Physician-Focused Payment Model Technical Advisory Committee

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

HIGHLIGHTS

- Rural providers lack capital to finance the up-front costs of transitioning to Alternative Payment Models (APMs). Providing up-front payments to support the adoption of health information technology (health IT) infrastructure and data analytics, increasing the percentage of the overall spend on primary care, and establishing glide paths to sustainable participation in value-based care can encourage rural providers to participate in population-based total cost of care (PB-TCOC) models.
- Low patient volume in rural areas can challenge providers' willingness to take on financial risk. Low volume can also impact patient attribution, benchmarking, and performance measurement. Promoting collaboration among rural providers in a region to spread fixed costs and create a greater pool of patients to balance downside risk can help address challenges related to low volume.
- Rural providers face unique challenges related to caring for rural patients. For example, rural patients commonly have complex health care and social needs. Implementing team-based reimbursement can help to increase the use of high-touch, proactive, multidisciplinary, team-based care across professions (e.g., nurses, community health workers) and organizations to promote care coordination and case management.
- Beyond payment policy solutions, additional supporting policies can help to address health care challenges common in rural areas. For example, strategies to address rural provider workforce shortages include improving rural provider recruitment and training opportunities, increasing the role of rural academic medical centers, and increasing the supply of non-physician rural health providers.

INTRODUCTION

Rural health care providers face challenges that impact their readiness and ability to participate in value-based care. Increasing the adoption of value-based care in rural areas is critical. Approximately 63 percent of U.S. counties are designated as rural areas, which comprise nearly 15 percent of the U.S. population, or 46.3 million people. Rural areas can be defined based on different factors, such as population size and density, proximity to a metropolitan area, geography, and geographic remoteness. It is important to note, however, that there is substantial heterogeneity among rural health care providers. For example, rural providers can differ in the services they offer and in statutory requirements. They may also have different resources depending on their relationship with a local hospital or integrated delivery system.

Rural providers tend to participate in Alternative Payment Models (APMs), including population-based total cost of care (PB-TCOC) models and Accountable Care Organizations (ACOs), at a lower rate than their non-rural counterparts. An analysis conducted by the Government Accountability Office showed that 11.9 percent of providers in rural and Health Professional Shortage Areas[1] participated in advanced APMs in 2019 compared with 14.8 percent of providers in other areas.[2] Rural physicians participating in advanced APMs were most commonly in family practice and internal medicine.

A lack of financial resources to invest in the transition to value-based care contributes to lower participation in APMs among rural compared with non-rural providers. These providers may care for too few Medicare patients to justify making investments in APMs. Providing up-front financial support to address rural providers' lack of capital to finance the costs of transitioning to APMs can facilitate their adoption of value-based care. Low patient volume—common in rural areas—can also impact rural providers' ability to participate in models. For example, low volume can challenge patient attribution, benchmarking, performance measurement, and financial risk management. Further, some models require participants to meet certain patient volume thresholds for participation.

In addition to challenges related to the transition to value-based care, providers face challenges with caring for rural patients. Many rural patients face health disparities and challenges with accessing care due to health-related social needs (HRSNs). Compared with non-rural areas, rural areas tend to have an older population; lower income, educational attainment, and health literacy; lower life expectancy; a higher rate of premature death; higher rates of chronic disease, obesity, and substance use disorders; less access to mental health and substance use treatment facilities; limited broadband access; and low adoption of health IT. Beyond payment policy solutions, additional supporting policies can help to address these challenges.

RECOMMENDATIONS FOR INCREASING RURAL PROVIDERS' PARTICIPATION IN PB-TCOC MODELS

Different opportunities can help address rural providers' challenges related to lack of capital to finance the costs required to participate and take on financial risk in APMs. Additional opportunities can address challenges related to patient attribution, benchmarking, performance measurement, using health IT and data analytics, and adopting telehealth.

Funding Rural Participation in APMs

Rural providers lack capital to finance the up-front costs necessary to transition to value-based care, improve infrastructure, enhance data sharing, adopt telehealth technology, and build a population-based, team-based approach. Rural practices need sustainable and stable funding to participate in APMs. Such funding can come from expanding service areas, subsidizing practices, and/or creating partnerships with community-based organizations.

Several potential approaches to fund rural provider participation in value-based care are:

- Include up-front funding, such as population-based prospective payments or global budgets, in model design to provide rural practices with necessary start-up funds. A fixed up-front payment, regardless of patient volume, can help rural providers invest in high-quality primary and

[1] Health Professional Shortage Areas (HPSAs) can be geographic areas, populations, or facilities that have a shortage of primary, dental, or mental health care providers.

[2] Government Accountability Office. Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas. GAO-22-104618. November 2021. https://www.gao.gov/assets/720/717649.pdf

specialty care. Global budgets may be particularly useful as they typically include all payers, which could improve payment stability for rural providers.

