance in APMs
- Approaches for Incorporating Rural Providers in PB-TCOC Model Design
- Incentives for Increasing Rural Providers' Participation in Population-Based Models
- Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas

Appendix A

Data Definitions of Rural

Rural Areas Have Fewer PCPs and Specialists Per 100,000 Population Than Non-Rural Areas

Variable	Mean		
	National Total	Non-Rural Subtotal	Rural Subtotal
Proportion under age 65 without health insurance, 2019	11.94	10.62	12.72
PCPs per 100,000 population, 2020	43.45	52.89	37.94
Specialists per 100,000 population, 2020	83.28	146.38	46.46
Cardiovascular Disease (CVD) specialists per 100,000 population, 2020	2.27	4.27	1.10
Gastroenterology specialists per 100,000 population, 2020	1.38	2.93	0.47
Neurological surgery specialists per 100,000 population, 2020	0.62	1.37	0.17
FQHCs and RHCs per 100,000 population, 2021	17.20	6.73	23.39
Short-term hospital beds per 100,000 population, 2020	249.41	188.94	284.70

Access to Care, Utilization of Services, and Provider Supply – National and Regional Totals

Variable	Mean (Standard Deviation)									
	National Total	New England Total	Middle Atlantic Total	East North Central Total	West North Central Total	South Atlantic Total	East South Central Total	West South Central Total	Mountain Total	Pacific Total
Proportion under age 65 without health insurance, 2019	11.94 (5.12)	7.03 (3.12)	6.63 (1.99)	8.26 (2.25)	10.62 (4.2)	13.33 (4.19)	11.91 (3.4)	17.91 (5.97)	12.82 (3.39)	10.07 (3.50)
PCPs per 100,000 population, 2020	43.45 (33.85)	81.64 (33.94)	54.42 (42.75)	43.27 (29.56)	42.02 (39.69)	42.75 (29.55)	36.83 (25.37)	33.59 (25.96)	46.44 (32.95)	63.91 (40.76)
Specialists per 100,000 population, 2020	34.63 (57.24)	235.14 (211.56)	177.23 (298.50)	86.58 (112.62)	51.44 (120.11)	99.41 (131.09)	70.98 (98.36)	53.12 (82.59)	77.66 (87.75)	114.49 (108.29)
CVD specialists per 100,000 population, 2020	2.27 (4.71)	7.02 (8.42)	6.18 (8.46)	2.45 (3.97)	1.14 (4.77)	2.85 (4.45)	2.16 (4.27)	1.39 (2.8)	1.63 (4.11)	2.37 (2.78)
Gastroenterology specialists per 100,000 population, 2020	1.38 (3.21)	4.18 (4.69)	4.03 (7.51)	1.34 (2.63)	0.63 (2.89)	1.87 (3.1)	1.25 (2.64)	0.88 (2.07)	0.81 (1.86)	1.71 (2.27)
Neurological surgery specialists per 100,000 population, 2020	0.62 (2.08)	1.37 (2.66)	1.61 (5.22)	0.61 (1.52)	0.42 (2.29)	0.72 (1.83)	0.53 (1.58)	0.42 (1.26)	0.54 (1.58)	0.68 (1.2)
FQHCs and RHCs per 100,000 population, 2021	17.20 (21.18)	9.64 (11.09)	5.73 (9.78)	11.31 (12.11)	25.44 (26.56)	11.87 (15.81)	21.21 (21.46)	18.09 (20.11)	21.56 (25.51)	15.60 (23.62)
Short-term hospital beds per 100,000 population, 2020	249.41 (429.12)	189.29 (127.04)	256.6 (288.4)	182.15 (185.52)	381.70 (548.74)	185.57 (281.93)	280.26 (766.28)	192.14 (214.83)	296.35 (434.97)	182.24 (218.78)

Comparison of Selected Ways of Identifying Rural Areas

Agency	Geographic Unit Used	Rural Definition	Uses	Limitations
U.S. Census Bureau	Census Blocks and Block Groups	<p>2010: All population, housing and territory not included within an urban area</p> <ul style="list-style-type: none"> Urbanized Areas (UAs) of 50,000 or more people; Urban Clusters (UCs) of 2,500 to 49,999 people. <p>2020: All population, housing and territory not included within an urban area consisting of at least either 2,000 housing units or 5,000 people.</p>	Researchers analyzing trends in urban and rural areas	Does not follow city or county boundaries; Overcounts number of people in rural areas (classifies many suburban areas as rural)
OMB	County	<p>2013: All non-metropolitan areas (consisting of counties) including</p> <ul style="list-style-type: none"> Micropolitan Counties (counties that are part of Micropolitan Statistical Areas with a core urban area of 10,000 to 49,999) Non-Core Counties 	Used for CMS designation of Critical Access Hospitals, Medicare Dependent Hospitals and Sole Community Hospitals.	Includes some rural areas in metropolitan areas; undercounts number of people in rural areas
USDA	County (RUCC)	<p>2013: Distribution of counties in OMB-designated non-metropolitan counties by:</p> <ul style="list-style-type: none"> Population density (20,000-49,999, 2,500-19,999, less than 2,500); and Adjacency to an OMB-designated metropolitan area 	Researchers analyzing trends in nonmetro areas	Some metropolitan counties include rural Census tracts

Comparison of Selected Ways of Identifying Rural Areas, Continued

Agency	Geographic Unit Used	Rural Definition	Uses	Limitations
HRSA	Census Tracts* (Modified Rural-Urban Commuting Area [RUCA])	<ul style="list-style-type: none"> All OMB-designated non-metropolitan counties All Census tracts in OMB-designated metropolitan counties with USDA RUCA codes 4-10 based on: <ul style="list-style-type: none"> Population Density and Urbanization (Large Urban Cluster of 10,000 to 49,999, Small Urban Cluster of 2,500 to 9,999) Daily Commuting Patterns (Flow within or to Urban Cluster) Large area Census tracts in OMB-designated metropolitan counties of at least 400 square miles in area with population density of 34 or less per square mile with RUCA codes 2-3 Can be applied to ZIP codes Can be used as a proxy to identify very remote, frontier-like areas. For example, a RUCA code of 10 is assigned to isolated, small rural Census tracts, whereas a RUCA code of 1 is assigned to urban areas. RUCAs are available by Census tract and ZIP code area. 	<p>Rural Health Grant and Program Eligibility, eligibility for CMMI's CHART model</p> <p>Provide information about differences within counties</p>	Metropolitan and non-metropolitan counties can include Census tracts with very different characteristics

Note: Census tracts are statistical subdivisions of a county that aim to have roughly 4,000 inhabitants. Tract boundaries are usually visible features, such as roads or rivers, but they can also follow the boundaries of national parks, military reservations, or American Indian reservations.

Appendix B
Rural Participation Incentives and Activities in
CMMI Models

Key Characteristics of Selected CMMI Models with Rural Participation Components – Models that Include Rural Providers

Model Name	Clinical Focus	Components Relevant to Rural Providers
Accountable Health Communities (AHC)	Primary care	Coordination between health care services and community services organizations; applicants are required to screen at least 75,000 beneficiaries annually
Bundled Payments for Care Improvement Advanced (BPCI-A)	Cross-clinical focus	Voluntary model; a single retrospective bundled payment with one risk track and 90-day clinical episodes; there are eight Clinical Episode Service Lines Groups with 29 inpatient, three outpatient and two multi-setting Clinical Episode Categories; payment is tied to performance on quality measures; CAHs, hospitals participating in the Rural Community Hospital demonstration, and rural hospitals participating in the Pennsylvania Rural Health Model, are excluded from the definition of an acute care hospital for purposes of BPCI Advanced
Comprehensive Primary Care Plus (CPC+)	Primary care	CPC+ was a national advanced primary care medical home model that aimed to strengthen primary care through regionally-based multi-payer payment reform and delivery transformation; the program included two practice tracks with incrementally advanced delivery requirements and various payment options
Emergency Triage, Treat, and Transport (ET3)	Emergency care	With the support of local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches, ambulance suppliers and providers will triage people seeking emergency care based on their presenting needs; the model aims to ensure Medicare FFS beneficiaries receive the most appropriate care, at the right time, and in the right place; the model may help make EMS systems more efficient and will provide beneficiaries broader access to the care they need; beneficiaries who receive treatment from alternative destinations may also save on out-of-pocket costs; an individual can always choose to be brought to an ED if they prefer; addresses challenges with ED utilization as a substitute for primary care-treatable conditions via telehealth interventions
Expanded Home Health Value-Based Purchasing Model (Expanded HHVBP)	Home health care	HHAs receive adjustments to their Medicare fee-for-service payments based on their performance against a set of quality measures, relative to their peers' performance; performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year)