- Given that primary care is often underfunded in rural communities, a greater percentage of the overall spend on health care could be devoted to primary care in rural settings to support providers with addressing rural patients' health and social needs.
- Implement team-based reimbursement. The use of high-touch, proactive, multidisciplinary, team-based care in rural health—both across professions (e.g., nurses, community health workers [CHWs]) and across organizations—can help to address rural patients' health needs by supporting care coordination and case management. To incentivize and make team-based collaboration sustainable, primary care providers' (PCPs') compensation should be increased, and non-medical staff should qualify for reimbursement. Compensating and building partnerships with CHWs and implementing wraparound payments to fund services provided by CHWs can also address HRSNs.
- Establish glide paths to sustainable participation for rural providers in value-based care. For example, rural providers may benefit from glide paths to value-based payment models to build infrastructure, train staff, and develop community partnerships with minimal initial financial risk.

Financial Risk

Rural providers tend to be averse to financial risk due to a lack of reserves to cover potential losses. Low patient volumes can lead to less predictable spending and utilization patterns, which can increase financial risk for rural providers. Additionally, rural providers are commonly unable to control cost of care because rural patients are often referred to other settings to receive tertiary care. Regionalization and risk pooling may reduce financial risk of participating in value-based care for rural providers. However, appropriate risk adjustment for or exclusion of events beyond rural providers' control should be considered.

Patient Attribution

Patient attribution approaches identify which health care provider is accountable for managing a patient's care and thus qualifies for financial rewards or shared savings. Attributed panel sizes can hinder rural providers' participation in APMs. Because PCP billing generally drives attribution, rural practices that do not have a PCP lose volume that would otherwise be attributable to the practice. Additionally, rural providers, particularly Federally Qualified Health Centers (FQHCs), face challenges with maintaining patient attribution from year to year due to patients frequently switching providers or discontinuing care. Some rural patients forego regular primary care, potentially due to transportation barriers or other HRSNs.

There are several opportunities to address challenges with patient attribution in rural areas. Increasing the number of patients attributed to a single provider, attributing patients to providers based on the population base the provider serves, allowing patients to be attributed to certain non-physician providers, and counting telehealth visits as in-person visits can help address challenges related to low patient volume. This challenge can also be addressed by treating all services provided by FQHCs and Rural Health Clinics (RHCs) as primary care services that qualify the visit for attribution, as FQHCs and RHCs generally operate for the purpose of providing primary care services in rural, shortage, and underserved areas. Additionally, using multiyear approaches for patient attribution can help address issues with having few providers in rural areas.

Benchmarking

Benchmarks serve as the targets health care providers are expected to meet in terms of delivering high-quality, cost-effective care. Regional benchmarking—where targets are used to compare providers' performance within a specific geographic area—can unfairly penalize some rural providers when they succeed in lowering costs. Although regional benchmarks are intended to reward providers who have lower costs relative to peers within their region, this benchmarking method does not adjust for market-level factors for rural health care providers in the same way that it does for non-rural providers. Given that rural regions tend to have fewer patients and providers compared with non-rural regions, rural providers care for a larger proportion of their region's beneficiary population compared with non-rural providers—and therefore represent a larger share of the market. Regional benchmarking can result in comparing rural providers to a benchmark that largely reflects themselves, termed the "rural glitch." This issue can make it difficult for rural providers to demonstrate improvements relative to a valid benchmark.

Addressing issues related to benchmarking is critical to be able to assess change in performance among rural health care providers. The use of regionally weighted benchmarks may help address the rural glitch. Rural providers can also collaborate in a region to spread fixed costs and create a greater pool of patients to balance downside risk. Additionally, the use of alternative measures of success, such as demonstrating a decrease in spending over time rather than meeting an annual spending benchmark, may be appropriate for rural providers.

Performance Measurement

Low case volume can reduce the reliability and validity of performance measurement results. For example, with a small, attributed patient population, outliers can have a substantial impact on performance results and potentially prevent rural providers from receiving payments under value-based care arrangements. Some Centers for Medicare & Medicaid Services (CMS) value-based programs have excluded rural providers from public reporting based on low case volumes. To address challenges related to low case volume, rural providers in the same region can pool data to share risk for their populations and increase the denominator used for performance measures. Pooling data can reduce the influence of outliers on performance results and allow providers to meet benchmarks or earn performance-based payments.

Rural patients tend to be disproportionately impacted by health conditions compared with non-rural patients, making comparisons in performance between rural and non-rural settings difficult. Risk adjustment should be used to account for differences in risk factors within and across rural patient populations. Additionally, to ensure that measures appropriately assess the performance of rural providers, performance measures should be tailored to the type of rural provider or health care service offered. As previously mentioned, alternative measures of success may also be needed for rural providers. For example, emergency departments (EDs) are an important source of after-hours care in rural markets. Assessing a reduction in ED utilization in rural areas may not appropriately reflect value-based care transformation. Further, to encourage shared responsibility for chronic disease outcomes and preventive care utilization in rural areas, incentives can be aligned across primary care practices and EDs.