Key Characteristics of Selected CMMI Models with Rural Participation Components – Models that Include Rural Providers, Continued

Model Name	Clinical Focus	Components Relevant to Rural Providers
Global and Professional Direct Contracting (GPDC)/Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)	Primary and specialty care	Supports Standard, New Entrant, and High Needs Population ACOs/DCEs to reduce practices' administrative burden, allowing health care providers greater flexibility in how they deliver care and rewarding them for improving quality (GPDC) and advancing health equity, promoting provider leadership and governance, and protecting beneficiaries (ACO REACH); eligible providers include providers in group practice, networks of individual practices of providers, hospitals employing providers, FQHCs, RHCs, and CAHs; rural participation includes FQHCs, RHCs, and CAHs are potentially eligible participants and may be included in DCE provider networks; provides incentives for supporting underserved communities
Independence at Home (IAH) Demonstration	Primary care, chronically ill	Provides participating practices with financial incentives for improving care in primary care settings and for beneficiaries with multiple chronic conditions; practices must be led by physicians or nurse practitioners and serve at least 200 eligible beneficiaries; beneficiaries are eligible if they have two or more chronic conditions, are enrolled in Medicare FFS, need help with two or more function activities, have had a non-elective inpatient admission in the past year, and have received acute or subacute rehabilitation in the past year; aims to reduce the need for on-site services
Integrated Care for Kids (INCK)	Primary care	Supports states and local providers to conduct early identification and treatment of children with health-related needs across settings and develop sustainable APMs under which states and local providers will share accountability for cost and outcomes; addresses challenges related to access and integration and telehealth
Maryland All-Payer Model (MDAPM)	All hospital services	Shifted all hospital revenue into global payment models. Improvements in quality of care for Maryland residents were evaluated through both hospital quality and population health measures. All Maryland hospitals were involved in the model; all hospitals in the state operated under global budgeting, and all but one rural hospital in the total patient revenue system remained within the 0.5 percent budget corridor.
Maryland Total Cost of Care (MDTCOC)	Care provided in hospitals	A per capita limit on Medicare total cost of care in Maryland, holding the state fully at risk for Medicare beneficiaries

Key Characteristics of Selected CMMI Models with Rural Participation Components – Models that Include Rural Providers, Continued

Model Name	Clinical Focus	Components Relevant to Rural Providers
Medicare Care Choices Model (MCCM)	Providing supportive services for hospice/palliative/end of life care to Medicare beneficiaries	Participating hospices provided services that were available under the Medicare hospice benefit for routine home care and respite levels of care, but could not be separately billed under Medicare Parts A, B, and D; Model services were available around the clock, 365 calendar days per year; participants were less likely to reside in rural areas
Medicare Diabetes Prevention Program Expanded Model (MDPP)	Diabetes (Type 2)	MDPP is a performance-based payment model paid by the CMS claims system; structured behavioral change intervention; RHCs and FQHCs must re-enroll as MDPP suppliers and use the CMS-1500 claim form while filing for reimbursement; MDPP services should be included as non-reimbursable costs on the case report to avoid any possible duplications; MDPP services do not need to be furnished in a traditional health care setting, but must follow the requirements for MDPP locations; beneficiaries in rural areas can receive services from a practitioner in a different location through telehealth; addresses challenges with distance to provider as a burden in chronic disease maintenance
Million Hearts (Million Hearts Cardiovascular Disease (CVD) Risk Reduction Model)	Heart disease and stroke	Randomized controlled trial that sought to bridge a gap in cardiovascular care by providing targeted incentives for health care practitioners to engage in beneficiary cardiovascular disease risk calculation and population-level risk management; participating practices were randomly assigned to be part of a control group or intervention group; rural providers participated in the Model, although they were not the focus of the Model
Next Generation Accountable Care Organization (NGACO)	Primary and specialty care	Enable provider groups to assume higher levels of financial risk and reward than available under previous ACO models; alignment-eligible facilities included CAHs billing professional services for outpatient care, FQHCs, and RHCs; benefit enhancements, including Telehealth Expansion Waiver and Chronic Disease Management Reward (Gift Card); no specific rural focus
Part D Enhanced Medication Therapy Management Model (MTM)	Medication management	Provides Part D sponsors with additional payment incentives and allows for regulatory flexibilities to target enrollees and offer tailored services; eligibility requires a minimum enrollment of 2,000 beneficiaries; regulatory flexibilities allowed for individualized and risk-stratified interventions

Key Characteristics of Selected CMMI Models with Rural Participation Components – Models that Include Rural Providers, Continued

Model Name	Clinical Focus	Components Relevant to Rural Providers
Primary Care First Model Options (PCF)	Primary care	Enables primary care practices to offer a broader range of health care services to meet patient needs, including patients with complex chronic needs; FQHCs and RHCs are excluded from participating in PCF; Model enables PCPs to offer a broader range of health care services that meet the needs of their patients
Value in Opioid Use Disorder Treatment (Value in Treatment) Demonstration Program	Opioid use disorder	Provides per beneficiary per month care management fees (CMF) and a performance-based incentive to increase access to opioid use disorder treatment services, improve physical and behavioral health outcomes for these beneficiaries, and reduce Medicare expenditures. Entities include physicians, group practices, hospital outpatient departments, FQHCs, RHCs, community mental health centers (CMHCs), opioid treatment programs, CAHs, and clinics certified as community behavioral health clinics. The program aims to reduce hospitalizations and ED visits, instead providing care in outpatient settings.
Vermont All-Payer ACO Model (VTAPM)	Broad	Provides funding for start-up investment to bring together Vermont physicians, hospitals, and other care providers to better coordinate care for patients with Medicare, Medicaid, or commercial insurance. The model aims to incentivize coordination to achieve ACO scale, all-payer and Medicare financial and health outcomes, and quality of care targets. Participation is voluntary for both providers and payers. Only two of eight CAHs in Vermont are participating in the Medicare program, due to financial constraints. Rural FQHCs and RHCs are eligible, but participation among small practices is limited.

Key Characteristics of Selected CMMI Models with Rural Participation Components – Models that Target Rural Providers