Rural areas tend to have staff with limited experience in performing health care data extraction and analysis, and applying measurement results to inform quality improvement efforts. Rural providers may need modified measurement approaches, such as adapting electronic data collection, to ensure that measures appropriately assess their performance in value-based care.

Health IT and Data Analytics

Rural practices should be equipped with comprehensive electronic health records with timely and accurate data dashboards to track patients and manage their health care. A lack of financial resources prevents many rural providers from adopting health IT infrastructure, serving as a barrier to participation in APMs. Rural providers also lack access to data. For example, rural providers use health information exchange (HIE) to a lesser extent than non-rural providers, and there is room to improve HIE between rural and non-rural providers. Rural providers also commonly have difficulty with collecting and reporting reliable, timely, and accurate data to identify HRSNs and improve health outcomes. Many rural providers lack training on data analysis, financial modeling, and decision support systems to effectively use health IT and inform value-based care. Up-front funding can help rural providers adopt and enhance health IT infrastructure. In addition, the provision of technical assistance and value-based incentives can improve health IT engagement.

Telehealth

Telehealth and digital interventions are promising strategies to bridge gaps in access to care and address health care workforce shortages in rural areas. For example, use of specialty electronic consultations (e-consults) can improve access to specialists and reduce health disparities in rural areas. However, it is important to note that the benefits telehealth and digital interventions offer are limited if broadband services are unavailable. Audio-only telehealth solutions may be needed in rural areas with limited infrastructure. In some cases, rural patients may need funds to access the technology necessary for telehealth, such as funds to access a cell phone.

Bonus payments can support the development of telehealth infrastructure in rural areas. Additionally, provider incentives can increase the use of telehealth. For example, ACOs can provide resources to support providers' use of telehealth, assuming shared financial risk encourages providers to use telehealth only when it is a cost-effective approach.

SUPPORTING POLICIES

Effectively implementing PB-TCOC models in rural areas will require supporting policies to assist in increasing rural providers' readiness for value-based care and improving health outcomes. Implementing such policies will require a multipronged approach to successfully improve rural infrastructure, enhance sustainable funding, increase community health organization capacity, and reduce health disparities. For example, screening for HRSNs in EDs and hospitals, compensating CHWs to address HRSNs, and having hospitals serve as conveners of social service providers can help to reduce health disparities among rural patients.

One critical rural health care challenge is provider workforce shortages. Opportunities to expand the rural provider workforce include improving provider recruitment and training opportunities, increasing the role of rural academic medical centers, improving the financial viability of practicing in rural areas, and increasing the supply of non-physician providers. Additionally, supporting rural providers to adopt telehealth technologies can increase access to specialists and reduce health disparities in care in rural areas.

Implementing a multipronged approach to address challenges faced by rural health care providers and patients could bring together state and federal governments, including Health and Human Services (HHS) agencies that address rural health, as well as public and private payers to make systematic changes in rural health care delivery and financing.

CONCLUSION

Providing financial incentives can address the lack of capital that rural providers have to finance up-front costs of transitioning to APMs, expanding health IT infrastructure, and building a team-based approach. Increasing spending on primary care, implementing team-based reimbursement, and establishing glide paths to sustainable participation in value-based care can support rural providers in their transition to PB-TCOC models. Different strategies can also help increase rural health care providers' willingness to take on financial risk and adopt APMs. Promoting collaboration among rural providers in a region has the potential to spread fixed costs and create a greater pool of patients to balance downside risk. Creating a greater pool of patients can also increase the denominator for performance measures, producing more reliable estimates, and address challenges related to patient attribution and benchmarking.

Additional supporting policies beyond payment policies can also mitigate challenges rural health care providers face with caring for rural patients. These policies may aim to address health care provider workforce shortages, increase rural infrastructure, enhance sustainable funding, increase community health organization capacity, and reduce health disparities.

Practice transformation must take place before payment reform; that is, practice transformation should inform how payment models are designed in rural areas. Because different types of rural areas face different types of challenges, each area will require a tailored solution to encourage health care delivery transformation. Improving rural participation in PB-TCOC models will require a wide range of policy initiatives that extend beyond value-based care.

RESOURCES

The following resources are publicly available on the ASPE PTAC website:

- Report to the Secretary: Encouraging Rural Participation in PB-TCOC Models
- Environmental Scan: Encouraging Rural Participation in PB-TCOC Models
- Preliminary Comments Development Team (PCDT), Encouraging Rural Participation in PB-TCOC Models, September 18, 2023
- Rural Health Disparities and Differences in Definitions of Rurality
- Trends in Traditional Medicare Spending and Outcomes in Urban and Rural Areas

ABOUT PTAC

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to make comments and recommendations to the Secretary of Health and Human Services on proposals for physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities. Within this context, PTAC also reflects on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Accordingly, PTAC has held an ongoing series of theme-based discussions on developing and implementing value-based care. The content in this PTAC Issue Brief is based on publicly available information from PTAC's theme-based discussions, including PTAC presentations and recommendations, presentations by stakeholders and experts, environmental scans, original research, and PTAC reports to the Secretary.

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