Model Name	Clinical Focus	Components Relevant to Rural Providers
Community Health Access and Rural Transformation (CHART)	Primary care	Enhance beneficiaries' access to health care services by ensuring that rural providers remain financially sustainable for years to come and can offer additional services such as those that address SDOH, including food and housing; addresses challenges by increasing financial stability for rural providers through new reimbursement processes that provide up-front investments and predictable, capitated payments and removes regulatory burden by providing waivers that increase operational and regulatory flexibility for rural providers
Frontier Community Health Integration Project Demonstration (FCHIP)	Essential services	CAHs serve as the hubs for health care activities in frontier areas, but they often serve few inpatients; CMS expects CAHs to increase access to services that are often unavailable in frontier communities with the goal of avoiding expensive transfers to hospitals in larger communities; CMS will evaluate whether providing these services in frontier communities can improve the quality of care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures; eligibility criteria include adhering to the requirements of the Rural Hospital Flexibility Program of the Social Security Act; describe intent in meeting community health needs in areas of telehealth, nursing facility care, and ambulance services; be located in a state where at least 65 percent of the counties have six or fewer residents per square mile; limited to CAHs in Montana, Nevada, and North Dakota; addresses challenges with HIT infrastructure, capacity, and financial resources
Pennsylvania Rural Health Model (PARHM)	Inpatient and outpatient services	Participating hospitals are paid a fixed amount upfront, regardless of patient volume, to invest in high-quality primary and specialty care that addresses community-specific needs; participating hospitals must develop and submit a rural health transformation plan to the Pennsylvania Department of Health and CMMI; aims to support care delivery design activities for inpatient and outpatient hospital services to improve quality and preventive care tailored to the specific community
Rural Community Hospital Demonstration	Inpatient care	To test feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be CAHs; addresses challenges related to reimbursement under IPPS or SNF PPS

Forthcoming Model

- Making Care Primary (MCP) Model
 - Launching July 1, 2024
 - 10.5-year Medicaid payment and care delivery model
 - Goals: To improve care management and care coordination, equip primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' clinical needs and HRSNs
 - Offers upside only performance incentive for FQHCs

Appendix C
Rural Participation Activities in Proposals
Submitted to PTAC

Selected PTAC Proposals that Included or Targeted Rural Populations

Eleven of the proposals that have been submitted to PTAC included or targeted rural populations. Two PFPM proposals directly addressed challenges related to participation of rural providers in alternative payment models to some degree. Nine other proposals also included or focused on rural providers in their model design.

PFPM Proposals That Included Rural Populations in Their Model Design

Proposals with an Advanced Primary Care Focus:

- American Academy of Family Physicians (AAFP)

Proposals with a Specialty Focus – Acute Management:

- American College of Emergency Physicians (ACEP)
- Icahn School of Medicine at Mount Sinai (Mount Sinai)
- Personalized Recovery Care (PRC)

Proposals with a Specialty Focus – Chronic Management:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- Renal Physicians Association (RPA)
- Avera Health (Avera)

Proposals with a Specialty Focus – Specialty Integration:

- The American College of Surgeons (ACS)

PFPM Proposals that Focused on Rural Populations in Their Model Design

Proposals with an Advanced Primary Care Focus:

- Dr. Antonucci (Antonucci)

Proposals with a Specialty Focus – Acute Management:

- University of New Mexico Health Sciences Center (UNMHSC)

Other Proposals that Focused on Rural Populations in Their Model Design

Proposals with an Advanced Primary Care Focus:

- Mercy Accountable Care Organization (Mercy ACO)*

*PTAC concluded that the criteria for PFPMs established by the Secretary are not applicable to this proposal.

Key Characteristics of Selected PTAC PFPM Proposals that Focused on Rural Populations and Components Relevant to Rural Participation in Alternative Payment Models

Submitter Name	Clinical Focus	Patient Population	Rural Participation Components	Payment Design Features
1. Antonucci	Primary Care	Primary Care	Applies features of the Patient-Centered Medical Home model to a capitation model for outpatient services. Any primary care physician or independent nurse practitioner could participate, irrespective of practice size or geographic restrictions. Patient panel sizes would be limited to no more than 1,500 patients per physician; thus, under the proposed model, small practices would have the resources to expand, and all practices would have the resources to provide e-visits and telehealth.	Capitated PBPM with shared risk
2. UNMHSC	Cerebral emergent care	Patients with neurological emergencies	Within condition specialty care around an acute care event, including emergency medicine, hospitalists, family medicine, primary care, and internal medicine physicians in the rural setting, and telemedicine physician specialists in disciplines such as neurosurgery, neurology, and critical care	Additional one-time payment without shared risk

Key Characteristics of Selected PTAC PFPM Proposals that Included Rural Populations and Rural Participation Components

Submitter Name	Clinical Focus	Components Relevant to Rural Providers
1. American Academy of Family Physicians (AAFP)	Primary Care	Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange; to account for differences in rural practice patterns, E&M visits used for attribution can be provided in multiple settings, not only ambulatory and/or office-based settings; applicable to physicians who are employed or independent
2. American Academy of Hospice and Palliative Medicine (AAHPM)	Serious illness and palliative care	Two-track structure: Payment Incentives or Shared Savings and Shared Risk; capability to perform assessments and delivery services through interdisciplinary team; capability to respond on 24/7 basis to manage issues associated with patient's health conditions and functional limitations (may use telehealth); non-billing clinicians can be included on the PCT; telehealth can be used to deliver more efficient care; Model is designed to be accessible to rural providers who may not be able to participate in models with a higher level of risk
3. American College of Emergency Physicians (ACEP)	ED services	Proposal calls for facilitating appropriate discharge, informing patients of treatment options, managing unscheduled care episodes by protocol, and arranging post-discharge home visits; eligible clinical staff include ED physicians, physician assistants, nurse practitioners, clinical nurse specialists, and clinical social workers; although not designed for rural providers, the Model can be implemented in rural hospitals and CAHs; rural hospitals would have to focus on appropriate transfers to other facilities; Model can be integrated into other APMs, and can be used regardless of employment model
4. The American College of Surgeons (ACS)	Cross-clinical focus	The proposed episode model is based on shared accountability, integration, and care coordination as fundamental building blocks; the episode grouper automatically identifies most of the clinicians who are participating in the care for a patient during a defined episode of care; MIPS-eligible clinicians; rural providers can join with other providers under the umbrella of a new corporate entity or convener group
5. Avera Health (Avera)	Primary care (geriatricians) in skilled nursing facilities (SNFs)	Telemedicine and multidisciplinary team allow expertise to be shared over a wide geography; dually eligible beneficiaries are eligible for this model; smaller practices can increase their participation slowly over time as they recruit partner nursing facilities; telemedicine allows for sharing expertise over wide geography; to implement telemedicine infrastructure in rural practices, there are several federal grant programs that can provide financial assistance
6. Icahn School of Medicine at Mount Sinai (Mt. Sinai)	Inpatient services in home setting	Multidisciplinary care around an acute care event; goal of reducing complications and readmissions; flexibility to accommodate non-participating physician consultants, using hospitalists if physicians in home care are scarce, and leveraging telehealth; to achieve critical mass of patient, services, staff, propose maximizing intake hours by staggering staff hours and developing policies (e.g., stocking own medications) for services dependent on vendors with delivery limitations; instituting HaH at Night, recruiting patients after hours and holding them in the ED or observation unit until the morning when home services can more readily be arranged; expanding the range of services provided; having program variants and flexibility in the payment model

Key Characteristics of Selected PTAC PFPM Proposals that Included Rural Populations and Rural Participation Components, Continued

Submitter Name	Clinical Focus	Components Relevant to Rural Providers
7. Personalized Recovery Care (PRC)	Inpatient services in home setting	Hospital-level care being received at home mitigates risk to patients that typically occurs upon discharge from acute care facility; commercial and Medicare Advantage patients meeting clinical requirements; network approach may reduce concerns with adequate patient volume without unnecessarily admitting patients
8. Renal Physicians Association (RPA)	End-stage renal disease (ESRD)	Condition-specific, episode-of-care payment model (Clinical Episode Payment—CEP) for incident dialysis patients; Medicare beneficiaries with ESRD requiring transition to dialysis therapies; nephrologists and nephrology groups of all sizes, in rural and non-rural areas; CEP requires little additional infrastructure creation that renders it feasible in rural regions; physician-provided, Medicare-covered services are reimbursed as they have been traditionally, under the current physician fee schedule payment methodology

Key Characteristics of Other PTAC Proposals that Focused on Rural Populations

Submitter Name	Clinical Focus	Patient Population	Rural Participation Components	Payment Design Features
1. Mercy ACO*	Primary/Preventive Care	Rural health clinic (RHC) providers	Improve preventive care screening, increase the number of Medicare Annual Wellness Visits (AWVs) delivered to rural beneficiaries, and reduce burden on physicians. Provide a separate payment for this service and relax Medicare physician supervision rules in this setting to allow non-practitioners including Registered Nurses (RNs) to provide these newly separately paid AWV services without the involvement of a physician or non-physician practitioner.	Separately payable Medicare annual wellness visit for RHCs if performed on the same date of service as another billable service

*PTAC concluded that the criteria for PFPMs established by the Secretary are not applicable to this proposal.

Appendix D
Lessons Learned from CMMI Models That
Targeted Rural Providers

Overview of CMMI Models That Have Targeted Rural Providers

Model Name	Description	Participants	Years Active
Frontier Community Health Integration Project (FCHIP) Demonstration	Tested new models of integrated, coordinated health care in the most sparsely-populated rural counties. Model focused on ambulance services, skilled nursing facility care, and telehealth.	CAHs	2016 - present
Community Health Access and Rural Transformation (CHART) Model	Offered capitation payments and regulatory flexibility for participating rural health systems	Lead Organizations comprised of state health agencies and hospitals	2021 – 2023* (Withdrawn)
Pennsylvania Rural Health Model (PARHM)	PA Rural Hospitals operate under a fixed global budget for inpatient and outpatient services and engage in care transformation plans to improve quality of care.	Pennsylvania hospitals in rural areas	2019-2024
Rural Community Hospital Demonstration	Tests the feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be CAHs	Hospitals serving rural areas	2004 - present
ACO Investment Model (AIM)	Tested the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current MSSP ACOs to transition to arrangements with greater financial risk	ACOs	2015-2019

*In March 2023, CMMI announced that the CHART Model would end early on September 30, 2023, noting a lack of hospital participation.

Comparison of How CMMI Has Defined Rural Areas in Models That Have Targeted Rural Providers

Model Name	Rural-specific Eligibility Criteria
Frontier Community Health Integration Project (FCHIP) Demonstration	Critical Access Hospital located in a state in which at least sixty-five percent of the counties in the state have six or less residents per square mile.
Community Health Access and Rural Transformation (CHART) Model	Lead organization must represent a rural community comprised of county or census tracts that meet HRSA's rural definition: <ul style="list-style-type: none"> • All non-metropolitan counties • All metropolitan census tracts with RUCA Codes* 4-10 and • Large area metropolitan census tracts of at least 400 sq. miles in areas with population density of 35 or less per sq. mile with RUCA codes 2-3
Pennsylvania Rural Health Model (PARHM)	Critical Access Hospitals located in PA located within municipalities less than the statewide population density of 284 persons per square mile.
Rural Community Hospital Demonstration	A Metropolitan Statistical Area (as defined by the OMB) that has a population of less than one million.
ACO Investment Model (AIM)	CMMI accepted applications from ACOs to participate in AIM. To determine the degree to which the ACO served rural populations, they required applicants to provide the percentage of provider delivery sites in either: <ul style="list-style-type: none"> • A Non-metropolitan county, or; • A Metropolitan county with an assigned RUCA code between 4 and 10.

Appendix E
Lessons Learned for Rural Participation from
Other Federal Programs

Characteristics of Rural Participation in Other Federal Programs

	HACRP (Hospital-Acquired Condition Reduction Program, effective 2014-present)	HRRP (Hospital Readmissions Reduction Program, effective 2012-present)	Hospital VBP (Hospital Value-Based Purchasing Program, effective 2012-present)
Exclude CAHs	✓	✓	✓
Offer quality reporting exemptions	✓		✓
Include rural-relevant performance measures	✓	✓	✓
Include modifications to measurement that apply to rural providers		✓	
May have disproportionate penalties for hospitals that furnish care to higher proportions of vulnerable and underserved patients	✓	✓	